STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157645	A. BUILDING _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HOME HEALTH CARE LLC	1531 W OAK STREET ZIONSVILLE, IN 46077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS The visit was for a Federal Recertification and State Relicensure survey of a Medicare Home Health Provider. Survey Dates: 06/28/21 to 7/14/2021 Facility #: 012680 Provider/CCN#: 157645 Medicaid #: 201083120 Census: 15 During this survey, Pure Home Health Care, LLC is precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning July 14, 2021 to July 13, 2023 for being found out of compliance with the Conditions of Participation 42 CFR 484.50 Patient Rights; 484.55 Comprehensive Assessment; 484.60 Care Planning, coordination, quality of care; 484.65 Quality Assessment Performance Improvement; and 484.105 Organization and Administration of Services. These deficiencies reflects State Findings cited in accordance with 410 IAC 17.	G 000		
G 406	Quality Review Completed on 8/18/21 by Area 3 Patient rights CFR(s): 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the	G 406		

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

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G 406	Continued From page 1	G 406		

right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights.
This CONDITION is not met as evidenced by:
Based on record review and interview, the agency failed to ensure that all patients received the contact information for the agency administrator, including the administrator's name and business phone number in order to receive complaints (See G414); failed to ensure patients participate and be informed about the care and services to be provided (See G434); failed to ensure patients were informed about the liability for payment (See G440); failed to ensure all patients were advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local Home Health Agencies (See G444); failed to ensure all patients were informed in writing of the agency's policies for transfer and discharge (See G452); failed to assist patients in transferring to another provider when the payer would no longer cover services provided by the agency (See G456); failed to ensure they documented in the clinical record the circumstances that warranted discharge for cause, including disruptive or dangerous behavior, and failed to document the agency's efforts to resolve the problem prior to discharging for cause (See G462).

The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care.

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G 414	Continued From page 2	G 414		
G 414	HHA administrator contact information CFR(s): 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. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure that all patients received the contact information for the agency administrator, including the administrator's name and business phone number in order to receive complaints, in 3 (Patient 3, 4, 5) of 3 active patients who received home visits and 1 (Patient #6) of 1 interview conducted without a home visit. Findings include: 1. On 7/1/21 at 2:05 PM, a visit was conducted in the home of patient #3, SOC date 01/10/20. During the visit the surveyor asked patient #3 if the agency provided a folder upon admission. Patient #3 stated they had moved approximately 6 weeks ago and the folder must have been lost during the move. When queried as to whether she knew who the agency administrator was, the patient stated she did not know. When queried as to who she would contact if she had a complaint the patient stated she would "tell the aide, or I could probably call the office." When queried as to who she would speak with at the office if she had a complaint, patient #3 stated she would speak with the nurse. Review of the clinical record, including admission documents, for patient #3, start of care (SOC or soc) date 01/10/20, failed to evidence documentation specifying the patient received	G 414		

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information on admission that included the name of the administrator and the administrator's number in order to receive complaints.

2. On 07/02/21 at 2 PM a visit was conducted in the home of patient #4. Review of the admission folder present in the patient's home failed to evidenced the administrator's name, or the administrator's number in order to receive complaints. When queried as to whether she knew the name of the administrator, patient #4 stated she did not. When queried as to who she would contact if she had a complaint, the patient stated she would call employee B.

Review of the clinical record for patient #4, soc 12/04/20, failed to evidence documentation which specified the patient received information on admission that included the name of the administrator and the administrator's number in order to receive complaints.

3. Review of the clinical record for patient #6, soc 11/19/20, failed to evidence documentation which specified the patient received information on admission that included the name of the administrator and the administrator's number in order to receive complaints.

On 7/14/21 at 12:16 PM, a phone interview was conducted with patient #6. The patient was queried as to whether he received a folder from the agency upon admission. Patient #6 stated he could not remember. When queried as to whether he knew who the agency administrator was,patient #6 stated no. When queried as to who he would notify if he had a complaint, the patient stated he would tell his nurse. Patient #6 denied knowing he could voice concerns or

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G 414	Continued From page 4	G 414		

complaints to the administrator.

4. On 6/30/21 at 10:15 AM, the administrator was queried as to whether the agency provided a folder or binder to the patient prior to or at admission, that included all admission paperwork and/or information required upon admission. The administrator stated they give a folder, and all or the policies were in the patient handbook which is part of the folder. The surveyor requested an example folder to be provided after the interview was completed. On 7/1/21 at 11:15 AM, the administrator submitted an admission folder and stated it included all items given to the patient at the admission visit except the clinical forms such as the OASIS (Outcome and Assessment Information Set) form. Review of the agency admission packet revealed an untitled document that included blank spaces for the name and number of agency staff, such as "Your Nurse: ___." but failed to evidence administrator information. Review of the complete folder contents failed to evidence the administrator's information, including name and business phone number in order to receive complaints.

5. During a home visit on 7/7/21 at 10:10 AM, when asked to review the patient's admission packet, the patient provided two folders and stated the patient stated that on 6/21/21, the admission paperwork provided was difficult to read due to the faded ink but the agency provided a newer folder with readable documents on 7/6/21, the day prior to the surveyor home visit. A review of both folders failed to evidence documentation which specified the patient received information on admission that included the name of the administrator and the administrator's number in order to receive

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G 414	Continued From page 5 complaints. During this time, the patient was queried as to whether they knew whom to file a complaint with at the agency in which they responded "No".	G 414		
G 434	Participate in care CFR(s): 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. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure patients participate and be informed about the care and services to be provided in 3 of 5 active records reviewed . (Patients 4, 5, 6) Findings include: 1. Review of a policy titled "Service Agreement, policy c-160" revealed "A Service Agreement shall be developed with all clients upon admission, before care is provided. The service agreement will identify the services to be provided, disciplines providing care .... "	G 434		

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2. During a home visit on 7/2/21 at 2 PM, patient #4's admission folder was reviewed and revealed a document titled "Admission Service Agreement Home Health" which was signed by the patient on 12/4/20. The document failed to evidence the services the patient would receive.

Review of the clinical record for patient #4 start of care 12/4/20, revealed an untitled document signed by the patient which evidenced the patient received verbal and written information and explanation regarding "Notice of Services provided and rate sheet, Statement of present Privacy Rights/ Privacy Practices/ Privacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protectives/ HIPAA (Health Information Portability and Accountability Act) Patient Handbook, Emergency and Safety Planning" but failed to evidence the patient participated in, and was advised of both verbally and in writing, the services the patient would receive.

Review of a document titled "Admission Service Agreement Home Health", signed by the patient on 12/4/20, evidenced a section titled "Liability for Payment", which was blank. The document failed to evidence the services the patient would receive.

During an interview on 7/12/21 at 5:23 PM, the administrator and alternate clinical manager were interviewed concerning admission documents. They were queried as to the "Admission Service Agreement" for patient #4 and why it was blank in the patient home, but the document in the clinical record was completed. The administrator and alternate clinical manager had no further information.

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3. Review of the clinical record for patient #6, start of care , 11/19/20 revealed an untitled document signed by the patient which evidenced the patient received verbal and written information and explanation regarding "Notice of Services provided and rate sheet, Statement of present Privacy Rights/ Privacy Practices/ Privacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protectives/ HIPAA (Health Information Portability and Accountability Act) Patient Handbook, Emergency and Safety Planning" but failed to evidence the patient participated in, and was advised of both verbally and in writing, the services the patient would receive.

Review of a document titled "Admission Service Agreement Home Health", signed by the patient on 11/19/20, failed to evidence the services the patient was receiving.

