STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 300018139	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/21/2022
NAME OF PROVIDER OR SUPPLIER: CARDINAL HOME HEALTH SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE: 7863 BROADWAY STE 202, 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
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Facility ID: 006655 Survey dates: 2/14/2022-2/21/2022 At this Emergency Preparedness survey, Cardinal Home Health Services, Inc., was found to not be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E0000		2022-04-09
N0000	Initial Comments This visit was for a re-licensure survey of a home health agency. Facility ID: 006655 Survey Dates: 2/14/2022 - 2/21/2022	N0000	N000 Cardinal Home Health Services is submitting the following Plan of Correction in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction is not intended as an admission, does not constitute an admission by and should not be	2022-04-09

			Home Health Services that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. Cardinal Home Health Services desires this Plan of Correction to be considered our Allegation of Compliance.” Cardinal Home Health Services retained the services of a qualified RN consultant effective March 3, 2022.	
G0000	This visit was for a Federal Recertification and State Re-licensure survey. Facility ID: 006655 Survey Dates: 2/14/2022 - 2/21/2022 Cardinal Home Health Services, Inc. is precluded from providing its own home health aide training and competency evaluation for a period of two years from 02/21/2022 02/21/2024, due to being found out of compliance with Conditions of Participation 484.60 Care Planning, Coordination of Care and Quality of Care, 484.65 Quality Assessment and Performance Improvement, 484.70 Infection Prevention and Control, 484.75 Skilled Professional Services, and 484.80 Home Health Aide Services. Quality Review Completed 03/11/2022	G0000	G0000 Cardinal Home Health Services is submitting the followingPlan of Correction in response to the 2567 issued by ISDH and/or CMS as it isrequired to do by applicable state and federal regulations. The submission ofthis Plan of Correction is not intended as an admission, does not constitute anadmission by and should not be construed as an admission by Cardinal HomeHealth Services that the findings and allegations contained herein are accurateand true representations of the quality of care and services provided topatients of the Agency. Cardinal Home Health Services desires this Plan ofCorrection to be considered our Allegation of Compliance.” Cardinal Home Health Services retained the services of aqualified RN consultant effective March 3, 2022.	2022-04-09
E0001	Establishment of the Emergency Program (EP) 486.360 §403.748, §416.54, §418.113, §441.184, §460.84,	E0001	E0001 See E0009, E0017, E0021, E0023,	2022-04-08

	§482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on record review and interview, the home health agency failed: to develop and maintain an emergency preparedness plan which included a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation (see tag E0009); to develop and implement individualized emergency preparedness plans for the patients which provided appropriate instructions, in the event of an emergency, to communicate with the agency (see tag E0017);		E0024, E0030, E0033, E0039 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	to develop and implement emergency preparedness policies and procedures which included procedures to follow-up with on-duty staff and patients to determine services that are needed in the event there in an interruption in services during or due to an emergency and must inform State and local emergency preparedness officials about any on-duty staff or patients they are unable to contact (see tag E0021); to ensure a policy included a system for medical documentation that preserves patient information, protects patient confidentiality, and secures and maintains availability of records in the event of an emergency (see tag E0023); to ensure a policy included the use of volunteers or other emergency staffing in the event of an emergency (see tag E0024); to develop and maintain an emergency preparedness communication plan which included names and contact information for staff, patients' physicians, volunteers and other agencies (E0030); to develop and maintain an emergency preparedness communication plan which included a method for sharing information and medical documentation for patients under the agency's care, as necessary, with other health providers to maintain the continuity of care and a means for providing information about the general condition and location of patients under the agency's care as permitted (see tag E0033); and to conduct exercises to test the emergency plan annually (see tag E0039). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment and resulted in the agency being found out of compliance with the condition 42 CFR 484.102 Emergency preparedness.			
E0009	Local, State, Tribal Collaboration Process 494.62(a)(4)	E0009	E0009	2022-04-09

	§403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Based on record review and interview, the agency failed to ensure an emergency preparedness plan was developed and maintained to include a process for cooperation and collaboration with local, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency preparedness. The findings include: Review on 2/16/2022, of an undated agency document titled "Emergency Preparedness Plan" stated, "... Cardinal Home Health Emergency plan is to provide mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care, and to ensure continuation of care, and to ensure continuation of care and/or services to the patient population being served &. Review of the agency's emergency preparedness binder failed to evidence a process		Administrator will maintain an emergency preparedness planthat includes a process for cooperation and collaboration with local, regional,State, and Federal emergency preparedness officials' efforts to maintain anintegrated response during a disaster or emergency preparedness. (On-going) Administrator will implement a process for cooperation andcollaboration with local, regional, State, and Federal emergency preparednessofficials. Administrator will create a list of local, regional, State, andFederal emergency preparedness officials names and numbers. (On-going) Administrator will review process at least every 2 years andas needed and make revisions as needed. If revisions are made staff will beinformed of any changes that pertain to them. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur. E0009 Administrator has contacted emergency preparedness coalitionfor region 1. Administrator will attend scheduled meetings with the coalition.The meeting that was to occur in March 16th was cancelled. Next meeting willbe April 20th, 2022. Administratorwill create a list of local, county, state and federal emergency planningauthorities. The list	

	and collaboration with local, regional, State and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency preparedness. During an interview on 2/16/2022, at 1:48 PM, the administrator indicated he went to district emergency preparedness planning meetings in the past. The administrator indicted the emergency preparedness plan does not include a process for the collaboration and cooperation with local, regional, State, and Federal emergency preparedness officials.		will be reviewed at least yearly and revise as necessary.	
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on record review and interview, the agency failed to develop and implement individualized emergency preparedness plans for the patients which provided appropriate instructions, in the event of an emergency in 4 of 5 active clinical records reviewed. (#1, #2, #3, #4) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Emergency Operations Plan and Policies revised January 2020, stated, & Mitigation activities & will be undertaken in an effort to lesson the severity and impact of a potential emergency. Such activities include: &	E0017	E0017 Director of Nursing will review all current patientsindividualized emergency preparedness plans to ensure they are accurate andcomplete. Any plan that is not accurate or complete will be corrected byclinician. (4/9/2022) Director of Nursing/designee will audit all admissions doneeach week to ensure the individualized emergency preparedness plan is accurateand complete. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) Director of Nursing will instruct clinicians that emergencyplan is to be reviewed minimally at recertification time and revised as needed.Clinician will document the plan was reviewed and whether revisions were made. (4/9/2022) Director of Nursing/designee will review allrecertifications done each week to ensure there is documentation the emergencyplan was reviewed and revised if needed. Once 100%	2022-04-09

	Developing an individual emergency preparedness plan for each patient as part of the comprehensive assessment &. 2. Clinical record review on 2/18/2022, for patient #1, start of care 9/4/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 12/28/2021 2/25/2022. This document indicated the patient s safety precautions included oxygen precautions and indicated the patient used oxygen as needed. This document indicated the patient had a wound to the left great toe, to which the skilled nurse was to provide wound care twice a week. Review of an agency document titled Patient Individualized Emergency Plan , signed and dated by registered nurse (RN) D on 9/4/2020, failed to evidence the patient s oxygen and wound care supplies. This document failed to provide patient instructions for a safe space in the patient s home, a safe meeting place in the patient s neighborhood, and a safe meeting place outside of the neighborhood in the event of an emergency. During an interview on 2/18/2022 at 11:56 AM, the alternate administrator indicated the individualized emergency plan should include oxygen and wound care supplies and indicated the form should be completed. 3. Clinical record review on 2/17/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022. This document evidenced the patient s diagnoses included, but were not limited to, pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) to the left and right buttocks, gastrostomy (a tube surgically inserted into the stomach through the abdomen used to administer nutrition, fluid, and/or medication), and diabetes (a chronic condition which affects the way the body processes blood sugar). This document indicated the skilled nurse was to clean the wounds with normal saline (a solution used to clean wounds) and apply barrier ointment. Review of this		compliance is achieved 10%will be audited quarterly to ensure is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

document indicated the patient had a foley catheter (an indwelling plastic tube inserted into the bladder to drain urine).

Review of an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Recertification , dated and electronically signed by RN D on 1/7/2022, indicated the patient was NPO (nothing by mouth) and received tube feedings four times a day through his gastrostomy.

Review of an undated agency document titled Patient Individualized Emergency Plan , signed by RN D, failed to evidence the patient s wound care, tube feeding, and foley catheter needs.

During an interview on 1/21/2022, at 1:14 PM, the alternate administrator indicated the wound care, tube feeding, and foley catheter was not included in the individualized emergency preparedness plan and indicated it should have been.

4. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled OASIS-D1 Start of Care , electronically signed by RN F and dated 1/8/2022. Review of the comprehensive assessment indicated the patient had a pressure ulcer stage III (an open pressure ulcer with full thickness loss of skin) the left buttock, a pressure ulcer stage III to the right buttock, and a pressure ulcer stage III to the left heel.

Review of an undated agency document titled Patient Individualized Emergency Plan , signed by RN F, indicated the patient had a wound to the left heel and failed to evidence the patient s wounds to the left buttock and the right buttock.

During an interview on 2/21/2022, at 2:06 PM, the alternate administrator indicated all the patient s wounds should be included on the individualized emergency plan.

5. Clinical record review on 2/17/2022, for patient #4, start of care 2/2/2022, evidenced an agency document titled OASIS-D1 Start of Care with a visit date of 2/2/2022. This document indicated the patient was assessed to

	have poor balance, a shuffling and unsteady gait, limited range of motion to both lower extremities, muscle weakness, a history of falls, and at risk for falls. This document indicated the patient required human assistance for activities and used a wheelchair and walker. Review of an undated agency document titled Patient Individualized Emergency Plan , signed and dated by the alternate administrator on 2/2/2022, failed to evidence the patient s restricted mobility to include the assistance required with ambulation. During an interview on 2/18/2022, at 3:58 PM, the alternate administrator indicated the individualized emergency plan should indicate the patient s required use of a wheelchair or walker.			
E0021	HHA- Procedures for Follow up Staff/Pts. 484.102(b)(3) §484.102(b)(3) Condition of Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact. Based on record review and interview, the agency failed to ensure a policy included the agency must inform state and local officials of on-duty staff and patients that are unable to be reached in the event of an emergency. The findings include: Review on 2/16/2022, of an undated agency document titled "Emergency Preparedness	E0021	E0021 Administrator will revise the Emergency Preparedness Plan toadd agency must inform state and local officials of on-duty staff and patientsthat are unable to be reached. (4/9/2022) Administrator will in-service on this revision to theEmergency Preparedness Plan. (4/9/2022) Administrator will review the Emergency Preparedness Plan atleast every 2 years and as needed and revise if needed. If revisions are madeagency staff will be in-serviced on the revisions. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-09

	Plan" stated, "... Cardinal Home Health Emergency plan is to provide mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care, and to ensure continuation of care, and to ensure continuation of care and/or services to the patient population being served &. Review of the agency's emergency preparedness binder failed to evidence a policy that included the agency must inform state and local officials of on-duty staff and patients that are unable to be reached. During an interview on 2/16/2022, at 1:48 PM, the administrator stated, It is not a feasible option for us to go rescue everyone. The administrator indicated the policy needs to be clearer.		E0021 Administrator has created a process for notifying local,county and state officials of any patients and on duty staff that cannot bereached. Administrator/Director of Nursing/designee will call all on-duty staffthat is not at office and patients once emergency occurs. If unable to reachemployee or patient another call will be placed in 15 minutes. If still unableto reach employee or patient the Administrator will be notified. Administratoror person appointed by Administrator will contact the local, county and stateofficials of inability to reach employee or patient. If agency is contacted byemployee or patient the Administrator or person appointed by Administrator willbe notified and will notify local, county and state officials contact has beenmade with the employee or patient.	
E0023	Policies/Procedures for Medical Documentation 494.62(b)(4) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E0023	E0023 Administrator will implement a policy that includes a systemfor medical documentation that preserves patient information, protects patientconfidentiality, and secures and maintains availability of records in the eventof an emergency. (4/9/2022) Administrator will in-service agency staff on this policy. (4/9/2022) Administrator will review the emergency preparedness plan atleast every 2 years and as needed and make revisions are needed. If revisionsare made agency	2022-04-09

[(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records.

*[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following:

(i) Preserves patient information.

(ii) Protects confidentiality of patient information.

(iii) Secures and maintains the availability of records.

*[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

Based on record review and interview, the agency failed to ensure a policy included a system for medical documentation that preserves patient information, protects patient confidentiality, and secures and maintains availability of records in the event of an emergency.

The findings include:

Review on 2/16/2022, of an undated agency document titled "Emergency Preparedness Plan" stated, "... Cardinal Home Health Emergency plan is to provide mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care, and to ensure continuation of care, and to ensure continuation of care and/or services to the patient population being served &.

Review of the agency's emergency preparedness binder failed to evidence a policy that included a system for medical documentation that preserves patient information, protects patient confidentiality, and secures and maintains availability of records in the event of an emergency.

During an interview on 2/16/2022, at 1:48 PM,

staff will be in-serviced on those changes. (On-going)

The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

	the administrator indicated the agency used an electronic health record. The administrator stated, If we were hacked, it would be catastrophic. The administrator indicated the policy did not include the system for medical documentation in the event of an emergency.			
E0024	Policies/Procedures-Volunteers and Staffing 494.62(b)(5) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the agency failed to ensure a policy included the use of volunteers or other emergency staffing in the event of an emergency.	E0024	E0024 Administrator will implement a policy that includes the useof volunteers or other emergency staffing the event of an emergency. It willinclude the tasks they will be permitted to do. (4/9/2022) Administrator will in-service agency staff on this policy. (4/9/2022) Administrator will review the emergency preparedness manualat least every 2 years and as needed and revise as needed. If any revisions aremade agency staff will be notified of changes. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-09

	The findings include: Review on 2/16/2022, of an undated agency document titled "Emergency Preparedness Plan" stated, "... Cardinal Home Health Emergency plan is to provide mitigation, preparation, response and recovery to disasters or emergencies affecting the environment of care, and to ensure continuation of care, and to ensure continuation of care and/or services to the patient population being served &. Review of the agency's emergency preparedness binder failed to evidence a policy that included the use of volunteers or other emergency staffing the event of an emergency. During an interview on 2/16/2022, at 1:48 PM, the administrator indicated the agency has not included the use of volunteers in their emergency preparedness plan. When queried what the agency would do if an emergency left few or no staff available, the administrator indicated the agency would group patients with the available staff and indicated he has not included that in the emergency preparedness policy.			
E0030	Names and Contact Information 494.62(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff.	E0030	E0030 Administrator/designee will update the phone list for allagency employees. An updated copy will be placed in the on-call book. Administratorand Director will have an updated copy. (4/9/2022) Administrator/designee will review and update employee listmonthly to ensure it is accurate. If changes are made a new copy will be placedin the on-call book and Administrator and Director will be given an updatedcopy. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to	2022-04-09

(ii) Entities providing services under arrangement.

(iii) Patients' physicians

(iv) Other [facilities].

(v) Volunteers.

*[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians

(iv) Other [hospitals and CAHs].

(v) Volunteers.

*[For RNHCIs at §403.748(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Next of kin, guardian, or custodian.

(iv) Other RNHCIs.

(v) Volunteers.

*[For ASCs at §416.45(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Volunteers.

*[For Hospices at §418.113(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Hospice employees.

(ii) Entities providing services under arrangement.

ensure that this deficiency is corrected and will notrecur.

(iii) Patients' physicians.

(iv) Other hospices.

*[For HHAs at §484.102(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Volunteers.

*[For OPOs at §486.360(c):] The communication plan must include all of the following:

(2) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Volunteers.

(iv) Other OPOs.

(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).

Based on record review and interview, the agency failed to ensure the communication plan included names and contact information for staff in the event of an emergency.

The findings include:
Review of an untitled agency policy on 2/16/2022, titled Emergency Management Policy stated, & A listing of all staff members and telephone numbers will be included in the agency s on-call book &.

Review on 2/16/2022, of the emergency preparedness binder evidenced an agency document titled "Employee Phone List dated 12/27/2021. This document failed to evidence the names and contact information for home health aide (HHA) N and HHA S were included.

During an interview on 2/16/2022, at 1:48 PM,

	the alternate administrator indicated the employee phone tree was outdated.			
E0033	Methods for Sharing Information 494.62(c)(4)-(6) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Based on record review and interview, the agency failed to ensure the communication plan included a method for sharing information and	E0033	E0033 Administrator will ensure the communication plan includes amethod for sharing information and medical documentation for patients under theagency's care with other health care providers to maintain continuity of care,and in the event of an evacuation, a means of releasing patient information andproviding general information about the general condition and location ofpatients under the agency's care. (4/9/2022) Administrator will in-service agency staff on the plan. (4/9/2022) Administrator will review the emergency preparedness manualat least every 2 years and as needed and revise as needed. If revisions aremade Administrator will in-service staff on the changes. (On-going) Administrator/designee will review and revise the patientroster. An updated copy will be placed in the call book. (4/9/2022) Administrator/designee will review and revise as needpatient roster weekly. If revisions are made an updated copy will be placed inthe call book. (On-going) 4/9/2022 for plan of corrections listed below: The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected	2022-04-09

	medical documentation for patients under the agency s care with other health care providers to maintain continuity of care, and in the event of an evacuation, a means of releasing patient information and providing general information about the general condition and location of patients under the agency s care. The findings include: Review on 2/16/2022, of the emergency preparedness binder evidenced an undated agency document titled Emergency Preparedness Plan . This document stated, & If the patient is unharmed but the home is damaged or unsafe and the telephone system is working, contact family or friends that the patient may request and make arrangements for the patient s transportation &. Review of a document titled "Patients dated 12/27/2021, failed to evidence the names and patient information for patient #3, start of care 1/8/2022, patient #4, start of care 2/2/2022, and patient #5, start of care 2/2/2022. During an interview on 2/16/2022, at 1:48 PM, the administrator indicated the patient roster is outdated and should be updated as patients come and go.		and will notrecur.	
E0039	EP Testing Requirements 494.62(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]:	E0039	E0039 Administrator will schedule an exercise to test emergencypreparedness. Administrator will ensure all agency staff and agency leadersparticipate. (4/9/2022) Administrator will ensure an exercise to test emergencypreparedness is conducted at least yearly. Will ensure there is documentation forthis exercise. (On-going)	2022-04-09

	(2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]

(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]

(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a

of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed.

*[For LTC Facilities at §483.73(d):]

(2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise.

(B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed.

*[For ICF/IIDs at §483.475(d)]:

(2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or.

(B) If the ICF/IID experiences an actual natural or

man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.

*[For HHAs at §484.102]

(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at

least annually. The HHA must do the following:

(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the HHA's response to and maintain

documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.

(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

*[RNCHIs at §403.748]:

(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:

(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.

Based on record review and interview, the agency failed to conduct exercises to test the emergency preparedness plan at least annually.

The findings include:
Review on 2/16/2022, of the emergency preparedness binder failed evidenced an undated agency document titled Addendum 7-001 (9/20/17) as approved by the Governing Body which stated, & The organization will document the table top exercise during emergency or actual Response to emergencies. On a yearly basis, the table top exercise with

	the participation of the organization s leaders and staff will be conducted &. Review failed to evidence the agency conducted an exercise to test the emergency preparedness plan since 11/30/2020. During an interview on 2/16/2022, at 1:48 PM, the administrator indicated the last table top exercise was performed on 11/30/2020.			
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 observation, record review, and interview, the agency failed to ensure the OASIS (Outcome and Assessment Information Set, a comprehensive assessment data collection tool) accurately reflected the patient s status in 2 of 5 active clinical records reviewed. (#3, #5) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Reporting of OASIS Information revised February 2021, stated, & Agency staff will ensure that the accuracy of OASIS data reflects the patient s status at time of assessment and data collection &. 2. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled OASIS-D1 Start of Care , electronically signed and dated by registered nurse (RN) F on 1/8/2022. This document indicated the patient s activity was up as tolerated with a walker and the patient had a shuffling gait. This document indicated at the OASIS question M1860, the patient was chairfast and unable to ambulate. During an observation of care at the patient s home on 2/21/2022, at 1:17 PM, physical therapist (PT) G assisted the patient with ambulation using the walker. During an interview on 2/21/2022, at 1:19 PM,	G0374	G0374 Director of Nursing will in-service all nurses/therapists oncompleting the OASIS accurately. (4/1/2022) Director of Nursing/designee will audit all OASIS doneweekly to ensure they are completed accurately. Once 100% compliance is achieved10% will be audited quarterly to ensure compliance is maintained. (On-going) Unable to correct chart cited insurvey as patient #1 was transfer-discharge. Director of Nursing will ensure the OASIS for patient #5,cited in survey, is corrected. (3/3/2022) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-01

	was incorrectly marked by the RN and indicated the patient was not chairfast. 3. Clinical record review on 2/17/2022, for patient #5, start of care 2/2/2022, evidenced an unsigned agency document titled OASIS-D1 Start of Care , with a visit date of 2/2/2022. This document indicated the OASIS question M0080, which indicated which discipline completed the assessment, was not completed. This document indicated the OASIS question M1845, which provided the assessment of the patient s ability to provide toilet hygiene, was not completed. During an interview on 2/18/2022, at 4:00 PM, the alternate administrator indicated the answer to the question M0080 was the RN was the discipline that completed the assessment. At 4:08 PM, the alternate administrator indicated the patient probably needed help to complete toilet hygiene.			
G0414	HHA administrator contact information 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. Based on observation, record review, and interview, the agency failed to ensure the patients were provided the name of the administrator to receive complaints in 3 of 3 home visits conducted. (#1, #2, #3) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Compliance with Laws and Regulations and Disclosure of Information revised March 2018, stated, & The Agency and its staff will furnish services in compliance with all applicable federal, state and local laws and regulations &. 2. Review of an untitled, undated agency document on 2/14/2021, within a folder	G0414	G0414 Administrator/designee will create a form that shows who thecurrent Administrator is. (3/18/2022) Director of Nursing will ensure all current patients aregiven written information on who the Administrator is. (3/30/2022) Director of Nursing will instruct clinicians to document inchart patient was provided written notice on who current Administrator is. (4/5/2022) Director of Nursing/designee will audit all current patientcharts to ensure there is documentation patient was given written notice of whoAdministrator is. (4/8/2022)	2022-04-08

	identified by the alternate administrator as the patient admission folder, stated, & If you need assistance, have questions, or have a complaint about our agency, staff or services, please contact us at: & [Alternate Administrator] Administrator &. 3. During an interview at the entrance conference on 2/14/2022, at 10:14 AM, the alternate administrator indicated she was the alternate administrator and employee A was the administrator. 4. During an observation of care at the home of patient #1, start of care 9/4/2020, on 2/16/2022, at 10:18 AM, an agency folder was not observed in the home. The name and contact information for the administrator was not observed to have been provided to the patient. 5. During an observation of care at the home of patient #2, start of care 7/16/2021, on 2/16/2022, at 11:25 AM, the agency home folder was observed in the patient s bedroom. Inside of the agency folder, an undated, untitled agency document was observed, which stated, & & If you need assistance, have questions, or have a complaint about our agency, staff or services, please contact us at: & [Alternate Administrator] Administrator &. The name of the administrator was not observed to have been provided to the patient. 6. During an observation of care at the home of patient #3, start of care 1/8/2022, on 2/18/2022, at 1:08 PM, the agency home folder was observed in the patient s home. Inside of the agency folder, an undated, untitled agency document was observed, which stated, & & If you need assistance, have questions, or have a complaint about our agency, staff or services, please contact us at: & [Alternate Administrator] Administrator &. The name of the administrator was not observed to have been provided to the patient. 7. During an interview on 2/15/2022, at 9:48 AM, when queried why the alternate administrator was listed as the administrator on the untitled document in the patient admission folder, the alternate administrator stated, Oh, I		Administrator/designee will ensure anytime there is a changein Administrator patients receive written notice of who new Administrator is.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur. G414 Administrator and Director of Nursing have started processof labels being made that will identify who administrator is, business addressand telephone number These labels willbe placed in patient admission booklets at their homes and staff will informpatients of this, as well as documenting that this occurred. Office Staff isalso notifying patients and caregivers to inform them of administrator andcontact information.as well clinical manager and director of clinicalservices.	

	need to change that.			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to ensure the patient was informed of and consented to care in advance of the frequency of visits and changes in the care to be furnished in 2 of 7 clinical records reviewed. (#1, #7) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Patient Bill of Rights and Responsibilities stated, & Patients have the right: & Participate in, be informed about and consent or refuse care in advance of and during treatment & with respect to: & The frequency of visits & Any changes in the care to be furnished &. 2. Clinical record review on 2/16/2022, for patient #1, start of care, 9/4/2020, evidenced an agency document titled Admission Consent , signed by the patient and dated 9/4/2020. This document indicated the patient was informed of and consented to receiving home health aide services 3 times a week for 3 weeks and then 2 times a week for 6 weeks. Review evidenced an agency document titled	G0434	G0434 Director of Nursing/designee will instruct nurses/therapiststhe patient must be informed in advance of any changes in services and thisnotification must documented. (4/1/2022) Director of Nursing/designee will audit all admissions doneweekly to ensure the frequency listed on consent form matches the frequency onthe plan of care/485. If it doesn’t there needs to be documentationpatient/caregiver was informed of the change in service in advance. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) Director of Nursing/designee will audit all verbal orderswritten weekly. If there is an order that changes frequency of a discipline theremust be documentation patient was informed of the frequency change in advanceof the change. Once 100% compliance is achieved 10% will be audited quarterlyto ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-01

	Home Health Certification and Plan of Care for certification period 12/28/2021 2/25/2022, signed by the physician on 1/23/2022. This document indicated the patient was to receive home health aide services 3 times a week for 8 weeks. Review failed to evidence the patient was informed of in advance of the changes in the home health aide frequency. During an interview on 2/18/2022, at 11:57 AM, the alternate administrator indicated patients should be notified of changes. The alternate administrator indicated she would check for when the patient was informed of the change in the home health aide frequency. No further documentation was provided. 3. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled Admission Consent , signed and dated by the patient on 11/20/2021. This document indicated the patient would receive skilled nursing services. Review of an agency document titled PT [physical therapy] Evaluation , electronically signed by PT L and dated 12/8/2021, evidenced the patient would receive PT services 2 times a week for 4 weeks. Review failed to evidence the patient was informed of the change in services to include the physical therapy evaluation in advance of the change in services. During an interview on 2/18/2022, at 11:25 AM, the alternate administrator indicated she did not see documentation the patient was notified in advance of the PT evaluation. The alternate administrator indicated we need to document our verbal communication to the patient. 17-12-3(b)(2)(D)(ii)(BB)			
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be:	N0440	N0440 Administrator has revised the Organizational Chart toreflect all positions agency has including social worker and to ensure thelines of	2022-03-15

(1) clearly set forth in writing; and

(2) readily identifiable.

Based on record review and interview, the administrator failed to ensure the organization, services furnished, and lines of authority for the delegation of responsibility was clearly set forth in writing and readily identifiable.

The findings include:

Review of an agency policy obtained on 2/21/2022, titled Organization and Services Administration revised March 2018, stated, & Organization, services furnished, administrative control and the lines of authority for the delegation of responsibility for patient care are clearly defined in writing and are readily identifiable &.

Review of pre-survey information obtained from the Indiana Department of Health on 2/14/2022, indicated employee A was the administrator and the clinical supervisor and indicated employee B was the alternate clinical supervisor.

During an interview at the entrance conference on 2/14/2022, at 10:14 AM, employee B indicated she was the clinical supervisor and person C, nurse consultant, was the alternate nursing supervisor. Employee B indicated the agency provided social work services.

Review of an agency document on 2/14/2022, titled Organizational Chart , revised 10/12/11, evidenced the administrator and director of nursing were the same position and reported to the board of directors. The document indicated the alternate director of nursing and the administrator were the same position. This document failed to evidence the agency provided social work services.

During an interview on 2/15/2022, at 9:25 AM, employee B indicated she would update the organizational chart to include social work services. Employee B indicated the lines of

authority are clear. (3/14/2022)

Administrator has revised the Organizational Chart to showAdministrator, Director of Nursing, Alternate Administrator and AlternateDirector of Nursing are separate positions on the organizational chart. 3/14/2022)

Administrator will in-service all agency staff on therevised organizational chart. (3/15/2022)

Administrator will submit documentation to ISDH to clarifywho the Administrator, Director of Nursing, Alternate Administrator andAlternate Director of Nursing are. (3/15/2022)

The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

See attachment A (Organizational Chart)

BOARD OFDIRECTORS

ADMINISTRATOR ALTERNATE ADMINISTRATOR

DIRECTOR OFNURSING
ALTERNATE DIRECTOR
OF NURSING

ADMIN. ASSISTANT

	chart for the administrator, alternate administrator, director of nursing, and alternate director of nursing. Employee B indicated each of those positions were separate people and the organizational chart did not reflect the separate positions. Employee B indicated the director of nursing reported to the administrator and not the board of directors. Employee B indicated person C was a contracted nurse consultant. Employee B indicated she was unsure why employee A was listed with the Indiana Department of Health as the nursing supervisor. During an interview on 2/16/2022, at 4:02 PM, person C indicated her role with the agency was as a nurse consultant and not as the alternate nursing supervisor.		RN PT OT SPEECH SOCIAL WORKER AIDE LPN PATIENTS	
N0447	Home health agency administration/management 410 IAC 17-12-1(c)(4) Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on observation, record review, and interview, the administrator failed to ensure the accuracy of public information. The findings include: Review of an agency job description on 2/15/2022, titled Administrator , signed by the administrator and dated 3/2/2020, stated, & Responsibilities: & Ensures accuracy of public information materials &. Review of pre-survey information obtained from the Indiana Department of Health on 2/14/2022, evidenced the agency s hours of operation were 9 AM 5 PM Monday through Friday. During an observation on 2/15/2022, at 9:25	N0447	N0447 Agency office hours are 9a-5p Monday thru Friday. If agencychanges hours Administrator will submit proper documentation to ISDH showingnew hours and post new hours on office door. Administrator will ensure officehours are Administrator/designee would ensure staff are informed of new hours.Director of Nursing/designee would ensure patients/caregivers are informed ofnew hours. (Ongoing) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-03-21

	AM, the entrance door to the agency was observed to have posted on the door the hours of operations as 9 AM 4 PM Monday through Friday. Review failed to evidence the public information posted on the door of the agency accurately reflected the information provided by the Indiana Department of Health. During an interview on 2/15/2022, at 10:09 AM, the alternate administrator indicated the agency s hours of operation were 9 AM 4 PM and was unsure when the hours of operation changed.			
G0458	Outcomes/goals have been achieved 484.50(d)(3) The transfer or discharge is appropriate because the physician or allowed practitioner, who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved, and the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services; Based on record review and interview, the agency failed to ensure the patient was discharged because the physician responsible for the plan of care and the agency agreed the measurable goals and outcomes set forth in the plan of care had been achieved in 1 of 1 closed clinical record reviewed with a discharge reason of goals met. (#6) The findings include: Review of an agency policy obtained 2/15/2022, titled Discharge Criteria and Planning revised February 2021, stated, & Patient will be discharged from services as follows: & The discharge is appropriate because the physician/practitioner who is responsible for the home health plan of care and the Agency agree that measurable outcomes and goals set forth in the plan of care have been achieved and the Agency and the physician/practitioner responsible for the home health plan of care agree that the patient no longer needs the Agency s services &.	G0458	G0458 Unable to correct chart cited in survey as patient hadalready been discharged. Director of Nursing will in-service nurses/therapists thatif patient's goals are not met they can't discharge with reason of goals met. Reasonfor discharge must be accurate. (4/1/2022) Director of Nursing/designee will audit all discharges done eachweek to ensure the reason for discharge is appropriate listed. If reason is dueto patient meeting goals there must be documentation indicating goals were met.Once 100% compliance is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going) Director of Nursing will in-service nurses/therapists onneed to notify MD at discharge whether patient goals have been met. (4/1/2022) Director of Nursing/designee will audit all discharges doneeach week to ensure there is documentation indicating whether patient goalswere met. Once 100% compliance is achieved 10% will	2022-04-01

	Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/25/2021 1/23/2022, which was signed and dated by the physician on 12/16/2021. This document indicated the patient was to receive skilled nursing services 1 time a week for 8 weeks beginning the week of 11/28/2021 and home health aide services 2 times a week for 9 weeks. This document indicated the patient s goals included, but were not limited to, have a tolerable level of pain rated 0-2 on a scale of 0-10, have absence of edema (swelling), and would not have signs and symptoms of complications related to hemorrhoids. Review evidenced the discharge plan was to discharge when the patient demonstrated necessary skills to self-manage disease process and when the patient s pain level stabilized. Review evidenced agency documents titled SN [skilled nurse] Teaching/Training Visit , electronically signed by registered nurse (RN) D. Review of documents dated 12/2/2021, 12/9/2021, 12/23/2021, 12/30/2021, 1/3/2022, and 1/20/2022, indicated the patient had daily pain to the knees rated 5 on a scale of 0-10. These documents indicated the patient had rectal bleeding from hemorrhoids and indicated the patient had 1+ pitting edema to the legs. Review evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Discharge , electronically signed by RN D and dated 1/19/2022. This document indicated the patient had generalized pain the time rated 3 on a scale of 0-10. Review indicated the patient had edema to the lower extremities and had hemorrhoids with rectal bleeding. Review indicated the reason for discharge was the patient s goals were met. Review failed to evidence the patient met goals.		be audited quarterly toensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	During an interview on 2/18/2022, at 11:02 AM, the alternate administrator indicated the patient did not meet goals and indicated the physician was not made aware of the patient had not met goals prior to discharge.			
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 agency failed to ensure personnel records included an orientation to the job, a limited national criminal history within 3 days of patient contact, and an annual performance evaluation in 11 of 13 personnel records reviewed. (A, B, C, D, E, F, G, I, M, N, O) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Personnel Records revised February 2021, stated, & The personnel record or personnel information for an employee will include, but not limited to, the following: &Performance appraisal/evaluation form & employee orientation & Criminal history check &. 2. Personnel record review on 2/15/2022, for employee A, hire date 6/1/2018, failed to evidence an annual performance evaluation	N0458	N0458 Administrator/Director of Nursing will complete annualperformance evaluations for employee A (hire date 6/1/2018) for 2021 and 2022. (3/23/2022) Administrator/Director of Nursing will complete annualperformance evaluation for employee B (hire date 6/1/2018) for 2021 and 2022. (3/27/2022) Administrator/Director of Nursing will complete annualperformance evaluation for employee C (hire date 9/18/2019) for 2021 and 2022. (3/23/2022) Administrator/Director of Nursing will complete annual performanceevaluation for employee D (hire date 5/2/2019) for 2021 and 2022. (3/23/2022) Administrator/Director of Nursing will complete annualperformance evaluation for employee E (hire date 6/20/2019) for 2021. (3/23/2022) Administrator/designee will complete another criminalbackground check for employee E. (3/23/2022) Administrator/designee will complete an orientation to thejob checklist for employee F (hire date 6/30/2021). (3/25/2022) Administrator/Director of Nursing will	2022-03-27

since 3/2/2020.