Review of a document titled "Episode Manager", revealed the document provided blank spaces for Admit Date, RN/LPN (Registered Nurse/ Licensed Practical Nurse), HHA (Home Health Aide), and other services along with blanks for the frequency of each service, followed by a section for the clinician signature. The document was blank, and unsigned by either the clinician or patient.

Review of a document titled "Coordination of Care" evidenced sections for the name of provider, phone number, services provided, and frequency. The document was blank.

4. A review of the agency's admission packet on 7/7/21 contained an agency form titled "Episode

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Manager". This document reveals an admit date and discipline sections to be completed for each service and their frequencies. The form has an area that is to be signed by the admitting clinician.

5. The clinical record of patient #5 was reviewed on 7/8/21. The clinical record failed to evidence the document "Episode Manager" nor did the clinical record evidenced that the patient was informed verbally and in writing of the services and frequency of services to be provided.

A review of the plan of care for the certification period 6/21/21 to 8/19/21, revealed the patient was receiving skilled nursing services 1 time a week and physical therapy services 2 times weekly.

During a home visit on 7/7/21 at 10:10 AM, when asked to review the patient's admission packet, the patient provided two folders and stated the patient stated that on 6/21/21, the admission paperwork provided was difficult to read due to the faded ink but the agency provided a newer folder with readable documents on 7/6/21, the day prior to the surveyor home visit. A review of both folders verified the patient's statement.

During another interview with patient #5 on 7/8/12 at 4:17 PM, when asked if she was informed of her rights and if she was involved in the development of her plan of care, the patient stated that he/she and another family member asked the nurse what they were signing and the registered nurse informed them it was for billing and so the agency could take care of them. Patient #5 stated that they didn't have anything discussed with them about when people were coming or time of day. Patient #5 stated that they

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G 434	Continued From page 9 had no idea of what to expect. 410 IAC 17-12-3 (b)(2)(D)(i)(AA)&(BB) 410 IAC 17-12-3 (b)(2)(D)(ii)(AA)&(BB)	G 434		
G 440	Payment from federally funded programs CFR(s): 484.50(c)(7)(i, ii, iii, iv) Be advised, orally and in writing, of- (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (iii) The charges the individual may have to pay before care is initiated; and (iv) Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f). This ELEMENT is not met as evidenced by: Based on record and interview, the agency failed to ensure patients were informed about the liability for payment in 3 of 5 active records reviewed. (Patients # 4, 5, 6) Findings include: 1. Review of a policy titled "Service Agreement, policy c-160" revealed "A Service Agreement shall be developed with all clients upon admission,	G 440		

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G 440	Continued From page 10	G 440		

before care is provided. The service agreement will identify the services to be provided, disciplines providing care, charges and expected sources of reimbursement for services. The client will be informed of their liability for payment."

2. Review of the clinical record for patient #4 start of care 12/4/20, revealed an untitled document signed by the patient which evidenced the patient received verbal and written information and explanation regarding "Notice of Services provided and rate sheet, Statement of present Privacy Rights/ Privacy Practices/P rivacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protectives/HIPAA (Health Information Portability and Accountability Act) Patient Handbook, Emergency and Safety Planning" but failed to evidence a rate sheet, or that the patient was informed of their liability for payment.

Review of a document uploaded to the agency EMR (Electronic Medical Record) titled "Admission Service Agreement Home Health", signed by the patient on 12/4/20, evidenced a section titled "Liability for Payment". the document evidenced an "X" next to "I am not a participatient member of an HMO (Health Maintenance Organization)" and an "X" next to "Medicaid (Project 100% covered after meeting spend down and/or other requirements.)" However, during a home visit on 7/2/2021 at 1 PM the patient's admission folder was reviewed and revealed the same document, signed by the patient on 12/4/20, which was blank.

During an interview on 7/12/21 at 5:23 PM, the administrator and alternate clinical manager were interviewed concerning admission documents.

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G 440	Continued From page 11	G 440		

They were queried as to how the patient was notified of liability for payment as well as the "Admission Service Agreement" for patient #4 and why it was blank in the patient home but the document in the clinical record was completed. The administrator and alternate clinical manager had no further information.

3. Review of the clinical record for patient #6, start of care , 11/19/20 revealed an untitled document signed by the patient which evidenced the patient received verbal and written information and explanation regarding "Notice of Services provided and rate sheet, Statement of present Privacy Rights/ Privacy Practices/ Privacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protectives/ HIPAA (Health Information Portability and Accountability Act) Patient Handbook, Emergency and Safety Planning" but failed to evidence a rate sheet, or that the patient was infored of thier liabiity for payment.

Review of a document titled "Admission Service Agreement Home Health", signed by the patient on 11/19/20, evidenced a section titled "Liability for Payment", which was blank. The document failed to evidence the services the patient was receiving.

4. A review of the agency's admission packet on 7/7/21, revealed a form titled "Admission Service Agreement." The form contains information on consent for service, Authorization for Release of Information, Liability for Payment, Assignment of Benefits, Consolidated Billing. Each section has information to be checked off as applicable.

5. During a home visit with patient #5 on 7/7/21

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G 440	Continued From page 12 at 10:10 AM, a request to review the patient's admission folder was made. The "Liability for Payment" section of the "Admission Service Agreement" was blank. A review of the agency's copy of the "Admission Service Agreement" within patient #5's clinical record, the "Liability for Payment" section was left blank. 6. During an interview with administrator and alternate clinical director on 7/12/21 at 2:00 PM, the alternated clinical director was questioned if all forms were to be filled out at time of admission for the patient's information, which she stated "yes" and once the admission was turned in it was all scanned into the system.	G 440		
G 444	State toll free HH telephone hotline CFR(s): 484.50(c)(9) Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients were advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local Home Health Agencies in 4 of 5 active patient records reviewed. (patients #3, 4, 5, 6) Findings include: 1. During a home visit on 6/30/21 at 2:15 PM with	G 444		

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patient #3, the patient was asked if the surveyor could review the agency folder presented at admission. Patient #3 stated she did not know where the folder was because they's moved approximately 6 weeks ago. Patient #3 was queried concerning what she would do if she had a concern or complaint related to services. Patient #3 stated she would tell person L. When queried as to whether she was aware of the home health toll free number and that she could report complaints around the clock, patient #3 stated she was not aware of that number.

Review of the clinical record for patient #3 revealed an untitled document signed by the patient which evidenced the patient received verbal and written information and explanation regarding "Notice of Services provided and rate sheet, Statement of present Privacy Rights/Privacy Practices/Privacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protectives/HIPAA (Health Information Portability and Accountability Act) Patient Handbook, Emergency and Safety Planning" but failed to evidence the patient was advised of the home health telephone hot line and its information.

2. During a home visit on 7/2/21 at 2 PM, the admission folder for patient #4 was reviewed, including the patient handbook, and failed to evidence the patient was advised verbally and/or in writing of the home health telephone hot line and its information. The patient was queried as to who she would notify if she had a complaint about services. Patient #4 stated she would notify her nurse. When queried as to whether she was aware of the home health toll free number and that she could report complaint around the clock,

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patient #4 stated she was not aware of the number.

Review of the clinical record for patient #4 revealed an untitled document signed by patient #4 on 12/4/20, which evidenced the patient received verbal and written information and explanation regarding "Notice of Services provided and rate sheet, Statement of present Privacy Rights/Privacy Practices/Privacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protectives/HIPAA (Health Information Portability and Accountability Act) Patient Handbook, Emergency and Safety Planning" but failed to evidence the patient was advised of the home health telephone hot line and its information.