3. Personnel record review on 2/15/2022, for employee B, hire date 6/1/2018, failed to evidence an annual performance evaluation since 3/8/2020.

4. Personnel record review on 2/15/2022, for employee C, hire date 9/18/2019, failed to evidence an annual performance evaluation since 3/11/2020.

5. Personnel record review on 2/15/2022, for employee D, hire date 5/2/2019, failed to evidence an annual performance evaluation since 3/8/2020.

6. Personnel record review on 2/15/2022, for employee E, hire date 6/20/2019, first patient contact date 7/1/2019, failed to evidence an annual performance evaluation since 3/11/2020. Review evidenced a document titled INkless-Complete Record Detail , which the alternate administrator identified as the background check. This document failed to evidence a date completed and failed to evidence the results of the background check.

7. Personnel record review on 2/15/2022, for employee F, hire date 6/30/2021, failed to evidence an orientation to the job.

8. Personnel record review on 2/15/2022, for employee G, first patient contact date 10/3/2019, evidenced a document titled INkless-Complete Record Detail , which the alternate administrator identified as the background check, with a date received on 2/17/2020. Review failed to evidence the background check was submitted by the agency within 3 days of direct patient contact.

9. Personnel record review on 2/15/2022, for employee I, hire date 7/2/2012, failed to evidence an annual performance evaluation since 3/11/2020.

10. Personnel record review on 2/15/2022, for employee M, hire date 12/9/2019, failed to evidence an annual performance evaluation since 3/8/2020.

11. Personnel record review on 2/15/2022, for

complete annualperformance evaluation for employee I (hire date 7/2/2012) for 2021 and 2022. (3/25/2022)

Administrator/Director of Nursing will complete annualperformance evaluation for employee M (hire date 12/9/2019) for 2021 and 2022. (3/25/2022)

Administrator will instruct Director of Nursing/designee thatperformance evaluations must be done on all employees yearly. (3/25/2022)

Administrator will ensure criminal background checks are runno later than days after first patient contact. (3/25/2022)

Administrator/designee will audit all new employee files toensure they have all required documentation, to include orientation to job andcriminal background checks, before they are allowed to see patients. (3/25/2022)

Administrator/Director of Nursing/designee will create atracking system to ensure employee performance evaluations are done timely. (3/25/2022)

Administrator/designee will review monthly, at end of month,list of performance evaluations due that month to ensure they are done. (3/25/2022)

Administrator/designee will review all current employeefiles to ensure they have required documentation to include a criminalbackground check, if required, orientation to job checklist and yearlyperformance evaluations. Any

	employee N, first patient contact date 3/30/2017, evidenced a document titled Direct Screening , which the alternate administrator identified as the background check, dated 4/4/2017. Review failed to evidence the agency requested the background check within 3 days of direct patient contact. 12. Personnel record review on 2/15/2022, for employee O, first patient contact date 11/7/2018, evidenced a document titled INkless-Complete Record Detail , which the alternate administrator identified as the background check, with a date received on 11/26/2018. Review failed to evidence the agency requested the background check within 3 days of direct patient contact. 13. During an interview on 2/15/2022, at 12:27 PM, the alternate administrator indicated the agency completed a performance evaluation at least every 3 years. At 12:36 PM, the alternate administrator indicated she could not locate an orientation for employee F. At 12:41 PM, the alternate administrator indicated there should be a background check completed before the employee sees patients. The alternate administrator indicated she was unsure where the background results were for employee E.		documents will be madecompliant. (3/25/2022) Administrator will revise the “Personnel Records” policy tosay performance evaluations will be done annually. (3/25/2022) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur. See attachment B – “Personnel Records” policy Personnel Records POLICY Personnel files will be established and maintained for allstaff. All information will be considered confidential and will be madeavailable to authorized management personnel only PURPOSE To maintain personnel files on current and formeremployees. REFERENCE The Joint Commission CANHC Standards: HR.01.02.01, HR.01.0205; Medicare cop484.75(b), 484.100, 484.115;CHAP Standards: HRM.3.1, HRM.4.1, LG.3.1•, ACHC Standards: HH2-6B.01, HH4-1A.01, HH4-2C.01,	

HH4-2D.01, HH4-2H.01

PROCEDURE

1. The personnel record or personnel informationfor an employee will include, but not be limited to, the following:

Employmentapplication/resume.

Observedcompetencies if required: initial duringorientation, when thereare concerns or it is a task/skill that employee requests a refresher or hasnever done for all patientcare staff.

Home Health Aide competencyevaluation: initially and annually.

References,if obtained, or work history.

1-9 form — separate folder.

Salaryrecaps.

Change of status forms.

CPR,if required (online CPR certification is acceptable with in-person verificationof competency).

Performanceappraisal/evaluation forms.

Verificationof education, certification and/or licensure.

Agency employee orientation.

Inserviceeducation record.

Otherdata which is directly related to the employment, promotion, additionalcompensation, disciplinary action or termination.

Criminalhistory check, if required by law.

Jobdescription: reviewed and signed by employee.

Certification for specialty areas of practice,if applicable.

Datedand signed withholding statements. National sex offender registry

HOME HEALTH AIDE COMPETENCY INITIALLY AND ANNUALY

Agenciesin receipt of funds from Medicare, Medicaid and all other federal plans andprograms verify that individuals hired are not on the Office of the InspectorGeneral (OIG) List of Excluded Individuals and Entities (LEIE). To help avoidthe potential for civil monetary penalties, OIG strongly encourages home andcommunity-based providers to routinely check the LEIE to ensure that new hiresand current employees are not on the excluded list. OIG is required by law toexclude from participation in all federal health care programs individuals andentities convicted of the following types of criminal offenses (1) Medicare orMedicaid fraud, as well as any other offenses related to the delivery of itemsor services under Medicare, Medicaid, SCHIP or other State health careprograms; (2) patient abuse or

neglect; (3) felony convictions for other healthcare related fraud, theft or other financial misconduct; and (4) felonyconvictions relating to unlawful manufacture, distribution, prescription ordispensing of controlled substances. Agency will checkOIG at least every 6 months.

2. The health record for applicable employees willinclude:

• PPD tests or chest x-ray results based onAgency's TB risk assessment.

• Evidence of HBV: administration or declination

• Physical

• Any other Agency required health requirements.

3. Employee health information must be maintainedin files separate from personnel files and in a separate location.

4. Personnel records are confidential and will bereleased only to authorized management for review.

e Release of personnel information on current and terminatedemployees without written authorization from the employee will be limited toverification of date of hire, date of termination and job title.

• When unemployment or other type of claim isfiled, necessary information will be released as required by law.

5. Only designated

			Administrator, Director ofClinical Services,mayaccess personnel files. Anyone else must havepermission from Administrator. 6. Personnel files will be stored in metal filecabinets that locks in Administrator'soffice. . Employees may review theirpersonnel records only in the presence of Administrator/designee.. 8. Personnel records will be retainedfor minimally five years after employee leaves the Agency, or according toapplicable state law.	
G0460	Patient refuses services 484.50(d)(4) The patient refuses services, or elects to be transferred or discharged; Based on record review and interview, the agency failed to ensure the patient was discharged because the patient refused services in 1 of 1 closed clinical record reviewed with a discharge reason of patient requested discharge. (#7) The findings include: Review of an agency policy obtained 2/15/2022, titled Discharge Criteria and Planning revised February 2021, stated, & Patient will be discharged from services as follows: & Patient refuses services or elects to be discharged. & A patient who occasionally declines a service is distinguished from a patient who refuses services altogether, or who habitually declines skilled care visits. It is the patient s right to refuse services. It is the Agency s responsibility to educate the patient to the risks and potential adverse outcomes that can result from refusing services. In the case of	G0460	G0460 Unable to correct documentation for patient cited in surveyas they had already been discharged. Director of Nursing will in-service nurses/therapists onneed to attempt to reschedule any missed visits. There must be documentation inchart of attempts to reschedule missed visits. (4/8/2022) Director of Nursing/designee will review all missed visitreports done each week to ensure there is documentation clinician attempted toreschedule visit. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) Director of Nursing will in-service nurses/therapists onneed to document conversation with patient/caregiver as to	2022-04-08

patient refusals of skilled care, the Agency must document its communication with the physician/practitioner who is responsible for the patient s home health plan of care, as well as the measures the Agency took to investigate the patient s refusal and the interventions the Agency attempted in order to obtain patient participation with the plan of care &.

Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/19/2021 1/17/2022, which was signed by the physician on 12/16/2021. This document indicated skilled nursing services were to be provided 1 time a week for 9 weeks.

Review evidenced an agency document titled PT [physical therapy] Plan of Care , electronically signed and dated by PT L on 12/8/2021. This document indicated the PT would provide services 2 times a week for 4 weeks.

Review of agency documents titled Missed Visit , electronically signed and dated by registered nurse (RN) F on 12/21/2021, 12/28/2021, and 1/4/2022, indicated the patient refused the visit. Review failed to evidence the patient was offered to reschedule the missed visits.

Review evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Discharge , electronically signed by the alternate administrator and dated 1/13/2022. This document indicated the patient was discharged from the agency on 1/13/2022 per patient request.

Review failed to evidence documentation of communication with the patient/caregiver regarding the patient s request to discharge. Review failed to evidence the agency educated the patient to the risks and potential adverse outcomes that can result from refusing services per the agency s policy. Review failed to evidence the agency documented the measures the agency took to investigate the patient s

why patient wants tobe discharged, what the potential adverse outcomes could be for refusingservices, what measures were taken to investigate patient's refusal andattempts made to obtain patient participation in their plan of care. (4/1/2022)

Director of Nursing will in-service nurses/therapists oncommunicating with MD regarding discharging patient. This communication must be documented inchart. (4/1/2022)

Director of Nursing will instruct nurses/therapists tonotify Director when a patient is needing discharged. (4/1/2022)

Director of Nursing/designee will audit weekly thedocumentation of patients needing discharged, until they are discharged, toensure there is documentation showing conversation with patient/caregiver as towhy patient wants to be discharged, what the potential adverse outcomes couldbe for refusing services, what measures were taken to investigate patient'srefusal, attempts made to obtain patient participation in their plan of careand MD has been contacted regarding potential discharge. Once 100% complianceis achieved 10% will be audited quarterly to ensure compliance is maintained.(On0going)

The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

	refusal and the interventions the agency attempted to obtain patient participation with the plan of care per the agency s policy. During an interview on 2/14/2022, at 5:10 PM, the patient s caregiver indicated the patient did not request to be discharged from the agency and indicated the patient was still receiving services from the agency. The patient s caregiver indicated the agency informed him the patient needed to be recertified but was not informed that the agency had discharged the patient. During an interview on 2/18/2022, at 11:22 AM, the alternate administrator indicated the patient was discharged because the patient had refused skilled nursing visits. The administrator indicated there was no documentation of communication with the physician regarding the potential discharge from the agency due to missed visits. The alternate administrator indicated there was no documentation of education provided by the agency to the potential risks of refusing skilled visits and interventions taken by the agency to ensure the patient participated with the plan of care.			
N0460	Home health agency administration/management 410 IAC 17-12-1(g) Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.	N0460	N0460 The Director of Nursing cited in survey is no longeremployed at agency so employee file cannot be brought into compliance. Administrator will be responsibleto complete a performance evaluation annually for Director of Nursing. (Ongoing) Administrator has revised the "Personnel Records" Policy toshow performance evaluations will be done annually. (3/20/2022) The Administrator will be responsible for	2022-03-20

Based on record review and interview, the agency failed to ensure the personnel record for the supervising nurse included an annual performance evaluation.

The findings include:

Review of an agency policy obtained 2/21/2022, titled Personnel Records revised February 2021, stated, & The personnel record or personnel information for an employee will include, but not limited to, the following: &Performance appraisal/evaluation form &.

Personnel record review on 2/15/2022, for employee B, hire date 6/1/2018, failed to evidence an annual performance evaluation since 3/8/2020.

During an interview on 2/15/2022, at 12:27 PM, the alternate administrator indicated the agency completed a performance evaluation at least every 3 years.

ensure that this deficiency is corrected and will notrecur.

See attachment B – revised “Personnel Records” policy

Personnel Records

POLICY

Personnel files will be established and maintained for allstaff. All information will be considered confidential and will be madeavailable to authorized management personnel only

PURPOSE

To maintain personnel files on current and formeremployees.

REFERENCE

The Joint Commission CANHC Standards: HR.01.02.01, HR.01.0205; Medicare cop484.75(b), 484.100, 484.115;CHAP Standards: HRM.3.1, HRM.4.1, LG.3.1•, ACHC Standards:

HH2-6B.01, HH4-1A.01, HH4-2C.01, HH4-2D.01, HH4-2H.01

PROCEDURE

1. The personnel record or personnel informationfor an employee will include, but not be limited to, the following:

Employmentapplication/resume.

Observedcompetencies if required: initial duringorientation, when thereare concerns or it is a task/skill that employee requests a refresher or hasnever done for all patientcare staff.

Home Health Aide competencyevaluation: initially and annually.

References,if obtained, or work history.

1-9 form — separate folder.

Salaryrecaps.

Change of status forms.

CPR,if required (online CPR certification is acceptable with in-person verificationof competency).

Performanceappraisal/evaluation forms.

Verificationof education, certification and/or licensure.

Agency employee orientation.

Inserviceeducation record.

Otherdata which is directly related to the employment, promotion, additionalcompensation, disciplinary action or termination.

Criminalhistory check, if required by law.

			Jobdescription: reviewed and signed by employee. Certification for specialty areas of practice,if applicable. Datedand signed withholding statements. National sex offender registry HOME HEALTH AIDE COMPETENCY INITIALLY AND ANNUALY	

Agenciesin receipt of funds from Medicare, Medicaid and all other federal plans andprograms verify that individuals hired are not on the Office of the InspectorGeneral (OIG) List of Excluded Individuals and Entities (LEIE). To help avoidthe potential for civil monetary penalties, OIG strongly encourages home andcommunity-based providers to routinely check the LEIE to ensure that new hiresand current employees are not on the excluded list. OIG is required by law toexclude from participation in all federal health care programs individuals andentities convicted of the following types of criminal offenses (1) Medicare orMedicaid fraud, as well as any other offenses related to the delivery of itemsor services under Medicare, Medicaid, SCHIP or other State health careprograms; (2) patient abuse or neglect; (3) felony convictions for other healthcare related fraud, theft or other financial misconduct; and (4) felonyconvictions relating to unlawful manufacture, distribution, prescription ordispensing of controlled substances. Agency will checkOIG at least every 6 months.

2. The health record for applicable employees willinclude:

- PPD tests or chest x-ray results based onAgency's TB risk assessment.
- Evidence of HBV: administration or declination
- Physical

- Any other Agency required health requirements.

3. Employee health information must be maintainedin files separate from personnel files and in a separate location.

4. Personnel records are confidential and will bereleased only to authorized management for review.

e Release of personnel information on current and terminatedemployees without written authorization from the employee will be limited toverification of date of hire, date of termination and job title.

- When unemployment or other type of claim isfiled, necessary information will be released as required by law.

5. Only designated Administrator, Director ofClinical Services,mayaccess personnel files. Anyone else must havepermission from Administrator.

6. Personnel files will be stored in metal filecabinets that locks in Administrator'soffice. .

Employees may review theirpersonnel records only in the presence of Administrator/designee..

. Personnel records will be retainedfor minimally five years after employee leaves the Agency, or according toapplicable state law.

N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months.	N0464	N0464 Unable to correct PPD issue for employee N cited in surveyas issue is from 2017. Administrator/designee will audit newly hired employee filesto ensure there is proper documentation for PPD testing to include a secondstep if needed before they are allowed to provide patient care. (Ongoing) Administrator has revised the “Occupational Exposure toTuberculosis/Prevention of Transmission of TB Plan” policy so it reflectsproper process for PPD testing. (3/20/2022) Administrator has revised the “Health Screening” policy soit reflects proper process for PPD testing. (3/20/2022) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur. See attachment C - Occupational Exposure toTuberculosis/Prevention of Transmission of TB Plan See attachment D – Health Screening policy HEALTH SCREENING POLICY Eachemployee having direct contact with clients must have documentation of	2022-03-20

Based on record review and interview, the agency failed to ensure employees with direct patient contact had a baseline two-step tuberculin skin test in 1 of 1 personnel record reviewed for home health aides with direct patient contact prior to 3/6/2020. (N)

The findings include:

Review of an agency policy obtained 2/21/2022, titled Personnel Records revised February 2021, stated, & The personnel record or personnel information for an employee will include, but not limited to, the following: & The health record for applicable employees will include: & PPD [purified protein derivative, a skin test which tests for tuberculosis, a contagious disease which usually affects the lungs] tests & based on Agency s TB [tuberculosis] risk assessment &.

Review of an agency policy obtained 2/21/2022, titled Occupational Exposure to Tuberculosis/Prevention of Transmission of TB Plan revised February 2021, stated, & For employees who have not had a documented negative PPD test during the preceding 12 months, the baseline PPD testing will include the two-step method &.

Personnel record review on 2/15/2022, for employee N, first patient contact date 3/30/2017, failed to evidence a two-step skin test was completed prior to patient contact.

During an interview on 2/15/2022, at 12:36 PM, the alternate administrator indicated she did not see a second step TB test for the employee.

baselinehealth screening prior to providing care to clients. This includes, at aminimum, TB skin testing via the Mantoux method. Testing will be offered at nocost to the employee. This testing includes the pre-placement evaluation,administration and interpretation of TB Mantoux skin tests and periodicevaluation.

PURPOSE

Toensure adequate health status of each worker and to ensure quality of eachworker to perform essential job functions.

Toensure all agency employees and personnel working under contract are free fromcommunicable disease before providing direct client care.

SPECIAL INSTRUCTIONS

I. Pre-employment physical examinationwill be performed by a physician or nurse practitioner as mandated by state law.The physical may not be more than one hundred eighty (180) days old at time offirst patient contact.. Health screening will occur after aconditional offer of employment is made. Repeat testing will be required ifdeemed necessary by the Director of Nursing for individuals with signs ofcommunicable disease.

2.On any employee or contract personnel providing direct client care, there shallbe documentation of completion of a tuberculin (TB) skin test, via the Mantouxmethod. If there is documented evidenceof a negative skin test within the twelve months prior to

employment noTB test is required until time for annual. If the employee does not have documentedevidence of a negative Mantoux skin test within the past twelve months,employee must be given a two-step TB test. Employee may not seepatients until the second step is read.

TheTB skin test may be administered in the agency by a Registered Nurse. The TBskin test consent and results shall be documented.

TBskin test results shall be evaluated by a Registered Nurse

within48-72 hours and documented as "nonsignificant" (negative) or"significant" (positive) in millimeters of induration. Ifemployee is not able to take the TB test they must have a chest x-ray at timeof hire. Report must indicate there is no sign of active tuberculosis. Employeewill be required to complete the TB Questionnaire yearly.

OccupationalExposure to Tuberculosis/ Prevention of Transmission of TB Plan

POLICY

ThisAgency will comply with the current OSHA Enforcement Policy and Procedure forOccupational Exposure to Tuberculosis (TB) as well as Centers for DiseaseControl (CDC) guidelines.

PURPOSE

Toprotect exposed employees against TB

REFERENCE

TheJoint Commission CAMHC Standards: IC.OI .05.01, IC.D2.01.01, IC.02.03.01•,Medicare

CoP#s•. 484.65, 484.70(a), (b), (c), 484.100, 484.105(a)•, CHAP Standards:IPC.8.1, LG.3.1•, ACHC Standard: HH7-1A

RELATEDDOCUMENTS

"AnnualTB Risk Assessment" and "PPD Annual Employee Aggregage Database"forms

PROCEDURE

1. Responsibility for the TB infection controlprogram is assigned to the Director of Clinical Services. The Director ofClinical Services is given the authority to implement and enforce TB infectioncontrol policies and procedures.

2. The Director of Clinical Services will performannual risk assessment surveillance for the Agency to determine the need, typeand frequency of testing/assessment for direct care staff. Regardless of therisk level, the management of patients with known or suspected infectious TBwill not vary. Risk definitions include:

			Very low risk: Applies to an entirefacility in which patients with active TB are not admitted to inpatient areasbut may receive initial assessment and diagnostic evaluation or outpatientmanagement in outpatient areas. Patients who may have active TB and need inpatientcare are promptly referred to an appropriate facility. Low risk: Areas or groups in which the PPDtest conversion rate is not greater than that for areas or groups in whichoccupational exposure to TB is unlikely or than previous conversion rates for thesame area or group. No clusters of PPD test conversions have occurred.Person-to-person transmission of TB has not been detected, and fewer than six(6) TB patients have been treated per year. Care0) 5.15.1 Intermediaterisk: Same as low risk, except that six (6) or moreTB patients are treated per year.	

Ughrisk: Areas or occupational groups in which the PPDtest conversion rate is significantly greater than for areas or groups in whichoccupational exposure to TB is unlikely or than previous conversion rates forthe same area or group and epidemiologic evaluation suggest nosocomialtransmission. An epidemiologic evaluation suggests nosocomial transmission ofTB. Possible person-to-person transmission of TB has been detected.

3 The occurrence of drug-resistant TB inthe patient population served or a relatively high prevalence of HIV infectionsamong patients served or employees may increase the concern about thetransmission of TB and may influence the decision regarding which protocol tofollow, e.g., high risk classification may be selected.

4. The Agency may have a combination ofrisk areas at any given time. The appropriate protocol will be implemented foreach area or group. When cough-inducing procedures are performed on patientswho may have active TB, the Agency will at least implement the intermediaterisk assessment.

5 A diagnosis of TB may be considered for any patient who has apersistent cough, e.g., a cough lasting 3 weeks or longer, unexplained weightloss, night sweats and/or other signs/symptoms suggestive of active TB.

6. High risk groups include:

Injecting drug users known to

be HIVseronegative.

Children less than 4 years of age.

Persons who have other medical conditions thatreportedly increase the risk for progressing from latent TB infection to activeTB infection:

Silicosis.

Gastrectomy or jejuno-ileal bypass.

10% or greater below ideal body weight.

Chronic renal failure with renal dialysis.

Diabetes mellitus.

Highdose corticosteroid or other immunosuppressive therapy.

Some hematologic disorders, includingmalignancies (e.g., leukemias or lymphomas). Other malignancies.

HIV and/or AIDS.

High prevalence groups include:

Persons born in countries that have a highprevalence of TB.

Persons from medically underserved, low incomepopulations (e.g., alcoholics, homeless, housing projects).

Forrner or past residents of

other correctional facilities, nursing homes).

An induration of 15mm or greater is classifiedas positive in persons who do not meet any of the preceding criteria.

Recent converters aredefined on the basis of both size of induration and age of the person beingtested.

1 Omm or greater increase within a 2 year periodis classified as a recent conversion for persons less than 35 years of age.

15mm or greater increasewithin a 2 year period is classified as a recent conversion for persons 35years of age or older.

Early identification ofindividuals with active TB or at high risk for active TB includes informationobtained at time of patient referral or at time of first home visit andsubsequent visits.

7. The home management of those patients withsuspected or confirmed infections includes: Implementation of precautions to preventexposure until communicability has been eliminated bydrugs including:

Instructing patients to cover coughs andsneezes.

Instructing patients who are on TB medicationsabout the importance of taking medications as prescribed (unless adverseeffects are seen).

Employee use of NIOSH-approved high efficiencyparticulate air respirator (the minimally acceptable level of respiratoryprotection) in the following circumstances:

When employees enter the homes or rooms ofindividuals with suspected or confirmed infectious TB disease.

When employees perform high hazard procedures onindividuals who have suspected or confirmed TB disease including but notlimited to: aerosolized medication (e.g., pentamidine), sputum induction,endotracheal procedures and/or suctioning procedures.

Performance of cough-inducing procedures in awell-ven-„ilated area away from other persons.

A cough-inducing procedure performed on patientswho have infectious TB should not be done in the patient's home unlessabsolutely necessary.

When medically necessary to be performed in thehome, procedure should be performed in a well-ventilated area away from otherpersons.

Employee should consider opening a window toimprove ventilation or collecting the specimen while outside the dwelling.

The employee collecting the specimen must wearrespiratory protection during the procedure.

To the extent possible, isolation of the patientaway from other residents in an area with the maximum possible ventilation.

If agreeable with the patient, placement of awarning sign outside the room or home:

"Special Respiratory Isolation" or o Adescription of the necessary precautions.

Precautions may be discontinued when patient isno longer infectious.

8. Respiratory protective devices should meetrecommended performance criteria. These include:

- Ability to filter particles Imm in size in theunloaded state (not loaded with dust) with a filter efficiency of greater thanor equal to 95% (NIOSH = 95 or greater).

- Ability to be qualitatively or quantitativelyfit tested in a reliable way to obtain a facial leakage of less than or equal to 10%.

- Ability to fit different facial sizes andcharacteristics of employees.

- Ability to be checked for face piece fit, inaccordance with OSHA and good industrial hygiene practice, by employees eachtime respirators are used.

			• CDC guidelines reference OSHA requirements foruse of respiratory protective devices which are certified by NIOSH. 9. Respiratory protection should be used: eBy employees entering homes in which patients with known or suspectedinfectious TB are living. • Employeeswhen performing cough-inducing or aerosol-generating procedures on suchpatients. • Whereadministrative and engineering controls are not likely to protect employee frominhaling infectious airborne droplet nuclei. 10. Patients suspected of having TB should wearsurgical masks when not in TB isolation rooms to reduce the expulsion ofdroplet nuclei into the air. NOTE:These patients do not need to wear particulate respirators which are designedto filter the air before it is inhaled by the person wearing the respirator. 11. All employees will receive education regardingTB that is relevant to their particular occupational group, before initial assignmentand annually. The program will include the following elements:	

			Basic concepts oftransmission, pathogenesis and diagnosis, including the difference betweenlatent and active TB infection, the signs and symptoms of TB and thepossibility of re-infection. Potentialfor occupational exposure. Principlesand practices of infection control that reduce risk for transmission. Purpose of PPD skin testing, significance of apositive test and the importance of participating in the skin test program. Principlesof preventive therapy for latent TB. Employee'sresponsibility to seek prompt medical evaluation if a PPD test conversiondevelops or if symptoms develop that could be caused by TB. Principlesof drug therapy for active TB. Importanceof notifying the Agency if the employee is diagnosed with active TB. Responsibility of the Agency to maintain theconfidentiality of the employee while ensuring that the employee who has TBreceives therapy. Highrisks associated with TB infection in persons who have HIV infection or othercauses of severely impaired cell-mediated immunity. Potentialdevelopment of cutaneous anergy as immune functions decline. Informationregarding the efficacy and safety of BCG vaccination and the	

principles of PPDscreening among BCG recipients.

Agency'spolicy on voluntary work reassignment options for immunocompromised employees.

12 Employees will be counseled regarding:

Theneed to follow existing recommendations for infection control to minimize therisk for exposure to infectious agents.

The potential risks toseverely immunocompromised persons associated with caring for patients who havesome infectious diseases including TB.

Makingreasonable accommodations for employees who have health conditions thatcompromise cell-mediated immunity and who work in settings where they may beexposed to Mycobacterium tuberculosis.

Immunocompromisedemployees will be referred to health professionals who can individually counselthe employees regarding their risk for TB.

Agencywill offer, but not compel, a work setting in which the immunocompromisedemployee wound have the lowest possible risk for occupational exposure totuberculosisincluding consideration of the provisions of the "Americans withDisabilities Act of 1990."

Immunosuppressedemployees should

have appropriate follow up and screening for infectiousdiseases, including TB. Employees who are known to be HIV infected or otherwiseseverely immunosuppressed should be zested for cutaneous anergy at the time ofPPD testing.

Considerationwill be given to retesting at least every 6 months, those immunocompromisedemployees who are potentially exposed to Mtuberculosis because of the high risk for rapid progression to active TB ifthey become infected. Information provided by employees regardingtheir immune status will be treated confidentially. If the employee requestsvoluntary job reassignment, confidentiality will be maintained.

13. Any employee who has a persistent cough (lastinggreater than or equal to 3 weeks), especially in the presence of other signs orsymptoms compatible with active TB, should be evaluated promptly for TB. Theemployee should not return to the workplace until a diagnosis of TB has beenexcluded or until the employee is on therapy and a determination has been madethat the employee is noninfectious.

14. Employees will be screened for TB when:

Riskassessment will identify which employees have potential for exposure totuberculosisand the frequency with which the exposure mayoccur. Information is used to determine whichemployees to include in the skin testing program and the frequency with whichthey should be tested.

Ifemployees are from risk groups with increased prevalence to TB, considerationmay be given to including them in the skin testing program, even if -hey do nothave potential for occupational exposure so that converters can be identifiedand preventive therapy offered. During the pre-employment physical, employeeswho have potential for exposure totuberculosis,including those with a history of BCG vaccination willhave baseline PPD skin testing performed.

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For employees who havenot had a documented negative PPD test during the preceding 12 months, thebaseline PPD testing will include the two-step method.

Agency employeesconsidered at risk include all patient care staff (RN, LPN, PT, LPTA, OT, COTA,MSW, SLP and HHA). Supervisory personnel who make even occasional home visitsare also considered at risk.

Employeeswho have a documented history of a positive PPD test, adequate treatment fordisease or adequate preventive therapy for infection will be

unless they develop signs of symptoms suggestive of TB.

PPDnegative employees will undergo repeat PPD testing annually.. Inaddition, these employees will be tested whenever they have been exposed to aTB patient and appropriate precautions were not observed at the time ofexposure.

All PPD tests will beadministered, read and interpreted in accordance with current guidelines byspecified trained personnel. At the time of the reading, employees will beinformed about the interpretation of both positive and negative PPD testresults.In any area where transmissionof M tuberculosis is known to haveoccurred, an evaluation should be conducted and the frequency of skin testingshould be determined according to the applicable risk category.

PPDtest results will be recorded confidentially in the individual employee healthrecord and in an aggregate database for all PPD test results. The databaseshould be analyzed annually to estimate the risk for acquiring new infection.

Employeesat risk are screened and tested as defined in state or local law andregulation, as well as Agency's exposure risk.

In the absence of stateor local law and regulation or Agency identified risk, screening and testingoccurs per current CDC guidelines.

15. Employees who have

positive PPD test results oractive TB will be evaluated and managed as follows:

Allemployees with newly recognized positive PPD tests result or PPD testconversions will be evaluated promptly for active TB. Evaluation will include aclinical examination and a chest radiograph.

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Ifan employee's PPD test result converts to positive, a history of confirmed orsuspected TB exposure will be obtained in an attempt to determine the potentialsource. When the source of exposure is known, the drug susceptibility oftuberculosisfrom the source should be determined and recorded in the employee's healthrecord, where it will be available if the employee subsequently develops activeTB and needs therapy.

Routinechest radiographs are not required for asymptomaticPPD negative employees.

Employeeswith positive PPD test results should have achest radiograph as part of the initial evaluation of the PPD test. Ifnegative, repeat chest radiographs are not needed, unless symptoms develop thatcould be attributed to TB. More frequent monitoring for symptoms of TB will beconsidered for ræent converters and other PPD positive employees who are atincreased risk for developing active TB. Employees with pulmonary or laryngeal TB willbe excluded from the

workplace until they are noninfectious.

Beforethe employee who has TB can return to the workplace, the Agency must havedocumentation from the health care provider that the employee is receivingadequate therapy, cough has resolved and the employee has had three consecutivenegative sputum smears collected on different days.

Afterwork duties are resumed and while the employee rernains on therapy, Agency mustreceive periodic documentation from the health care provider that the employeeis being maintained on effective drug therapy for the recommendedtime period and that the sputum AFB smears continue to be negative.

Employeeswith active laryngeal or pulmonary TB who discontinue treatment before they arecured will be evaluated promptly for infectiousness. If it is determined thatthey are still infectious, they will be excluded from the workplace untiltreatment has been resumed, an adequate response has been documented and threeor more consecutive AFB smears collected on different days have been negative.

Employees who have TB at sites other than theltmg or larynx usually do not need to be excluded from the workplace, if adiagnosis of concurrent pulmonary TB has been ruled out.

Employeesreceiving preventive treatment for latent TB will not be restricted from theirusual work activities.

Employeeswith latent TB who cannot

take or who do noz accept or complete a full courseof preventive therapy will not be excluded from the workplace. They will be counseledabout the risk for developing active TB and instructed regularly to seek promptevaluation if signs and symptoms develop that could be caused by TB.

16. As soon as a patient or employee is known orsuspected to have active TB, the patient or employee should be reported to thepublic health department so that appropriate follow up can be arranged and acommunity contact investigation can be performed. The public health departmentwill protect the confidentiality of the patient or employee in accordance withstate and local laws.

17. The Agency and health department will coordinatetheir efforts to perform appropriate contact investigations on patients andemployees who have active TB.

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18. In accordance with state and local laws andregulations, results of all AFB positive sputum smears, cultures positive for M. tuberculosis and drug susceptibilityresults will be reported to the public health department as soon as theseresults are available.

19Public health department may be able to assist the Agency with planning andimplementing various aspects of a TB infection control program,

and outbreak investigations.

20.All reports (exposure/medical) of an employee are confidential and may beaccessed when the record is within the regulation definition.

- Arecord of TB skin testing results and medical evaluations and treatment is anemployee medical record within the regulation definitions.

- Recordsmust be handled so that the OSHA compliance officer may determine compliancewith the regulations.

21 TB infections (positive TB Mantoux skin test orPPDs and TB disease) will be recorded

on the "OSHA 300 Log." A positive skin test for TB, evenon baseline testing (except if positive on pre-employment screening), isrecordable on the log because there is a presumption of work-relatedness.

22 If an employee's TB infection which was recordedon the log progresses to TB disease during the five-year maintenance period,the original log entry must be updated to reflect the new information. Becauseit is clinically difficult to determine if TB disease resulted from the sourceindicated by the skin test conversion or from subsequent exposures, only onecase should be entered to avoid double counting.

EXPOSURE DETERMINATION

FOR TUBERCULOSIS

All employees who will have contact with clients must be aware ofthe possibility of exposure to an individual with knownor suspected tuberculosis.

All employees, including employees working under contract, willreceive infection control orientation and training during their agencyorientation.

Infection control practices including those related totuberculosis exposure will be reviewed at least annually and as deemednecessary.

All employees, including employees working under who are at riskfor exposure to individuals with known or suspected tuberculosis, will havepersonal protective equipment issued to them. This specifically includes aparticulate respirator approved by OSHA for tuberculosisprevention.

All employees who may have contact with individuals suspected ofhaving tuberculosis will be informed prior to accepting assignment with theclient.