3. Review of the clinical record for patient #6 start of care date 11/19/21 revealed an untitled document signed by patient #5, undated, which evidenced the patient received verbal and written information and explanation regarding "Notice of Services provided and rate sheet, Statement of present Privacy Rights/Privacy Practices/Privacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protectives/ HIPAA (Health Information Portability and Accountability Act) Patient Handbook, Emergency and Safety Planning" but failed to evidence the patient was advised of the home health telephone hot line and its information.

During an interview with patient #6 on 7/14/21 at 12:10 PM, the patient stated he was happy with his current nurse, but had disliked his previous nurse. When queried as to who he would speak with should he have another complaint, patient #6 stated he would tell his nurse. When queried as

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to whether he had an agency folder at home or had received a patient handbook, the patient stated he did not know. When queried as to whether he was aware of the home health toll free number and that he could report complaints around the clock, patient #6 stated he was not aware of the number.

4. On 6/30/21 at 10:15 AM the administrator was asked to provide a complete copy of the agency admission packet and paperwork. On 7/1/21 at 11:15 AM the administrator submitted an agency folder and stated it contained all documents for admission except for clinical documents, such as assessment documents. Review of the folder and its contents failed to evidence the toll free number for complaints, including hours of operation and its purpose. On 7/14/21 at 2:00 PM, during an interview, the administrator was queried as to whether the folder provided on 7/1/21 at 11:15 AM contained templates of all admission documents. The administrator stated it was a complete and accurate representation of what the patients receive upon admission. When queried as to the toll free number for complaints, the administrator stated she thought it was in the patient handbook. The administrator had no further information.

5. A review of the agency's admission packet/ folder on 7/7/21 contained a welcome letter from the administrator, which lists only the agency's phone number. The State of Indiana healthcare hotline number is listed but the contact information, the hours of operation and it's purpose is absent.

6. During a home visit on 7/7/21 at 10:10 AM, Patient #5's admission packet/ folder was

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G 444	Continued From page 16 reviewed and failed to evidence the State of Indiana complaint hotline, contact information, and the hours of operation. During this time, patient #5 was asked if they knew how to file a complaint in which they responded "no". The patient stated they wasn't provided a number to the Indiana Department of Health and didn't know she could file a complaint if needed.	G 444		
G 446	410 IAC 17-12-3(b)(2)(C) Contact info Federal/State-funded entities CFR(s): 484.50(c)(10)(i,ii,iii,iv,v) Be advised of the names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides: (i) Agency on Aging (ii) Center for Independent Living (iii) Protection and Advocacy Agency, (iv) Aging and Disability Resource Center; and (v) Quality Improvement Organization. This ELEMENT is not met as evidenced by: Based on record review, the agency failed to ensure they supplied the names, addresses, and telephone numbers for all Federally funded and State funded entities that serve the areas where the patient resides for 2 of 2 admission packet/ folder reviewed during a home visit. (Patient #4 & 5) Findings include: 1. A review of the agency's admission packet/ folder on 7/7/21 contained "The Home Health Care Patient Bill of Rights." Under the section	G 446		

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G 446	Continued From page 17 titled Advocacy Resources failed to evidence the name, addresses, and telephone number of the Agency on Aging; Center for Independent Living; and the Protection and Advocacy Agency. 2. During a home visit on 7/8/21 at 10:10 AM, patient #5's admission packet/ folder was reviewed and the Patient Bill of Rights failed to evidence the names, addressess, and telephone numbers of the area- Agency on Aging; Center for Independent Living; and the Protection and Advocacy Agency. 3. During a home visit on 07/11/2021 at 2 PM, the admission packet/ folder for patient #4 was reviewed. The Patient Bill of Rights failed to evidence the names, addressess, and telephone numbers of the area- Agency on Aging; Center for Independent Living; and the Protection and Advocacy Agency. Review of the other documents present in the folder, including the patient handbook, failed to evidence any other agency numbers or contact information. During an interview on 7/12/21 at 5:23 PM, the administrator and alternate clinical manager were interviewed concerning admission documents. They were queried as to why all the Federally funded and State funded entities that serve the areas of where the patient resides, in which the administrator and alternate clinical manager had no further information to provide.	G 446		
G 452	Transfer and discharge CFR(s): 484.50(d) Standard: Transfer and discharge. The patient and representative (if any), have a right to be informed of the HHA's policies for	G 452		

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transfer and discharge. The HHA may only transfer or discharge the patient from the HHA if:
This STANDARD is not met as evidenced by:
Based on record review and interview, the agency failed to ensure all patients were informed in writing of the agency's policies for transfer and discharge in 2 of 5 active patients reviewed (Patients #4, 6) and 1 patient discharged for cause. (Patient #1)

Findings include:

1. Review of an agency policy titled "Client Discharge Process, C-500" revealed "Discharge Procedure: ... The Registered Nurse ... shall ensure that the treatment goals and client outcomes have been met or ... appropriate referrals are made ... to meet continuing client needs; ... agency documentation will include ... Evidence that the decision was not made unilaterally. The client, family, and physician participated in the decision ... If there are unmet needs ... documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated; Documentation of a communication with the client, including the rationale for discharge, will be kept in the client file with copies sent to the primary physician." Discharge and transfer criteria included "The patient and/or family have threatened agency staff, have weapons in the home or the home is ... an unsafe environment for agency staff;... There is a threat to patient safety due to home environment; The patient ... will be informed of the change ...; Agency staff will complete a discharge summary that includes ... Patient status at the time of admission ...; Statement of care and interventions provided and outcomes of care; Status at discharge/last visit/current medications,

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therapies, and continuous care needs; Name of person or organization assuming responsibility for care; Instructions and referrals given to the patient ...; Reason for discharge and date of discharge; A copy of the discharge summary is mailed to the physician upon request." The agency failed to follow it's policy for discharge for cause, including documenting an unsafe environment, communication with the patient, physician, and other care entities, name of individuals assisting patient after discharge, assistance with transfer to another service provider, ongoing or unmet needs, and a detailed discharge summary.

2. Review of the agency's patient handbook revealed a page titled "Medicare Requirements and Payment" which evidenced "Once these goals are met, you will be ready for discharge... There are other circumstances that could lead you to being discharged. These reasons are: Your physician determines you no longer require home care. You relocate outside the agency region. You are not exhibiting responsibility towards meeting your health care goals. The home care agency determines that they can no longer meet your needs according to their policies . If you are to be discharged or transferred to another agency you will be given advance notice unless it is an emergency or unplanned. We will provide the necessary information for your continued care to the receiving agency. All discharges and transfers will be documented in your chart. A discharge assessment will be completed and discharge instructions provided. If community resources are needed we will be happy to provide you with a referral." The handbook failed to include the agency's complete policy information on discharge and transfer as found in agency

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policies C-500, C-820, and C-840 (see interview below) and included discharge for cause, discharge due acuity needs that exceed agency capability, that the agency must arrange a safe and appropriate transfer to other care entities when the patient's needs exceed the agency's capabilities, discharge/transfer for no payer, if goals/outcomes have been achieved, if the physician agrees that services are no longer needed, if the patient refuses services or elects to be transferred or discharged, if the patient is non-compliant, that the agency must notify the physician when considering discharge for cause, that the agency must make efforts to resolve behavior problems and document those efforts, that the agency must provide the patient with contact information for other agencies or providers who may be able to provide care, discharge/transfer if the patient dies or the agency ceases to operate, and required timeframe for notice, including 30 day notice for Medicaid Waiver insurance and 15 day notice for Medicare certified agencies.