Theagency will establish a mechanism to prevent exposure, identify exposures and implementtreatment to prevent disease:

TB skin tests (Mantoux) will be given at thetime of employment, using the two-step method if unable to provide proofof a negative PPD in the past 12 months. The tests will berepeated annually and/or at the time of suspected or known exposure. (Seehealth screening policy).

Employees with known or

			suspected exposure willbe monitored on a regular schedule. Employees who have a positive Mantoux test priorto employment must show evidence that they have been evaluated by a physicianand have no evidence of active disease. If an employee's skin test converts to positive,they would be referred for a chest x-ray and physical examination. (See HealthScreening Policy) If an employee exhibits symptoms of tuberculosis, they wouldnot be allowed to provide direct care until they had received a release fromthe physician. If a client exhibits symptoms of tuberculosis,employees will observe infection control precautions including wearing theparticulate respirator until they are informed the client does not have thedisease. Clinical supervisors will notify the client's physician and requestthat the client be evaluated for the disease.	
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health	N0488	N0488 Unable to correct the 2 discharged charts cited in survey asthey were discharged several months ago. Director of Nursing/designee will in-service clinicians onrequirement to provide patients with a fifteen (15) day notice of dischargewhen required. Patient is to be informed of reason for	2022-03-15

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 agency failed to develop and implement a policy requiring a notice of discharge of service to the patient at least 15 days calendar days before the agency's services are stopped in 2 of 2 closed clinical records reviewed. (#6, #7)

The findings include:

1. Review of an agency policy obtained 2/15/2022, titled Discharge Criteria and Planning revised February 2021, stated, & The patient is informed of discharge plan in a timely manner &. Review failed to evidence the agency s policy included a 15 day notice of discharge to the patients.

2. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled Physician Order , electronically signed and dated by the alternate

discharge. MD must becontacted to discuss discharge. There must be documentation in patient chartreflecting this. (3/15/2022)

Director of Nursing will instruct clinicians they are toinform Director of Nursing when they are going to discharge a patient. (Ongoing)

Director of Nursing/designee will audit the documentation ofany patient that is being discharged to ensure there is documentation patienthas been given fifteen (15) day notice of discharge, reason for discharge andMD has been contacted. Once 100% compliance is achieved 10% of discharges willbe audited quarterly to ensure compliance is maintained. (Ongoing)

Administrator has revised the “Discharge Criteria andPlanning” policy to say agency will provide patient with fifteen (15) daynotice of discharge when required. (3/15/2022)

The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

See attachment E – “Discharge” policy

CLIENT DISCHARGE PROCESS

POLICY

Discharge Planning isinitiated for every home care client at the time of the client's admission forhome care. The transfer process is based on the client's

patient was discharged from the agency per patient request.

Review evidenced an agency document titled Home Health Discharge Summary (Auto Generated), which was electronically signed by registered nurse (RN) D and dated 1/24/2022. This document indicated the patient was discharged due to goals being met.

Review of agency documents titled SN [skilled nurse] Teaching/Training Visit , electronically signed by RN D and dated 1/3/2021 and 1/10/2022, failed to evidence discharge notice was provided to the patient.

Review of an agency document titled Home Health Change of Care Notice (HHCCN) , signed by the patient on 1/19/2022, indicated the agency was discontinuing skilled nursing, physical therapy and home health aide services. Review failed to indicate the patient was provided a 15 day notice prior to discharge.

Review failed to evidence documentation of communication with the patient regarding the reason for discharge.

During an interview on 2/14/2022, at 4:13 PM, the patient indicated she did not request a discharge from the agency and was not provided a discharge notice. The patient indicated she currently receives nursing and home health aide services from the agency. The patient indicated RN D comes to her house every 2 weeks and indicated the last time the nurse was at her home was on 2/10/2022. The patient indicated home health aide C comes to her home 2 times a week on Tuesday and Thursday to provide personal care.

During an interview on 2/18/2022, at 10:49 AM, the alternate administrator indicated the patient s reason for discharge was due to goals met and indicated no discharge notice had been provided to the patient in advance of discharge from the agency.

3. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled OASIS-D1 Discharge , electronically signed by the

assessed needs.

PURPOSE

To facilitate theclient's discharge or transfer to another entity

To ensure continuity ofcare, treatment and services when needed.

To assure collaborationwith the physician, client, family and other disciplines in planning fordischarge from the agency

SPECIAL INSTRUCTIONS

DischargeProcedure:

1. Planningfor discharge is provided as part of the ongoingassessment of needs and in accordance with expected care outcomes. Theclient/family will participate in this process beginning with the initialassessment visit.

2. Client'sneeds for continuing care to meet physical and psychological needs areidentified and clients are told in a timely manner of the need to plan fordischarge or transfer to another level of care/organization.They are informed of the reason for discharge andanticipated needs for services after discharge.

3. Thephysician will be involved in the discharge plan and specific ongoing careneeds will be identified and addressed as part of the plan.

4. Theimpending discharge will be reviewed with other members of the home care teamto assure coordination

alternate administrator and dated 1/13/2022. This document indicated the patient was discharged from the agency on 1/13/2022 per patient request.

Review of an agency document titled Home Health Change of Care Notice (HHCCN) , signed by the patient on 1/13/2022, indicated the agency was discontinuing skilled nursing and physical therapy services. Review failed to indicate the patient was provided a 15 day notice prior to discharge.

During an interview on 2/14/2022, at 5:10 PM, the patient s caregiver indicated the patient did not request to be discharged from the agency and indicated the patient was still receiving services from the agency. The patient s caregiver indicated the agency informed him the patient needed to be recertified but was not informed that the agency had discharged the patient.

During an interview on 2/18/2022, at 11:22 AM, the alternate administrator indicated the patient was discharged because the patient had refused skilled nursing visits. The administrator indicated there was no documentation of communication with the patient/caregiver and physician regarding the potential discharge from the agency due to missed visits.

4. During an interview on 2/15/2022, at 9:48 AM, the alternate administrator indicated the agency tried to inform the patients of discharge notice 2 visits prior to discharge.

and continuity with the client andfamily/caregivers.

5. TheRegistered Nurse or Therapist shall review the clinical record to assureaccuracy and completion. A Discharge Plan shall be developed that is documentedin writing and includes all written/verbal instruction regarding the client' songoing care needs and available resources provided to the client and family.

6. TheRegistered Nurse/Therapist shall ensure that the treatment goals and clientoutcomes have been met or, if unmet needs are present, appropriate referralsare made to agencies/institutions to meet continuing client need

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clientoutcomes have been met or, if unmet needs are present, appropriate referralsare made to agencies/institutions to meet continuing client needs.

7. Refer to the Client Transfer Policy foradditional information on the transfer referral process.

8. Agency will notify, as part

careentity involved in care of patient of the plan to discharge.

9. Upon discharge to self-care, the client willreceive verbal/written information regarding community services, mediation use,any procedures/treatments to be performed, and follow-up visits for physiciancare.

10. To avoid charges of "abandonment" atthe time of discharge agency documentation will include the following:

a. Evidence that the decision was not madeunilaterally. The client, family and physician participated in the decision todischarge client from the

agency.

b. Notification shall be made 15 days prior todischarge.

c. Evidence that the client no longer qualifies forhome care services.

d. If there are unmet needs and the agency is nolonger able to meet those needs, documentation will demonstrate thatappropriate notice was given (verbal and written) and referrals made asindicated.

e. Patient/caregiver will be given a list of otheragencies they can contact to inquire about services. Agency will assist withcontacting these agencies if patient/caregiver request.

f. Documentation of all communication with theclient, including the rationale for discharge, will be kept

in the clientfile with copies sent to the primary physician.

11. Discharge Criteria:

Criteria for dischargemay include, but are not limited to the following:

a. The client has reached defined goals and is nolonger in need of home care.

b. The client's care has become such that it isunsafe and medically inappropriate to maintain the client in his/her home.

c. Client is non-compliant with the establishedplan of treatment.

d. Medical approval or supervision has been terminated.Or the physician fails to give or sign orders in a timely manner.

e. The contracting payer terminates authorizationfor service.

f. The client terminates payment for service.

g. The client chooses to use another home healthcare company.

h. The client is hospitalized and thehospitalization period is greater than

60 days or exceeds the current home care episode of care.

60 days or exceeds thecurrent home

care episode of care.

i. Client moves out of the agency's service area.

j. Services needed by the client are not providedby the agency.

k. Nofunding is available to provide the care.

l. The client and/or family have threatened agencystaff, have weapons in the home or the home is in some other way an unsafeenvironment for agency staff.

12. Criteria for transferring a client to an acuteor sub acute care facility:

a. The client has demonstrated deterioration,appearance of acute symptoms, adverse effects of medical treatment, or otherchange jn status.

b. There is a threat to client safety due to unsafehome environment, absence of physician, family, or caregiver involvement.

13. The client and caregiver will be informed of thechange in status and be encouraged to provide input to the physician regardingthe Plan of treatment.

14. The physician will order the client to be transferred,as appropriate.

			15. A discharge OASIS assessment will be completedas appropriate. 16. Agency staff will complete a discharge summarythat includes the following information: a. Client status at the time of admission to theagency b. Statement of client needs, interventions andoutcomes of care c. Status at discharge/last visit/currentmedications, therapies, and continuing care needs d. Name of person or organization assumingresponsibility for care e. Instructions and referrals given to theclient/family/caregiver f. Reason for discharge and date of discharge 17 A copy of the discharge summary is sent via faxor mail to the physician within five (5) business days of discharge.	
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the agency failed to ensure a registered nurse (RN)	G0514	G0514 Director of Nursing will in-service nurses on requirementthat Start of Care Assessments must be done by an RN not an LPN when nursing isordered at start of care. (4/1/2022) Director of Nursing will instruct nurses/therapists theymust sign their	2022-04-01

	conducted the initial assessment to determine the immediate care and support needs of the patient in 1 of 1 partial clinical record reviewed. (#8) The findings include: Review of an agency policy obtained 2/21/2022, titled Initial Assessments/Comprehensive Assessments revised February 2021, stated, & The initial assessment visit is conducted to determine the immediate care and support needs of the patient. & RN must complete the comprehensive assessment & when skilled nursing is ordered. & The Initial Comprehensive Assessment also includes: & Physical assessment/review of systems and pertinent physical findings &. During an interview on 2/16/2022, at 4:02 PM, person C, nurse consultant, indicated the alternate administrator contacted her inquiring if 3 new patients should be added to the survey s active patient roster. Person C indicated the alternate administrator explained the initial comprehensive assessments were completed by a licensed practical nurse (LPN) and not a RN. Clinical record review on 2/18/2022, for patient #8, start of care 2/10/2022, evidenced an unsigned agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Start of Care with a visit date of 2/10/2022. This document failed to evidence who the clinician was that completed the assessment. This document indicated the patient had no wounds. Review of an unsigned agency document titled SN [skilled nurse] Wound Care Visit with a visit date of 2/15/2022, which indicated the patient had a pressure ulcer (wound to the skin and underlying tissue resulting from prolonged pressure to the skin) stage III (an open pressure ulcer with full thickness loss of skin) to the right gluteal cleft (the crease at the bottom of the spine where the buttocks split) and a pressure ulcer stage III to the left gluteal cleft. The document indicated the onset date for both		(4/1/2022) Director of Nursing/designee will audit all documentationdone each week to ensure it is signed by clinician completing it and theirtitle. Once 100% compliance is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going) Director of Nursing will in-service nurses/therapists onneed to assess any wounds patient has on admission. If patient refuses theclinician is to call Director of Nursing who speak with patient/caregiver to explainclinician needs to assess the wounds. If patient still refuses clinician willcontact MD and document this. If patient is to be seen for wound care andrefuses to let the admitting nurse/clinician assess the wound then nurse needsto contact Director of Nursing and MD would be notified that patient refuses tolet clinician assess the wound(S) and therefore agency is unable to providecare due to refusal. (4/1/2022) Director of Nursing/designee will audit all admission OASISdone each week to ensure there is documentation of wounds being assessed if patienthas wounds. If patient refuses to let clinician assess wounds there must bedocumentation Director of Nursing and MD was notified. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going)	

	wounds was 10/21/2019. During an interview on 2/18/2022, at 9:00 AM, the alternate administrator indicated she completed the initial assessment on 2/10/2022 and indicated the patient would not allow the alternate administrator to assess the wounds on the patient s buttocks. The alternate administrator indicated she was aware the patient had wounds to his buttocks because the patient had a prior admission with the agency before transferring to the hospital on 1/19/2022. The alternate administrator indicated LPN J completed the wound assessment when LPN J went on a visit on 2/10/2022 because LPN J was more familiar with the patient and his wounds from his prior admission. The alternate administrator indicated LPN J conducted the visit on 2/15/2022 and indicated there was not a visit note from LPN J for 2/10/2022. 17-14-1(a)(1)(A)		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure the comprehensive assessment reflected the patient s current health status in 3 of 5 active clinical records reviewed. (#2, #3, #5) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Initial Assessments/Comprehensive Assessments revised February 2021, stated, & The Agency s comprehensive assessment includes the use of the Outcome and Assessment Information Set (OASIS) items for all patients & The Initial Comprehensive Assessment also includes: & Physical assessment/review of systems and pertinent physical findings &. 2. Review of an agency policy obtained 2/21/2022, titled Reassessments/Update of the Comprehensive Assessment revised February	G0528	G0528 Director of Nursing will in-service nurses/therapists onrequirement for comprehensive assessments to reflect the patient’s currenthealth status. If there are abnormalities they must be documented. If patienthas a port it must be reflected on assessment as well as indicate who isresponsible to care for it. The assessment is to be a comprehensive assessmentand include all body systems. If there are wounds the depth needs to bedocumented if wound is open. (4/1/2022) Director of Nursing/designee will audit all comprehensiveassessments done each week to ensure they reflect the patient’s current healthstatus, are complete, address abnormalities and if there are ports it indicateswho is responsible to care for it. If there are wounds the depth	2022-04-01

	2021, stated, & Minimally, the comprehensive assessment must be updated and revised: & Recertification &. 3. Clinical record review on 2/17/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Recertification , signed and dated by registered nurse (RN) D on 1/7/2022. This document indicated the patient had two pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin), one on the left buttock and one on the right buttock. Review evidenced a subsection titled Potential Risk for Infection Assessment , which failed to evidence the patient s wounds were checked to be included in the risk of infection assessment. This document indicated the wounds to the right and left buttocks were stage II (an open pressure ulcer with partial thickness loss of skin) and failed to evidence the assessment included the depth of the wounds. Clinical record review on 2/17/2022, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022. This document indicated the patient was NPO (nothing by mouth) and had a gastrostomy (a tube surgically inserted into the stomach through the abdomen used to deliver nutrition, fluids, and/or medication). This document failed to evidence aspiration (when food, fluid or another substance enters the airway or lungs accidentally, may occur when there is difficulty with swallowing) precautions were noted. During an interview on 2/18/2022, at 12:10 PM, the alternate administrator indicated the wounds should have been included in the risk of infection assessment. At 12:17 PM, the alternate administrator indicated aspiration precautions should have been included in the comprehensive assessment due to the patient s NPO status. 4. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled OASIS-D1 Start of		must be listedif wound is open. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) Director of Nursing will in-service nurses/therapists onneed to ensure wounds have the depth measured and documented. If patient haswounds they are to be included in the risk of infection assessment. (4/1/2022) Director of Nursing/designee will audit all documentationsubmitted each week to ensure if patient has a wound that the measurementsinclude the depth and they are included in the risk of infection assessment.Once 100% compliance is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going) Director of Nursing will in-service nurses/therapists thatany precautions appropriate to patient must be listed on the plan of care andnoted in the assessment. This includes aspiration precautions. (4/1/2022) Director of Nursing/designee will audit all assessments andplans of care to ensure any precautions appropriate to patient are listed. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

1/8/2022. Review of the comprehensive assessment indicated the patient s diagnoses included, but were not limited to, malignant neoplasm (abnormal mass of tissue) of the prostate and bone and indicated the skilled nurse was to educate on the signs and symptoms of potential complications of the malignant neoplasm to the bone and prostate. The comprehensive assessment indicated the patient had abnormal bowel sounds and failed to evidence what about the bowel sounds were abnormal.

During an interview at the patient s home on 2/18/2022, at 1:17 PM, the patient s caregiver indicated the patient had a port in his chest from when he received chemotherapy. The patient s caregiver indicated the port had been in his chest for over a year but was no longer accessed. The patient s caregiver indicated she was unsure if the port was to be flushed.

Review failed to evidence the port in the patient s chest was included in the comprehensive assessment.

During an interview on 2/21/2022, at 1:15 PM, the alternate administrator indicated the abnormal bowel sounds should have been assessed to include what was abnormal on the assessment. At 2:05 PM, the alternate clinical manager indicated the port should have been included on the comprehensive assessment.

5. Clinical record review on 7/20/2020, for patient #5, start of care 2/2/2022, evidenced an agency document titled OASIS-D1 Discharge , electronically signed by the alternate administrator and dated 11/8/2021. This document failed to evidence the comprehensive assessment included an assessment of the gastrointestinal (GI) system (the digestive system).

During an interview on 2/18/2022, at 3:59 PM, the alternate administrator indicated the comprehensive assessment should include the assessment of the GI system.

6. During an interview on 2/18/2022, at 12:12 PM, the alternate administrator indicated the

	and width and should include depth if the wound is open. 17-14-1(a)(1)(B)			
N0529	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the agency failed to ensure a written summary report for each patient was sent to the physician at least every 2 months in 3 of 5 clinical records reviewed receiving services for at least 60 days. (#1, #2, #5) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Compliance with Laws and Regulations and Disclosure of Information stated, & The Agency and its staff will furnish services in compliance with all applicable federal, state and local laws and regulations &. 2. Clinical record review on 2/16/2022, for patient # 1, start of care 9/4/2020, evidenced agency documents titled 30-Day Summary/Case Conference dated and signed by the alternate administrator on 11/15/2021, 12/15/2021, and 1/28/2022. Review failed to evidence the physician was sent the summary of care. 3. Clinical record review on 2/17/2022, for patient #2, start of care 7/16/2021, evidenced an	N0529	N0529 Director of Nursing will in-service clinicians on need tosend 30 day summary to MD. Clinician is to document in chart that the 30 daysummary was sent to MD via fax or mail. If it is faxed the confirmation page isto be uploaded to patient chart. (3/15/2022) Director of Nursing/designee will audit all patient chartsweekly to ensure if the 30 day summary is done there is documentation in chartit was sent to MD and there is a fax confirmation page if faxed. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (Ongoing) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-03-31

	Conference dated and signed by the alternate administrator. Review failed to evidence the physician was sent the summary of care. Review of agency documents titled Home Health End-of-Episode Summary (Auto-Generated) , signed by registered nurse (RN) D, and dated 11/23/2021 and 1/28/2022, failed to evidence the physician was sent the summary of care. 4. Clinical record review on 2/17/2022, for patient #5, start of care 7/20/2020, evidenced agency documents titled 30-Day Summary/Case Conference , electronically signed by the alternate administrator and dated 9/30/20021 and 10/29/2020. These documents failed to evidence the physician was sent the summary of care. 5. During an interview on 2/18/2022, at 10:41 AM, the alternate administrator indicated the 30-Day Summary document is used to for the summary of care. The alternate administrator indicated the electronic health record should indicate the document was sent to the physician and indicated the electronic health record did not show the summary of care had been sent. The alternate administrator indicated she did not have any record to include a fax confirmation the physician was sent the summary of care at least every 60 days.			
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 observation, record review, and interview, the agency failed to ensure the patient s medication was reviewed to identify any potential adverse effects and drug reactions in 7 of 7 clinical records reviewed. (#1, #2, #3, #4, #5, #6, #7) The findings include: 1. Review of an agency policy obtained on	G0536	G0536 Director of Nursing will ensure the medication profile forpatients #1, #2, #3, #4, #5, #6, #7 cited in survey, is revised to accuratelyreflect medications patient takes including dose. This includes medicatedlotions/creams, eye drops, pain meds. (3/27/2022) Director of Nursing will in-service nurses on requirement toreview patient's medications at admission and at every visit. All meds atadmission are to be	2022-04-01

2/18/2022, titled Initial Assessments/Comprehensive Assessment revised February 2021, stated, & Each patient s comprehensive assessment includes a review of all medications the patient is currently taking & The Agency nurse must consider and document each medication that the patient is taking to identify: Significant side effects. Significant drug interactions. Noncompliance with medication. Duplicate drug therapy. Potential adverse effects &.

2. Review of an agency policy obtained on 2/18/2022, titled Medications Reconciliation revised February 2021, stated, & At time of admission, the admitting RN [registered nurse] & will create and document a complete list of medications that patient is taking at home & Any concerns or discrepancies will be reconciled by a RN with the patient s physician/practitioner. Discrepancies include duplications, omissions, changes, contraindications and/or unclear information & Medications ordered while the patient is receiving care will be compared to the medication list/profile. The medication list/profile will be updated with each new or changed medication &.

3. During an observation of care on 2/16/2022, at 9:59 AM, at the home of patient #1, start of care 9/4/2020, the patient s medications were observed in a box under the coffee table in the living room. Leucovorin (a medication used to treat or prevent serious blood cell disorders caused by certain medications) and Centrum (a multivitamin) were observed in the box of medications. Home Health Aide C was observed applying lotion from a bottle labeled Ammonium Lactate (a topical medication used to treat dry, scaly skin conditions) to the patient s legs.

Clinical record review on 2/16/2022, evidenced an agency document titled Medication Profile . This document failed to be signed and dated by a clinician. Review failed to evidence Leucovorin, Centrum, and Ammonium Lactate were reviewed to identify potential side effects.

During an interview on 2/18/2022, at 12:02 PM,

reviewed to identify any potential adverse effects and drugreactions. Anytime a new medication is added the nurse must review meds to identifyany potential adverse effects and drug reactions. This includes lotions/creams,eye drops, pain meds. (4/1/2022)

Director of Nursing will in-service nurses/therapists thatwhen reviewing medications at each visit the medication profile is to berevised when there is a med change – change in dose, frequency, medicationdiscontinued or added. The medication profile is to be signed with title ofclinician and dated each time it is revised. (4/1/2022)

Director of Nursing will in-service nurses/therapists onneed to enter all medications patient takes into the electronic medical recordand run drug interactions. (4/1/2022)

Director of Nursing will audit all visit notes submitted weeklyto ensure if there is a new medication listed it has been added to theelectronic medication profile and drug interactions run. Once 100% complianceis achieved 10% will be audited quarterly to ensure compliance is maintained. (In-going)

Director of Nursing will ensure all printed medicationprofiles are signed by agency clinician. Medication reconciliation is to bedone by agency clinician with the patient. There is to be documentation inelectronic record that medication reconciliation has been done with patient.Once 100% compliance is achieved 10% will be audited quarterly

	the alternate administrator indicated the medication profile was last signed and dated in the electronic medical record by person A on 2/5/2022. 4. During an observation of care on 2/16/2022, at 11:48 AM, for patient #2, start of care 7/16/2021, the patient s medications were observed in a bag provided by the patient s daughter. Atorvastatin (a medication used to treat high cholesterol) and Donepezil (a medication used to treat Alzheimer s Disease, a disease affecting memory loss and cognitive abilities) were observed in prescription bottles in the bag. Amlodipine (a medication used to treat high blood pressure) was observed with a label that indicated the patient was to take 5 milligrams (mg) daily. A bottle labeled Prednisolone (a medication used to treat inflammation and allergies of the eye) was observed on the patient s dresser. The patient s daughter indicated the bottle was eye drop medication for the patient s eyes. Clinical record review on 2/16/2022, evidenced an agency document titled Medication Profile . This document failed to be signed and dated by a clinician. Review failed to evidence Atorvastatin, Donepezil, and Prenisolone. This document indicated the patient was to take Amlodipine 10 mg daily. During an interview on 2/18/2022, at 12:02 PM, the alternate administrator indicated the medication profile was last signed and dated in the electronic medical record by person A on 2/5/2022. 5. During an observation of care on 2/18/2022, at 1:17 PM, for patient #3, start of care 1/8/2022, the patient s medications were observed in a box provided by the patient s caregiver. Metalozone (a medication that reduces the amount of water in the body to treat fluid retention and high blood pressure), Vitamin D3 (vitamin supplement), and Dulcolax (a medication used to treat constipation) were observed in the patient s box of medications. During an interview at the patient s home on		(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

2/18/2022, at 1:17 PM, the patient s caregiver indicated the patient was administered Basaglar (a type of insulin, an injectable medication used to treat high blood sugar) 24 units in the morning and 50 units in the evening. Patient s caregiver indicated the patient no longer takes Linzess (a medication used to treat chronic constipation and irritable bowel syndrome).

Clinical record review on 2/21/2022, evidenced an agency document titled SN [skilled nurse] Wound Care Visit , electronically signed by licensed practical nurse (LPN) H and dated 1/25/2022. This document indicated the LPN assessed the patient s pain to be rated 2 on a scale of 0-10. This document indicated the patient s pain was relieved by medication.

Review evidenced an agency document titled Medication Profile . This document failed to be signed and dated by a clinician. Review failed to evidence Metalozone, Vitamin D3, and Dulcolax. This document indicated the patient was to take Linzess daily and Basaglar 15 units in the morning and 45 units in the evening. This document failed to evidence a medication for pain was reviewed.

During an interview on 2/21/2022, at 1:15 PM, the alternate administrator indicated the medication profile was last signed and dated in the electronic medical record by person A on 2/5/2022. At 1:33 PM, the alternate administrator indicated she was unsure what pain medication the patient was taking and indicated the medication should have been included on the medication profile and reviewed for potential adverse effects.

6. Clinical record review on 2/21/2022, for patient #4, start of care 2/2/2022, evidenced an agency document titled Medication Profile . This document failed to be signed and dated by a clinician. Review failed to evidence the patient s medication had been reviewed for potential side effects.

During an interview on 2/21/2022, at 12:20 PM, the alternate administrator indicated the medication profile was signed by person A on 2/19/2022.

7. Clinical record review on 2/21/2022, for patient #5, start of care 2/2/2022, evidenced an agency document titled Medication Profile . This document failed to be signed and dated by a clinician. Review failed to evidence the patient s medication had been reviewed for potential side effects.

During an interview on 2/21/2022, at 12:20 PM, the alternate administrator indicated the medication profile was signed by person A on 2/19/2022.

8. Clinical record on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled Medication Profile . This document failed to be signed and dated by a clinician. Review failed to evidence the patient s medication had been reviewed for potential side effects.

During an interview on 2/21/2022, at 12:20 PM, the alternate administrator indicated the medication profile was signed by person A on 1/6/2022.

9. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled Medication Profile . This document failed to be signed and dated by a clinician.

Review of agency documents titled SN Teaching/Training Visit , electronically signed by RN F and dated 11/23/2021, 12/2/2021, 12/7/2021, and 12/14/2021, indicated the patient used laxatives (medication used for the treatment of constipation) and/or enemas (a treatment to treat constipation by injecting a solution into the colon through the rectum). Review failed to evidence the medication profile included a laxative or enema had been reviewed for potential adverse effects.

During an interview on 2/18/2022, at 11:16 AM, the alternate administrator indicated there was not a laxative or enema that had been reviewed for potential adverse effects.

During an interview on 2/21/2022, at 12:20 PM, the alternate administrator indicated the medication profile was signed by person A on

	1/22/2022. 10. During an interview at the entrance conference on 2/14/2022, at 10:14 AM, the alternate administrator indicated the medication review is completed when the medication is entered on to the medication profile in the electronic medical record. The alternate administrator indicated the drug interactions are checked when the RN clicks the drug interaction button on the medication profile in the electronic medical record. The alternate administrator indicated if the medication is not entered in the medication profile, the medication has not been reviewed for drug interactions. 11. During an interview on 2/18/2022, at 11:24 PM, when queried why the printed copies of the medication profile were not signed or dated, the alternate administrator indicated the document should be signed and dated by the clinician who reviewed the medications. The alternate administrator indicated person A, a registered nurse from a company that performs the agency s quality assurance, signed and dated the medication profiles and indicated she was unsure why the medication profiles were not signed when printed. The alternate administrator indicated person A was not a direct employee, did not provide direct patient care, and did not conduct the medication reconciliation with the patient. The alternate administrator indicated person A used the list of medications obtained by the nurse who completed the comprehensive assessment in the home. 17-14-1(a)(1)(B)			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than-	G0544	G0544 Director of Nursing will in-service clinicians that whenpatient has a significant change the comprehensive assessment is to be updated.This would include new wounds. (4/1/2022)	2022-04-01

	Based on record review and interview, the agency failed to ensure the comprehensive assessment was updated and revised to include new wounds in 1 of 3 active clinical records reviewed with wounds. (#2) The findings include: Review of an agency policy obtained 2/21/2022, titled Reassessments/Update of the Comprehensive Assessment revised February 2021, stated, & The comprehensive assessment (including OASIS [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] data elements) must be updated and revised as frequently as the patient s condition warrants due to a major improvement or decline in health status & Each patient will be reassessed when: A significant change in condition, status, diagnosis, care, environment or support system occurs. A marked improvement of worsening of a patient s condition, which changes, and was not anticipated in, the patient s plan of care would be considered a major decline or improvement in the patient s health status that would warrant an update and revision of the comprehensive assessment &. Clinical record review on 2/17/2022 and 2/21/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled OASIS-D1 Recertification , signed and dated by registered nurse (RN) D on 1/7/2022. This document indicated the patient had 2 pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (an open pressure ulcer with partial thickness loss of skin), 1 located on the left buttock and 1 located on the right buttock. Review of an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022, which was signed by the physician on 2/4/2022, indicated the patient had a pressure ulcer to the left buttock and a pressure ulcer to the right buttock. The document indicated the skilled nurse was to clean the wounds with normal saline (a solution used to clean wounds) and		Director of Nursing will audit all visit/communication notessubmitted weekly. If there is documentation of a significant change in patientstatus Director will ensure that the comprehensive assessment has been updatedto reflect the change. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	apply barrier ointment. Review of an agency document titled SN [skilled nurse] Wound Care Visit , dated and electronically signed by RN D on 2/9/2022, evidenced two new pressure ulcers Stage II to the left lateral buttock. Review of an agency document titled Physician Order , electronically signed and dated by the alternate administrator on 2/9/2022, evidenced the 2 wounds to the left lateral buttocks were to be cleaned with normal saline, apply anasept gel (an antimicrobial wound gel) to the wound bed, apply calcium alginate (a highly absorptive wound dressing), and cover with mepilex (a foam dressing) 2 times a week. Review failed to evidence the comprehensive assessment was updated and revised to reflect the 2 wounds to the left lateral buttock. During an interview on 2/18/2022, at 12:39 PM, the alternate administrator indicated a new wound is a significant change and indicated the comprehensive assessment was not updated and revised. 17-14-1(a)(1)(B)			
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	G0570	G0570 See G0572, G0574, G0578, G0580, G0584, G0588, G0590, G0592,G0598, G0606, G0614, G0616, G0618, G0622 Director of Nursing will ensure OASIS D-1 for patient #4,cited in survey, is signed by clinician who completed assessment. (3/3/2022) Director of Nursing will audit all OASIS assessments doneeach week to ensure if documentation indicates patient would benefit fromtherapy or social worker there is documentation MD was contacted to discusspatient status and request an order for therapy/social	2022-04-01

individualized and followed by all agency staff (See tag G0572); the plan of care included all required information / elements for the treatment of the patient (See tag G0574); services and treatment were provided as ordered by a physician (See tag G0578); all treatments provided by agency staff were ordered by a physician (See tag G0580); the physician's verbal orders were documented in the patient's clinical record to include a signature, date and time of the order and failed to ensure the verbal orders were authenticated and dated by the physician (See tag G0584); the plan of care was reviewed by the patients primary care physician at least every 60 days (See tag G0588); physicians were promptly notified of a change in the patient's condition (See tag G0590); the plan of care was revised to reflect current health status and nursing needs (See tag G0592); revisions to the plans for patient discharge were communicated to the physician responsible for the plan of care (See tag G0598); coordination of care for all services provided to the patient (See tag G0606); the written visit schedule was provided to patients (See tag G0614); written instructions were provided to the patient for the patient's medication schedule and instructions (See tag G0616); the treatments to be administered by agency personnel were provided to the patient and caregiver in writing (See tag G0618); and the name and contact information of the clinical manager were provided in writing to the patient and caregiver (See tag G0622).

The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care.

A deficient practice citation was also evidenced at this standard as follows:

Based on record review and interview, the

worker. If agency isunable to provide therapy services they will notify MD. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going)

Director of Nursing will instruct clinicians that when theyreceive a verbal order they are write the order at the time. (4/1/2022)

The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

agency failed to ensure the patient s medical and social needs were met in 3 of 7 clinical records reviewed. (#4. #5, #6)

The findings include:

1. Review of an agency policy obtained 2/21/2022, titled Plan of Care CMS [Centers for Medicare and Medicaid Services] #485 [a document used by the home care agency and serves as the plan of care] and Physician/Practitioners Orders revised February 2021, stated, & Patients are accepted for treatment on the reasonable expectation that Agency can meet the patient s medical, nursing, rehabilitative and social needs &.
2. Review of an agency policy obtained 2/21/2022, titled Care Planning Process revised February 2021, stated, & In order to assure that care provided is appropriately planned to meet each patient s specific needs and problems, the Agency will utilize data/information gathered during patient assessments in the care planning process &.

3. Clinical record review on 2/17/2022, for patient #4, start of care 2/2/2022, evidenced an unsigned agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Start of Care with a visit date of 2/2/2022. This document indicated the patient had poor balance, a shuffling and unsteady gait, limited range of motion to both lower extremities, muscle weakness, a history of falls, and at risk for falls. Review failed to evidence the agency offered the patient physical therapy (PT) services and failed to evidence the agency met the patient s need for physical therapy services based on the comprehensive assessment.

During an interview on 2/18/2022, at 3:47 PM, when queried why the patient was not offered physical therapy services based on the initial comprehensive assessment, the alternate administrator indicated the patient was accepting of physical therapy services. The alternate administrator stated, We had a little tightness in [physical therapist I] schedule. The alternate administrator indicated the agency

could have had another PT complete the evaluation.

4. Clinical record review on 2/17/2022, for patient #5, start of care 2/2/2022, evidenced an unsigned agency document titled OASIS-D1 Start of Care with a visit date of 2/2/2022. This document indicated the patient had an unsteady gait, poor balance, had limited range of motion to both lower extremities, required the use of a walker for ambulation, had a history of falls, was at a risk of falls, and had limited endurance. Review failed to evidence the agency offered the patient physical therapy services and failed to evidence the agency met the patient s need for physical therapy services based on the comprehensive assessment.