3. Review of the clinical record for patient #1, start of care date 11/9/20, revealed an untitled and undated admission document signed by patient #1. A titled "Acknowledgement of Information" evidenced the patient received verbal and written information and explanation regarding the following: Notice of Services provided and rate sheet, Statement of present Privacy Rights/Privacy Practices/Privacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protective/ HIPAA (Health Information Portability and Accountability Act), Patient Handbook, and Emergency and Safety Planning." The document failed to include evidence the patient was notified in writing of the

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agency's policy on discharge/transfer other than the information in the patient handbook.(see review of patient handbook below)

4. Review of the clinical record for patient #3, start of care date 11/19/20, revealed a document signed by the patient which evidenced the patient received verbal and written information and explanation regarding "Notice of Services provided and rate sheet, Statement of present Privacy Rights/ Privacy Practices/ Privacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protective/ HIPAA (Health Information Portability and Accountability Act) Patient Handbook, Emergency and Safety Planning" but failed to evidence the patient was informed verbally and in writing of the agency's full discharge and transfer policies.

5. Review of the clinical record for patient #4, start of care date 12/4/20, revealed an untitled and undated admission document signed by patient #4 on 12/4 20. The section titled "Acknowledgement of Information" evidenced the patient received verbal and written information and explanation regarding the following: Notice of Services provided and rate sheet, Statement of present Privacy Rights/Privacy Practices/ Privacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protective/ HIPAA (Health Information Portability and Accountability Act), Patient Handbook, and Emergency and Safety Planning." The document failed to evidence the patient was informed verbally and in writing of the agency's full discharge and transfer policies.

6. During an interview on 6/30/21 at 10:30 AM, the administrator stated the policy and procedure

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manual was not available as hard copy but was stored electronically on the agency's shared drive, or M-drive. The administrator submitted a printed copy of the table of contents and stated it included all agency policies and procedures. Review of the policies revealed "Discharge Summary, C - 820", which outlined the requirements for the discharge summary; "Client Discharge Process, C - 500", which revealed instructions for the discharge and transfer process and discharge criteria; and "Client Transfer - C - 840, which outlined transfer instructions and criteria. The policies failed to evidence information explaining the 30-day requirement for waiver and/or the 15-day notice required for Medicare certified agencies.

7. During an interview on 6/30/21 at 10:30 AM, the administrator stated the policy and procedure manual was not available as hard copy but was stored electronically on the agency's shared drive, or M-drive. The administrator submitted a printed copy of the table of contents and stated it included all agency policies and procedures. Review of the policies revealed "Discharge Summary, C - 820", which outlined the requirements for the discharge summary; "Client Discharge Process, C - 500", which revealed instructions for the discharge and transfer process and discharge criteria; and "Client Transfer - C - 840, which outlined transfer instructions and criteria. The policies failed to evidence information explaining the 30-day requirement for waiver and/or the 15-day notice required for Medicare certified agencies.

8. During an interview on 6/30/21 at 11:15 PM, the administrator was queried as to how and when patients were notified of the agency's

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G 452	Continued From page 23 discharge and transfer policies. The administrator stated, "All our policies are in the patient handbook." On 7/14/21 at 2:20 PM the administrator was asked if there was any further information that patient's received related to discharge or transfer. The administrator stated that all policies were in the patient handbook, which was given upon admission to the agency. The administrator had no further information.	G 452		
G 456	Patient/payer will no longer pay for services CFR(s): 484.50(d)(2) The patient or payer will no longer pay for the services provided by the HHA; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to assist patients in transferring to another provider when the payer would no longer cover services provided by the agency for 1 of 2 discharged patients reviewed. Findings include: 1. Review of an agency policy titled "Client Discharge Process, C-500" revealed "Discharge Procedure: ... The Registered Nurse ... shall ensure that the treatment goals and client outcomes have been met or ... appropriate referrals are made ... to meet continuing client needs; ... agency documentation will include ... Evidence that the decision was not made unilaterally. The client, family, and physician participated in the decision ... If there are unmet needs ... documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated; Documentation of a communication with the client, including the rationale for discharge, will be kept in the client	G 456		

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file with copies sent to the primary physician." Discharge and transfer criteria included "The patient and/or family have threatened agency staff, have weapons in the home or the home is ... an unsafe environment for agency staff;... There is a threat to patient safety due to home environment; The patient ... will be informed of the change ...; Agency staff will complete a discharge summary that includes ... Patient status at the time of admission ...; Statement of care and interventions provided and outcomes of care; Status at discharge/last visit/current medications, therapies, and continuous care needs; Name of person or organization assuming responsibility for care; Instructions and referrals given to the patient ...; Reason for discharge and date of discharge; A copy of the discharge summary is mailed to the physician upon request." The agency failed to follow it's policy for discharge for cause, including documenting an unsafe environment, communication with the patient, physician, and other care entities, name of individuals assisting patient after discharge, assistance with transfer to another service provider, ongoing or unmet needs, and a detailed discharge summary.

2. Review of an agency policy titled "Clinical Decision Making, policy c-115" revealed "Continuing care to clients is based upon comprehensive assessments of care and services needed, physician orders, and identified payer source. If the agency is unable to provide care, either because of no contract with payer or lack of payer source, the client will be discharged to another provider following the transfer/discharge policy. Clients/family will be informed of the reason."

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3. Review of the clinical record for patient #6 revealed a document signed by the patient on 11/19/20, which evidenced the patient received verbal and written information and explanation regarding "Notice of Services provided and rate sheet, Statement of present Privacy Rights/Privacy Practices/Privacy Act Statement - Home Health Care Records, Report of Notice of Privacy Protectives/HIPAA (Health Information Portability and Accountability Act) Patient Handbook, Emergency and Safety Planning" but failed to evidence the patient was informed verbally and in writing of the agency's full discharge and transfer policies.

Further review of the record for patient #6 revealed the patient was placed on hold effective 6/10/21 due to no payor source. The patient was receiving skin care with medicated cream for yeast to excoriated abdominal and groin folds and was unable to apply the cream due to mobility and extreme obesity. Review of the clinical record failed to evidence the patient was offered an option to transfer to another provider with the assistance of the agency. (see agency policy "Services on Hold, policy c-630), was assisted by the agency to find alternate care, or the agency ensured the patient had ongoing assistance with skin care in the absence of home health care.

On 7/8/21 at 1 PM, patient #6 was interviewed concerning the services. The patient stated he was told the insurance authorization had expired and a request for renewal was pending. The patient stated a daughter had tried to help with care because the patient was unable to apply the cream, but the daughter was not comfortable doing so. When queried as to how the excoriated areas were doing, the patient declined further

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discussion.

G 462 Before discharge for cause HHA must:
CFR(s): 484.50(d)(5)

The HHA determines, under a policy set by the HHA for the purpose of addressing discharge for cause that meets the requirements of paragraphs (d)(5)(i) through (d)(5)(iii) of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired. The HHA must do the following before it discharges a patient for cause:
This ELEMENT is not met as evidenced by:
Based on record review and interview, the agency failed to ensure they documented in the clinical record the circumstances that warranted discharge for cause, including disruptive or dangerous behavior, and failed to document the agency's efforts to resolve the problem prior to discharging for cause in 1 of 1 patients reviewed for discharge for cause.