During an interview on 2/18/2022, at 4:07 PM, the alternate administrator indicated she had received a verbal order from the patient s physician for physical therapy services and indicated she had not yet written the verbal order. The alternate administrator indicated the agency was waiting for the return of PT I to complete the PT evaluation and indicated the agency had not met the patient s need for PT services.

5. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled OASIS-D1 Recertification , electronically signed and dated by RN D on 11/22/2021. This document indicated the patient s primary diagnosis was heart disease with heart failure and used oxygen at 2 liters per minute as needed. This document indicated the patient lived alone with no available caregivers. Review indicated the patient had urinary incontinence (loss of bladder control), had poor balance, had an unsteady gait, had limited range of motion, was at risk for falls, and needed assistance with activities of daily living (ADL).

Review failed to evidence the agency evaluated the patient s need for and provided social work services.

During an interview on 2/16/2022, at 11:55 AM, RN D indicated the patient lives alone,

	was unable to walk, weighs over 300 pounds, and uses a wheelchair. RN D stated, She has COPD [chronic obstructive pulmonary disease, a lung disease causing difficulty breathing) and heart disease real bad. RN D indicated the patient needs assistance. During an interview on 2/18/2022, at 10:00 AM, the alternate administrator indicated social services should evaluate a patient for services if the patient did not have a caregiver or lived alone. At 11:04 AM, the alternate administrator indicated the social worker should have been called. 6. During an interview at the entrance conference on 2/14/2022, at 10:14 AM, the alternate administrator indicated the agency provided PT and social work services. 17-13-1(a)			
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 agency failed to ensure services were provided to the patient as directed in the plan of care in 7 of 7 clinical records reviewed. (#1, #2, #3, #4, #5, #6, #7) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Plan of Care CMS [Centers for Medicare and Medicaid Services] #485 [a document used by the home care agency and serves as the plan of care] and Physician/Practitioners Orders revised	G0572	G0572 Director of Nursing/designee will review patient schedulesweekly to ensure the ordered frequency for each discipline is followed. Iffrequency is not met is there a missed visit note, does missed visit noteindicate reason for missed visit and is there documentation agency attempted tomake up that visit during that week. Once 100% compliance is achieved 10% willbe audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-01

February 2021, stated, & Each patient must receive the home health services that are written in an individualized plan of care &.

2. Clinical record review on 2/16/2022, for patient # 1, start of care 9/4/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 12/28/2021 2/25/2022, which was signed by the physician on 1/23/2022. This document indicated the patient was to receive skilled nursing services one time a week for 9 weeks. Review failed to indicate the patient received skilled nursing services during the week of 1/30/2022 as directed in the plan of care.

Review of an agency document titled Missed Visit , signed and dated by the registered nurse (RN) D on 2/1/2022, indicated the patient refused the visit. This document failed to evidence the patient was offered to reschedule the visit during the week of 1/30/2022.

During an interview on 2/28/2022, at 11:43 AM, the alternate administrator indicated the agency did not provide skilled nursing services during the week of 1/30/2022 as directed in the plan of care.

3. Clinical record review on 2/17/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022, which was signed by the physician on 2/4/2022. This document indicated the patient was to receive skilled nursing services 1 time a week for 9 weeks. Review failed to evidence skilled nursing services were provided during the week of 1/30/2022 as directed in the plan of care.

Review of an agency document titled Missed Visit , electronically signed and dated by RN D on 2/3/2022, indicated the patient refused the visit. This document failed to evidence the patient was offered to reschedule the visit during the week of 1/30/2022.

During an interview on 2/18/2022, at 12:27 PM, the alternate administrator indicated the agency

week of 1/30/2022.

4. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/8/2022 3/8/2022, which was signed by the physician on 2/4/2022. This document indicated the patient was to receive home health aide (HHA) services 2 times a week for 8 weeks beginning the week of 1/9/2022. Review failed to evidence HHA services were provided 2 times during the week of 1/16/2022, 1/23/2022, 1/30/2022, 2/6/2022, and 2/13/2022, as directed in the plan of care.

Review of agency documents titled Missed Visit , electronically signed and dated by home health aide (HHA) E and dated 1/20/2022, 1/25/2022, 2/1/2022, 2/8/2022, and 2/15/2022, indicated the family/caregiver was able to assist the patient. Review failed to evidence the reason for the missed visits and failed to evidence the patient was offered to reschedule the visit during the week of 1/16/2022, 1/23/2022, 1/30/2022, 2/6/2022, and 2/13/2022.

Review of an agency document titled PT [physical therapy] Plan of Care , electronically signed by PT I and dated 1/12/2022, indicated the patient was to receive PT services 1 time a week for 1 week and 2 times a week for 4 weeks. Review failed to evidence the patient received PT services during the week of 1/23/2022, week 3 of PT services, and during the week of 1/30/2022, week 4 of PT services, as ordered in the plan of care.

Review of agency documents titled Missed Visit electronically signed by PT I, indicated the patient refused the PT visit because he was tired on the document dated 1/25/2022. Review of the document dated 1/27/2022 and 2/1/2022 indicated the patient refused the PT visits. Review failed to evidence the patient was offered to reschedule the visits during the week of 1/23/2022 and 1/30/2022.

During an interview on 2/21/2022, at 1:43 PM, the alternate administrator indicated there was no documentation of attempts to reschedule the

missed visits.

5. Clinical record review on 2/17/2022, for patient #4, start of care 10/1/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/25/2021 1/23/2022, which was signed by the physician on 12/16/2021. This document indicated skilled nursing services would be provided 1 time a week for 8 weeks beginning the week of 11/28/2021. Review failed to evidence skilled nursing services were provided during the week of 1/2/2022.

Review of an agency document titled Missed Visit , electronically signed and dated by licensed practical nurse (LPN) J on 1/5/2022, evidenced the patient refused the visit. Review failed to evidence the patient was offered to reschedule the visit during the week of 1/2/2022.

During an interview on 2/18/2022, at 3:49 PM, the alternate administrator indicated skilled nursing services were not provided during the week of 1/2/2022 and indicated there was no documentation the patient was offered to reschedule the visit.

6. Clinical record review on 2/17/2022, for patient #5, start of care 7/20/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 9/13/2021 11/11/2021, which was signed by the physician on 10/6/2021. This document indicated skilled nursing services were to be provided 1 time a week for 9 weeks. Review failed to evidence skilled nursing services were provided during the week of 9/26/2021 as directed in the plan of care.

Review of an agency document titled Missed Visit , electronically signed by the alternate administrator and dated 9/29/2021, evidenced the patient refused the visit. Review failed to evidence the patient was offered to reschedule the visit during the week of 9/26/2021.

During an interview on 2/18/2022, at 4:11 PM, the alternate administrator indicated skilled nursing services were not provided during the week of 9/26/2021 and indicated there was no

documentation the patient was offered to reschedule the visit.

7. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/25/2021 1/23/2022, which was signed and dated by the physician on 12/16/2021. This document indicated the agency was to provide skilled nursing services 1 time a week for 8 weeks beginning the week of 11/28/2021 and indicated the agency was to provide home health aide services 2 times a week for 9 weeks. Review failed to evidence the agency provided skilled nursing services as directed in the plan of care during the week of 12/12/2021. Review failed to evidence the agency provided home health aide services 2 times a week as directed in the plan of care during the week of 11/25/2021.

Review evidenced agency documents titled Missed Visit , electronically signed and dated by HHA C on 11/25/2021 and 11/27/2021, which indicated the family/caregiver was able to assist the patient and failed to evidence the reason for the missed visits. Document electronically signed and dated by RN D on 12/15/2021, indicated the patient refused the visit. Review failed to evidence the patient was offered to reschedule the missed visits.

During an interview on 2/18/2022, at 10:33 AM, the alternate administrator indicated the agency did not provide home health aide services during the week of 11/25/2021 and indicated the agency did not provide a skilled nursing visit during the week of 12/12/2021.

8. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/19/2021 1/17/2022, which was signed by the physician on 12/16/2021. This document indicated skilled nursing services were to be provided 1 time a week for 9 weeks. Review failed to evidence skilled nursing services were provided during the weeks of

	directed in the plan of care. Review of agency documents titled Missed Visit , electronically signed and dated by RN F on 12/21/2021, 12/28/2021, and 1/4/2022, indicated the patient refused the visit. Review failed to evidence the patient was offered to reschedule the missed visits. During an interview on 2/18/2022, at 11:18 AM, the alternate administrator indicated skilled nursing services were not provided during the weeks of 12/21/2021 and 12/28/2021. The alternate administrator indicated there were no offers to reschedule the visits. 9. During an interview on 1/21/2022, at 1:27 PM, the alternate administrator indicated the missed visit document should indicate why the visit was missed and if the patient was offered to reschedule the visit. 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (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.	G0574	G0574 Director of Nursing willin-service clinicians on what must be included on the patient's plan of care: (4/1/2022) (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 ofvisits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations;	2022-04-01

(xiii) Patient and caregiver education and training to facilitate timely discharge;

(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;

(xv) Information related to any advanced directives; and

(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.

Based on observation, record review, and interview, the agency failed to ensure the plan of care was individualized to include all medications, services, treatments, and patient-specific interventions in 5 of 7 clinical records reviewed. (#1, #2, #3, #6, #7)

The findings include:

1. Review of an agency policy obtained 2/21/2022, titled Plan of Care CMS [Centers for Medicare and Medicaid Services] #485 [a document used by the home care agency and serves as the plan of care] and Physician/Practitioners Orders revised February 2021, stated, & The individualized plan of care must include the following: & The types of services, supplies and equipment required & All medications and treatments & Patient-specific interventions and education, measurable outcomes and goals &.

(viii) Activities permitted;

(ix) Nutritional requirements;

(x) All medications andtreatments;

(xi) Safety measures to protectagainst injury;

(xii) A description of thepatient's risk for emergency department visits and hospital re-admission, andall necessary interventions to address the underlying risk factors.

(xiii) Patient and caregivereducation and training to facilitate timely discharge;

(xiv) Patient-specificinterventions and education; measurable outcomes and goals identified by theHHA and the patient;

(xv) Information related to anyadvanced directives; and

(xvi) Any additional items the HHAor physician or allowed practitioner may choose to include.

	2. Clinical record review on 2/16/2022, for patient # 1, start of care 9/4/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 12/28/2021 2/25/2022. This document indicated the skilled nurse was to report to the physician if unrelieved pain was more than 6 on a scale of 0 10 and indicated the skilled nurse was to report to the physician if severe pain rated more than 7 on a scale of 0 10 was not relieved with pain medication. This document indicated the skilled nurse was to provide skilled nursing services 1 time a week for 9 weeks. This document indicated the patient s safety precautions included oxygen precautions and indicated the patient used oxygen as needed. The patient s medication included Breo Ellipta (an inhaled medication used to treat chronic obstructive pulmonary disease and asthma). Review of agency documents titled SN [skilled nurse] Wound Care Visit dated 12/29/2021, 1/5/2022, 1/12/2022, 1/19/2022, 1/26/2022, 2/9/2022, and signed by registered nurse (RN) D, indicated the RN filled the pill box. The plan of care failed to evidence the skilled nursing services included the fill of the pill box. During an interview on 2/18/2022, at 11:39 AM, the alternate administrator indicated the plan of care was unclear with what pain rating should be reported to the physician and indicated the plan of care should not have different pain reporting parameters for when to notify the physician. At 11:54 AM, the alternate administrator indicated the plan of care should include the skilled nursing intervention of filling the pill box. During an observation of care at the patient s home on 2/16/2022, at 9:59 AM, no oxygen or oxygen supplies were observed in the patient s home. The patient indicated she no longer uses oxygen and had the oxygen supply company pick up her oxygen a long time ago. The patient s medications were observed, and Breo Ellipta was not observed in the patient s medications. The patient indicated she no longer took her inhaler medication. Home Health Aide (HHA)		Director of Nursing willin-service clinicians on need to ensure 485/plan of care is individualized foreach patient. This will be based on assessment of patient and MD orders. Thisincludes listing all medications, DME/supplies, precautions, specific ordersfor wound/stoma care, for tube feedings – name/amount/frequency of feeding/amount and frequency of water flushes, tasks to be provided by disciplines. (4/1/2022) Director of Nursing will ensurenurse contacts MD for patient #1, cited in survey, to obtain clarificationorder to clarify specific pain level that MD is to benotified of, add medication set up, list meds that are no longer being usedby patient, add briefs and safety precautions. (3/27/2022) Director of Nursing will ensurenurse contacts MD for patient #2, cited in survey, to obtain verbal order toadd the specific stoma site care that is to be done, what the foley catheter isto be inflated with, goals related to diabetes, the type of formula, amount,frequency of tube feedings, water flushes, oxygen and aspiration precautions,medication prefills. (3/27/2022) Unable to correct issues withpatient #3 cited in survey as discharge 3/4/2022. Unable to correct issues withpatient #6	

	labeled Ammonium Lactate (a topical medication used to treat dry, scaly skin conditions) to the patient s legs. Review failed to evidence the plan of care was individualized to reflect the patient s current medication and safety precautions. Patient was observed wearing incontinence briefs. Review failed to evidence the plan of care included incontinence briefs were included in the patient s medical supplies. During an interview on 2/18/2022, at 11:55 AM, the alternate clinical manager indicated oxygen should not be listed on the plan of care if the patient was not using it. At 12:00 PM, the alternate administrator indicated the ammonium lactate was not included on the plan of care but should be. At 12:02 PM, the alternate administrator indicated the Breo Ellipta inhaler should not be included on the plan of care if the patient was no longer taking the medication. At 12:03 PM, the alternate administrator indicated incontinence briefs should be included in the patient s supplies on the plan of care. 3. During an observation of care on 2/16/2022, at 10:58 AM, at the home of patient #2, start of care 7/16/2021, an oxygen concentrator (a medical device for oxygen therapy) and an oxygen tank were observed in the corner of the patient s bedroom. Clinical record review on 2/17/2022, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Recertification , dated and electronically signed by RN D on 1/7/2022, which indicated the patient was NPO (nothing by mouth) and received tube feedings of Diabetic Source (a type of tube feeding formula) 2 cans four times a day through his gastrostomy. Review indicated the patient was to receive 100 milliliters (ml) of water through the gastrostomy before and after tube feedings. Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022. This document evidenced the patient s diagnoses included, but were not limited to, pressure		cited in survey as the certification period expired 1/23/22. Director of Nursing will in-service the clinician that didthe plan of care cited on the issues cited. (3/19/2022) Unable to correct issues with patient#7 cited in survey as the certification period expired 1/17/22. Director ofNursing will in-service the clinician that did the plan of care cited on theissues cited. (3/22/2022) Director of Nursing/designee willaudit all 485/plans of care done each week to ensure they contain all therequired components, are applicable, and individualized to each patient. Theassessment, medication profile will be reviewed and compared to the plan ofcare to ensure all information on plan of care is accurate. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) to the left and right buttocks, gastrostomy (a tube surgically inserted into the stomach through the abdomen used to administer nutrition, fluid, and/or medication), and diabetes (a chronic condition which affects the way the body processes blood sugar). This document indicated the skilled nurse was to provide stoma (an opening in the body) care at the gastrostomy site and failed to evidence what the individualized care was to be provided at the site. This document indicated the patient was NPO (nothing by mouth). Review of this document indicated the patient had a foley catheter (an indwelling plastic tube inserted into the bladder to drain urine), which the skilled nurse was to change monthly. This document indicated the nurse was to inflate the catheter balloon to 10 milliliters (ml), and the plan of care failed to evidence with what substance the balloon was to be inflated. Review of the plan of care indicated blood sugar parameters for the patient and failed to evidence patient-specific goals related to the diagnosis of diabetes. This document indicated the patient was NPO and received tube feedings and failed to evidence the type of formula, the amount, and the frequency of the tube feedings the patient received. Review failed to evidence the water flushes through the gastrostomy the patient was to receive. This document failed to include oxygen and aspiration (when food, fluid or another substance enters the airway or lungs accidentally, may occur when there is difficulty with swallowing) precautions as individualized patient safety measures.

During an interview on 2/18/2022, at 12:08 PM, the alternate administrator indicated the stoma care was probably to clean the site with normal saline (a solution used to clean wounds) and apply a split gauze. At 12:16 PM, the alternate administrator indicated the oxygen precautions should have been included on the plan of care. At 12:17 PM, the alternate administrator indicated aspiration precautions should have been included in the comprehensive assessment due to the patient s NPO status. At 12:19 PM, the alternate administrator indicated the foley

catheter balloon was to be inflated with normal saline and indicated it should be included in the plan of care. At 12:20 PM, the alternate administrator indicated patient-specific goals that should have been included on the plan of care related to the diagnosis of diabetes included blood sugars would remain within a specific range and the patient would not have any signs and symptoms of hyperglycemia (high blood sugar) and hypoglycemia (low blood sugar).

During an interview on 2/21/2022, at 1:14 PM, the alternate clinical manager indicated the information about the tube feedings and the water flushes should be included on the plan of care.

Review of agency documents titled SN [skilled nurse] Wound Care Visit dated 1/18/2022, and signed by RN D, indicated the RN filled the pill box. The plan of care failed to evidence the skilled nursing services included the fill of the pill box.

During an interview on 2/18/2022, at 12:25 PM, the alternate administrator indicated all skilled nursing interventions should be listed on the plan of care including the fill of the pill box.

4. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/8/2022 3/8/2022. This document indicated the skilled nurse was to report to the physician if unrelieved pain was more than 6 on a scale of 0 10 and indicated the skilled nurse was to report to the physician if severe pain rated more than 7 on a scale of 0 10 was not relieved with pain medication.

During an interview on 2/21/2022, at 1:15 PM, the alternate administrator indicated she was unsure what the patient s individualized pain parameter was and indicated it was unclear on the plan of care.

Clinical record review on 2/21/2022, evidenced an agency document titled SN [skilled nurse] Wound Care Visit , electronically signed by

1/25/2022. This document indicated the LPN assessed the patient s pain to be rated 2 on a scale of 0-10. This document indicated the patient s pain was relieved by medication. The plan of care failed to evidence a medication for pain was included.

During an interview on 2/21/2022, at 1:33 PM, the alternate administrator indicated she was unsure what pain medication the patient was taking and indicated it should have been included on the plan of care.

5. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled OASIS-D1 Recertification , electronically signed and dated by RN D on 11/22/2021. This document indicated the patient lived alone with no available caregivers.

During an interview on 2/16/2022, at 11:55 AM, RN D indicated the patient lives alone.

Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/25/2021 1/23/2022, which was signed and dated by the physician on 12/16/2021. This document indicated the patient s discharge plan was to discharge to the care of the caregiver and indicated the caregiver was to demonstrate the necessary skills to aid the patient in managing disease process. Review failed to evidence the plan of care was individualized to include discharge plans for the patient living alone without a caregiver.

During an interview on 2/18/2022, at 11:04 AM, the alternate administrator indicated the patient lived alone, did not have a caregiver, and the plan of care was not correct.

6. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/19/2021 1/17/2022. This document evidenced the patient s medications included, but were not limited to, Voltaren gel (a topical pain medication typically used to treat arthritis) daily to affected area for joint paint. The plan of care failed to evidence which joints of the body

	were affected and where the medication was to be applied. Review of agency documents titled SN Teaching/Training Visit , electronically signed by RN F and dated 11/23/2021, 12/2/2021, 12/7/2021, and 12/14/2021, indicated the patient used laxatives (medication used for the treatment of constipation) and/or enemas (a treatment to treat constipation by injecting a solution into the colon through the rectum). Review failed to evidence the plan of care included a laxative medication or enema treatment as documented to be used by the patient. During an interview on 2/18/2022, at 11:16 AM, the alternate administrator indicated there was not a laxative or enema that had been reviewed for potential adverse effects. During an interview on 2/18/2022, at 11:06 AM, the alternate administrator indicated she thought the affected areas where the patient was to apply the Voltaren gel were the patient s knees but was unsure. At 11:16 AM, the alternate administrator indicated the plan of care did not include the laxative medication or enema treatment. 17-13-1(a)(1)(D)(viii, ix, x, xiii)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on observation, record review, and interview, the agency failed to ensure treatments and services were provided as ordered by the physician in 3 of 7 clinical records reviewed. (#2, #5, #7) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Plan of Care CMS [Centers for Medicare and Medicaid Services] #485 [a document used by the home care agency and	G0580	G0580 Director of Nursing will in-service clinicians onrequirement to follow wound care orders as given by MD and an order must beobtained from MD to give a flu vaccine. (4/1/2022) Director of Nursing will ensure clinician contacts MDregarding patient #2, cited in survey, to clarify wound care orders – what wasto be done for each wound and obtain an order for the care that was provided. (3/30/2022)	2022-04-01

	serves as the plan of care] and Physician/Practitioners Orders revised February 2021, stated, & Drugs, services and treatments are administered by staff only as ordered by physician/practitioner &. 2. Clinical record review on 2/17/2022 and 2/21/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Recertification , signed and dated by RN D on 1/7/2022. This document indicated the patient had 2 pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (an open pressure ulcer with partial thickness loss of skin), 1 located on the left buttock and 1 located on the right buttock. Review of an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022, which was signed by the physician on 2/4/2022, indicated the patient had a pressure ulcer to the left buttock and a pressure ulcer to the right buttock. The document indicated the skilled nurse was to clean the wounds with normal saline (a solution used to clean wounds) and apply barrier ointment. Review of an agency document titled SN [skilled nurse] Wound Care Visit , dated and electronically signed by RN D on 2/9/2022, evidenced two new pressure ulcers Stage II to the left lateral buttock. Review of an agency document titled Physician Order , electronically signed and dated by the alternate administrator on 2/9/2022, evidenced the 2 wounds to the left lateral buttocks were to be cleaned with normal saline, apply anasept gel (an antimicrobial wound gel) to the wound bed, apply calcium alginate (a highly absorptive wound dressing), and cover with mepilex (a foam dressing) 2 times a week. During an observation of care at the patient s home on 2/16/2022, at 11:19 AM, the patient was observed lying on his right side with an uncovered, open area to the left buttock and an		Unable to correct issue found with patient #6, cited insurvey, as issue goes back to 9/2021. Unable to correct issue found with patient #7, cited insurvey, as issue goes b ack to 12/2/21. Director of Nursing/designee will audit all visit notessubmitted weekly. Visits for wound care will be compared to the plan ofcare/verbal orders to ensure wound care is being done as ordered by MD. Anynote that indicates a flu vaccine was administered there needs to be an orderto administer it. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

uncovered, open area to the right buttock. The patient was observed to have a transparent, adhesive dressing to the right buttock on the right side of the uncovered, open area to the right buttock. RN D indicated the uncovered, open area to the left buttock and the uncovered, open area to the right buttock were the original wounds. RN D was observed removing the transparent, adhesive dressing to the right buttock and 2 open areas were observed to the right of the uncovered, open area on the right buttock. At 11:23 AM, RN D was observed spraying a liquid identified by RN D as normal saline on open area to the left buttock and 3 open areas to the right buttock. RN D was observed wiping the open areas with a gauze pad and was observed spreading the skin on the buttock while wiping the open areas. An open area at 5 o clock from the open area to the left buttock was observed to the inner left buttock. At 11: 25 AM, RN D was observed applying a gel from a bottle labeled Anasept to a white material RN D identified as alginate. RN D was observed applying the white material with the gel onto the middle right buttock open area and to the outer right buttock open area. RN D was observed covering the inner right buttock open area, the middle right buttock open area, and the outer right buttock open area with a foam dressing RN D identified as a mepilex dressing. RN D was not observed applying the barrier cream to the inner right buttock open area before covering with the foam dressing as ordered by the physician on the plan of care. RN D was observed applying a cream RN D identified as calmoseptine (a barrier ointment to protect the skin from moisture) to the open area on the left buttock and to the open area at 5 o clock of the open area on the left buttock on the inner left buttock.

During an interview on 2/21/2022, at 12:55 PM, the alternate administrator indicated the skilled nurse should follow the physician order for wound treatments. At 1:08 PM, the alternate administrator indicated she was unsure why the wound documentation from RN D on 2/9/2022 documented the 2 open areas to the left lateral buttocks when RN D identified the 2 observed open areas on the right buttock to be the new

wounds. The alternate administrator indicated there was not a wound treatment order for the calmoseptine applied to the open area to the left inner buttock and indicated there was not an order for the anasept and alginate applied to the open areas on the right middle buttock and the right outer buttock. The alternate administrator indicated the physician order on 2/9/2022 was supposed to be for the two new wounds to the right lateral buttock and indicated the RN must have documented the wrong location. The alternate administrator indicated there was not an order for the anasept gel, alginate, and foam dressing that was applied to the right inner buttock. The alternate administrator indicated the RN should have applied barrier cream as indicated in the plan of care.

3. Clinical record review on 2/17/2022, for patient #5, start of care 7/20/2020, evidenced an agency document titled SN Teaching/Training Visit , electronically signed by licensed practical nurse (LPN) K and dated 9/21/2021. This document indicated the patient had eye lid surgery on 9/16/2021 and the eye had 9 sutures. Review indicated the nurse assessed a surgical wound to the right lateral eye with an incision to include 9 intact sutures with an onset date of 9/16/2021. This document indicated the nurse cleaned the surgical wound with normal saline and left open to air. Review failed to evidence a physician s order for the treatment to the right eye surgical wound for the cleaning of the wound.

During an interview on 2/18/2022, at 4:13 PM, the alternate administrator indicated there was not a physician order for the treatment to the right eye surgical wound.

4. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled SN Teaching/Training Visit , electronically signed by RN F and dated 12/2/2021. This document indicated the RN administered the influenza vaccine to the right upper arm. Review failed to evidence an order for the administration of the influenza vaccine.

During an interview on 2/16/2022, at 1:44 PM,

	the alternate administrator indicated the agency obtained a physician order for the influenza vaccine before administering to the patient. During an interview on 2/18/2022, at 11:08 AM, the alternate administrator indicated there should have been a physician order for the influenza vaccine administration. The alternate administrator indicated she would check for an agency policy on the administration of vaccines. No additional information was provided. 17-13-1(a)			
G0584	Verbal orders 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. Based on record review and interview, the agency failed to ensure the clinician receiving the physician's verbal orders documented the order in the patient's clinical record to include a signature, date and time of the order and failed to ensure the verbal orders were authenticated and dated by the physician in 2 of 7 clinical records reviewed. (#5, #6) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Physician/Practitioner Orders Verbal Orders revised February 2021, stated, & When a verbal order is received, the order must be written down & A record of this order is documented on a supplemental order form. &	G0584	G0584 Director of Nursing will in-service clinicians onrequirement that physician verbal orders obtained from MD must be written whenreceived and be signed by clinician receiving order, be timed and dated whenreceived. (4/1/2022) Director of Nursing/designee will audit all verbal orderswritten each week to ensure they are signed by clinician and have time/datereceived. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) Director of Nursing will ensure the clinician that did thestart of care oasis for patient #5, cited in survey, signs the OASISassessment. (2/19/2022) Director of Nursing will ensure a plan of care is sent to MDfor patient #5, cited in survey, for certification period 2/2-4/2/2022. (2/23/2022)	2022-04-01

	authenticated by a licensed staff and submitted to the Agency within three (3) business days after receipt(s) &. 2. Clinical record review on 2/17/2022, for patient #5, start of care 2/2/2022, evidenced an agency document titled SN [skilled nurse] Teaching/Training Visit , electronically signed by licensed practical nurse (LPN) J and dated 2/9/2022. This document indicated the patient had some pain to the left knee and the nurse obtained an order for diclofenac sodium (a medication used to treat joint pain, swelling, and stiffness) gel. No plan of care was evidenced for the patient. Review failed to evidence a verbal order was written for the diclofenac sodium gel. During an interview on 2/18/2022, at 4:16 PM, the alternate administrator indicated there was not a verbal order written for the diclofenac sodium gel. Review evidenced an unsigned agency document titled OASIS-D1 Start of Care with a visit date of 2/2/2022. This document indicated the patient had an unsteady gait, poor balance, had limited range of motion to both lower extremities, required the use of a walker for ambulation, had a history of falls, was at a risk of falls, and had limited endurance. Review failed to evidence the agency offered the patient physical therapy (PT) services and failed to evidence a physician s order for PT services. During an interview on 2/18/2022, at 4:07 PM, the alternate administrator indicated she had received a verbal order from the patient s physician for physical therapy services and indicated she had not yet written the verbal order. 3. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled SN Teaching/Training Visit , electronically signed and dated by registered nurse (RN) D on 12/2/2021, which stated, & complaints [sic] of an abnormal feeling in the chest after nebulizer treatments [medications inhaled via a mist]. Md [medical doctor] notified of findings. States to order a		Director of Nursing will in-service clinicians onrequirement to sign/date all documentation. (4/1/2022) Director of Nursing will audit all OASIS assessments doneeach week to ensure if documentation indicates patient would benefit fromtherapy there is documentation MD was contacted to discuss patient status andrequest an order for therapy. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur. Requesting an IDR for: 3. Clinical record review on 2/14/2022, for patient #6,start of care 1/29/2021, evidenced an agency document titled “SNTeaching/Training Visit”, electronically signed and dated by registered nurse(RN) D on 12/2/2021, which stated, “… complaints [sic] of an abnormal feelingin the chest after nebulizer treatments [medications inhaled via a mist]. Md[medical doctor] notified of findings. States to order a chest X-ray, md officecalled to schedule X-ray….” Review failed to evidence a verbal order waswritten for the chest	

	chest X-ray, md office called to schedule X-ray &. Review failed to evidence a verbal order was written for the chest x-ray. During an interview on 2/18/2022, at 10:50 AM, the alternate administrator indicated the nurse did not write the verbal order given by the physician because the agency did not arrange the chest x-ray. 17-14-1(a)(H)		at 10:50 AM, thealternate administrator indicated the nurse did not write the verbal ordergiven by the physician because the agency did not arrange the chestx-ray.17-14-1(a)(H)	
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the agency failed to ensure the plan of care was reviewed by the physician responsible for the plan of care no less than every 60 days in 4 of 5 clinical records reviewed receiving agency services for at least 60 days. (#1, #2, #4, #6) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Plan of Care CMS [Centers for Medicare and Medicaid Services] #485 [a document used by the home care agency and serves as the plan of care] and Physician/Practitioners Orders stated, & The individualized plan of care must be reviewed and revised by the physician/practitioner who is responsible for the home health plan of care and the Agency as frequently as the patient s condition or needs require, but no less frequently than once every 60 days &. 2. Clinical record review on 2/16/2022, for patient # 1, start of care 9/4/2020, evidenced agency documents titled Home Health Certification and Plan of Care . Review of the document for certification period 8/30/2021 10/28/2021, evidenced the plan of care was signed by the physician on 9/2/2021. Review of	G0588	G0588 Director of Nursing will implement a tracking process toensure 485/plan of care are signed by MD at least every 60 days. Every plan ofcare will be entered on log. (4/1/2022) Director of Nursing will review tracking log weekly againstall plans of care done each week to ensure they are on the log. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-01

10/29/2021 12/27/2021, evidenced the plan of care was signed by the physician on 11/10/2021. Review of the document for certification period 12/28/2021 2/25/2022, evidenced the plan of care was signed by the physician on 1/23/2022. Review failed to evidence the physician reviewed the plan of care at least every 60 days.

3. Clinical record review on 2/17/2022, for patient #2, start of care 7/16/2021, evidenced agency documents titled Home Health Certification and Plan of Care . Review of the document for certification period 11/13/2021 1/11/2022, was signed by the physician on 11/29/2021. Review of the document for certification period 1/12/2022 3/12/2022, was signed by the physician on 2/4/2022. Review failed to evidence the physician reviewed the plan of care at least every 60 days.

4. Clinical record review on 2/17/2022, for patient #4, start of care 10/1/2020, evidenced agency documents titled Home Health Certification and Plan of Care . Review of the document for certification period 9/26/2021 11/24/2021 was signed by the physician on 9/30/2021. Review of the document for certification period 11/25/2021 1/23/2022 was signed by the physician on 12/16/2021. Review failed to evidence the physician reviewed the plan of care at least every 60 days.

5. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced agency documents titled Home Health Certification and Plan of Care . Review of the document for certification period 9/26/2021 11/24/2021 indicated the physician signed the plan of care on 10/12/2021. Review of the document for certification period 11/25/2021 1/23/2022 indicated the physician signed the plan of care on 12/16/2021. Review failed to evidence the physician reviewed the plan of care at least every 60 days.

6. During an interview on 2/18/2022, at 11:43 AM, the alternate clinical manager indicated the physician should review the plan of care every 60 days.

	17-13-1(a)(2)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on observation, record review, and interview, the agency failed to ensure the physician was notified of changes in the patient s condition or needs that suggest outcomes are not being achieved and/or the plan of care should be altered in 4 of 7 clinical records reviewed. (#1, #2, #6, #7) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Plan of Care CMS [Centers for Medicare and Medicaid Services] #485 [a document used by the home care agency and serves as the plan of care] and Physician/Practitioners Orders revised February 2021, stated, & The Agency must promptly alert the relevant physician(s)/practitioners to any changes in the patient s condition or needs that suggest outcomes are not being achieved and/or that the plan of care should be altered &. 2. Review of an agency policy obtained 2/21/2022, titled Pain Assessment and Reassessment revised January 2020, stated, & When a patient s pain is not relieved, the nurse or therapist will intervene appropriately. Such interventions may include: Notification of patient s physician &. 3. During an observation of care at the home of patient #1, start of care 9/4/2020, on 2/16/2022, at 9:59 AM, home health aide (HHA) C was observed assisting the patient with a sponge bath while the patient sat on the toilet. The patient was observed to have a dry dressing on the right knee. The patient indicated it was a rash and complained of itching to the area. Clinical record review on 2/18/2022, failed to	G0590	G0590 Director of Nursing will in-service all clinicians onrequirement to notify MD of any changes in patient condition, which includeschanges in skin, pain outside of acceptable level for patient and anything thatmight require a change in the plan of care. This includes notifying MD of painthat is not relieved with current med or pain that is above the level med is tobe used for. (4/1/2022) Director of Nursing/designee will audit all visit notessubmitted each week to ensure any patient with pain has documentationindicating MD has been notified if pain level is higher than the level the painmed is to used for and any patient that has a documented change in conditionhas documentation MD was contacted to report the change and indicate if any neworders were received. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) Director of Nursing will in-service clinicians onrequirement to follow wound care orders as given by MD. (4/1/2022) Director of Nursing/designee will audit all visit notessubmitted weekly. Visits for wound care will be compared to the plan ofcare/verbal orders to ensure wound care is being done as ordered by MD. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained. (On-going) The Administrator will be responsible for	2022-04-01

evidence the physician was notified of a rash to include a dry dressing to the patient s right knee and the patient s complaint of itching.

During an interview on 2/18/2022, at 11:54 AM, the alternate administrator indicated she was not sure what the dressing to the right knee was for and indicated the physician had not been notified of the patient s rash and dressing to the right knee.

Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 12/28/2021 2/25/2022, signed and dated by the physician on 1/23/2022. This document indicated the patient s diagnoses included, but were not limited to, a non-pressure ulcer (a wound not related to pressure applied to the skin) to the left great toe, rheumatoid arthritis (a chronic disorder causing pain, stiffness, swelling, and a loss of function in the joints), chronic pain syndrome, spinal stenosis (a narrowing of spaces within the spine putting pressure on the nerves), and spondylosis (degenerative wear and tear of the spinal discs). This document evidenced the patient s medications included, but were not limited to, Acetaminophen (a medication used to treat pain and fever) 1000 milligrams (mg) every 8 hours as needed for pain rated 1-3 on a scale of 0-10. This document failed to evidence the patient s medications included any other medication used to treat pain. Review evidenced the goals included, but were not limited to, the patient would have a decrease in pain to a tolerable level of 0-2 on a scale of 0-10 within 1-2 weeks.

Review of agency documents titled SN [skilled nurse] Wound Care Visit , dated 12/29/2021 and 1/5/2022, and electronically signed by RN D, evidenced the patient s pain was rated 4 on a scale of 0-10 and assessed to be daily. Documents dated 1/12/2022, 1/19/2022, 1/26/2022, and 2/9/2022, and electronically signed by registered nurse (RN) D, indicated the patient had pain rated 5 on a scale of 0-10 and assessed to be daily. Review failed to evidence the patient s medication included a pain medication for the treatment of pain rated greater than 3 on a scale of 0-10. Review failed

monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

to evidence the agency contacted the physician regarding the patient s pain level was assessed to be greater than 3, which the patient s only pain medication was ordered to use for pain 1-3 on a scale of 0-10.

During an interview on 2/18/2022, at 12:04 PM, the alternate administrator indicated the physician had not been notified of the patient s pain rating and indicated the agency should contact the physician to get other pain medication orders.

4. Clinical record review on 2/17/2022 and 2/21/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Recertification , signed and dated by RN D on 1/7/2022. This document indicated the patient had 2 pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (an open pressure ulcer with partial thickness loss of skin), 1 located on the left buttock and 1 located on the right buttock.

Review of an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022, which was signed by the physician on 2/4/2022, indicated the patient had a pressure ulcer to the left buttock and a pressure ulcer to the right buttock. The document indicated the skilled nurse was to clean the wounds with normal saline (a solution used to clean wounds) and apply barrier ointment.

Review of an agency document titled SN [skilled nurse] Wound Care Visit , dated and electronically signed by RN D on 2/9/2022, evidenced two new pressure ulcers Stage II to the left lateral buttock.

Review of an agency document titled Physician Order , electronically signed and dated by the alternate administrator on 2/9/2022, evidenced the 2 wounds to the left lateral buttocks were to be cleaned with normal saline, apply anasept gel (an antimicrobial wound gel) to the wound bed, apply calcium alginate (a highly absorptive

wound dressing), and cover with mepilex (a foam dressing) 2 times a week.

During an observation of care at the home of patient #2 on 2/16/2022, at 11:19 AM, the patient was observed lying on his right side with an uncovered, open area to the left buttock and an uncovered, open area to the right buttock. The patient was observed to have a transparent, adhesive dressing to the right buttock on the right side of the uncovered, open area to the right buttock. RN D indicated the uncovered, open area to the left buttock and the uncovered, open area to the right buttock were the original wounds. RN D was observed removing the transparent, adhesive dressing to the right buttock and 2 open areas were observed to the right of the uncovered, open area on the right buttock. At 11:23 AM, RN D was observed spraying a liquid identified by RN D as normal saline on open area to the left buttock and 3 open areas to the right buttock. RN D was observed wiping the open areas with a gauze pad and was observed spreading the skin on the buttock while wiping the open areas. An open area at 5 o clock from the open area to the left buttock was observed to the inner left buttock. At 11: 25 AM, RN D was observed applying a gel from a bottle labeled Anasept to a white material RN D identified as alginate. RN D was observed applying the white material with the gel onto the middle right buttock open area and to the outer right buttock open area. RN D was observed covering the inner right buttock open area, the middle right buttock open area, and the outer right buttock open area with a foam dressing RN D identified as a mepilex dressing. RN D was not observed applying the barrier cream to the inner right buttock open area before covering with the foam dressing as ordered by the physician on the plan of care. RN D was observed applying a cream RN D identified as calmoseptine (a barrier ointment to protect the skin from moisture) to the open area on the left buttock and to the open area at 5 o clock of the open area on the left buttock on the inner left buttock.

Review of an agency document on 2/21/2022,

titled SN Wound Care Visit , dated and electronically signed by RN D on 2/16/2022, indicated barrier ointment was applied to the right and left buttock wounds. This document indicated anasept gel, calcium alginate, and a mepilex dressing was applied to the two left lateral buttock wounds. This document failed to evidence the physician was notified of the observed open area locations to the right inner buttock and the right outer buttock. This document failed to evidence the physician was notified of the open area to the left inner buttock.

During an interview on 2/21/2022, at 1:08 PM, the alternate administrator indicated she was unsure why the wound documentation from RN D on 2/9/2022 documented the 2 open areas to the left lateral buttocks when RN D identified the 2 observed open areas on the right buttock to be the new wounds. The alternate administrator indicated there was not a wound treatment order for the calmoseptine applied to the open area to the left inner buttock and indicated there was not an order for the anasept and alginate applied to the open areas on the right middle buttock and the right outer buttock. The alternate administrator indicated the physician order on 2/9/2022 was supposed to be for the two new wounds to the right lateral buttock and indicated the RN must have documented the wrong location. The alternate administrator indicated the physician had not been notified of the correct wound location and indicated the physician should have been notified of the new area observed to the left inner buttock.

5. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/25/2021 1/23/2022, which was signed and dated by the physician on 12/16/2021. This document indicated the patient s diagnoses included, but were not limited to, gout (a form of arthritis causing severe pain, redness, and swelling). This document evidenced the patient s medications included, but were not limited to, Tylenol (a

medication used to treat pain and fever) 650mg every 8 hours as needed for pain rated 1-3 on a scale of 0-10. This document failed to evidence the patient s medications included any other medication used to treat pain. Review evidenced the goals included, but were not limited to, the patient would have a decrease in pain to a tolerable level of 0-2 on a scale of 0-10 within 1-2 weeks.

Review evidenced agency documents titled SN Teaching/Training Visit , electronically signed by RN D and dated 12/2/2021, 12/9/2021, 12/23/2021, 12/30/2021, 1/3/2022, and 1/20/2022, indicated the patient s pain was rated 5 on a scale of 0-10 and indicated the pain was daily. Review failed to evidence the patient s medication included a pain medication for the treatment of pain rated greater than 3 on a scale of 0-10. Review failed to evidence the agency contacted the physician regarding the patient s pain level was assessed to be greater than 3, which the patient s only pain medication was ordered to use for pain 1-3 on a scale of 0-10.

During an interview on 2/18/2022, at 11:00 AM, the alternate administrator indicated the agency should have called the physician to inform him of the patient s pain level and ask for an order for pain medication that would better treat the patient s pain.

6. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/19/2021 1/17/2022, which was signed and dated by the physician on 12/16/2021. This document indicated the patient s diagnoses included, but were not limited to, fracture of the left femur (long bone located in the upper leg). This document evidenced the patient s medications included, but were not limited to, Tylenol (a medication used to treat pain and fever) 650mg every 8 hours as needed for pain rated 1-3 on a scale of 0-10 and Voltaren gel (a topical pain medication typically used to treat arthritis) daily. This document failed to evidence the patient s medications included any other medication used to treat pain. Review

	evidenced the goals included, but were not limited to, the patient would have a decrease in pain to a tolerable level of 0-2 on a scale of 0-10 within 1-2 weeks. Review evidenced agency documents titled SN Teaching/Training Visit signed by RN F and dated 11/23/2021 and 12/2/2021, which indicated the patient had daily pain to the joints rated 4 on a scale of 0-10. Documents dated 12/7/2021 indicated the patient had daily pain to the left lower extremity rated 5 on a scale of 0-10. Document dated 12/14/2021 indicated the patient had daily pain to the left lower extremity rated 4 on a scale of 0-10. Review failed to evidence the agency contacted the physician regarding the patient s pain level was assessed to be greater than 3. During an interview on 2/18/2022, at 11:05 AM, the alternate administrator indicated the agency should have notified the physician the patient s pain was not managed and requested an order for another pain medication. 17-13-1(a)(2)			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on observation, record review, and interview, agency failed to ensure the plan of care was revised to reflect the patient s current status in 4 of 7 clinical records reviewed. (#1, #2, #3, #5) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Plan of Care CMS [Centers for Medicare and Medicaid Services] #485 [a document used by the home care agency and serves as the plan of care] and Physician/Practitioners Orders revised February 2021, stated, & A revised plan of care must reflect current information from the	G0592	G0592 Director of Nursing will in-service clinicians that plan ofcare must have all treatments listed that clinician is to provide. (4/1/2022) Director of Nursing/designee will review all plans of caredone each week to ensure they have all the treatments clinician is to provide.The assessment will be reviewed and compared to the plan of care. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) Director of Nursing will in-service aides they are to notifythe RN of any changes in patient condition which would include	2022-04-01

	patient s updated comprehensive assessment, and contain information concerning the patient s progress toward the measurable outcomes and goals identified by the Agency and patient in the plan of care &. 2. During an observation of care at the home of patient #1, start of care 9/4/2020, on 2/16/2022, at 9:59 AM, home health aide (HHA) C was observed assisting the patient with a sponge bath while the patient sat on the toilet. The patient was observed to have a dry dressing on the right knee. The patient indicated it was a rash and complained of itching to the area. The HHA was not observed reporting the dry dressing, the rash, and the patient s complaint of itching to the RN. Clinical record review on 2/18/2022, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 12/28/2021 2/25/2022. This document failed to evidence the plan of care was revised to include treatment for a rash to include a dry dressing to the patient s right knee. During an interview on 2/18/2022, at 11:54 AM, the alternate administrator indicated she was not sure what the dressing to the right knee was for and indicated the plan of care had not been revised to include the patient s rash and dressing to the right knee. 3. Clinical record review on 2/17/2022 and 2/21/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Recertification , signed and dated by registered nurse (RN) D on 1/7/2022. This document indicated the patient had 2 pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (an open pressure ulcer with partial thickness loss of skin), 1 located on the left buttock and 1 located on the right buttock. Review of an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022,		change in skincondition, any new dressings and document this. (4/1/2022) Director of Nursing/designee will audit all aide notessubmitted weekly to ensure if there is documentation of a change in patientcondition there is documentation RN was notified. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) Director of Nursing will in-services clinicians they are toreport changes in patient condition or anything on plan of care that may needrevised based on current plan of care and document any orders given by MD. (4/1/2022) Director of Nursing will review all orders obtained weeklyto ensure any orders regarding wound care are accurate. This will be done bycomparing the order to the assessment documentation to ensure the correctlocation(s) are documented. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On0going) Director of Nursing will audit all clinician documentationsubmitted weekly to ensure if there is documentation of a change in patientcondition there is documentation MD was notified and whether there were anychanges in the plan of care. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected	

which was signed by the physician on 2/4/2022, indicated the patient had a pressure ulcer to the left buttock and a pressure ulcer to the right buttock. The document indicated the skilled nurse was to clean the wounds with normal saline (a solution used to clean wounds) and apply barrier ointment.

Review of an agency document titled SN [skilled nurse] Wound Care Visit , dated and electronically signed by registered nurse (RN) D on 2/9/2022, evidenced two new pressure ulcers Stage II to the left lateral buttock.

Review of an agency document titled Physician Order , electronically signed and dated by the alternate administrator on 2/9/2022, evidenced the 2 wounds to the left lateral buttocks were to be cleaned with normal saline, apply anasept gel (an antimicrobial wound gel) to the wound bed, apply calcium alginate (a highly absorptive wound dressing), and cover with mepilex (a foam dressing) 2 times a week. Review failed to evidence the plan of care was revised and updated to reflect the patient s 2 wounds to the left lateral buttock and the new treatment order.

During an interview on 2/21/2022, at 12:59 PM, the alternate administrator indicated the plan of care had not been updated to include the 2 wounds to the left lateral buttock and the treatment order. The alternate administrator asked, Should the plan of care be revised?

4. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled SN Wound Care Visit , electronically signed by licensed practical nurse (LPN) H and dated 2/10/2022. Review evidenced the LPN assessed skin tear wounds to the left lower extremity with an onset date of 2/10/2022.

Review of an agency document titled Physician Order , signed and dated by the physician on 2/18/2022, indicated the wound care to the left lower leg was to clean the wound with wound wash, apply anasept gel, cover with telfa (a nonadhesive dressing), and wrap with coban (a self-adhering bandage) 2 times a week.

During an observation of care at the home on

and will notrecur.

2/18/2022, at 1:15 PM, the patient was observed to have 20+ scabbed areas on the left shin and 8 scabbed areas on the right shin. No dressing was noted to the patient s scabbed areas.

Review of an agency document titled Home Health Certification and Plan of Care for certification period 1/8/2022 3/8/2022, failed to evidence the plan of care had been revised to reflect the wounds to the left and right lower extremities and failed to evidence the wound treatment ordered for the left lower extremity.

During an interview on 2/21/2022, at 1:57 PM, the alternate administrator indicated the plan of care had not been revised to include the wounds to the bilateral lower extremities.

5. Clinical record review on 2/17/2022, for patient #5, start of care 7/20/2020, evidenced an agency document titled SN Teaching/Training Visit , electronically signed by LPN K and dated 9/21/2021. This document indicated the patient had eye lid surgery on 9/16/2021 and the eye had 9 sutures. Review indicated the nurse assessed a surgical wound to the right lateral eye with an incision to include 9 intact sutures with an onset date of 9/16/2021. This document indicated the nurse cleaned the surgical wound with normal saline and left open to air.

Review of an agency document titled Home Health Certification and Plan of Care for certification period 9/13/2021 11/11/2021, failed to evidence the plan of care was revised to include the surgical wound and treatment to the right eye.

During an interview on 2/18/2022, at 4:13 PM, the alternate administrator indicated the plan of care was not revised to reflect the surgical wound and treatment to the right eye.

6. During an interview on 2/18/2022, at 12:25 PM, the alternate administrator indicated the plan of care consisted of the CMS (Centers for Medicare and Medicaid Services) form 485.

17-14-1(a)(1)(C)

G0598	Discharge plans communication 484.60(c)(3)(ii) (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). Based on record review and interview, the agency failed to ensure revisions to the plans for patient discharge were communicated to the physician responsible for the plan of care in 2 of 2 closed clinical records reviewed. (#6, #7) The findings include: 1. Review of an agency policy obtained 2/15/2022, titled Discharge Criteria and Planning revised February 2021, stated, & The patient is informed of discharge plan in a timely manner & Physician and other care providers will be informed and knowledgeable of discharge &. 2. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/25/2021 1/23/2022, which was signed and dated by the physician on 12/16/2021. This document indicated the patient was to receive skilled nursing services 1 time a week for 8 weeks beginning the week of 11/28/2021 and home health aide services 2 times a week for 9 weeks. This document indicated the patient s goals included, but were not limited to, have a tolerable level of pain rated 0-2 on a scale of 0-10, have absence of edema (swelling), and would not have signs and symptoms of complications related to hemorrhoids. Review evidenced the discharge plan was to discharge when the patient demonstrated necessary skills to self-manage disease process and when the patient s pain level stabilized. Review evidenced agency documents titled SN [skilled nursing] Teaching/Training Visit ,	G0598	G0598 Unable to correct charts cited in survey as patients havealready been discharged. Director of Nursing will in-service clinicians on whendischarging patients for goals met documentation must show goals have been met.If discharging patient when goals are not met MD must notified goals are notmet and informed of reason why discharge is occurring. Patient must also benotified if being discharged for reason other than their original goal of beingdischarged when goals met. (4/1/2022) Director of Nursing will in-service nurses/therapists thatif patient's goals are not met they can't discharge with reason of goals met.Reason for discharge must be accurate. (4/1/2022) Director of Nursing/designee will audit all discharges doneeach week to ensure the reason for discharge is appropriate listed. If reasonis due to patient meeting goals there must be documentation indicating goalswere met. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-01

electronically signed by registered nurse (RN) D. Review of documents dated 12/2/2021, 12/9/2021, 12/23/2021, 12/30/2021, 1/3/2022, and 1/20/2022, indicated the patient had daily pain to the knees rated 5 on a scale of 0-10. These documents indicated the patient had rectal bleeding from hemorrhoids and indicated the patient had 1+ pitting edema to the legs.

Review evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Discharge , electronically signed by RN D and dated 1/19/2022. This document indicated the patient had generalized pain the time rated 3 on a scale of 0-10. Review indicated the patient had edema to the lower extremities and had hemorrhoids with rectal bleeding. Review indicated the reason for discharge was the patient s goals were met. Review failed to evidence the patient met goals and failed to evidence the agency communicated the change in discharge plans to the patient and physician.

During an interview on 2/18/2022, at 11:02 AM, the alternate administrator indicated the patient did not meet goals and indicated the physician was not made aware of the change in discharge plans to discharge the patient without goals being met.

3. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/19/2021 1/17/2022, which was signed by the physician on 12/16/2021.

Review evidenced an agency document titled OASIS-D1 Discharge , electronically signed by the alternate administrator and dated 1/13/2022. This document indicated the patient was discharged from the agency on 1/13/2022 per patient request.

Review failed to evidence documentation of communication with the patient/caregiver regarding the patient s request to discharge.

During an interview on 2/14/2022, at 5:10 PM,

	not request to be discharged from the agency and indicated the patient was still receiving services from the agency. The patient s caregiver indicated the agency informed him the patient needed to be recertified but was not informed that the agency had discharged the patient. During an interview on 2/18/2022, at 11:22 AM, the alternate administrator indicated the patient was discharged because the patient had refused skilled nursing visits. The administrator indicated there was no documentation of communication with the physician regarding the potential discharge from the agency due to missed visits.			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on observation, record review, and interview, the agency failed to coordinate care of services provided to the patient in 2 of 2 clinical records reviewed with physical therapy services. (#3, #7) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Coordination of Patient Care revised February 2021, stated, & The Agency must: & Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care by all disciplines &. 2. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Start of Care , electronically signed by registered nurse (RN) F and dated 1/8/2022.	G0606	G0606 Director of Nursing will in-service clinicians onrequirement to coordinate care with all entities providing care to patient.That includes other disciplines within the agency. Clinician is to reportchanges in patient condition including new pain, edema, wound/open areas, falls(witnessed/unwitnessed) to the nurse, therapist and/or aide as appropriate. Ifpatient is receiving services from another agency documentation must indicatename of agency, services provided, frequency and days provided. (4/1/2022) Director of Nursing will audit all admissions done weekly toensure if there is documentation patient is receiving services from anotheragency it states name of agency, service(s) being provided, frequency and daysprovided. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) Director of Nursing will review all	2022-04-01

This document indicated the patient had pain to the lower extremity rated 4 on a scale from 0-10. This document failed to evidence the patient had pitting edema (excess fluid built up in the body and when pressure is applied, causes an indentation). This document indicated the patient was to receive skilled nursing services 1 time a week for 2 weeks and then 2 times a week for 7 weeks and home health aide (HHA) services 2 times a week for 8 weeks.

Review of an agency document titled PT [physical therapy] Plan of Care , electronically signed by PT I and dated 1/12/2022, indicated the patient was to receive PT services 1 time a week for 1 week and 2 times a week for 4 weeks.

Review evidenced agency documents titled SN [skilled nurse] Wound Care Visit , electronically signed by licensed practical nurse (LPN) H. Review of documents dated 1/14/2022, 1/17/2022, and 1/20/2022, evidenced the LPN assessed the patient to have no pain. Review of the document dated 1/25/2022, evidenced the LPN assessed the patient s pain rated 2 on a scale from 0-10 to the buttocks. Review failed to evidence the LPN coordinated care with the RN, HHA, and PT and informed them of the patient s new pain location to the buttocks. Review of the document dated 2/10/2022, evidenced the LPN assessed skin tear wounds to the left lower extremity. Review failed to evidence the LPN coordinated care with the HHA and PT and informed them of the patient s new wounds to the left lower extremity. Review of the documents dated 2/8/2022, 2/10/2022, and 2/14/2022, indicated the patient had pitting edema at a degree of 2+ on a scale of 0 to 4+. Review of these documents failed to evidence the LPN notified and coordinated care with the RN, PT, and HHA regarding the pitting edema.

During an observation of care at the home on 2/18/2022, at 1:15 PM, the patient was observed to have swollen lower extremities between the knees and ankles.

During an interview at the patient s home on

documentation submittedweekly to ensure if there is mention of another agency providing service thereis documentation show name, service(s) being provided, frequency and days. Ifthere is a change in patient condition there must be documentation otherdisciplines providing care in agency have been notified of the changes. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained. (On-going)

The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

2/18/2022, at 1:15 PM, the patient s caregiver indicated the patient s legs weep (severe swelling that causes fluid to leak from the skin) from the swelling. The patient s caregiver indicated the patient has neuropathy (damage to the nerves most often to the hands and feet and a common symptom of diabetes) and has fallen over a dozen times to include the most recent fall 3 weeks ago.

Review of an agency document titled Incident Log , electronically singed by LPN H and dated 1/31/2022, evidenced the patient had a fall without injury while attempting to stand up. This document failed to evidence the PT was notified regarding the patient s fall.

During an interview on 2/21/2022, at 1:34 PM, the alternate administrator indicated the LPN should have informed the other disciplines involved in the patient s care of the new location of pain so the pain could be monitored. At 1:47 PM, the alternate administrator indicated the LPN should have communicated to the HHA and PT providing care to the patient so they were aware of the new wounds. At 2:03 PM, the alternate administrator indicated staff involved in the care of the patient was not notified of the swelling. At 2:37 PM, the alternate administrator indicated the PT should have been notified so the PT could work on strengthening and ambulation with the patient.

3. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled OASIS-D1 Start of Care , electronically signed and dated by RN F on 11/20/2021. This document indicated the patient had generalized pain rated a 4 on a scale of 0-10. This document indicated the patient received services by agency B. Review failed to evidence care coordination to include the type and frequency of services provided by agency B.

During an interview on 2/18/2022, at 11:36 AM, the alternate administrator indicated she thought agency B provided homemaker services and was unsure of the frequency agency B provided services.

	Review of an agency document titled PT Evaluation , electronically signed and dated by PT L on 12/8/2021, evidenced the patient had moderate pain to the left shoulder. Review failed to evidence the PT coordinated care with the RN regarding the new location of pain to the left shoulder. This document indicated PT was to provide services 2 times a week for 4 weeks. During an interview on 2/18/2022, at 11:14 AM, the alternate administrator indicated the PT did not document care coordination with the RN regarding the left shoulder pain and indicated the PT should have called the RN. Review evidenced agency documents titled SN Teaching/Training Visit , electronically signed by RN F. The document dated 12/7/2021, indicated the patient had pain to the left lower extremity rated 5 on a scale of 0-10 and pain to the left lower extremity rated 4 on a scale of 0-10. Review failed to evidence the RN coordinated care with the PT regarding the new location of pain to the left lower extremity. During an interview on 2/18/2022, at 11:17 AM, the alternate administrator indicated the RN should have notified the PT to coordinate care regarding the patient s pain to the left lower extremity so PT could have tried to alleviated pain with movement. 17-12-2(g) 17-12-2(h)			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review and interview, the agency failed to provide the patient and caregiver in writing with a copy of the visit schedule in 3 of 3 home visits conducted. (#1, #2, #3) The findings include: 1. Review of an agency policy obtained	G0614	G0614 Director of Nursing will instruct the clinician they are tocomplete the visit calendar in patient home folder. Calendar needs to indicatefrequency of each discipline to provide care. The clinician will mark the aidevisits on schedule. If RN does admission and therapy/social work evals areordered RN will mark calendar with “PT/OT/ST/MSW	2022-04-07

2/21/2022, titled Patient Bill of Rights and Responsibilities revised February 2021, stated, & Patients have the right: & To be informed of: Visit schedule and frequency &.

2. During an observation of care at the home of patient #1, start of care 9/4/2020, on 2/16/2022, at 10:18 AM, an agency folder was not observed in the home. The written visit schedule was not observed to have been provided to the patient.

3. During an observation of care at the home of patient #2, start of care 7/16/2021, on 2/16/2022, at 11:25 AM, the agency home folder was observed in the patient s bedroom. Inside of the agency folder, a blank calendar was observed. The written visit schedule was not observed to have been provided to the patient.

4. During an observation of care at the home of patient #3, start of care 1/8/2022, on 2/18/2022, at 1:08 PM, the agency home folder was observed in the patient s home. A written visit schedule was not observed in the folder or in the patient s home.

5. During an interview on 2/18/2022, at 10:02 AM, the alternate clinical manager indicated patients are provided a written copy of their visit schedule by a blank calendar that is provided inside of the agency home folder that is provided to the patients. The alternate administrator indicated staff is to fill out the calendar with their planned visits.

is completed that discipline will mark their frequency and visits oncalendar and document they updated visit calendar with their visit frequency. Clinicianwill document in chart that the visit schedule was completed (for ordereddisciplines) and placed in home folder. Each time a clinician/aide visits theywill correct the visit day on calendar if visit is different than day marked oncalendar originally. Visit calendar is to be left in folder at time ofadmission, revised as needed and a new one created and put in folder each timea recertification is done. (4/7/2022)

Director of Nursing will audit all admissions and recertificationsdone weekly to ensure there is documentation visit calendar was created andplaced in home folder. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. Will audit all evaluationssubmitted each week to ensure there is documentation the visit calendar wasupdate. Once 100% is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going)

Director of Nursing will instruct clinicians to review allvisit calendars in home folders of current patients. Any patient without acompleted visit calendar will have their calendar updated. Clinician willdocument they reviewed visit calendar and indicate whether it needed revisionif so the revision was done. (4/7/2022)

Director of Nursing/designee will audit all documentationweekly to ensure all patients have documentation regarding

			the status of visitcalendars. This will be done until all current patients have documentationshowing visit calendars have been reviewed and are up to date. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review and interview, the agency failed to provide the patient and caregiver in writing with a copy of the medication schedule and instructions in 3 of 3 home visits conducted. (#1, #2, #3) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Patient Bill of Rights and Responsibilities revised February 2021, stated, & Patients have the right: & To be informed of: & Patient medication schedule/instructions &. 2. During an observation of care at the home of patient #1, start of care 9/4/2020, on 2/16/2022, at 10:18 AM, an agency folder was not observed in the home. A written copy of the medication schedule and instructions was not observed to have been provided to the patient. 3. During an observation of care at the home of patient #2, start of care 7/16/2021, on 2/16/2022, at 11:25 AM, the agency home folder was observed in the patient s bedroom. A written copy of the medication schedule and instructions was not observed in the folder or in the patient s home. 4. During an observation of care at the home of	G0616	G0616 Director of Nursing will instruct all clinicians to checkfor home folder in current patient homes and document if folder was available. Iffolder is present clinician is to check to see if there a copy of medicationlist with instructions. If folder cannot be located clinician will notifyDirector of Nursing and a new folder will be provided with copies of anydocuments that should be in folder. If a new folder is to be taken to home theclinician will document when the new folder is provided to patient. (4/9/2022) Director of Nursing will audit all documentation submittedweekly by clinicians to ensure there is documentation indicating the homefolder was located or a new folder was taken to home. If there wasdocumentation no medication list was in folder there must be documentation acopy of medication list was taken to home and placed in folder. Once allcurrent patients have documentation there is a home folder/medication list thisaudit will cease. The Administrator will be responsible for monitoring thesecorrective actions to	2022-04-09

	at 1:08 PM, the agency home folder was observed in the patient s home. A written copy of the medication schedule and instructions was not observed in the folder or in the patient s home. 5. During an interview on 2/18/2022, at 10:02 AM, the alternate clinical manager indicated patients are provided a copy of their medication list and indicated the skilled nurse should check for the medication list at every home visit and replace it if needed.		ensure that this deficiency is corrected and will notrecur.	
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review and interview, the agency failed to provide the patient and caregiver in writing with the treatments to be administered by agency personnel in 3 of 3 home visits conducted. (#1, #2, #3) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Patient Bill of Rights and Responsibilities revised February 2021, stated, & Patients have the right: & To be informed of: & Treatments to be administered by Agency staff &. 2. During an observation of care at the home of patient #1, start of care 9/4/2020, on 2/16/2022, at 10:18 AM, an agency folder was not observed in the home. A written copy of the treatments to be provided by the agency personnel was not observed to have been provided to the patient. 3. During an observation of care at the home of patient #2, start of care 7/16/2021, on 2/16/2022, at 11:25 AM, the agency home folder was observed in the patient s bedroom. A written copy of the treatments to be provided by the agency personnel was not observed in the agency folder and was not observed to be	G0618	G0618 Director of Nursing will instruct all clinicians to checkfor home folder in current patient homes and document if folder was available.If folder cannot be located clinician will notify Director of Nursing and a newfolder will be provided with copies of any documents that should be in folder.If a new folder is to be taken to home the clinician will document when the newfolder is provided to patient. (4/9/2022) Director of Nursing will audit all documentation submittedweekly by clinicians to ensure there is documentation indicating the homefolder was located or a new folder was taken to home. Once all current patientshave documentation there is a home folder this audit will cease. Director of Nursing will in-service clinicians that patientsare to be provided a copy of what specific treatments they are to be provided.A copy of the 485 will be placed in home folder once completed. It will be updatedas needed and a new provided with every certification period. Clinicians	2022-04-09

	provided to the patient. 4. During an observation of care at the home of patient #3, start of care 1/8/2022, on 2/18/2022, at 1:08 PM, the agency home folder was observed in the patient s home. A written copy of the treatments to be provided by the agency personnel was not observed in the folder or in the patient s home. 5. During an interview on 2/18/2022, at 10:02 AM, the alternate clinical manager indicated the patients are not provided a copy of their specific treatments provided by the agency. The alternate administrator indicated the packet inside of the agency folder that was provided to the patient upon admission listed which services the agency provided.		willdocument in chart when a 485 is provided to patient and placed in home folder. (4/9/2022) Director of Nursing will instruct clinicians they are totake a copy of the current 485 to each patient and document they providedpatient with 485 and explained to this shows what treatments are to beprovided. (4/9/2022) Director of Nursing/designee will audit all documentationweekly to ensure there is documentation a 485 has been placed in home folder.Once 100% compliance is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. Based on observation, record review and interview, the agency failed to provide the patient and caregiver in writing with the name and contact information of the clinical manager in 3 of 3 home visits conducted. (#1, #2, #3) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Patient Bill of Rights and Responsibilities revised February 2021, stated, & Patients have the right: & To be informed of: & Name of clinical manager & and contact information &. 2. During an observation of care at the home of patient #1, start of care 9/4/2020, on 2/16/2022,	G0622	G0622 Administrator will create a notice showing name of theclinical manager and their contact details. Administrator will instructclinicians to provide their current patients with a copy of this notice anddocument in chart patient was provided copy of this information. (3/25/2022) Director of Nursing/designee will audit all documentationsubmitted weekly to ensure there is documentation patient was provided copy ofnotice stating who clinical manager is and their contact details. Once everypatient has documentation they received this notice	2022-03-28

	observed in the home. The name and contact information of the clinical manager was not observed to have been provided to the patient. 3. During an observation of care at the home of patient #2, start of care 7/16/2021, on 2/16/2022, at 11:25 AM, the agency home folder was observed in the patient s bedroom. The name and contact information of the clinical manager was not observed in the agency folder and was not observed to have been provided to the patient. 4. During an observation of care at the home of patient #3, start of care 1/8/2022, on 2/18/2022, at 1:08 PM, the agency home folder was observed in the patient s home. The name and contact information of the clinical manager was not observed in the agency folder and was not observed to have been provided to the patient. 5. During an interview on 2/18/2022 at 10:02 AM, the alternate clinical manager indicated the patients had not been provided the name and contact information of the clinical manager and indicated the patient admission folder would be updated to provide the patient the name and contact information of the clinical manager.		this audit will cease. The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the quality assurance and performance	G0640	G0640 See G0650, G0652, G0654, G0658 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-01

	the performance improvement activities considered incidence, prevalence and severity of problems (see tag G0650); failed to ensure the performance improvement activities lead to an immediate correction of any identified problem that directly or potentially threatens the health and safety of patients (see tag G0652); failed to ensure the performance improvement activities tracked adverse patient events, analyzed their causes and implemented preventative actions (see tag G0654); failed to measure the success of the performance improvement activities and track performance to ensure that improvements are sustained (see tag G0654); and failed to conduct performance improvement projects (see G0658). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 484: 65 Condition: Quality Assessment / Performance Improvement.			
G0650	Incidence, prevalence, severity of problems 484.65(c)(1)(ii) (ii) Consider incidence, prevalence, and severity of problems in those areas; and Based on record review and interview, the home health agency failed to ensure the performance improvement activities considered incidence, prevalence, and severity of problems. The findings include: Review of an agency policy obtained 2/21/2022, titled Quality Assessment and Performance Improvement (QAPI) Plan and Program stated, & Data collection must include: & High volume: care/service/process occurs frequently or affects large numbers of patients/staff. Problem prone processes:	G0650	G0650 Due to the increasing prevalence of severity of the woundsresulting in hospitalization recorded by the agency in 2021 Administrator andDirector of Nursing will review performance actions from 2021 and revise themfor 2022. These actions will be reviewed quarterly and revised as needed basedon findings for the previous quarter. (4/1/2022) Administrator/Director of Nursing will document dataobtained from the performance improvement activities to show what activities ledto immediate improvement of wounds and hospitalizations due to wounds.	2022-04-01