Findings include:

1. Review of an agency policy titled "Incident Reporting, B-340" revealed "An incident is defined as any occurrences that involves an employee, client, or family member that is not consistent with regular routine." The policy further revealed the agency "1. ...will document and report all incidents that deviate from routine agency operations and will or could result in injury or potential harm ...; 2. Incidents include ... b. Client endangerment ... d. Staff endangerment ...; 4. Client outcomes shall be documented in the progress report if necessary. When indicated the

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PURE HOME HEALTH CARE LLC	1531 W OAK STREET ZIONSVILLE, IN 46077

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G 462	Continued From page 27 ... supervisor will notify the client's physician ... 11. ... documentation will address the objective facts in the client record; 12. ... Incident reports will be filed in the clinical data base. The administrative file will contain the original report, follow-up report, and specific interventions taken to prevent re-occurrence." 2. Review of an agency policy titled "Client Discharge Process, C-500" revealed "Discharge Procedure: ... The Registered Nurse ... shall ensure that the treatment goals and client outcomes have been met or ... appropriate referrals are made ... to meet continuing client needs; ... agency documentation will include ... Evidence that the decision was not made unilaterally. The client, family, and physician participated in the decision ... If there are unmet needs ... documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated; Documentation of a communication with the client, including the rationale for discharge, will be kept in the client file with copies sent to the primary physician." Discharge and transfer criteria included "The patient and/or family have threatened agency staff, have weapons in the home or the home is ... an unsafe environment for agency staff;... There is a threat to patient safety due to home environment; The patient ... will be informed of the change ...; Agency staff will complete a discharge summary that includes ... Patient status at the time of admission ...; Statement of care and interventions provided and outcomes of care; Status at discharge/last visit/current medications, therapies, and continuous care needs; Name of person or organization assuming responsibility for care; Instructions and referrals given to the patient ...; Reason for discharge and date of	G 462		

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discharge; A copy of the discharge summary is mailed to the physician upon request." The agency failed to follow it's policy for discharge for cause, including documenting an unsafe environment, communication with the patient, physician, and other care entities, name of individuals assisting patient after discharge, assistance with transfer to another service provider, ongoing or unmet needs, and a detailed discharge summary.

3. Review of the clinical record for patient #1 revealed a recertification assessment completed by the alternate administrator, dated 4/7/21 at 8:30 AM, revealed patient #1 "Relies on support of family and friends." An emergent care/safety measures section evidenced "no falls" but failed to evidence concerns of current or previous drug use, violence, or police involvement with the patient of and evidenced "Is there suspicion of patient abuse, neglect, and/or exploitation? - No." Safety issues identified cluttered pathways for safe mobility, difficulty with transfers, risk for skin breakdown, unsafe ambulation with interventions. The narrative note evidenced "Patient has mental and emotional issues. She also has unsafe ambulation and transfers. Up a tolerated and appetite fair. Needs HHA (home health aide) to assist with daily needs. Lives with son and daughter in law." The assessment failed to evidence the patient was in an unsafe environment due to drugs and failed to evidence documentation of domestic disturbances or that the policy had been in the home multiple times, and failed to evidence the physician was notified, and any discharge planning related to possible discharge for cause.

Review of a plan of care, certification period

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G 462	Continued From page 29 3/9/21-5/7/21, evidenced patient #1 received home health aide and personal care aide services approximately 6 days per week. Safety measures evidenced to keep pathways clear. Risk for emergency room and/or hospitalization evidenced history of falls with injury, taking more than 5 medications, and exhaustion, but failed to evidence any risks related to an unsafe environment including drugs in the home and domestic violence. The plan of care failed to evidence the patient relied on the support of family and friends and lived with her son and daughter-in-law. The goals, outcomes, and comments sections were blank, and failed to include current or previous goals or comments related to an unsafe environment, including drug use, violence, or police involvement. Under "Discharge" the plan of care evidenced "Able to remain in residence with assistance of caregiver" but failed to evidence safety concerns related to the patient's living situation, or possible need to discharge related to ongoing issues of drug use by the patient's primary caregivers, domestic violence, or police involvement. The plan of care failed to evidence a clinical summary, including that the police had been called to the home multiple times, suspected drug use, and violence by the patient's primary caregivers, or that the patient, physician, and other care entities were informed of ongoing concerns. Review of the SN (skilled nurse) visit note dated 3/8/21 at 9 AM evidenced "Relies on support of family and friends." Safety issues identified were cluttered pathways, difficulty with transfers, risk for skin breakdown, and unsafe ambulation. An emergent care/safety measures section evidenced "no falls" and evidenced "Is there suspicion of patient abuse, neglect, and/or	G 462		

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exploitation? - No." Safety Issues Identified evidenced cluttered pathways for safe mobility, difficulty with transfers, risk for skin breakdown, unsafe ambulation and evidenced no interventions for safety/fall risk were performed this visit. The narrative note evidenced "Patient has a history of falls and ER (emergency room) trips. She now has Pt (physical therapist) which helps her with transfers and ambulation. She lives with son and daughter in law ... Main companionship is son and wife and Pt. (physical therapist)" The note failed to evidence the patient was in an unsafe environment due to drugs and failed to evidence documentation of domestic disturbances or that the policy had been in the home multiple times, and failed to evidence any discharge planning related to possible discharge for cause.

Review of the aide visit notes for 3/9/21 - 4/14/21 and personal care worker visit notes for 3/9/21 - 4/12/21 failed to evidence the aide made reports to the supervisor, case manager, or administrator concerning reports of drugs in the home, domestic disturbance, or police.

Review of a SN (skilled nurse) Discharge Summary, signed by the alternate clinical manager and dated 4/22/21, evidenced patient #1's reason for discharge was "unsafe environment", patient condition was "unchanged", and condition of discharge was "Pt. [patient] is in a poor environment. The police have been to the home on several occassions [sic] due to drugs, domestic disturbances. Pure's staff no longer feels safe in the home. CICOA (Area Agency on Aging and Disability) cm (case manager) notified. 4/22 was the last call made to pt (patient)." The discharge disposition was unknown, and

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discharge instructions evidenced "Notified pt (patient) via phone that staff were not feeling safe in the home. Instructed pt to remove son and DIL (daughter in law) to maintain a safe environment. Instructed pt to [illegible] f/u (follow up) w/ (with) CICOA." The discharge summary failed to evidence the patient's status at admission, care/interventions/outcomes provided, status at discharge, last visit, and current needs. The summary also failed to include if instructions were given to the patient, current medications, assistance with finding another care provider, and the name and number of the patient's contact at CICOA.

4. Review of the agency incident log revealed an incident report dated 4/12/21, taken by the alternate clinical manager, which stated "CM (case manager) called notifying pt was not receiving HHA hours as anticipated. Writer called HHA. HHA states she had been gone but there are "drug deals" and fighting in the home .... Contacted office Mgr (manager) ... Police were at [illegible] residence ... Notified all appropriate staff about D/C. (discharge)" The report failed to evidence details including dates when environmental safety concerns were reported, dates when police were reported to be at the patient's home, dates when the aide(s) reported "drug deals", and dates when fighting was reported. The report also failed to include follow-up to concerns that the patient did not receive services as anticipated, and failed to include follow-up concerning the patient's immediate and ongoing safety in the home.

5. On 7/14/21 at 1:22 PM, the alternate clinical manager was queried concerning the circumstances in the patient's home and

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surrounding the patient's discharge. The alternate administrator stated she did not know much about the situation and would have to review the record and talk to the administrator, but stated she thought that the police had been called to the home several times. When queried as to where in the record there was documentation of multiple police visits, domestic violence, and concerns about drug use, the alternate clinical manager stated she would need to review the record. The surveyor asked, "In general, where would I find the notes showing communication between the agency, staff, physician, patient, and CICOA? I'm not seeing any documentation other than visit notes." The alternate clinical manager stated, "It should be there. But I'll have to talk to [name of administrator]. I'm just filling in you know. I don't really know this patient." No further information was available.