	for patients or staff. Such areas have the potential for negative outcomes and are associated with a diagnosis or condition for a particular patient group or particular component of Agency operation or historical problem areas &. Review of the agency s QAPI binder on 2/16/2022, evidenced agency documents titled Quality Assessment Performance Improvement Report . The document for the 1st quarter of 2021 indicated the agency reported 8 wounds. This document indicated the patient hospitalizations included, but were not limited to, 1 patient for cellulitis (an infection of the skin) and 1 patient for a gangrenous (dead tissue due to a lack of blood flow or infection) foot. The document for the 2nd quarter of 2021 indicated the agency reported 23 wounds and indicated a patient was admitted to the hospital for worsening lower extremity wounds. The document for the 3rd quarter of 2021 indicated the agency reported 24 wounds and indicated 1 patient was admitted to the hospital for cellulitis. The document for the 4th quarter of 2021 indicated the agency reported 29 wounds and indicated 1 patient was admitted to the hospital for a foot wound. These documents indicated the agency s performance actions for wound improvement were to monitor cellulitis, stasis ulcers (a wound caused by fluid build-up due to poor circulation), pressure ulcers (wound to the skin and underlying tissue resulting from prolonged pressure to the skin), surgical wounds, and other wounds. These documents indicated the agency would monitor wounds present upon admission as well as acquired while being services by the agency. Review failed to evidence a change in the performance improvement activities for wound from the 1st quarter of 2021 to the 4th quarter of 2021. Review failed to evidence the agency s performance improvement activities addressed the increasing prevalence of the wounds and the severity of the wounds resulting in hospitalization recorded by the agency. During an interview on 2/16/2022, at 2:18 PM, the alternate administrator indicated the		(On-going) Director of Nursing will in-service clinicians on the newperformance actions for 2022 regarding wounds to help decrease wounds, severityof wounds and hospitalizations for wounds. If performance actions are revisedDirector of Nursing will in-service clinicians on those changes. (On-going) Director of Nursing will review documentation of woundsweekly to monitor if they are improving or worsening, have any patients developedany new wounds, have there been any hospitalizations for wounds. If there areconcerns Director of Nursing will talk with clinician. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	performance actions did not change during 2021 to address the increase in prevalence of wounds.			
G0652	Activities lead to an immediate correction 484.65(c)(1)(iii) (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview, the home health agency failed to ensure the performance improvement activities lead to an immediate correction of any identified problem that directly or potentially threatens the health and safety of patients. The findings include: Review of an agency policy obtained 2/21/2022, titled Quality Assessment and Performance Improvement (QAPI) Plan and Program stated, & The QAPI Committee is responsible for taking appropriate action. Aggregate measures of performance for each process will be compared to pre-established performance expectations to determine if additional evaluation is required. If the performance is not met, the findings will be evaluated by the QAPI Committee to determine the systemic approach for making improvement. The systemic approach will include: & Test of strategy/action for change & Analyzing data from the test to determine if change improved performance &. Review of the agency s QAPI binder on 2/16/2022, evidenced agency documents titled Quality Assessment Performance Improvement Report . The document for the 1st quarter of 2021 indicated the agency reported 8 wounds. The document for the 2nd quarter of 2021 indicated the agency reported 23 wounds. The document for the 3rd quarter of 2021 indicated the agency reported 24 wounds. The document for the 4th quarter of 2021 indicated the agency reported 29 wounds. The document for the 2nd	G0652	G0652 Administrator will ensure the performance improvementactivities lead to an immediate correction of can identified problems that directlyor potentially threatens the health and safety of patients. (On-going) Administrator/Director of Nursing will revise the current performanceimprovement activities for wounds and hospitalizations. This will be based onQAPI findings for 4th quarter of 2021 and 1st quarter of2022. (4/9/2022) Administrator/Director of Nursing will in-service staff on thecurrent active action plan regarding patients with wounds and those at risk forhospitalization. (4/9/2022) Administrator will review quarterly the performanceimprovement activities with the Director of Nursing. They will assess theactions put in place the previous quarter. If the data shows there is not animprovement in the problem(s) identified new actions will be implementedimmediately. If new actions are implemented any staff who areinvolved/potential to be involved will be in-serviced on these new actions.(On-going)	2022-04-09

	quarter of 2021 indicated the agency had 16 patient hospitalizations and the document for the 3rd quarter of 2021 indicated the agency had 19 patient hospitalizations. Review failed to evidence the agency s performance improvement activities led to an immediate correction of identified problems with hospitalizations and wounds. During an interview on 2/16/2022, at 2:18 PM, the alternate administrator indicated the agency did not have a data to show what performance improvement activities led to immediate improvement. 17-12-2(a)		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
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 home health agency failed to ensure the performance improvement activities analyzed the causes of adverse patient events and implemented preventive actions. The findings include: Review of an agency policy obtained 2/21/2022, titled Quality Assessment and Performance Improvement (QAPI) Plan and Program stated, & The QAPI Committee will compile and analyze collected data. & Such assessment is initiated by: Comparison internally (levels, trends, patterns) & A summary of data collection, analysis, recommendations for improvement and report of cumulative findings will be prepared by the QAPI Committee &. Review of the agency s QAPI binder on 2/16/2022 evidenced agency documents titled Quality Assessment Performance Improvement Report . These documents indicated the agency reported the number of patient falls, the number	G0654	G0654 Administrator will ensure the QAPI Project Data Collectionand Analysis Summary is used. (4/8/2022) Administrator will ensure the QAPI Project Data Collectionand Analysis Summary is completed each quarter. (On-going) Administrator will ensure the performance improvementactivities analyze the causes of adverse patient events is completed eachquarter. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-08

	patients with wounds, and the number of patients with hospitalizations for each quarter. Review evidenced an agency document titled QAPI Project Data Collection and Analysis Summary revised October 2017 and failed to evidence the form was completed. Review failed to evidence the performance improvement activities analyzed the causes of adverse patient events. During an interview on 2/16/2022, at 2:18 PM, the alternate administrator indicated the agency did not have a break-down of data on causes of the adverse patient events. The alternate administrator indicated the agency has not used the QAPI Project Data Collection and Analysis Summary. 17-12-2(a)			
G0656	Improvements are sustained 484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained. Based on record review and interview, the home health agency failed to measure the success of the performance improvement activities and track performance to ensure that improvements are sustained. The findings include: Review of an agency policy obtained 2/21/2022, titled Quality Assessment and Performance Improvement (QAPI) Plan and Program stated, & Aggregate measures of performance for each process will be compared to pre-established performance expectations to determine if additional evaluation is required. If the performance expectation is not met, the findings will be evaluated by the QAPI Committee to determine the systemic approach for making improvement &. Review of the agency s QAPI binder on 2/16/2022 evidenced an undated agency	G0656	G0656 Administrator will ensure the QAPI program measures the successof the performance improvement activities and track performance to ensure thatimprovements are sustained. (4/9/2022) Administrator will ensure wounds are monitored by Directorof Nursing to show if the performance improvement activities are successful indecreasing wounds and hospitalizations for wounds. (on-going) Director of Nursing will create a tracking system for woundsthat shows whether wounds were present at admission or acquired, type of wound,location of wound, are they improving/worsening, has patient been hospitalizedas a result of wounds. (4/8/2022) Director of Nursing will be responsible to	2022-04-09

document titled Quality Improvement Program Indicators , which stated, & The QI [quality improvement] manager will assign records to reviewers. Results will be tabulated. & All problems will have an actions plan developed and will be evaluated until there is evidence of resolution &. Review evidenced agency documents titled Quality Assessment Performance Improvement Report . The document for the 1st quarter of 2021 indicated the agency reported 8 wounds. The document for the 2nd quarter of 2021 indicated the agency reported 23 wounds. The document for the 3rd quarter of 2021 indicated the agency reported 24 wounds. The document for the 4th quarter of 2021 indicated the agency reported 29 wounds. These documents indicated the agency s performance actions for wound improvement were to monitor cellulitis, stasis ulcers (a wound caused by fluid build-up due to poor circulation), pressure ulcers (wound to the skin and underlying tissue resulting from prolonged pressure to the skin), surgical wounds, and other wounds. These documents indicated the agency would monitor wounds present upon admission as well as acquired while being services by the agency. Review failed to evidence the agency monitored the wounds to measure the success of the performance improvement activities.

During an interview on 2/16/2022, at 2:18 PM, the alternate administrator indicated the agency does not have a quantitative way of showing things are getting better and stated, I know that s big for home health. The alternate administrator indicated the agency does not complete chart audits, and stated, We should probably do that. The alternate administrator indicated the agency does not have any tracking system for wounds to show the type of wounds the patients have, whether the wounds were admitted or acquired, and the data to show whether the wounds were improving or worsening.

17-12-2(a)

and discuss issues with Administrator at leastmonthly. (On-going)

The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the home health agency failed to document a performance improvement project. The findings include: Review of an agency policy obtained 2/21/2022, titled Performance Improvement Projects revised March 2018, stated, & The Agency will document the quality improvement projects undertaken, the reasons for conducting these projects and the measurable progress achieved on these projects & The Agency should have one performance improvement project either in development, ongoing or completed each calendar year &. Review of the agency s QAPI binder on 2/16/2022, failed to evidence the agency had a performance improvement project. During an interview on 2/16/2022, at 2:18 PM, the administrator indicated he does not recall doing a performance improvement project in the past. The administrator indicated he would like to monitor the trends on falls but has not implemented that yet.	G0658	G0658 Administrator will ensure agency has a performanceimprovement project for 2022 based on a problem area for agency. (4/8/2022) Administrator will ensure the performance improvementproject is revised yearly based on what problem areas for agency. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-08
G0680	Infection prevention and control 484.70 Condition of Participation: Infection prevention and control.	G0680	G0680 See G0682, G0686, G0687	2022-04-05

	The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. Based on observation, record review and interview, the home health agency failed to ensure: the agency followed accepted standards of practice for standard/universal precautions to prevent the transmission of infections (see tag G0682); staff was educated on infection control (see tag G0686); and policies and procedures were developed and implemented to ensure all staff are fully vaccinated for COVID-19 (see tag G0687). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.70 Infection Control.		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G068 2	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 standard/universal precautions to prevent the transmission of infections and failed to follow agency infection control policies and procedures in 3 of 3 home visits. (#1, #2, #3) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Hand Hygiene Policy and Compliance Program , revised July 2021, stated, & Indications for staff performing hand hygiene are: Before and after direct patient care. Before and after each procedure. & After contact with contaminated materials. Before re-entering nursing bag or patient s clean supplies...."	G068 2	G0682 Director of Nursing will in-service all current field staff(aides, nurses, therapists) on proper handwashing, proper use of gloves, properbag technique. (3/3/2022) Director of Nursing will in-service all field yearly on properhandwashing, proper use of gloves, proper bag technique. (On-going) Director of Nursing will in-service nurses on infectioncontrol when doing wound care, catheter care. (3/10/2022) RN’s will observe aides for proper infection controlprocesses if aide is present at a visit. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to	2022-03-2 1

2. Review of an agency policy obtained 2/21/2022, titled Standard Precautions revised July 2021, stated, & Perform hand hygiene after removing gloves &.

3. During an observation of care on 2/16/2022, at 9:55 AM, at the home of patient #1, start of care 9/4/2020, home health aide (HHA) C was observed washing the patient s arms, chest, and back while wearing gloves. HHA C was observed removing gloves, placing gloves in the trash, and applying new gloves. HHA C was not observed performing hand hygiene after removing gloves. At 10:07 AM, HHA C was observed washing the patient s buttocks and applying a barrier cream to the buttocks while wearing gloves. HHA was observed removing gloves, placing gloves in the trash, and applying new gloves. HHA C was not observed performing hand hygiene after gloves.

4. During an observation of care at the home of patient #2, start of care 7/16/2021, on 2/16/2022, at 11:23 AM, registered nurse (RN) D was observed spraying a liquid identified by RN D as normal saline on open area to the left buttock and 3 open areas to the right buttock while wearing gloves. RN D was observed wiping the open areas with a gauze pad and was observed spreading the skin on the buttock while wiping the open areas. An open area at 5 o clock from the open area to the left buttock was observed to the inner left buttock. RN D was not observed changing gloves and performing hand hygiene after cleaning one wound and before cleaning another wound. At 11:25 AM, RN D was observed applying a gel from a bottle labeled Anasept to a white material RN D identified as alginate. RN D was observed applying the white material with the gel onto the middle right buttock open area and to the outer right buttock open area. RN D was observed covering the inner right buttock open area, the middle right buttock open area, and the outer right buttock open area with a foam dressing RN D identified as a mepilex dressing while wearing gloves. RN D was not observed

and will notrecur.

changing gloves and performing hand hygiene after applying a treatment to one wound and before applying a treatment to another wound. At 11:28 AM, RN D was observed cleaning a brown, soft substance from the patient s groin and perineal area (the area between the scrotum and the anus on a male) with a wipe while wearing gloves. RN D was observed getting a clean wipe and cleaning a plastic tube observed to be inserted into the penis. RN D was not observed changing gloves and performing hand hygiene after cleaning the brown substance from the patient s groin and perineal area before cleaning the plastic tube inserted into the patient s penis. RN D was observed using the same wipe to clean the plastic tube inserted into the penis to clean the opening of the penis where the plastic tube was inserted. RN D was observed wiping the groin area with a clean wipe and brown substance was observed on the wipe. RN D was observed rolling the wipes into the patient s incontinent brief and reaching into a bag hanging on the patient s doorknob observed to contain clean wound care supplies to grab a plastic bag. RN D was observed placing the used incontinent brief into the plastic bag. RN D was not observed to have removed gloves and performed hand hygiene after cleaning the patient s penis, groin, and perineal area and removing the used brief from under the patient before reaching into the bag of clean wound care supplies. At 11:37 AM, RN D was observed removing a dry dressing from around a plastic tube inserted into the abdomen while wearing gloves. RN D was observed wiping around the area where the plastic tube was inserted into the abdomen with a clean gauze and applying a new dry dressing around the plastic tube inserted into the abdomen. RN D was observed removing gloves and applying new gloves and then observed assisting the patient to reposition in bed. RN D was not observed changing gloves and performing hand hygiene after removing old dressing from around the plastic tube inserted into the abdomen before applying the clean dressing, and RN D was not observed performing hand hygiene after removing old gloves and before applying new gloves.

	5. During an observation of care at the home of patient #3, start of care 1/8/2022, on 2/21/2022 at 1:08 PM, physical therapist (PT) G was observed entering his bag and removing a gait belt, wipes, gloves, and an exercise bag. PT G was not observed to have performed hand hygiene before entering his bag to remove items. 6. During an interview on 2/18/2022, at 10:02 AM, the alternate administrator indicated staff should apply hand sanitizer or wash their hands after removing gloves and before applying new gloves. At 3:57 PM, the alternate administrator indicated staff should wash their hands prior to entering their bag to remove supplies and equipment. 7. During an interview on 2/21/2022, at 1:00 PM, the alternate administrator indicated the skilled nurse should change gloves and apply hand sanitizer after cleaning one wound and before cleaning another wound and after applying a treatment to a wound and before applying a treatment to another wound. At 1:01 PM, the alternate administrator indicated catheter care on a male should be completed by cleaning the tip of the penis and then cleaning the catheter tubing. The alternate administrator indicated the skilled nurse should have removed gloves and applied hand sanitizer after cleaning the patient s perineal area and before reaching into a bag of clean wound care supplies. 17-12-1(m)			
G0686	Infection control education 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). Based on record review and interview, the agency failed to ensure staff was educated on infection control. The findings include: Review of an agency policy obtained 2/14/2022, titled Infection Control Plan ,	G0686	G0686 Director of Nursing will in-service all current field staff(aides, nurses, therapists) on infection control to include proper handwashing,proper use of gloves, proper bag technique. (3/3/2022)	2022-03-21

	revised March 2018, stated, & The Infection Control Plan & Establishes a training program upon employment which: Educates employees in the infection control program &. Review of an agency document titled In-Service Training , dated 6/11/2021, indicated the document was a sign-in sheet for staff in attendance for a training on basic infection control procedures. This document failed to evidence home health aide (HHA) E, physical therapist (PT) I, PT L, and medical social worker (MSW) T. During an interview on 2/18/2022, at 3:30 PM, the alternate administrator indicated all employees should be inserviced on infection control and was unsure why HHA E, PT I, PT L and MSW T were not provided infection control education. No further documents were provided.		Director of Nursing will in-service all field yearly oninfection control to include proper handwashing, proper use of gloves, properbag technique. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will not recur.	
G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement.	G0687	G0687 Administrator will review all current employee files toensure there is either copy of COVID vaccine card showing they are fullyvaccinated or copy of medical/religious exemption form. Anyone who does nothave the required documentation will not be permitted to work until they canprovide appropriate documentation. (3/21/2022) Administrator will ensure all new employees are able toprovide proof of being fully vaccinated, have received first dose of 2 doseseries or have submitted a medical/religious exemption. Until they can provideone of the mentioned requirements they will not be permitted to work for agency.(On-going)	2022-03-22

	(2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section;		Administrator has implemented the CMS COVID Vaccine Mandatepolicy. See attachment I (2/14/2022Date completed) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur. Attachment I – CMS COVID Vaccine Mandate Policy	

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

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

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

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

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

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

(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and

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

Based on record review and interview, the agency failed to develop and implement policies and procedures to ensure all staff are fully vaccinated for COVID-19.

The findings include:

Review of an untitled binder on 2/14/2022 the alternate administrator identified as the infection program binder, evidenced an untitled, undated document which included the agency s COVID-19 exposure response and the screening of patient and staff. Review failed to evidence policies and procedures which included a process for ensuring all staff are fully vaccinated for COVID-19, a process for ensuring the implementation of additional precautions for all staff who are not fully vaccinated for COVID-19, a process for tracking and documenting the COVID-19 vaccination status of staff, a process by which staff may request a COVID-19 vaccination exemption, a process for tracking and documenting information provided by staff requesting an exemption, and a contingency plan for staff who are not fully vaccinated for COVID-19.

During an interview on 2/14/2022, at 1:05 PM, the alternate administrator indicated all of the agency s policies regarding COVID-19 were in the binder identified as the infection control binder.

Personnel record review on 2/15/2022 for the administrator, start date 6/1/2018, failed to evidence COVID-19 vaccination or a vaccine exemption.

Personnel record review on 2/15/2022 for home health aide (HHA) E, start date 6/20/2019, failed to evidence COVID-19 vaccination or a vaccine exemption.

Personnel record review on 2/15/2022 for office assistant P, start date unknown, failed to evidence COVID-19 vaccination or a vaccine exemption.

Personnel record review on 2/15/2022 for occupational therapist (OT) Q, start date 2/5/2019, failed to evidence COVID-19 vaccination or a vaccine exemption.

During an interview on 2/15/2022, at 12:27 PM, when queried where was the COVID-19 policy

	administrator stated, There s no mandate so we aren t mandating that. The alternate administrator indicated she thinks HHA E has a vaccine exemption but the agency did not have a copy of it. At 12:42 PM, the alternate administrator indicated office assistant P was getting an exemption but did not have it yet. The alternate administrator indicated the agency did not have a vaccine status for OT Q. The alternate administrator indicated the administrator had received the COVID-19 vaccine and indicated he had not submitted his vaccine card yet. The alternate administrator provided a document for review on 2/15/2022, at 12:45 PM, titled Mandatory COVID-19 Vaccine Policy and Procedure , dated 11/15/2021. During an interview on 2/15/2022, at 1:15 PM, the administrator indicated the document provided at 12:45 PM was sent to the agency by association D in the fall. The administrator stated, As far as implementing it, no, we haven t really done that. I just printed it. As the driving force, [the alternate administrator] and I aren t very familiar with the policy.			
G0700	Skilled professional services 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. Based on record review and interview, the skilled professional failed to ensure the following: failed to develop and evaluate the plan of care (See tag G0708); failed to provide the services as indicated in the plan of care (See tag G0710); failed to provide the patient and caregiver education (See tag G0714); failed to prepare clinical notes (See tag G0716); failed to communicate with the physician and other	G0700	G0700 See G0708, G0710, G0714, G0716, G0718, G0720, G0722, G0724 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-03-31

	health care practitioners (See tag G0718); failed to participate in the agency's quality assurance and performance improvement (QAPI) program (See tag G0720); failed to participate in agency-sponsored in-service training (See tag G0722) and failed to provide supervision of the home health aide (See tag G0724). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.75 Skilled Professional Services.			
G0708	Development and evaluation of plan of care 484.75(b)(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); Based on observation, record review and interview, the physical therapist (PT) failed to develop the plan of care in 2 of 2 clinical records reviewed with PT services. (#3, #7) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Rehabilitative Services revised February 2021, stated, & An individual rehabilitative care plan is developed with the patient/family. & Services provided will be planned to meet each patient s individualized needs & Services provided by a physical or occupational therapist include: & Developing and revising the plan of care in consultation with the physician/practitioner and other care team members &. 2. During an observation of care at the home of patient #3, start of care 1/8/2022, on 2/18/2022, at 1:08 PM, PT G was observed obtaining the patient s blood pressure, heart rate, and pulse oximetery (a non-invasive test that measures the saturation of oxygen in the blood). Clinical record review on 2/21/2022 evidenced an agency document titled PT Evaluation ,	G0708	G0708 Director of Nursing will in-service clinicians on need tohave orders to obtain vital signs each visit. (4/5/2022) Director of Nursing will audit all current plans of care tosee which patients do not have orders to obtain vital signs each visit.Clinician will be instructed to contact MD to obtain order to do vital signsfor patients who do not have order. (4/5/2022) Director of Nursing/designee will audit charts for patientswho did not have vital signs on plan of care to ensure there is a verbal orderfor clinician to take vital signs each visit. Once 100% compliance is achievedthis audit will cease. Director of Nursing/designee will audit all new admissionsdone each to ensure plan of care has order for clinician to obtain vital signseach visit. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going)	2022-04-05

	electronically signed by PT I and dated 1/12/2022, and agency documents titled PT Visit , electronically signed by PT I and dated 1/18/2022, 1/19/2022, and 2/7/2022. These documents indicated the PT obtained vital signs to include blood pressure, heart rate, and respiration. Review evidenced an agency document titled PT Plan of Care , electronically signed by PT I and dated 1/12/2022, failed to evidence the PT was to obtain vital signs. 3. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced agency documents titled PT Visit electronically signed by PT L and dated 12/10/2021, 12/15/2021, 12/17/2021, 12/19/2021, 12/21/2021, and 12/29/2021, evidenced the PT obtained vital signs to include blood pressure, heart rate, respiration, temperature, and oxygen saturation. Review of an agency document titled PT Plan of Care , electronically signed and dated by PT L on 12/8/2021, failed to evidence the PT was to obtain vital signs. 4. During an interview on 2/21/2022, at 1:24 PM, the alternate administrator indicated the PT should have included obtaining vital signs in the PT plan of care. 17-14-1(b)(2)		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; Based on observation, record review and interview, the skilled nurse failed to provide services as ordered by the physician in the plan of care in 6 of 7 clinical records reviewed (#1, #2, #3, #4, #5, #6) and in 1 of 2 clinical records reviewed receiving physical therapy services. (#7) The findings include: 1. Review of an agency policy obtained	G0710	G0710 Director of Nursing will in-service clinicians onrequirement to follow the plan of care. That includes educating patient on areasnoted in plan, performing tasks as ordered in the time frame ordered,documenting caregiver's ability to do a task, notifying MD of vitals outside ofparameters, etc. (4/1/2022) Director of Nursing/designee will audit all visit notessubmitted weekly. They will be	2022-04-01

	2/21/2022, titled Nursing Services revised February 2021, stated, & Professional nursing service will be provided by a registered nurse and include: & Initiating the plan of care and revising as necessary. Providing those services and/or treatments &. The Licensed Practical Nurse or Licensed Vocational Nurse (LPN/LVN) will supplement the nursing care needs of the patient as provided by the Registered Nurse &. 2. Review of an agency policy obtained 2/21/2022, titled Rehabilitative Services revised February 2021, stated, & Services provided will be planned to meet each patient s individualized needs &. 3. Clinical record review on 2/16/2022, for patient # 1, start of care 9/4/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 12/28/2021 2/25/2022, which was signed by the physician on 1/23/2022. This document indicated the patient s diagnoses included, but were not limited to, venous insufficiency (a condition which causes blood not to return properly to the heart resulting in blood pooling in the legs), chronic pain syndrome, unspecified disorder of the thyroid, calculus (a solid mass made of crystals) of kidney, dependence on supplemental oxygen, and chronic non-pressure ulcer to the left foot. This document indicated the skilled nurse was to teach the patient on signs and symptoms of vascular disease to include swelling of the legs and ankles, validate the caregiver s ability for proper wound care management for the venous ulcer on the left great toe, teach the patient pain relief measures, teach the patient signs and symptoms related to the disorder of the thyroid, teach the patient signs and symptoms related to the calculus of the kidney, teach the patient on oxygen safety precautions, educate the patient on turning and repositioning every 2 hours, and educate the patient on methods to reduce friction and shear. Review of agency documents titled SN [skilled nurse] Wound Care Visit , dated 12/29/2021, 1/5/2022, 1/12/2022, 1/19/2022, 1/26/2022, and 2/9/2022, signed by registered nurse (RN) D,		compared to the plan of care/verbal orders toensure documentation follows the plan of care and any new orders obtained. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will not recur.	

indicated the patient had pitting edema (excess fluid built up in the body and when pressure is applied, causes an indentation) at a degree of 2+ on a scale of 0 to 4+. Review of the documents indicated the patient rated the pain 4-5 on a scale of 0-10 with a pain frequency of daily. Review failed to evidence the RN educated the patient on signs and symptoms of vascular disease to include swelling of the legs and ankles, validated the caregiver s ability for proper wound care management for the venous ulcer on the left great toes, educated the patient on signs and symptoms related to the disorder of the thyroid, educated the patient on signs and symptoms related to the calculus of the kidney, educated the patient on oxygen safety precautions, educated the patient on turning and repositioning every 2 hours, and educated the patient on methods to reduce friction and shear. Review failed to evidence the skilled nurse provided education on pain relief measures after the visit on 12/29/2021.

During an interview on 2/18/2022, at 11:51 AM, the alternate administrator indicated the skilled nurse should have educated the patient on pain relief measures and wound care at every visit.

4. Clinical record review on 2/17/2022 and 2/21/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022, which was signed by the physician on 2/4/2022. This document evidenced the patient s diagnoses included, but were not limited to, gastrostomy (a tube surgically inserted into the stomach through the abdomen used to administer nutrition, fluid, and/or medication) and pressure ulcers (wound to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (an open pressure ulcer with partial thickness loss of skin) to the right and left buttocks. This document indicated the skilled nurse was to provide stoma (an opening in the body) care at the gastrostomy site and perform a skilled assessment of all body systems including the integumentary system (the system of the body

pertaining to the skin, hair, and nails). This document indicated the patient had a foley catheter (an indwelling plastic tube inserted into the bladder to drain urine), which the skilled nurse was to change monthly. The plan of care indicated the skilled nurse was to change the foley catheter drainage bag every 2 weeks. This document indicated the skilled nurse was to notify the physician of a diastolic blood pressure (the pressure against the wall of the arteries when the heart is at rest, indicated by the bottom number of the blood pressure reading) of less than 60.

During an observation of care at the patient s home on 2/16/2022, at 10:58 AM, RN D was observed placing the blood pressure cuff on the patient s right wrist. RN D indicated the patient s blood pressure was 118/53. RN D was not observed notifying the physician of a diastolic blood pressure less than 60.

Review evidenced agency documents titled SN Wound Care Visit , signed by RN D. Document dated 2/16/2022, indicated the patient s blood pressure was 118/53. This document failed to evidence RN D notified the physician of the diastolic blood pressure less than 60. Documents dated 1/12/2022, 1/18/2022, 1/26/2022, and 2/9/2022, failed to evidence the RN provided gastrostomy care as directed in the plan of care. These documents failed to evidence the RN performed a wound assessment which included the depth of the wounds to the right and left buttocks.

During an interview on 2/18/2022, at 12:21 PM, the alternate administrator indicated the RN should have completed gastrostomy since it was on the plan of care as a skilled nurse intervention.

Review of an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Recertification , signed and dated by RN D on 1/7/2022, evidenced the foley catheter was last changed on 12/7/2021.

Review of an agency document titled SN Wound Care Visit , dated and signed by RN D

on 1/26/2022, evidenced the RN changed the patient s foley catheter. Review failed to evidence the foley catheter was changed within a month and failed to evidence the drainage bag was changed every 2 weeks as directed by the plan of care.

During an interview on 2/18/2022, at 12:26 PM, the alternate administrator indicated the RN should have changed the foley catheter before 1/7/2022 or before 30 days from the last catheter change. At 12:27 PM, the alternate administrator indicated she did not see the RN had changed the catheter bag as directed by the plan of care.

5. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/8/2022 3/8/2022, which was signed by the physician on 2/4/2022. Review indicated the patient s diagnoses included, but were not limited to, malignant neoplasm (abnormal mass of tissue) of the prostate and bone and indicated the skilled nurse was to educate on the signs and symptoms of potential complications of the malignant neoplasm to the bone and prostate. This document indicated the patient had a pressure ulcer stage III (an open pressure ulcer with full thickness loss of skin) the left buttock, a pressure ulcer stage III to the right buttock, and a pressure ulcer stage III to the left heel. This document skilled nursing services 1 time a week for 2 weeks and 2 times a week for 7 weeks to include a skilled assessment of all body systems including the integumentary system. Review indicated the skilled nurse was to educate the patient on the signs of symptoms of potential complications of the malignant neoplasm to the bone and prostate. Review indicated the skilled nurse was to weigh the patient weekly.

Review of agency documents titled SN Wound Care Visit dated 1/14/2022, 1/17/2022, 1/20/2022, 1/25/2022, 1/27/2022, 1/31/2022, 2/4/2022, 2/8/2022, 2/10/2022, 2/14/2022, and electronically signed by licensed practical nurse (LPN) H, failed to evidence the LPN performed a wound assessment which included the depth

of the wounds to the right buttock, left buttock, and the left heel. Review of these documents failed to evidence the LPN educated the patient on the signs of symptoms of potential complications of the malignant neoplasm to the bone and prostate as directed in the plan of care. Review failed to evidence the patient was weighed after 1/8/2022 as directed in the plan of care.

During an interview on 2/21/2022, at 2:07 PM, the alternate administrator indicated she did not see the skilled nurse weighed the patient.

6. Clinical record review on 2/17/2022, for patient #4, start of care 10/1/2020, evidenced agency documents titled Home Health Certification and Plan of Care for certification period 11/25/2021 1/23/2022, which was signed by the physician on 12/16/2021. This document indicated the patient s diagnoses included polyosteoarthritis (degeneration of cartilage causing pain and swelling of the joints) and gastro-esophageal reflux disease (GERD, the back flow of stomach acid). This document indicated skilled nursing services were to be provided 1 time a week for 9 weeks and indicated the skilled nurse was to educate the patient on signs and symptoms and disease process of polyosteoarthritis and educate the patient on signs and symptoms of GERD.

Review of agency documents titled SN Teaching/Training Visit , dated 12/1/2021, 12/08/2021, 12/15/2021, 12/23/2021, 12/28/2021, and 1/12/2021, electronically signed by LPN J, failed to evidence the LPN educated the patient on the signs and symptoms of polyosteoarthritis and GERD as directed in the plan of care.

During an interview on 2/17/2022 at 3:58 PM, the alternate administrator indicated the skilled nurse should educate the patient on polyosteoarthritis and GERD since it was on the plan of care.

Review on 2/21/2022, of an agency document titled Home Health Certification and Plan of Care for certification period 2/2/2022

administrator and dated 2/2/2022, evidenced the skilled nurse was to obtain the patient s weight weekly.

Review of agency documents titled SN Teaching/Training Visit , electronically signed by LPN J and dated 2/9/2022, failed to evidence the skilled nurse obtained the patient s weight. Review failed to evidence the patient s weight was obtained since 2/2/2022 as directed in the plan of care.

During an interview on 2/21/2022, at 2:35 PM, the alternate administrator indicated the nurse should have obtained the patient s weight and was unsure why it was not completed.

7. Clinical record review on 2/17/2022, for patient #5, start of care 7/20/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 9/13/2021 11/11/2022, signed and dated by the physician on 10/6/2021. Review indicated the patient s diagnoses included, but were not limited to, major depressive disorder, generalized anxiety disorder, and GERD. This document indicated skilled nursing services were to be provided 1 time a week for 9 weeks and indicated the skilled nurse was to educate the patient on altered mental/emotional status, signs and symptoms of GERD, and energy conservation techniques. This document indicated the skilled nurse was to weigh patient weekly.

Review of agency documents titled SN Teaching/Training Visit , electronically signed by LPN K and dated 9/14/2021 and 9/21/2021, and electronically signed by LPN J and dated 10/6/2021, 10/13/2021, 10/20/2021, and 10/27/2021, failed to evidence the skilled nurse educated the patient on altered mental/emotional status, signs and symptoms of GERD, and energy conservation techniques as directed in the plan of care. Documents dated 10/6/2021, 10/13/2021, 10/20/2021, and 10/27/2021, failed to evidence the patient was weighed weekly as directed in the plan of care.

During an interview on 2/18/2022, at 4:22 PM, the alternate administrator indicated the skilled

nurse did not weigh the patient weekly.

8. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/25/2021 1/23/2022, which was signed and dated by the physician on 12/16/2021. This document indicated the patient s diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease, a lung disease causing difficulty breathing), hemorrhoids, diabetes, and gout (a form of arthritis causing severe pain, redness, and swelling). This document indicated the skilled nurse was to notify the physician for systolic blood pressure (the pressure against the arteries when the heart contracts, indicated by the top number in the blood pressure reading) greater than 160. This document indicated the skilled nurse was to educate the patient on the signs and symptoms of COPD, educate on the management of hemorrhoids, educate on pain relief, educate on the management of gout, educate on the signs and symptoms of hyperglycemia and hypoglycemia, and educate on edema (swelling) of the legs.

Review evidenced agency documents titled SN Teaching/Training Visit , electronically signed by RN D. Review of document dated 1/10/2022, indicated the patient s systolic blood pressure was 162. Review failed to evidence the RN notified the physician of the systolic blood pressure greater than 160 as directed in the plan of care. Review of documents dated 12/2/2021, 12/9/2021, 12/23/2021, 12/30/2021, 1/3/2022, and 1/20/2022, indicated the patient s pain was rated 5 on a scale of 0-10. These documents indicated the patient had rectal bleeding from hemorrhoids. These documents failed to evidence the RN educated the patient on the management of hemorrhoids, the signs and symptoms of COPD, pain relief, the management of gout, and the signs and symptoms of hyper and hypoglycemia as directed in the plan of care. These documents indicated the patient had 1+ pitting edema to the legs and failed to evidence the RN provided

education on edema as directed in the plan of care on documents dated 12/9/2021, 12/23/2021, 12/30/2021, 1/3/2022, and 1/20/2022.

During an interview on 2/18/2022, at 10:44 AM, the alternate administrator indicated the RN should have notified the physician of the blood pressure. At 10:56 AM, the alternate administrator indicated the RN should have provided education on hemorrhoids to include the use of any medications to treat hemorrhoids, increasing fluid and fiber intake. The alternate administrator indicated the RN should have educated the patient on pain relief to include repositioning and not waiting until pain gets worse before taking pain medications. The alternate administrator indicated the RN should have educated the patient on edema to include elevating the feet and reducing the intake of salt in the diet.

9. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled PT [physical therapy] Plan of Care , electronically signed and dated by PT L on 12/8/2021. This document indicated the PT would provide services 2 times a week for 4 weeks and indicated the treatment plan included functional mobility training.

Review of agency documents titled PT Visit , electronically signed by PT L and dated 12/10/2021, 12/15/2021, 12/17/2021, 12/19/2021, 12/21/2021, and 12/29/2021, failed to evidence the PT provided functional mobility training as directed in the plan of care.