6. On 7/14/21 at 3:45 PM, the administrator and clinical manager were queried concerning the incident report taken by the alternate administrator on 4/12/21. The administrator stated the patient was discharged due to the agency having no available caregiver for the patient because the aide would not return due to safety concerns. The administrator stated there were drugs in the home, domestic disturbances, and the police had been called several times. When asked where that information was found in the patient's clinical record, the administrator stated it should be in the communication notes. The surveyor stated there were no communication notes. After review of the patient's record, the administrator confirmed there was no communication related to safety concerns, and stated she had emails she could print. The administrator confirmed the emails were not part

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G 462	Continued From page 33 of the patient's clinical record and stated there should have been documentation in the communication note of the patient's record.	G 462		
G 510	Comprehensive Assessment of Patients CFR(s): 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. This CONDITION is not met as evidenced by: Based on observation, record review and interview, the registered nurse failed to conduct the initial assessment visit within 48 hours of the referral to determine the immediate care and support needs of the patient (See G514); failed to ensure the comprehensive assessment was completed within 5 days of the start of care (G520); failed to ensure that all patients received a complete and accurate assessment that included health, psychosocial, functional, and cognitive status (G528); failed to ensure the comprehensive assessment included the reason for continued home health services (See G532); failed to ensure all patients received a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs (see G534); failed to complete a review of all medications the patient was currently using, including potential adverse effects, drug reactions, ineffective drug therapy, side effects, duplicate therapy, and noncompliance (See G536); and failed to send all	G 510		

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G 510	Continued From page 34 necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals, and treatment preferences to the receiving facility or health care practitioner to ensure effective care transitions (See G564). The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care.	G 510		
G 514	RN performs assessment CFR(s): 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. This ELEMENT is not met as evidenced by: Based on observation, record review and interview, the registered nurse failed to conduct the initial assessment visit within 48 hours of the referral to determine the immediate care and support needs of the patient for 1 of 1 newly admitted patient record reviewed. Findings include: 1. During a home visit on 7/7/2021 at 10:10 AM, patient #5 and a family member were discussing the delay of services and stated they had to go 3	G 514		

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weeks without therapy. Per the family member, they had expected someone to be there to do the admission on 6/9/21. The patient and family member stated that they had to go buy supplies to do dry dressings to the right knee incision and spoke with the hospice to find out what supplies to get and the ordering physician to see what treatment needed to be done. The family member stated initially, when they called the agency to find out when they were coming to admit the patient, they were told that they had to run the patient's insurance and it would be a week. The family member stated they waited two weeks and called the agency back and a date/ time was set but then no one showed up. When they called the agency to inquire why no one showed up as scheduled, the agency told them the orders had been canceled. The family member stated no one canceled the orders. The family member stated they called the Person B, the case manager with Entity F and Physician D, the surgeon/ order physician to verify that no one canceled the home health services. The family member stated a nurse finally showed up on 6/21/21, however, they were told that physical therapy was on vacation and wouldn't be able to see the patient for another week.

2. The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021. The clinical record revealed a hospital discharge document which revealed a diagnosis of right knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents revealed the patient received therapy post-operatively and was able to discharge home using a walker on 6/8/21. The referral and order for SN/PT/OT (Skilled Nurse/Physical Therapy/Occupational Therapy)

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was faxed to facility which has a time stamp date and time of 6/8/21 at 11:51 AM.

A review of a typed document on a blank sheet of paper which contained documentation between the agency and Entity F's "case manager" and Person C. The note indicated that on 6/9/21 at 11:55 AM, the agency "spoke with Case Management. Informed that patient had been accepted by another agency." The note was electronically signed by the Administrator. The note failed to evidence who was the case manager that was spoken to. Below the 6/9/21 entry, another note dated 6/18/21 at 1:36 PM, indicated "18th [Name of Person C] called the office to ask where we were. Informed [Person C] we were told another home health care started services. He/she stated they did not and wanted us to admit his/ her [patient #5] on Monday. We asked when PT would be needed, stated that he/ she was not thinking she would need physical therapy. I told [name of Person C] that when the admission nurse is out on Monday she can evaluate and see if at that time if [patient] would be interested. [Name of Person C] agreed and scheduled SOC to begin Monday. Write called [Entity F] case management to ask where the referral originally was sent. Case manager stated she was not working that day and did not have the answer. I informed her that that [sic] [name of Person C] called and we have schedule for SOC to be on Monday. Write called the MD office. Informed practice that [last name of patient] would be admitted on Monday per patient request. This note was electronically signed by the administrator and not by the Clinical Manager. The note failed to indicate which physician's was notified and who the Administrator spoken to, and failed to evidence that the physician approved this

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change.

A review of the patient's face sheet revealed the patient's primary physician was Physician E and not Physician D, who was the ordering physician.

A review of the Prior Authorization Request Form indicated the "Rendering Provider" was Physician E and not Physician D.

A review of the plan of care for the certification period of 6/21/21 to 8/19/21, indicated the primary physician listed was Physician E and not Physician D.

3. During an interview on 7/8/21 at 2:58 PM, when asked if the they had canceled the referral for home health services with Pure Home Health, Person B, a discharge case manager with Entity F, stated they did not cancel with Pure and has had many conversations with the agency. Person B indicated the agency wanted a face to face from Physician D and Person B had to educate the agency on what their face to face encounter looks like and it was tied into the order for home health services. Person B stated no one had sent patient #5's referral to another agency. Person B stated this agency was chosen because it was one of the few that would take this patient's insurance. The hospital case manager stated this was an ongoing issue with Pure Home Health for they have received multiple complaints from other families and other physicians who has ordered home health services with this agency and this agency's failure to start services timely after discharge.

On 7/8/21 at 1:28 PM, an Indiana Department of Health physician questionnaire was faxed to the

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ordering physician, Physician D. The document was returned to the surveyor on 7/16/21 and indicated Physician D was the primary care provider, the agency failed to notify the physician of their inability to admit the patient on or after 6/8/21, and failed to obtain orders to delay admission until 6/21/21. The document went on to state the physician's office was notified of the delay in admission by the patient's family member and that they did not give the agency approval to notify or obtain orders from the patient's primary care physician, Physician E in regards to the care of the patient right knee.

During an interview on 7/8/21 at 6:17 PM, Patient #5's family member, Person C, stated they had called the agency on 6/9/21 to inquire when someone would be out to start care. He was told that they were waiting on insurance verification. On 6/16/21 he had called again and was told that someone would be out on 6/18/21. When no one showed up he called the agency's office again was told that "someone" canceled the appointment. Per patient's son he told the office that no one from the family canceled the appointment and she needed home health. Person C was queried if Physician E is still patient 5's primary care physician. Person C stated the patient goes to Entity G, a county health clinic. Person C stated Physician E started there about one year ago and has never seen the patient. Physician D, the patient's surgeon, have been handling the patient's recent health issues because they related to his/her osteoarthritis.

During an interview on 7/12/21 at 2:00 PM, when asked why Patient #5's initial assessment/ admission occurred outside the 48 hours from the return home on 6/8/21 and referral, the

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G 514	Continued From page 39 administrator stated she called to talk to the hospital case manager, on 6/9/21 and was told at that time that the patient had been accepted by another home health company. During an interview on 7/13/21 at 12:21 PM, the 6/18/21 note written by the administrator was read to the patient's family member, Person C. When asked about the authenticity of the conversation, Person C denied stating that the patient was thinking on not having physical therapy for that was the reason for all the phone calls to the physician, hospital, and agency, when was physical therapy coming.	G 514		
G 520	5 calendar days after start of care CFR(s): 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the comprehensive assessment was completed within 5 days of the start of care for 1 of 1 newly admitted patient record reviewed. (Patient #5) Findings include: 1. Review of Policy C-145 Initial and Comprehensive Assessment stated " A comprehensive patient assessment will be completed within five (5) calendar days of the patient's start of care. 2. The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021.	G 520		

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The clinical record revealed hospital discharge documents which revealed a diagnosis of right knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents revealed the patient received therapy post-operatively and was able to discharge home using a walker on 6/8/21. The referral and order for SN/PT/OT were faxed to the facility which has a timestamp date and time of 6/8/21 at 11:51 AM.

A review of the start of care comprehensive assessment dated 6/21/21, failed to evidence any collaboration with a physical or occupational therapist.

A review of the initial physical therapy evaluation revealed the assessment was performed on 6/30/21, nine days after the admission date of 6/21/21.

The clinical record failed to evidence that an occupational therapist evaluated the patient and failed to evidence orders to discontinue services were received by the ordering physician.

During a home visit on 7/7/21 at 10:10 AM, the patient stated she was told by the admitting RN at the start of care that the physical therapist was on vacation and would be out to see them in 1 to 2 weeks.

During an interview 7/12/21 2:00 PM, when asked the time frame for assessments to be completed and what services should be in the comprehensive assessment, the administrator stated the comprehensive assessment needed to be completed in five (5) days and that all services that we're seeing the patient needed to be

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G 520	Continued From page 41 completed within the 5 days The clinical manager agreed with the administrator.	G 520		
G 528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure that all patients received a complete and accurate assessment that included health, psychosocial, functional, and cognitive status in 3 of 5 active patients reviewed. (Patients 3, 4, 5) Findings include: 1. Review of an agency policy titled "Initial and Comprehensive Assessment, C-145", evidenced that all baseline data to be used in measuring the patient's progress towards goals and other relevant information will be documented in the patient's clinical record, including all pertinent diagnoses, OASIS information (on skilled patients), a physical assessment including blood pressure, temperature, pulse, respiration, skin, pain, height, weight, allergies, nutritional, and other relevant data. Assessment should also include pertinent physical findings including constipation, dyspnea, skin breakdown, sleep disorders, nausea and vomiting, anxiety, dehydration, and a "head to toe assessment." The patient's functional status and level of assistance should be included and address eating, meal preparation, toileting, continence, transfer, ambulation, shopping, cleaning, bathing, dressing, use of telephone, mobility, and ability to take medications. The patient's medical and	G 528		

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psychosocial history, behavior, and neurological status, and the patient's family/caregiver's educational needs, abilities, motivation, and readiness to learn should also be addressed. The patient's psychosocial/behavioral history, emotional barriers to treatment, cognitive limitations, memory, family dynamics, coping mechanisms, reasoning/judgment, depression, suicide risk, response to loss, and educational needs should be assessed. The assessment should include the agencies and persons involved in the care of the patient, an evaluation of the home environment, emergency preparedness, presence of advance directives, wishes regarding care and treatment, equipment in the home or needed, symptoms of pain, caregiver availability, schedules, and availability should be assessed.

2. Review of an agency policy titled "Pain Assessment/Management, C-148" revealed "All clients admitted to the Agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment ... If the client has pain that interferes with activity or movement on a daily basis ... pain management will be a specific intervention on the plan of care... The assessment includes a measure of pain intensity and quality (character, frequency, location, and duration) ... Pain is assessed on every home visit and documented on a pain or symptom flow sheet. documentation will include the effectiveness of all pain interventions or modalities. The documentation will include what interventions were used and describe response/effectiveness of care ... Assessment of presence of pain and treatment/response will be incorporated into all agency assessment/reassessment tools."

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G 528	Continued From page 43 3. Review of an undated agency policy titled Initial and Comprehensive Assessment C-145...The assessment will be patient-specific and comprehensive to include the patient's need for home care, rehabilitative care, social... The assessment will also include the exact use of the current versions of the Outcomes and Assessment Information Set (OASIS). PROCEDURE 4. During the initial and comprehensive patient assessment, all baseline data to be used in measuring the patient's progress towards goals and other relevant information will be documented in the patient's clinical record, including the following information, if applicable: A. All pertinent diagnoses that may affect the need for services. D. Patient's functional status, including but not limited to...2. Meal preparation 5. Ambulation; 6. Shopping, cleaning, laundry; 10. Mobility. F. The patient's psychosocial/behavioral/neurological status...cognitive limitations, memory, role changes... reasoning/judgment and orientation. 4. According to www.wocn.org, a surgical wound closed by primary intention (sutures, staples, etc.) that is well approximated, does NOT granulate. It re-epithelializes. If there are any open areas, any dehiscence, or any area left open (secondary intention healing) then it should granulate to heal. 5. According to the Nursing 2021 journal, when documenting surgical incision site care, the professional journal states: " ... Document the anatomic location of the incision, including on which side of the body surgery was performed. Chart the length of the incision in centimeters and include the depth measurement whenever appropriate. Routine documentation helps you	G 528		

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track healing. Note the appearance of the incision and surrounding skin. What does the site look like? Do you see erythema, edema, purulent drainage, or any other signs of infections? Provide detailed information if the site isn't healing well. If necrotic tissue appears, for example, your documentation should include when it appeared, who was notified, the interventions ordered and provided, and the patient's response to those interventions. Assess pain by having the patient routinely rate his pain intensity on a standard pain-ratting scale. Indicate the type of materials used to keep the incision closed: sutures, staples or clips, retention sutures, or tape closure .... "

6. According to RN.com "Pain Assessment and Management" dated 12/31/2016, indicated " ... Pain is often referred to as the 'fifth vital sign,' and should be assessed regularly and frequently ... The assessment should include a physical examination and the systems in relation to pain evaluation. Areas of focus should include the site of the pain, musculoskeletal, and neurological system. Other components of history and physical assessment include: Patient's self-report of pain; Patient's behaviors and gestures that indicate pain; ... Specific aspects of pain: onset and duration, location, quality of pain [as described by the patient], intensity, aggravating and alleviating factors; Medication history; Disease or injury history; History of pain relief measures, including medications, supplements, exercise, massage, complementary and alternative therapies ... Functional and Psychosocial Assessment: ... Reports of patient's prior level of function; Observation of patient's behaviors while performing functional tasks; Patient or family's report of impact of pain on

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activities of daily living including work, self-care, exercise, and leisure; Patient's goal for pain management and level of function; Patient or family's report of impact of pain on quality of life; Cultural and developmental considerations; History of pain in relation to depression, abuse, psychopathology, chemical or alcohol use; Impact of pain on patient's cognitive abilities ... Pain management refers to the appropriate treatment and interventions developed in relation to pain assessment, and should be developed in collaboration with the patient and family...Pain management strategies include pharmacological and non-pharmacological approaches .... "

7. According to HHS (Health and Human Services) article dated 11/11/07, "The Narcotic Bowel Syndrome: Clinical Features, Pathophysiology and Management" indicates " ... Potential Physiological Mechanisms for Pathological Pain Facilitation: It is recognized that morphine and other opiates act on opioid receptors in enteric neurons with a variety of GI [gastrointestinal] effects that include reduced gastrointestinal and biliary motility and secretion producing nausea, vomiting, constipation, secondary intestinal pseudo-obstruction and gastroparesis [a condition that affects the stomach muscles and prevents proper stomach emptying] .... "