During an interview on 2/18/2022, at 11:12 AM, the alternate administrator indicated the PT did not document functional mobility training was provided.

10. During an interview on 2/18/2022, at 12:12 PM, the alternate administrator indicated the assessment of wounds should include length and width and should include depth if the wound is open.

11. During an interview on 2/21/2022, at 1:56

	skilled nurse should educate the patient per the plan of care. 17-14-1(a)(1)(H) 17-14-1(a)(2)(F)			
G0714	Patient and caregiver education 484.75(b)(5) Patient and caregiver education; Based on observation, record review and interview, the licensed practical nurse (LPN) failed to educate the patient and caregiver on swelling and wound prevention measures in 2 of 3 active clinical records reviewed with services provided by a LPN. (#3, #5) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Nursing Services revised February 2021, stated, & Professional nursing service will be provided by a registered nurse [RN] and include: & Counseling and educating the patient and family regarding the disease process, self-care techniques and prevention strategies. & The Licensed Practical Nurse or Licensed Vocational Nurse (LPN/LVN) will supplement the nursing care needs of the patient as provided by the Registered Nurse &. 2. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Start of Care , electronically signed by RN F and dated 1/8/2022. This document indicated the patient s diagnoses included, but were not limited to, diabetes (a chronic condition which affects the way the body processes blood sugar). This document indicated the patient had a history of falls, was at risk for falls, was at risk for skin breakdown, had poor balance, and had a shuffling gait. This document indicated the patient was up as tolerated with the use of a walker. Review evidenced agency documents titled SN	G0714	G0714 Director of Nursing will in-service clinicians onrequirement to educate patients/caregivers on swelling and wound preventionmeasures. Clinicians are to educate patients/caregivers on any change incondition to help prevent further problems. (4/6/2022) Director of Nursing/designee will audit all visit notessubmitted weekly to ensure if there are issues documented there is evidenceclinician instructed patient/caregiver on what to do for noted problems, etc tohelp prevent further problems. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-06

[skilled nurse] Wound Care Visit electronically signed by LPN H. Review of the documents dated 2/8/2022, 2/10/2022, and 2/14/2022, indicated the patient had pitting edema (excess fluid built up in the body and when pressure is applied, causes an indentation) at a degree of 2+ on a scale of 0 to 4+. Review of the document dated 2/10/2022, evidenced the LPN assessed skin tear wounds to the left lower extremity. Review of these documents failed to evidence the LPN educated the patient and caregiver on the pitting edema and the prevention of skin tears.

During an observation of care at the home on 2/18/2022, at 1:15 PM, the patient was observed to have swollen lower extremities between the knees and ankles. The patient was observed to have 20+ scabbed areas on the left shin and 8 scabbed areas on the right shin. No dressing was noted to the patient s scabbed areas.

During an interview at the patient s home on 2/18/2022, at 1:15 PM, the patient s caregiver indicated the patient had neuropathy (damage to the nerves most often to the hands and feet and a common symptom of diabetes) and has fallen over a dozen times to include the most recent fall 3 weeks ago. The patient s caregiver indicated the patient gets cuts on his legs from falling or bumping his legs on things. The patient s caregiver indicated the patient s legs weep (severe swelling that causes fluid to leak from the skin) from the swelling.

During an interview on 2/21/2022, at 1:58 PM, the alternate administrator indicated there was not documentation the LPN educated the patient/caregiver on the prevention of skin tears and indicated the LPN should have educated the patient to wear clothing or padding to protect the areas. At 2:03 PM, the alternate administrator indicated the LPN did not document the education to the patient/caregiver related to the patient s onset of pitting edema. The alternate administrator indicated education should include elevating the lower extremities.

3. Clinical record review on 2/17/2022, for patient #5, start of care 7/20/2020, evidenced an

	agency document titled SN Teaching/Training Visit , electronically signed by LPN K and dated 9/21/2021. This document indicated the patient had eye lid surgery on 9/16/2021 and the eye had 9 sutures. Review indicated the nurse assessed a surgical wound to the right lateral eye with an incision to include 9 intact sutures with an onset date of 9/16/2021. This document indicated the nurse cleaned the surgical wound with normal saline and left open to air. Review failed to evidence the LPN provided the patient and caregiver education regarding the wound care to the right eye. During an interview on 2/18/2022, at 4:21 PM, the alternate administrator indicated there was not documented education provided by the LPN regarding the surgical wound to the right eye and indicated the LPN should have reviewed the wound care with the patient and caregiver. 17-14-1(a)(2)(E)			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on observation, record review, and interview, the skilled nurse failed to accurately prepare clinical notes in 2 of 7 clinical records reviewed (#2, #5), and the physical therapist failed to accurately prepare clinical notes in 1 of 2 clinical records reviewed with physical therapy services. (#7) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Nursing Services revised February 2021, stated, & Professional nursing service will be provided by a registered nurse and include: & Preparing clinical and progress notes & The Licensed Practical Nurse or Licensed Vocational Nurse (LPN/LVN) will supplement the nursing care needs of the patient as provided by the Registered Nurse &. 2. Review of an agency policy obtained 2/21/2022, titled Rehabilitative Services revised February 2021, stated, & Services	G0716	G0716 Director of Nursing will in-service clinicians on completingtheir visit documentation accurately. This includes documenting the correctlocation of wounds, correct wound care process, assessing necessary bodysystems, completing medication reconciliation, correct fractured area. (4/6/2022)	2022-04-06

	provided by a physical or occupational therapist include: & Preparing clinical and progress notes &. 3. Clinical record review on 2/17/2022 and 2/21/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Recertification , signed and dated by registered nurse (RN) D on 1/7/2022. This document indicated the patient had 2 pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (an open pressure ulcer with partial thickness loss of skin), 1 located on the left buttock and 1 located on the right buttock. Review evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022. This document indicated the patient s diagnoses included, but were not limited to, pressure ulcers (wound to the skin and underlying tissue resulting from prolonged pressure to the skin) to the right and left buttocks and diabetes (a chronic condition which affects the way the body processes blood sugar). The document indicated the skilled nurse was to clean the wound to the right buttock and the left buttock with normal saline (a solution used to clean wounds) and apply barrier ointment. Review evidenced agency documents titled SN [skilled nurse] Wound Care Visit , signed by RN D. Document dated 1/12/2022, evidenced the primary diagnosis was a pressure ulcer to the right heel. Documents dated 1/12/2022, 1/18/2022, 1/26/2022, 2/9/2022, 2/16/2022, and 2/28/2022 failed to evidence diabetes was checked under the assessment of the endocrine (the system in the body made up of the body s hormones) section. During an interview on 2/18/2022, at 12:18 PM, the alternate administrator indicated the primary diagnosis on the skilled nurse visit note was incorrect and indicated the skilled nurse should check diabetes under the endocrine assessment.		Director of Nursing/designee will audit all visit notessubmitted weekly. Notes will be compared to the plan of care to ensuredocumentation matches what is on the plan of care. This includes documentingproper location of wounds, proper wound care process, assessing appropriatebody systems. There should also be documentation of medication reconciliation.Once 100% is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) Director of Nursing will have the unsigned OASIS D-1 startof care assessment done 2/2/2022 for patient #5, cited in survey, is signed byclinician who did assessment. (2/19/2022) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

Review of an agency document titled SN Wound Care Visit , dated and electronically signed by RN D on 2/9/2022, evidenced two new pressure ulcers Stage II to the left lateral buttock.

Review of an agency document titled Physician Order , electronically signed and dated by the alternate administrator on 2/9/2022, evidenced the 2 wounds to the left lateral buttocks were to be cleaned with normal saline, apply anasept gel (an antimicrobial wound gel) to the wound bed, apply calcium alginate (a highly absorptive wound dressing), and cover with mepilex (a foam dressing) 2 times a week.

During an observation of care at the home of patient #2 on 2/16/2022, at 11:19 AM, the patient was observed lying on his right side with an uncovered, open area to the left buttock and an uncovered, open area to the right buttock. The patient was observed to have a transparent, adhesive dressing to the right buttock on the right side of the uncovered, open area to the right buttock. RN D indicated the uncovered, open area to the left buttock and the uncovered, open area to the right buttock were the original wounds. RN D was observed removing the transparent, adhesive dressing to the right buttock and 2 open areas were observed to the right of the uncovered, open area on the right buttock. At 11:23 AM, RN D was observed spraying a liquid identified by RN D as normal saline on open area to the left buttock and 3 open areas to the right buttock. RN D was observed wiping the open areas with a gauze pad and was observed spreading the skin on the buttock while wiping the open areas. An open area at 5 o clock from the open area to the left buttock was observed to the inner left buttock. At 11: 25 AM, RN D was observed applying a gel from a bottle labeled Anasept to a white material RN D identified as alginate. RN D was observed applying the white material with the gel onto the middle right buttock open area and to the outer right buttock open area. RN D was observed covering the inner right buttock open area, the middle right buttock open area, and the outer right buttock open area with a foam dressing

RN D identified as a mepilex dressing. RN D was not observed applying the barrier cream to the inner right buttock open area before covering with the foam dressing as ordered by the physician on the plan of care. RN D was observed applying a cream RN D identified as calmoseptine (a barrier ointment to protect the skin from moisture) to the open area on the left buttock and to the open area at 5 o clock of the open area on the left buttock on the inner left buttock. At 11:55 AM, RN D exited the patient s home, and RN D was not observed to have completed a medication reconciliation.

Review of an agency document on 2/21/2022, titled SN Wound Care Visit , dated and electronically signed by RN D on 2/16/2022, indicated barrier ointment was applied to the right and left buttock wounds. This document indicated anasept gel, calcium alginate, and a mepilex dressing was applied to the two left lateral buttock wounds. This document failed to evidence the RN documented the anasept gel, calcium aginate, and mepilex dressing observed to be applied to the open area to the right inner buttock, the open area to the right middle buttock, and the open area to the right outer buttock. This document failed to evidence the RN documented the barrier cream observed to be applied to the left inner buttock. This document indicated the RN completed a medication reconciliation.

During an interview on 2/21/2022, at 1:03 PM, the alternate administrator indicated RN D should have looked at the patient s medication bottles and asked the family if there were any medication changes. At 1:13 PM, the alternate administrator indicated the RN should document the care that is provided and should document where the wound care was provided.

4. Clinical record review on 2/17/2022, for patient #5, start of care 2/2/2022, evidenced an agency document titled SN Teaching/Training Visit , electronically signed by LPN J and dated 2/9/2022. This document indicated the patient had a fracture and a partial weight bearing restriction.

Review of an unsigned agency document titled

	OASIS-D1 Start of Care , with a visit date of 2/2/2022, failed to evidence a fracture and a partial weight bearing restriction in the comprehensive assessment. During an interview on 2/18/2022, at 4:09 PM, the alternate administrator indicated the patient did have an old fracture but was unsure to what part of the body. The alternate administrator indicated the partial weight restriction was not current and the LPN documented the visit note incorrectly. 5. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 11/19/2021 1/17/2022. This document indicated the patient s diagnoses included, but were not limited to, dementia, and fracture of the left femur (the long bone in the upper leg). Review of an agency document titled PT [physical therapy] Plan of Care , electronically signed by PT L and dated 12/8/2021, evidenced the patient s medical diagnosis was hip fracture. Review failed to evidence the PT accurately prepared the PT document. During an interview on 2/18/2021, at 11:10 AM, the alternate administrator indicated she was unsure why the PT documented the patient s medical diagnosis was hip fracture and indicated the diagnosis should be the same as the diagnosis on the agency s plan of care. 17-14-1(a)(1)(E) 17-14-1(a)(2)(B) 17-14-1(c)(5)			
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on observation, record review and interview, the licensed practical nurse (LPN)	G0718	G0718	2022-04-06

	patient s change in status in 2 of 3 active clinical records reviewed with services provided by a LPN. (#3, #5) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Nursing Services revised February 2021, stated, & Professional nursing service will be provided by a registered nurse [RN] and include: & Informing the physician/practitioner and other staff of changes in the patient s needs & The Licensed Practical Nurse or Licensed Vocational Nurse (LPN/LVN) will supplement the nursing care needs of the patient as provided by the Registered Nurse &. 2. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Start of Care , electronically signed by RN F and dated 1/8/2022. This document indicated the patient s diagnoses included, but were not limited to, diabetes (a chronic condition which affects the way the body processes blood sugar). This document failed to evidence the patient had pitting edema (excess fluid built up in the body and when pressure is applied, causes an indentation). Review evidenced agency documents titled SN [skilled nurse] Wound Care Visit electronically signed by LPN H. Review of the documents dated 2/8/2022, 2/10/2022, and 2/14/2022, indicated the patient had pitting edema at a degree of 2+ on a scale of 0 to 4+. Review of these documents failed to evidence the LPN notified the physician regarding the pitting edema. During an observation of care at the home on 2/18/2022, at 1:15 PM, the patient was observed to have swollen lower extremities between the knees and ankles. During an interview at the patient s home on 2/18/2022, at 1:15 PM, the patient s caregiver indicated the patient s legs weep (severe swelling that causes fluid to leak from the skin)		Director of Nursing will in-service clinicians onrequirement to notify MD of change in patient status. Clinician is to notifythe appropriate MD who is responsible for the issue (i.e. – surgeon, eyedoctor, etc). (4/6/2022) Director of Nursing/designee will audit all visit notessubmitted weekly to ensure if there is a documented change in patient statusthere is documentation the proper MD was notified. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	from the swelling. During an interview on 2/21/2022, at 2:03 PM, the alternate administrator indicated the physician was not notified of the swelling and indicated the LPN should have informed the physician. 3. Clinical record review on 2/17/2022, for patient #5, start of care 7/20/2020, evidenced an agency document titled SN Teaching/Training Visit , electronically signed by LPN K and dated 9/21/2021. This document indicated the patient had eye lid surgery on 9/16/2021 and the eye had 9 sutures. Review indicated the nurse assessed a surgical wound to the right lateral eye with an incision to include 9 intact sutures with an onset date of 9/16/2021. This document indicated the nurse cleaned the surgical wound with normal saline and left open to air. Review failed to evidence the LPN contacted the patient s primary physician regarding the surgical wound and wound treatment to the right eye. During an interview on 2/18/2022, at 4:13 PM, the alternate administrator indicated the patient s primary physician was not the physician who performed the eye surgery and indicated the primary physician was contacted regarding the right eye surgery and wound treatment performed. 17-14-1(a)(2)(G)			
G0720	Participate in the HHA's QAPI program; 484.75(b)(8) Participation in the HHA's QAPI program; and Based on record review and interview, the agency failed to ensure skilled professionals participated in the agency s quality assurance performance improvement (QAPI) program. The findings include: Review of an agency policy obtained 2/21/2022, titled Skilled Professional Services stated, & Skilled professionals must assume responsibility for & Participation in the Agency	G0720	G0720 Administrator will ensure that at least one member from eachskilled discipline agency provides participates in the QAPI program. (On-going) Administrator will in-service skilled staff on need to haveat least one member from each skilled discipline agency provides participatesin the QAPI program. (4/2/2022)	2022-04-02

	s QAPI program &. Review of an untitled agency document titled with an effective date of 2/15/2022, evidenced registered nurse (RN) D provided skilled nursing services to patient #1, start date 9/4/2020. This document evidenced licensed practical nurse (LPN) H and physical therapist (PT) provided skilled nursing services to patient #3, start date 1/8/2022. Review of the agency s QAPI binder on 2/16/2022, failed to evidence the involvement of therapists in the QAPI program. During an interview on 2/16/2022 at 1:48 PM, the administrator indicated he and the alternate administrator were involved in QAPI. The administrator indicated no other skilled nurses than the alternate administrator was involved with QAPI and indicated therapists and social worker were not involved with QAPI. The administrator stated, Maybe their insight would be helpful.		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0724	Supervise skilled professional assistants 484.75(c) Standard: Supervision of skilled professional assistants. Based on record review and interview, the registered nurse (RN) failed to provide supervision of the licensed practical nurse (LPN) in 3 of 3 active clinical records reviewed with services provided by a licensed practical nurse. (#3, #4, #5) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Nursing Services revised February 2021, stated, & Professional nursing service will be provided by a registered nurse and include: & Supervising LVN (licensed vocational nurse)/LPNs &. 2. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/8/2022 3/8/2022, which was signed by	G0724	G0724 Director of Nursing will in-service nurses that woundassessment is to include the depth of wounds and documentation of visitreflects orders on the plan of care. (3/10/2022) Director of Nursing will audit all visit notes submittedweekly to ensure patients with wounds have depth of wound(s) documented and theplan of care is being followed including documentation of any education. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained. (On-going) Director of Nursing will in-service RN's that when doingsupervision of LPN they need to review their documentation to ensure it isbeing completed properly.	2022-04-09

	the physician on 2/4/2022. This document indicated the patient had a pressure ulcer (wound to the skin and underlying tissue resulting from prolonged pressure to the skin) stage III (an open pressure ulcer with full thickness loss of skin) the left buttock, a pressure ulcer stage III to the right buttock, and a pressure ulcer stage III to the left heel. This document skilled nursing services 1 time a week for 2 weeks and 2 times a week for 7 weeks to include a skilled assessment of all body systems including the integumentary system. Review of agency documents titled SN [skilled nurse] Wound Care Visit dated 1/14/2022, 1/17/2022, 1/20/2022, 1/25/2022, 1/27/2022, 1/31/2022, 2/4/2022, 2/8/2022, 2/10/2022, 2/14/2022, and electronically signed by licensed practical nurse LPN H, failed to evidence the LPN performed a wound assessment which included the depth of the wounds to the right buttock, left buttock, and the left heel. Review of an agency document titled LVN Supervisory Visit , electronically signed by the alternate administrator and dated 2/8/2022, indicated the LPN followed the patient s plan of care for completion of tasks as assigned. Review failed to evidence the registered nurse provided LPN supervision to ensure the LPN followed the plan of care as directed. During an interview on 1/21/2022, at 1:43 PM, the alternate administrator indicated the RN should have followed up with the LPN to inform her the assessment of depth of the wounds should be obtained. The alternate administrator indicated not all of the skilled nurse visit notes are reviewed by a RN and indicated the RN conducts the LPN supervisory visits by talking to the patient and not with the staff. 3. Clinical record review on 2/17/2022, for patient #4, start of care 10/1/2020, evidenced agency documents titled Home Health Certification and Plan of Care for certification period 11/25/2021 1/23/2022, which was signed by the physician on 12/16/2021. This		Supervisory visits are to be done in person. If thereare issues with documentation the RN is to contact LPN and discuss concerns. RNis to speak with the LPN regarding the patient for which the supervisory visitis being conducted on. (4/9/2022) Director of Nursing/designee will audit all supervisorynotes submitted weekly to ensure there is documentation RN made visit topatient to conduct visit, RN spoke with LPN. LPN visit notes will be reviewedto ensure if sup visit says plan of care was followed the visit notedocumentation reflects the plan of care was followed. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

document indicated the patient s diagnoses included polyosteoarthritis (degeneration of cartilage causing pain and swelling of the joints) and gastro-esophageal reflux disease (GERD, the back flow of stomach acid). This document indicated skilled nursing services were to be provided 1 time a week for 9 weeks and indicated the skilled nurse was to educate the patient on signs and symptoms and disease process of polyosteoarthritis and educate the patient on signs and symptoms of GERD.

Review of agency documents titled SN Teaching/Training Visit , dated 12/1/2021, 12/08/2021, 12/15/2021, 12/23/2021, 12/28/2021, and 1/12/2021, electronically signed by LPN J, failed to evidence the LPN educated the patient on the signs and symptoms of polyosteoarthritis and GERD as directed in the plan of care.

Review of an agency document titled LVN Supervisory Visit , electronically signed by the alternate administrator and dated 12/30/2021, indicated the LPN followed the patient s plan of care for completion of tasks as assigned. Review failed to evidence the registered nurse provided LPN supervision to ensure the LPN followed the plan of care as directed.

During an interview on 2/17/2022, at 3:56 PM, the alternate administrator indicated the LPN did not follow the plan of care, the RN does not review all of the LPN s notes, and conducts the supervisory visit over the phone with the patient and not with the staff.

4. Clinical record review on 2/17/2022, for patient #5, start of care 7/20/2020, evidenced an agency document titled SN Teaching/Training Visit , electronically signed by LPN K and dated 9/21/2021. This document indicated the patient had eye lid surgery on 9/16/2021 and the eye had 9 sutures. Review indicated the nurse assessed a surgical wound to the right lateral eye with an incision to include 9 intact sutures with an onset date of 9/16/2021. This document indicated the nurse cleaned the surgical wound with normal saline and left open to air.

	Review of an agency document titled Home Health Certification and Plan of Care for certification period 9/13/2021 11/11/2021, failed to evidence the plan of care included the surgical wound and treatment to the right eye. Review failed to evidence a physician s order for the treatment to the right eye surgical wound for the cleaning of the wound. Review of agency documents titled LVN Supervisory Visit , electronically signed by the alternate administrator and dated 9/30/2021, 10/29/2021 and 11/8/2021, indicated the LPN followed the patient s plan of care for completion of tasks as assigned. Review failed to evidence the registered nurse provided LPN supervision to ensure the LPN provided care as directed by the plan of care. During an interview on 2/18/2022, at 4:14 PM, the alternate administrator indicated the RN should have not marked the LPN was providing care as directed by the plan of care since there was not an order for the wound treatment provided to the right eye.			
G0750	Home health aide services 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Based on record review and interview, the home health agency failed to ensure: all home health aide care plans were completed and contained frequency of tasks to be performed (See tag G0798); all home health aides followed the aide care plan tasks developed by the skilled professional (See tag G0800); all home health aides reported changes in the patient s condition to a registered nurse or other appropriate skilled professional (See tag G0804); and all home health aide supervisory visits conducted ensured the home health aide was following the aide care plan (See tag G0818).	G0750	G0750 See G0798, G0800, G0804, G0818 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-05

	The cumulative effect of these systemic 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 484.80 Home Health Aide Services.			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on observation, record review, and interview, the home health agency failed to ensure the home health aides had complete, patient-specific written patient care instructions to be performed by the home health aides in 4 of 4 clinical records reviewed with home health aide services. (#1, #2, #3, #6) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Care Planning Process revised February 2021, stated, & The patient care plan for the Home Health Aide [HHA] will be: Home Health Aide assignment sheet: developed by a Registered Nurse & prior to Home Health Aide rendering care & and based on patient s health status and environment. & The assignment sheet/plan of care will include: Diagnosis & Functional limitation & Activities permitted. Nutritional requirements. Specific procedure to be performed &. 2. Clinical record review on 2/16/2022, for patient #1, start of care 9/4/2020, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 12/28/2021 2/25/2022. This document indicated the patient was receiving oxygen as needed and indicated oxygen precautions were included in the patient s safety precautions.	G0798	G0798 Director of Nursing will in-service clinicians onrequirement that aide care plans must have complete patient-specific writtencare instructions. This includes listing precautions specific to patient (I.e.– if on oxygen care plan needs to list oxygen precautions, aspirationprecautions, bleeding precautions, etc) and functional limitations. Listingpermitted activities appropriately. (2/22/2022) Director of Nursing will review all current aide care plansto ensure they are complete and have patient-specific care instructions. If acare plan is not complete or accurate the Director of Nursing will assign an RNto update the aide care to reflect patient-specific instructions. (4/9/2022) Director of Nursing/designee will audit all aide care plansat admission, recertification and anytime there is a change in patient statusto ensure aide care plan is patient specific and revisions are made to aidecare plan if needed. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to	2022-04-09

	Review of an agency document titled HHA Care Plan , signed and dated by registered nurse (RN) D on 12/23/2021, failed to include oxygen precautions in the patient s safety precautions. During an interview on 2/18/2022, at 11:43 AM, the alternate administrator indicated oxygen precautions should be included in the home health aide care plan. 3. During an observation of care on 2/16/2022, at 10:58 AM, at the home of patient #2, start of care 7/16/2021, an oxygen concentrator (a medical device for oxygen therapy) and an oxygen tank were observed in the corner of the patient s bedroom. Clinical record review on 2/17/2022, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022. This document evidenced the patient s diagnoses included, but were not limited to, pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) to the left and right buttocks. This document indicated the patient was NPO (nothing by mouth) and had a gastrostomy (a tube surgically inserted into the stomach through the abdomen used to deliver nutrition, fluids, and/or medication). This document indicated the patient was bedbound and unable to sit in a chair. This document indicated the patient was on complete bedrest. Review of an agency document titled HHA Care Plan , signed and dated by RN D on 1/7/2022, indicated the patient s primary diagnosis was a pressure ulcer to the right heel. This document failed to evidence oxygen precautions were noted. This document indicated the patient s diet was heart healthy and failed to evidence aspiration (when food, fluid or another substance enters the airway or lungs accidentally, may occur when there is difficulty with swallowing) precautions were noted. This document indicated the HHA was assigned to assist with ambulation and indicated the patient s permitted activities included sitting in the wheelchair and complete bedrest. Review failed to evidence the RN provided the HHA patient-specific information on the HHA care		ensure that this deficiency is corrected and will notrecur.	

plan related to the patient s diagnosis, diet, mobility, and safety precautions.

During an interview on 2/18/2022, at 12:15 PM, the alternate administrator indicated the patient used to have a wound to the right heel and indicated the care plan should have reflected the current diagnosis. At 12:16 PM, the alternate administrator indicated the oxygen precautions should have been included on the HHA care plan. At 12:17 PM, the alternate administrator indicated aspiration precautions and NPO status should have been included on the HHA care plan. At 12:18 PM, the alternate administrator indicated the activities permitted on the HHA care plan were inconsistent with both wheelchair and complete bedrest marked. The alternate administrator indicated the RN should not have assigned the HHA to assist with ambulation since the patient does not get out of bed.

4. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/8/2022 3/8/2022. This document indicated the patient s medications included, but were not limited to, Plavix (a blood thinning medication used to prevent heart attacks and strokes) and Aspirin (a blood thinning medication used to prevent heart attacks and strokes). The plan of care included anticoagulant precautions (safety measures to reduce the risk of bleeding) in the patient s safety measures.

Review of an agency document titled HHA Care Plan , electronically signed and dated by RN F on 1/8/2022, failed to include anticoagulant precautions. This document indicated the HHA was to obtain the patient s vital signs at every visit, to include temperature, heart rate, blood pressure, and respirations.

During an interview on 2/21/2022, at 1:15 PM, the alternate administrator indicated the RN should have included anticoagulant precautions in the HHA care plan. The alternate administrator indicated the agency does not

	the RN should not have assigned this task to the HHA on the HHA care plan. 5. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled Home Heath Certification and Plan of Care for certification period 11/25/2021 1/23/2022. This document indicated the patient s medications included, but were not limited to, Asprin, and indicated the patient s safety measures included bleeding precautions. Review of an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Recertification , electronically signed and dated by RN D on 11/22/2021, indicated the patient had urinary incontinence (loss of bladder control). Review of an agency document titled HHA Care Plan , electronically signed and dated by RN D on 11/22/2021, failed to evidence bleeding precautions were included in the patient s safety measures. This document failed to evidence the functional limitations included urinary incontinence. During an interview on 2/18/2022, at 10:49 AM, the alternate administrator indicated the bleeding precautions should have been included on the HHA care plan. The alternate administrator indicated the functional limitations on the HHA care plan should have included urinary incontinence. 17-14-1(m)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review, and	G0800	G0800	2022-04-05

interview, the home health agency failed to ensure the home health aides provided services that were ordered by the physician, included in the plan of care, and consistent with the aide care plan in 3 of 3 active clinical records reviewed with home health aide services. (#1, #2, #3)

The findings include:

1. Review of an agency policy obtained 2/21/2022, titled Home Health Aide Documentation revised March 2018, stated, & The HHA [home health aide] will document services rendered to the patient on the appropriate Home Health Aide charting form as directed in the Aide care plan/assignment sheet &.
2. Clinical record review on 2/16/2022, for patient #1, start of care 9/4/2020, evidenced an agency document titled HHA Care Plan , signed and dated by the registered nurse on 12/23/2021, failed to evidence the HHA was assigned to provide oral care. This document indicated the HHA was to assist the patient with a shower with a chair, assist the patient with a shower with a chair, provide nail care, and perform range of motion exercises at every visit. Review failed to evidence lotions or creams that were to be applied by the HHA to the patient.

During an observation of care at the patient s home on 2/16/2022, at 9:50 AM, HHA C was observed assisting the patient with a sponge bath while the patient sat on the toilet. At 10:12 AM, HHA C was observed handing the patient a cup. The patient was observed sipping from the cup and swishing fluid around in her mouth. HHA C was observed handing the patient another cup and the patient was observed spitting the fluid in her mouth into the cup. HHA C was observed handing the patient a cup which contained dentures. The patient was observed placing upper and lower full dentures into her mouth. At 9:59 PM, HHA C was observed applying lotion from a bottle labeled Ammonium Lactate (a topical medication used to treat dry, scaly skin conditions) to the patient

Director of Nursing will in-service aides on requirement tofollow the aide plan of care. They are not to do tasks that are not assigned onaide plan of care. If patient refuses a task be done then that task is to bemarked as refused. Otherwise all tasks are to be completed and documented. (2/22/2022)

Director of Nursing will in-service clinicians that aideplan of care must be accurate and specific to each patient. (4/5/2022)

Director of Nursing/designee will audit all aide care plansdone each week to ensure it is accurate and specific to each patient. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going)

Director of Nursing/designee will audit all aide visit notessubmitted weekly. They will be compared to the aide care plan to ensure documentationreflects aide plan of care. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going)

The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

s legs. At 10:07 AM, HHA C was observed applying cream to the patient s buttocks HHA C identified as barrier cream. The home health aide was not observed to have provided the patient with a shampoo, nail care and range of motion exercises.

Review of an agency document titled HHA Visit , dated 2/16/2022 and electronically signed by HHA C, failed to indicate HHA C documented the oral care assistance provided to the patient.

During an interview on 2/18/2022, at 11:39 AM, the alternate administrator indicated rinsing the mouth was considered oral care. At 11:52 AM, the alternate administrator indicated at some point the care changed to bathing the patient on the toilet rather than in the shower. At 12:00 PM, the alternate administrator indicated the HHA should not apply creams unless directed to do so on the HHA care plan.

3. Clinical record review on 2/17/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled Home Health Certification and Plan of Care for certification period 1/12/2022 3/12/2022, and signed by the physician on 2/4/2022. This document indicated the patient was bedbound and unable to sit in a chair. This document indicated the patient was on complete bedrest.

Review evidenced agency documents titled HHA Visit , dated 1/12/2022, 1/14/2022, 1/17/2022, 1/19/2022, 1/21/2022, 1/24/2022, 1/26/2022, 1/28/2022, 1/31/2022, 2/2/2022, 2/4/2022, 2/7/2022, 2/9/2022, 2/11/2022, and 2/14/2022, and signed by HHA E. These documents indicated the HHA assisted the patient with ambulation and failed to evidence the HHA completed tasks as ordered by the physician.

During an interview on 2/21/2022, at 1:06 PM, the alternate administrator indicated the HHA does not ambulate the patient but documented she did on the HHA visit notes since assist with ambulation was on the home health aide care plan as an assigned task.

4. Clinical record review on 2/21/2022, for

	patient #3, start of care 1/8/2022, evidenced an agency document titled HHA Care Plan , electronically signed and dated by RN F on 1/8/2022. This document indicated the HHA was to obtain vital signs to include temperature, blood pressure, heart rate and respiration every visit. This document indicated the HHA was to provide a shower with a chair every visit. The document evidenced the bed bath, assist with chair bath, assist with bedpan/urinal, and assist with the bedside commode were not applicable. Review of agency documents titled HHA Visit , electronically signed by HHA E indicated the HHA documented the HHA provided a bed bath, assisted with a chair bath, and failed to obtain vital signs on 1/13/2022, 1/15/2022, 1/18/2022, 1/27/2022, 2/4/2022, and 2/10/2022. These documents indicated the HHA assisted the patient with the bedpan/urinal on 1/13/2022, 1/15/2022, 1/18/2022, 1/27/2022, 2/4/2022, and 2/10/2022. The document dated 1/15/2022 indicated the HHA assisted with the patient with the bedside commode. Review failed to evidence the HHA provided care as directed by the HHA care plan. 5. During an interview on 2/18/2022, at 12:07 PM, the alternate administrator indicated the HHA should perform the care as directed on the HHA care plan. 6. During an interview on 2/21/2022, at 1:08 PM, the alternate administrator indicated the HHA should document the care provided to the patient.			
G0804	Aides are members of interdisciplinary team 484.80(g)(4) Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures. Based on observation, record review, and interview, the home health aide failed to report changes in the patient s condition to a registered nurse or other appropriate skilled professional	G0804	G0804 Director of Nursing will in-service aides on they are toreport changes in a patient’s position to the RN or other appropriate skilledprofessional (therapist). (2/22/2022) Director of Nursing/designee will audit all aide visit notessubmitted each week to ensure if there is documentation of a	2022-03-25

	(#1) The findings include: Review of an agency policy obtained 2/21/2022, titled Home Health Aide Documentation revised March 2018, stated, & The HHA [home health aide] will be responsible for reporting any changes in the patient s condition and/or other pertinent observations to the supervising RN [registered nurse]/Therapist &. During an observation of care at the home of patient #1, start of care 9/4/2020, on 2/16/2022, at 9:59 AM, home health aide (HHA) C was observed assisting the patient with a sponge bath while the patient sat on the toilet. The patient was observed to have a dry dressing on the right knee. The patient indicated it was a rash and complained of itching to the area. The HHA was not observed reporting the dry dressing, the rash, and the patient s complaint of itching to the RN. Clinical record review on 2/18/2022 failed to evidence documentation of a rash and an order for a dry dressing to the patient s right knee. Review on 2/21/2022, evidenced an agency document titled HHA Visit , dated 2/16/2022 and electronically signed by HHA C. Review failed to evidence the HHA reported the dressing to the right knee, the rash, and the patient s complaint of itching to the supervising RN. During an interview on 2/21/2022, at 1:09 PM, the alternate administrator indicated there was no documentation the home health aide reported the dry dressing and rash to the RN and indicated the home health aide should have reported it to the RN.		change in patientcondition there is documentation they reported it to the appropriate clinician.Once 100% compliance is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0818	HH aide supervision elements 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides	G0818	G0818 Director of Nursing will instruct clinicians	2022-04-04

furnish care in a safe and effective manner, including, but not limited to, the following elements:

(i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional;

(ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family;

(iii) Demonstrating competency with assigned tasks;

(iv) Complying with infection prevention and control policies and procedures;

(v) Reporting changes in the patient's condition; and

(vi) Honoring patient rights.

Based on record review and interview, the agency failed to ensure the home health aide (HHA) was supervised to ensure the aides furnished care that followed the patient s plan of care in 1 of 3 active clinical records reviewed with home health aide services. (#3)

The findings include:

Review of an agency policy obtained 2/21/2022, titled Home Health Aide Supervision revised February 2021, stated, & Home Health Aide Supervision must ensure that aides furnish care in a safe and effective manner including, but not limited to, the following elements: Following the patient s plan of care for completion of tasks assigned to a Home Health Aide by the registered nurse &.

Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled HHA Care Plan , electronically signed and dated by RN F on 1/8/2022. This document indicated the HHA was to obtain vital signs to include temperature, blood pressure, heart rate and respiration every visit. This document indicated the HHA was to provide a shower with a chair every visit. The document evidenced the bed bath, assist with chair bath, assist with bedpan/urinal, and assist with the bedside commode were not applicable.

Review of agency documents titled HHA Visit , electronically signed by HHA E indicated the HHA documented the HHA provided a bed bath, assisted with a chair bath, and failed to

that when doingsupervision visit for aide they are review aide charting to ensure the plan ofcare is being followed. If documentation indicates plan of care isn’t beingfollowed clinician should not state aide is following plan of care. RN wouldneed to speak with aide to discuss requirement to follow plan of care. (4/4/2022)

Director of Nursing/designee will audit all supervisoryvisits submitted each week to ensure they are completed accurately. If there isdocumentation aide isn’t following plan of care there should be documentationRN spoke with aide regarding following the plan of care. One 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going)

The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

	1/18/2022, 1/27/2022, 2/4/2022, and 2/10/2022. These documents indicated the HHA assisted the patient with the bedpan/urinal on 1/13/2022, 1/15/2022, 1/18/2022, 1/27/2022, 2/4/2022, and 2/10/2022. The document dated 1/15/2022 indicated the HHA assisted with the patient with the bedside commode. Review failed to evidence the HHA provided care as directed by the HHA care plan. Review of an agency document titled HHA Supervisory Visit , electronically signed by the alternate administrator and dated 1/22/2022, indicated the HHA followed the patient s plan of care for completion of tasks as assigned. Review failed to evidence the registered nurse provided home health aide supervision to ensure the home health aides followed the aide care plan as directed. During an interview on 1/31/2022, at 1:31 PM, the alternate administrator indicated the supervisory visit should not be documented that the HHA is following the care plan and indicated the RN should follow-up with the HHA to review the care plan. 17-14-1(n)			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on observation, record review, and interview, the administrator failed to be responsible for the day-to-day operations of the agency. The findings include: Review of an agency job description on 2/15/2022, titled Administrator revised March 2018, stated, & The Administrator ensures quality and safe delivery of home health care services and responsible for all day-to-day operations of the Agency &. The administrator failed to ensure the day-to-day operations of the home health	G0948	G0948 See plan of correction written for the following tags: Etags, G0374, G0414, G0434, G0436, G0458, G0460, G0514. G0528, G0536, G0544,G0570, G0572, G0574, G0580, G0584, G0588, G0590, G0592, G0598, G0606, G0614,G0616, G0622, G0640, G0660, G680, G0708, G0710, G0714, G0716, G0718, G0720,G0724, G0798, G0800, G804, G0818, G0958, G0960, G1012, G1022, G1024.	2022-04-05

	The administrator failed to ensure there was an Emergency Preparedness Program in place for the home health agency. Please see tags associated with federal regulation 42CFR 484.102. The administrator failed to ensure the accuracy of all reported OASIS assessment data. Please see tag G0374. The administrator failed to ensure the patients were provided the name of the administrator to receive complaints. Please see tag G0414. The administrator failed to ensure the patient was informed of and consented to care in advance of the frequency of visits and changes in the care to be furnished. Please see tag G0434. The administrator failed to ensure agency patients received all services ordered in the plan of care. Please see tag G0436. The administrator failed to ensure the patient was discharged because the physician responsible for the plan of care and the agency agree the measurable goals and outcomes set forth in the plan of care have been achieved. Please see tag G0458. The administrator failed to ensure the patient was discharged because the patient refused services. Please see tag G0460. The administrator failed to ensure a registered nurse (RN) conducted the initial assessment to determine the immediate care and support needs. Please see tag G0514. The administrator failed to ensure the comprehensive assessment reflected the patient s current health status. Please see tag G0528. The administrator failed to ensure the		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

comprehensive assessment medication reconciliation was reviewed by a registered nurse. Please see tag G0536.

The administrator failed to ensure the comprehensive assessment was updated and revised to include new wounds. Please see tag G0544.

The administrator failed to ensure the home health agency was meeting all the needs of agency patients. Please see tag G0570.

The administrator failed to ensure the plan of care for agency patients was followed, individualized and established by a primary care physician. Please see tag G0572.

The administrator failed to ensure the plan of care contained all required elements. Please see tag G0574.

The administrator failed to ensure all drugs, treatments, and services were only provided as ordered by a physician or other appropriate healthcare professional. Please see tag G0580.

The administrator failed to ensure the clinician receiving the physician's verbal orders documented the order in the patient's clinical record to include a signature, date and time of the order and failed to ensure the verbal orders were authenticated and dated by the physician. Please see tag G0584.

The administrator failed to ensure the plan of care was reviewed and revised by the primary care physician every 60 days. Please see tag G0588.

The administrator failed to ensure the primary care physician was promptly alerted to changes in the patient s condition. Please see tag G0590.

The administrator failed to ensure the plan of

care was revised to reflect the patient s current status. Please see tag G0592.

The administrator failed to ensure revisions to the plans for patient discharge was communicated to the physician responsible for the plan of care. Please see tag G0598.

The administrator failed to ensure there was coordination of care amongst all agency disciplines and with outside healthcare entities who serviced agency patients. Please see tag G0606.

The administrator failed to ensure there was a written visit schedule in all patients homes. Please see tag G0614.

The administrator failed to ensure there was a written, current medication schedule in all patients homes. Please see tag G0616.

The administrator failed to provide the patient and caregiver in writing with the treatments to be administered by agency personnel. Please see tag G0618.

The administrator failed to provide the patient and caregiver in writing with the name and contact information of the clinical manager. Please see tag G0622.

The administrator failed to ensure there was a Quality Assessment and Performance Improvement (QAPI) maintained at the home health agency. Please see tag G0640.

The administrator failed to ensure the governing body maintained an ongoing QAPI program. Please see tag G0660.

The administrator failed to ensure the home health agency maintained and documented an infection control program. Please see tag G0680.

The administrator failed to ensure the skilled professional developed the plan of care. Please see tag G0708.

The administrator failed to ensure all home health agency skilled professionals provided services as indicated on the plan of care. Please see tag G0710.

The administrator failed to ensure the skilled professional provided education to the patient and caregiver. Please see tag G0714.

The administrator failed to ensure skilled professionals created clinical notes and/or accurate complete notes for all services provided to patients. Please see tag G0716.

The administrator failed to ensure skilled professionals communicated with the physician with a patient s change in status. Please see tag G0718.

The administrator failed to ensure all home health agency staff participated in the agency's QAPI program. Please see tag G0720.

The administrator failed to ensure the skilled professional provided supervision of the licensed practical nurse (LPN). Please see tag G0724.

The administrator failed to ensure all home health aide care plans were completed by a skilled professional and included task frequencies. Please see tag G0798.

The administrator failed to ensure all services provided by the home health aide were ordered by the physician, included in the plan of care, permitted to be performed under state law and consistent with the home health aides training. Please see tag G0800.

The administrator failed to ensure the home health aide failed to report changes in the

	patient's condition to a registered nurse. Please see tag G0804. The administrator failed to ensure the supervising nurse ensured the home health aide followed the aide care plan. Please see tag G0818. The administrator failed to ensure the clinical manager provided oversight of the storage of medication. Please see tag G0958. The administrator failed to ensure the clinical manager provided oversight in making patient and personnel assignments. (See tag G0960). The administrator failed to ensure all clinical records contained all required documentation of services rendered by agency staff. Please see tag G1012. The administrator failed to ensure all clinical records contained a discharge summary that was sent to the primary care physician. Please see tag G1022. The administrator failed to ensure all clinical notes were clear, complete and appropriately authenticated. Please see tag G1024. During an interview on 2/18/2022, at 9:00 AM, the alternate administrator, when queried about the role of the nurse consultant, stated I take full responsibility for these things, but I relied on [person C, nurse consultant] to answer questions for me. 17-12-(c)(1)			
G0958	Clinical manager 484.105(c)	G0958	G0958 Director of Nursing will ensure when a	2022-03-21

Standard: Clinical manager.

One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following--

Based on observation, record review and interview, the clinical manager failed to provide oversight of the storage of medication used to provide tuberculosis (TB; a contagious bacterial infection usually affecting the lungs) skin tests and influenza vaccination to agency personnel.

The findings include:

Review of an agency policy obtained 2/21/2022, titled Medication Storage revised March 2018, stated, & If the Agency stores medications onsite in office, medications will be stored properly and safely. Medications will be stored under proper conditions to ensure stability, including: Storing at proper temperatures & and keeping temperature records &.
During an interview on 2/16/2022, at 1:41 PM, the alternate administrator, who self-identifies as the clinical manager, indicated the agency provided TB skin tests and influenza vaccines and indicated the medication was stored in the office.

During an observation on 2/16/2022, at 1:41 PM, a refrigerator was observed in the office. The thermometer inside of the refrigerator was observed to read 26 degrees Fahrenheit. A box labeled Tubersol (a medication used to administer TB skin tests) was observed on a shelf inside of the refrigerator. A vial labeled Tubersol inside of the box was observed to be open. No date of opening was observed on the vial or on the box of Tubersol. Observed on the box were storage guidelines from the manufacturer which indicated the medication should be stored between 35-46 degrees Fahrenheit. Observed on the box were guidelines by the manufacturer which indicated the medication should be discarded 30 days after opening. A box labeled Flucelvax Quadrivalent (a medication used to administer the influenza vaccine) was observed on the

box of Tubersol isopened it is dated. Will ensure Tubersol vial is discarded 30 days of date itwas opened if there is serum left. (On-going)

Director of Nursing/designee will monitor temperature ofrefrigerator where medications are stored to ensure temp stays between 35-46degrees. Temperature will be documented daily on a log sheet. (On-going)

Director of Nursing will instruct any clinician thatadministers the Tubersol to look for date vial was opened and if more than 30days old that vial is to be discarded and a new vial opened and dated. (2/22/2022)

The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.

	dose, pre-filled syringes observed inside of the box. Observed on the box were storage guidelines from the manufacturer which indicated the medication should be stored between 36-46 degrees Fahrenheit. The medications were not observed to be stored per manufacturer s guidelines. During an interview on 2/16/2022, at 1:44 PM, the alternate administrator indicated she was unsure when the vial of Tubersol was opened. The alternate administrator indicated she was unsure of the medication storage guidelines and indicated there were no refrigerator temperature logs. 17-12-1(d)			
G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, Based on record review and interview, the clinical manager failed to provide oversight of patient and personnel assignments. The findings include: Review of an agency job description on 2/15/2022, titled Clinical Manager , revised June 2018, stated, & Responsibilities: & Makes staff and patient assignments &. Review of an untitled agency document on 2/15/2022, which the alternate administrator identified as the staff s schedule, indicated registered nurse (RN) D was scheduled to visit patient #9, start of care 2/17/2020, on 2/15/2022. During an interview on 2/15/2022, at 10:58 AM, the alternate administrator, who self-identified as the clinical manager, indicated the staff is assigned their visits each week and then pick the day and time the visit will be conducted. When queried what time RN D was visiting patient #9 on 2/15/2022, the alternate administrator indicated RN D was conducting	G0960	G0960 Director of Nursing will in-service clinicians they are tonotify Director on Mondays by 10a of the date/time of the visits they have beenassigned for the week. If clinician makes a change in their visit schedule theyare to notify the Director of Nursing before making change so visit schedulecan be updated. (4/9/2022) Director of Nursing/designee will audit all visit notessubmitted weekly. Visit dates will be compared to the clinician's visitschedule. If they do not match Director of Nursing will talk with clinician toremind them they must notify Director/designee of the change in advance sooffice copy of schedule is accurate. Once 100% compliance is achieved 10% willbe audited quarterly to ensure compliance is maintained. (On-gong) The Administrator will be responsible for	2022-04-09

	patients RN D was visiting on 2/15/2022, the alternate administrator indicated she was not sure. 17-14-1(a)(1)(K)		monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G1012	Required items in clinical record 484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders; Based on record review and interview, the agency failed to ensure the clinical record contained clinical notes and a plan of care for 3 of 5 active clinical records reviewed. (#1 #4, #5) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Timely Submission of Patient Documentation revised February 2021, stated, & Itineraries with all visit reports attached, must be submitted the next scheduled work day, not exceeding three (3) business days &. 2. Review of an agency policy obtained 2/21/2022, titled Compliance with Laws and Regulations and Disclosure of Information revised March 2018, stated, & The Agency and its staff will furnish services in compliance with all applicable federal, state and local laws and regulations &. 3. Clinical record review on 2/18/2022, for patient # 1, start of care 9/4/2020, evidenced an agency document titled, HHA [home health aide] Visit , dated 2/14/2022, assigned to HHA C in the electronic health record. Review evidenced the visit note was blank. During an interview on 2/18/2022, at 11:47 AM, the alternate administrator indicated HHA C had conducted the HHA visit on 2/14/2022 but had not yet completed the visit note. 4. Clinical record review on 2/17/2022, for patient #4, start of care 2/2/2022, failed to evidence a plan of care.	G1012	G1012 Director of Nursing will in-service all field staff thatdocumentation, includes visit notes, is to be completed at the time of thevisit but no later than end of that day and submitted next day but no more than3 business days later. (4/5/2022) Director of Nursing/designee will audit all documentationsubmitted weekly to ensure it is completed and submitted timely. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) Director of Nursing will in-service clinicians that plan ofcare needs to be completed and submitted no more than 3 business days after admissionor recertification visit. (4/5/2022) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-05

	During an interview on 2/18/2022, at 3:40 PM, the alternate administrator indicated the plan of care was not developed yet and indicated maybe it would be completed by 2/21/2022. 5. Clinical record review on 2/17/2022, for patient #5, start of care 2/2/2022, failed to evidence a plan of care. During an interview on 2/18/2022, at 4:15 PM, the alternate administrator indicated the plan of care was not completed yet and indicated she would try to complete it over the weekend. 17-15-1(a)(1)-(7)			
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the home health agency failed to ensure the discharge summary was sent to the primary care physician in 1 of 2 active clinical records reviewed with a prior discharge from the agency (#5) and 2 of 2 closed clinical records reviewed. (#6, #7) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Discharge Summary revised February 2021, stated, & A Discharge Summary will be sent within 5 business days of patient discharge to the primary care practitioner &. 2. Clinical record review on 2/17/2022, for patient #5, start of care 7/20/2020, evidenced an agency document titled Physician Order ,	G1022	G1022 Director of Nursing will in-service clinicians onrequirement to complete discharge summary and fax/mail to MD within 5 businessdays of discharge. When discharge summary is sent to MD it is to be documentedin patient chart. (3/30/2022) Director of Nursing/designee will audit all discharges doneweekly to ensure there is a completed discharge summary and there isdocumentation it was faxed/mailed to MD with date sent. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-03-31

electronically signed by the alternate administrator and dated 11/8/2021, which indicated the patient was discharged from the agency on per patient request.

Review evidenced an agency document titled Home Health Discharge Summary (Auto Generated), which was electronically signed by the alternate administrator and dated 11/23/2021. This document failed to evidence the document was completed within 5 business days of the patient s discharge and failed to evidence the physician was sent the discharge summary.

3. Clinical record review on 2/14/2022, for patient #6, start of care 1/29/2021, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Discharge electronically signed and dated by registered nurse (RN) D on 1/19/2022. This document indicated the patient was discharged from the agency on 1/19/2022.

Review evidenced an agency document titled Home Health Discharge Summary (Auto Generated) , which was electronically signed by registered nurse D and dated 1/24/2022. This document failed to evidence the physician was sent the discharge summary.

4. Clinical record review on 2/15/2022, for patient #7, start of care 11/20/2021, evidenced an agency document titled OASIS-D1 Discharge , electronically signed by the alternate administrator and dated 1/13/2022. This document indicated the patient was discharged from the agency on 1/13/2022.

Review of an agency document titled Home Health Discharge Summary (Auto Generated) , which was electronically signed by the alternate administrator and dated 1/23/2022, failed to evidence the document was completed within 5 business days of the patient s discharge and failed to evidence the physician was sent the discharge summary.

5. During an interview on 2/18/2022, at 10:32 AM, the alternate administrator indicated the discharge summary is automatically generated

	by the electronic medical record. The alternate administrator indicated the clinical record did not indicate when the discharge summaries were sent to the physicians. At 4:14 PM, the alternate administrator indicated she did not know the discharge summary had to be sent to the physician within 5 business days. 17-15-1(a)(6)			
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 observation, record review, and interview, the agency failed to ensure the entries in the clinical record were accurate, complete, signed and dated in 5 of 5 active clinical records reviewed. (#1, #2, #3, #4, #5) The findings include: 1. Review of an agency policy obtained 2/21/2022, titled Medical Record Entries and Authentication revised March 2018, stated, & All entries in patient records will be legible, clear, complete and appropriately authenticated, dated and timed. All entries in the medical records will be authenticated by staff signature and title. By authenticating entries in the patient s record, staff is validating the correctness of the information &. 2. During an observation of care at the home of patient #1, start of care 9/4/2020, on 2/16/2022, at 9:50 AM, home health aide (HHA) C was observed assisting the patient with a sponge bath while the patient sat on the toilet. The home health was not observed to have provided the patient with a shampoo, nail care and range of motion exercises. Clinical record review on 2/21/2022, evidenced an agency document titled HHA Visit , dated	G1024	G1024 Director of Nursing will in-service all field staff onrequirement to document care provided to patient. The plan of care/aide plan ofcare is be followed. If something on plan is not done documentation mustindicate why not done. All documentation must be signed/dated by the employee.Documentation must accurately reflect patient status/condition. (4/1/2022) Director of Nursing/designee will audit all documentationsubmitted weekly to ensure it is complete, accurate and is signed/dated by theemployee. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) Director of Nursing will ensure the clinician(s) that didthe 2/2/2022 OASIS Start of Care for patient #4, #5, cited in survey, hascompleted and signed the start of care assessment. (2/19/2022) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2022-04-01

This document indicated the HHA provided a shower with chair, provided a shampoo, provided nail care, and provided range of motion. Review failed to evidence the clinical record was accurately completed to reflect the care provided.

During an interview on 2/21/2022, at 1:08 PM, the alternate administrator indicated the HHA should document the care provided to the patient.

3. Clinical record review on 2/17/2022, for patient #2, start of care 7/16/2021, evidenced an agency document titled SN [skilled nurse] Wound Care Visit , with a date assigned on 2/9/2022, in the electronic health record which indicated skilled nursing services had been provided to the patient to include wound care. The electronic health record indicated the visit dated 2/9/2022 was assigned to registered nurse (RN) D. Review of the document in the electronic health record failed to evidence the signature and date by the clinician who completed the visit note.

During an interview on 2/18/2022, at 12:29 PM, the alternate administrator indicated RN D might not have completed the visit note on 2/17/2022 to be able to sign the note. The alternate administrator indicated she would check the electronic health record to determine when RN D signed the note. No further information was provided.

Review of an undated agency document titled Patient Individualized Emergency Plan , signed by RN D failed to evidence the RN dated the document.

During an interview on 1/21/2022, at 1:14 PM, the alternate administrator indicated the RN should have dated the document.

4. Clinical record review on 2/21/2022, for patient #3, start of care 1/8/2022, evidenced an agency document titled HHA Care Plan , which was signed and dated by RN F on 1/8/2022. This document indicated the patient s functional limitations included amputation. Review failed to evidence the patient had an amputation.

During an interview on 2/21/2022, at 1:17 AM, the alternate administrator amputation had been checked by mistake.

5. Clinical record review on 2/17/2022, for patient #4, start of care 2/2/2022, evidenced an agency document titled OASIS-D1 [Outcome and Assessment Information Set, a comprehensive assessment data collection tool] Start of Care , which failed to evidence it was signed and dated by the clinician. This document indicated the patient was a male. Under a subtitle Admission Summary , this document indicated the patient was a female. This document indicated the skilled nurse was to provide services 1 time a week for 9 weeks starting the week of 11/29/2021.

During an interview on 2/18/2022, at 3:41 PM, the alternate administrator indicated she performed the start of care assessment on 2/2/2022 and had not signed the document yet because the document was not finished. At 3:49 PM, the alternate administrator indicated the patient was a male and was documented incorrectly. The alternate administrator indicated the start date of the skilled nurse services was incorrect and indicated it must have been a carry over from the previous assessment from the patient s prior admission with the agency.

6. Clinical record review on 2/17/2022, for patient #5, starts of care 7/20/2020 and 2/2/2022, evidenced an agency document titled OASIS-D1 Start of Care , with a visit date of 2/2/2022. This document failed to evidence it was signed and dated by the clinician.

During an interview on 2/18/2022, at 4:02 PM, the alternate administrator indicated she completed the start of care comprehensive

	assessment and indicated she had not signed and dated the document yet because the document was not finished. Review of an agency document, titled SN Teaching/Training Visit , dated 11/3/2021, failed to evidence a signature and date by the clinician. During an interview on 2/21/2022, at 2:57 PM, the alternate administrator indicated the note should be signed and dated. The alternate administrator indicated the skilled nurse visit was completed on 11/3/2021 by licensed practical nurse (LPN) J. 17-15-1(a)(7)			
N9999	Final Observations Review of Indiana Code 16-27-2.5 stated in "... Section 2.(a) A home health agency must: (1) have a written drug testing policy that is distributed to all employees; and (2) require each employee to acknowledge receipt of the policy. (b) A home health agency shall randomly test: (1) at least fifty percent (50 %) of the home health agency's employees who: (A) have direct contact with patients; and (B) are not licensed by a board or commission under IC 25; at least annually; or (2) when the home health agency has reasonable suspicion that an employee is engaged in the illegal use of a controlled substance...." Based on record review and interview, the home health agency failed to randomly drug tested at least 50% of the unlicensed employees with direct patient contact and failed to have a written drug testing policy.	N9999	N9999 Administrator has implemented a drug testing policy thatfollows Indiana Code. (3/11/2022) Administrator will determine how many aides (HHA/CNA's) wereemployed as of June 30, 2021 and will ensure 50% of that number is randomlytested by June 30, 2022. (3/21/2022) Administrator will determine in July each year how manyaides were employed as of June 30th and determine how many aides(equaling 50% of that number) are to be randomly tested between July that yearand June 30th of following year. (Ongoing) Administrator will create a tracking record and monitor itmonthly to ensure the proper number of random drug tests are done yearlybetween July 1 and June 30. (Ongoing) The Administrator will be responsible for monitoring thesecorrective actions to	2022-03-21

The findings include:

Review of an agency policy obtained 2/21/2022, titled Compliance with Laws and Regulations and Disclosure of Information stated, & The Agency and its staff will furnish services in compliance with all applicable federal, state and local laws and regulations &.

Review of an untitled, undated agency document on 2/15/2022, identified as the active patient list by the alternate administrator, evidenced 5 unlicensed staff having direct patient contact.

During an interview on 2/15/2022, at 12:49 PM, the alternate administrator indicated drug screens were completed at time of hire and randomly for 10% of all staff each year.

Review of documents on 2/15/2022, identified as random drug screen results for the past year by the alternate administrator, indicated random drug screens were conducted on speech therapist R, licensed practical nurse K, and registered nurse D. Review failed to evidence unlicensed staff having direct patient contact were randomly drug tested.

During an interview on 2/15/2022, at 1:03 PM, the alternate administrator indicated the agency had not obtained random drug screens for unlicensed staff.

During an interview on 2/15/2022, at 1:15 PM, the administrator indicated there was not an agency policy for drug screening and stated, I could see how we need one though so when we ask staff to do it, they know why.

ensure that this deficiency is corrected and will notrecur.

See attachment F – Drug Testing Policy

Purpose

Because CARDINALHOME HEALTH SERVICES ("the Agency") is a licensed home health agencyin Indiana, it is required, as a term of its license to operate as a homehealth agency, to implement a program to test job applicants and certainemployees for the illegal use of controlled substances. Furthermore, because the Agency providesservices to patients who may be frail and unable to care for their own needsand provides these services under programs regulated by state and federal laws,the Agency has a compelling obligation to eliminate substance abuse from itsworkforce. The illegal use of Controlled Substances by employees adverselyimpacts an employee’s job performance, as well as endangers other employees,our patients and the general public. It is therefore necessary that the Agencymaintain a work environment that is free from the effects of the illegal use ofcontrolled substances by unlicensed employees who will have direct patientcontact.

Policy

Definitions

CoveredApplicant. As used in this Policy and Procedure, the term "CoveredApplicant" means an individual who is not licensed by a Board orCommission under Title 25 of the Indiana Code and who is applying for aposition which will require the applicant to have direct patient contact.

CoveredEmployee. As used in this Policy and Procedure, the term "CoveredEmployee" means an employee who will have direct patient contact and whois not licensed by a Board or Commission under Title 25 of the Indiana Code.

RandomlySelected Covered Employees. As used in this Policy and Procedure, theterm "Randomly Selected Covered Employees" means the CoveredEmployees who are selected at Random to undergo a Test for ControlledSubstances.

Test forControlled Substances. As used in this Policy and Procedure, the term "Testfor Controlled Substances" means a test that utilizes a [blood/urine/sputum]specimen in a five-panel test that test the specimen for the presence ofamphetamines, cocaine, marijuana, opiates and PCP.

TESTINGPROCEDURES AND METHODS

A Covered Employee or an Applicant who is required toundergo a Test for Controlled Substances will provide a [blood/urine/sputum]sample as outlined in the Agency's sample collection procedures or outside lab'scollection procedures.

The Covered Employee or Applicant who is the subject of aTest for Controlled Substances will be provided with a written report of thetest results and any follow-up confirmation tests.

CONTROLLEDSUBSTANCE TESTING – APPLICANTS

All Covered Applicants will be provided a copy of this Policyand required to sign an acknowledgement that the Covered Applicant received acopy of this Policy. Covered Applicantswill also sign a consent form provided by the testing company authorizingdisclosure of the test results to the Agency. Upon completion of all other aspects of the hiring process, if adecision to hire a Covered Applicant is made, the Covered Applicant will beoffered employment conditioned upon taking and passing a Test for ControlledSubstances.

RefusingTest – Applicants

A Covered Applicant's refusal to submit to a Test for ControlledSubstances will be treated as if the Covered Applicant had taken the Test forControlled Substances and obtained a positive test. This will result in the Applicant'sconditional employment being terminated due to failure to take and pass a Testfor Controlled Substances.

Resultof Test - Applicants

If the Test for Controlled Substances results in a positivetest, the Covered Applicant will be given forty-eight (48) hours to produce avalid, current, subscription for the controlled substance for which theApplicant tested positive.

If the Covered Applicant cannot produce a valid, current,subscription, the Covered Applicant's conditional employment will be terminateddue to failure to take and pass a Test for Controlled Substances. A copy of the Policy, Acknowledgement andConsent will be maintained with the rest of the Applicant's applicationmaterials. The Applicant's test resultswill be maintained in a separate confidential file with the other applicants'test results.

If the Test for Controlled Substances results in a negativetest, the Covered Applicant will be immediately available to be scheduled towork. The Covered Applicant will beadded to the roster of Covered Employees. The individual's applicationmaterials, including the Policy, Acknowledgement and Consent will be placed inthe individual's personnel file. The test results will be placed in theconfidential portion of the individual's personnel file.

CONTROLLEDSUBSTANCE TESTING – COVERED EMPLOYEES

The organization's Covered Employees are required to undergoa Test for Controlled Substances under the following circumstances:

1. **Random Testing**: On or before June 30 of each year, the Agencywill subject the Randomly Selected Covered Employees to a Test for ControlledSubstances.

2. **Reasonable Suspicion testing**: A Covered Employeeshall be required to undergo a Test for Controlled Substances at any time theAgency has reasonable suspicion that a Covered Employee is engaged in theillegal use of

Suspicion" may exist based on, among other things:

a. Directobservation of drug or alcohol use or possession;

b. Observationof physical conditions which indicate symptoms of being under the influence ofdrug or alcohol, including but not limited to:

i. Odor;

ii. Gait;

iii. Speech;

iv. Appearance;

v. Statements;

vi. Evidence of use (for example,syringe or vile);

vii. Response to questions.

c. Apattern of abnormal conduct or erratic behavior (including but not limited toabsenteeism, tardiness, or deterioration in work performance);

d. Arrestor conviction for a drug-related offense, or being identified as the focus of acriminal investigation into illegal drug possession, use, or trafficking;

e. Anews report of a drug related arrest;

f. Informationprovided either by reliable and credible sources or that is independentlycorroborated; or

g. Newlydiscovered evidence that the employee has tampered with a previous drug/alcoholtest.

3. **Post-accident testing**: the Agency shall require a Covered Employeeto undergo a Test for Controlled Substances if the Covered Employee is involvedin an accident or incident while on the clock (i) which results in the CoveredEmployee or another person sustaining an injury, or (ii) which results indamage to the Agency’s property, the Covered Employee's property and/or thepatient's property, including damage to

equipment.

4. **Post-rehabilitation/return to work testing**: The Agency shallrequire an individual who was on a temporary leave of absence, FMLA or similartime off to undergo counseling for drug abuse to undergo a Test for ControlledSubstances before returning to work.

RandomTesting Procedure – Identifying the Sample

Beginning on July 1, 2017 and annuallythereafter, the Agency will determine the number of Covered Employees on itsemployee roster. The Agency will thenmultiple this number by 50% to identify the number of Covered Employees theAgency must randomly test before June 30 of the following year (the"Number of Required Tests").

Once theNumber of Required Tests is determined, the Agency will randomly select thatnumber of individuals from the list of all Covered Employees. These individuals will be identified on July1 but need not be tested immediately. The Agency must complete the Number of Required Tests on or before June30 of the next year.

In theevent a Covered Employee who is selected for testing is no longer employed atthe time the test is to be performed, another Covered Employee will be selectedfrom the list compiled on the immediately preceding July 1 at random. If, due to employee turnover, there are notenough Covered Employees on the July 1 list to perform the Number of RequiredTests, Covered Employees will be randomly selected from the population ofCovered Employees at the time the test is to be performed until the Number ofRequired Tests has been performed, even if this requires the Agency to testnewly hired employees who tested during the application process.

Whendetermining if the Number of Required Tests has been performed, the Agencyshall include the number of tests based upon Reasonable Suspicion it hasperformed during the year.

RefusingRequired Test

A Covered Employee's refusal to submit to a Test forControlled Substances will be treated the same as a positive test. It will result in immediate termination.

CoveredEmployee - Positive Results

If a Test for Controlled Substances performed on a CoveredEmployee is positive, the Covered Employee shall be informed of theresult.

1. Prescription. The Covered Employee shall be provided forty-eight (48) hours to produce a valid, current, prescription for the ControlledSubstance for which the individual tested positive. If the individual is able to produce a validprescription, a copy of the prescription shall be maintained in theindividual's personnel file and no action shall be taken against theindividual.

2. Verification. If the Covered Employee cannot produce avalid prescription, the Agency shall have the results of the Test for ControlledSubstances verified by having the test confirmed through a retesting of thesample by the testing entity (the "Verification Test"). The Covered Employee shall be responsible forthe charges for the Verification Test and will receive an invoice for the costof the Verification Test.

If the Verification Test confirms the original positive testthe Covered Employee will be terminated. A copy of the results of the Test forControlled Substances shall be placed in the confidential section of theEmployee's Personnel File. A copy of thewritten

termination including a statement that the termination is due to afailed Test for Controlled Substances.

NegativeResult of Test for Controlled Substance

If the Test for Controlled Substances returns a negative result,a copy of the test result shall be placed in the confidential portion of theEmployee's Personnel File.

VoluntaryReporting

It is the Agency's intent to assist its employees who havesubstance abuse problems. An employeewho voluntarily reports a substance abuse problem to the Administrator will be directedto EAP for coordinating a chemical dependency evaluation, rehabilitation, andfollow-up. If a leave of absence isnecessary, the employee will be considered for all eligible leaves of absenceallowed pursuant to Agency policy. However, this voluntary reporting provision will not prevent the Agencyfrom otherwise enforcing this policy and/or disciplining the employee forviolations of this or other Agency policies.

DrugTesting Records - Confidentiality

Records of all Tests for Controlled Substances, includingresults, Covered Employee prescription information and related informationmaintained by the Agency (the "Drug Testing Records") shall be theproperty of the Agency. These DrugTesting Records are subject to confidentiality requirements and the Agency willmaintain confidentiality. The Agencyshall keep each Covered Employee's Drug Testing Records in the confidentialmedical record portion of the Covered Employee's Personnel File.

DrugTesting Records – Release by Organization

Upon the written request of the applicant or Covered Employeetested, results of a Test for Controlled Substances shall be made available forinspection and copying to the applicant or Covered Employee. The Agency shall not release such records toany person other than the applicant or Covered Employee unless the applicant orCovered Employee, in writing following receipt of the test results, hasexpressly granted permission for the Agency to release such records.

The organization may release records of all drug and alcoholtest results and related information maintained by the

Agency for the followingreasons:

1. The records are evidence that may beadmissible in a proceeding before a court or an administrative agency in whicheither the Agency or the Covered Employee whose test results are being admittedis a named party to the lawsuit; or,

2. In order to comply with a validjudicial or administrative order.

SAMPLE:DRUG SCREENING AGREEMENT

Pre-employment Screening/Routine Screening

I have been informed that it is the policy of the Agency toperform pre-employment testing/random for the illegal use of drugs. The drugtest will be performed by the agency/lab chosen by agency. Agency will randomlydrug test a required percentage of staff yearly. Agency can randomly drug testwhen there is reasonable suspicion of drug use.

I have been informed, and I understand, that my consent tosubmit to the pre-employment/routine drug testing is completely voluntary on mypart, and that I have the right to refuse to submit to the test. I am aware, and have been told, that myrefusal to submit to the drug test will make me ineligible for employment withthe Agency. I am aware that refusing to submit to random drug testing willresult in my not being eligible for hire/termination of employment.

I have also been informed and am aware and hereby authorizethat the results of the drug test may be released to the Agency. I understandthat the information will be used to determine whether I am eligible for employmentwith the Agency.

With full knowledge of the above information, I have decidedto voluntarily submit to the requested drug test by the Agency and inrecognition of this agreement, to sign this consent form.

Date ______________
EmployeeSignature
____

Date ______________

____
____

____
____

REFUSAL

TO SUBMIT TO DRUG SCREEN

I hereby refuse to authorize testing for the illegal use ofdrugs. I understand that my refusalmeans that I am ineligible for employment with the Agency.

____
__
____
____

Signature
Date Witness
Date

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See 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