8. According to Nursing.connection.com dated 2019, indicated " ... Nursing Considerations: Nurses are in an ideal position to identify patients at risk for constipation and to assess for signs and symptoms. Obtain the patient's health history, noting risk factors such as inadequate fluid intake, decreased mobility, and comorbid conditions. Assess the patient's diet, including

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fiber intake. Perform medication reconciliation, including the use of over-the-counter medications and herbal supplements. Look for anything that may contribute to constipation or be used for self-treatment, such as laxatives. Ask about the patient's oral health; changes in appetite; patterns of bowel movements; consistency, color, and size of the stool; seepage of stool; degree of straining during bowel movements; ignoring the urge to defecate; and nausea, vomiting, or other GI complaints. Ask about the patient's living conditions ... eating or swallowing difficulties that may contribute to weight loss, changes in skin integrity [such as hemorrhoids, anal fissures, and skin ulcerations], and risk of falls in patients who use laxatives .... "

9. Review of the clinical record for patient #3 revealed a document titled " Skilled Nursing Visit Note - POC (Plan of Care) Recertification" dated 7/2/21, which evidenced a low risk for hospitalization due only to taking more than 5 medications, but failed to assess other risks, including but not limited to diabetic risks, poor circulation, risk of COVID, and risk for falls due to unsteady gait. The assessment evidenced the patient never used a magnifying glass, but during a home visit on 7/1/21 at 2:05 PM, the patient used a large magnifying glass to review the medication list on the plan of care. (see home visit below) The patient was a diabetic, and the integumentary assessment evidenced immobility, neuropathy, and poor circulation, however, a Braden Scale and diabetic foot assessment were not completed. The patient's skin was WNL (within normal limits) but the assessment failed to define normal limit parameters. The cardiovascular status evidenced shortness of breath and fatigue, with poor circulation, however,

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perfusion was WNL. The document evidenced a diagnosis of peripheral vascular disease but failed to include assessment for edema, peripheral pulses, or capillary refill. Review of the endocrine system evidenced diabetes type 2, blood sugar results within expected normal range, and complications related to neuropathy, peripheral vascular disease, and poor circulation, but failed to evidence what complications were identified, what was a normal range for blood sugars, a review of the patient's last blood sugar/sugars, or patient's understanding of diabetes. A review of the musculoskeletal system evidenced abnormal gait (needed assistance to prevent falls), poor strength and endurance, and joint pain but failed to include a pain assessment. The clinician listed rheumatoid, gout, psoriatic, septic, and generalized arthritis but failed to include them as active diagnoses. The assessment failed to include a therapy assessment, including a full functional assessment and failed to include a depression screening. The patient's knowledge and compliance with diet were fair, with no changes, but failed to include the current diet. A category labeled "Home Health Aide frequency tool" evidenced the patient was independent for ambulation, transfer, and ADLs continent of bowel/bladder, and ADLs, but failed to evidence a frequency or interventions for the aide. Safety measures included transfer precautions but stated the patient was also independent in transfers, and skin breakdown precautions but did not evidence what precautions were needed on an independent and ambulatory patient. The assessment evidenced functional limitations of endurance and ambulation despite the patient's independence and absence of a device. The assessment failed to evidence a full medication

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reconciliation was completed for all medications and included current and correct dose, frequency, route, and name for all medications. A narrative note evidenced the patient was unable to complete ADLs and IADLs due to unsafe ambulation and shortness of breath, despite being assessed as independent for mobility. The assessment failed to include all pertinent diagnoses and full physical, cognitive, functional, psychosocial The assessment failed to include full health, psychosocial, functional, and cognitive assessments that were accurate and made sense.

10. On 7/2/21 at 1 PM, a home visit was conducted with patient #4. Before the home visit, the alternate clinical manager, the patient's nurse, stated the patient was receiving services due to having a stroke. The nurse stated that the patient's mother assisted her with activities, and at the moment her brother-in-law was staying with her to remodel the house. The nurse stated the facility the patient was placed in for rehabilitation had recommended long-term placement, however, the patient insisted on coming home and caring for her children. The nurse stated the patient had long and short-term memory deficits and often forgot to take her pills, which was why the agency was assisting. During the visit, the nurse stated that the patient had not taken the previous evening's pills. The nurse was observed saying to the patient, "Remember [name of patient], take all of your pills." No further intervention was observed related to the leftover pills. When queried as to why the patient was unable to safely take her oral medications, but could safely measure and correctly take insulin, the nurse had no further information. When asked if the nurse obtained blood sugar from the

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patient, she stated no. The surveyor asked if the patient would be willing to review her glucometer, and the patient was unable to find it. No further interventions were observed concerning the glucometer. When queried concerning her diabetes, the patient stated she had a history of hypoglycemia requiring emergency intervention and verified her children "know what to do." When queried as to whether there was an emergency plan, the patient and nurse both stated no.

Review of the clinical record for patient #4, contained a referral which evidenced the following diagnosis: Cerebral infarction, unspecified, Type 2 diabetes mellitus without complications, Migraine, unspecified, Major depressive disorder, recurrent severe without psychiatric features, other idiopathic peripheral autonomic neuropathy, essential hypertension, other symptoms, and signs with cognitive functions following other cerebral vascular diseases, other symptoms and signs with cognitive functions following cerebral infarction, altered mental status, unspecified, feeding difficulties, other abnormalities of gait and mobility, unsteadiness on feet, other lack of coordination, cognitive-communication deficit.

Review of a document for patient #4, titled "Recert OASIS (Recertification Outcome Assessment and Information Set), dated 5/31/21 at 11:30 AM, revealed a primary diagnosis of cerebral infarction, unspecified, with additional diagnoses of other idiopathic peripherals [sic], type 2 diabetes mellitus w [sic], essential (primary) hypert [sic], diabetes due to underlying. The diagnoses failed to be complete and failed to include all pertinent diagnoses listed from the referral. The document evidenced "Needs other health care", but failed to evidence what other

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health care was needed. The speech assessment was "normal". No further speech or cognitive assessment was included, despite a diagnosis of cognitive-communication deficit. The patient had chronic pain in the feet daily/ intermittently, described as burning neuropathy, that interfered with activity, mood, and appetite, however, OASIS question M1242 - Frequency of Pain interfering with Activity or Movement evidenced "Patient has pain that does not interfere with activity or movement." Clinical findings evidenced cerebrovascular accident, fatigue, weakness, and neuropathy, but failed to evidence a complete neurological assessment including migraine headaches and cognitive levels and processes, The musculoskeletal status evidenced abnormal gait, daily fatigue and weakness in both lower extremities contradicted by strength/endurance WNL (within normal limits), and patient swayed when walking but clinical findings evidenced "No problems noted." Patient #4 was independent in all self-care, toileting, ambulating, and transferring, however, safety issues identified included "unsafe ambulation, improper medication administration, and lack of tub rails/grab bars. The assessment failed to evidence a fall assessment, depression screening, and Braden Scale. Cardiovascular status evidenced the patient fatigued easily, had hypertension and peripheral vascular disease, but was WNL. The assessment failed to define normal limits and failed to include perfusion, capillary refill, edema, or peripheral pulses. The patient "understood exercise program" but the assessment failed to include what exercises the patient did. It also failed to include parameters for blood pressure, weight, a specific diet plan related to heart disease and diabetes. The assessment also failed to include teaching or

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assessment related to CV (cerebral vascular disease). The narrative revealed the patient was a brittle diabetic but failed to evidence blood sugar parameters, a correct sliding scale, and an emergency plan; evidenced "blood sugar results within expected/normal range - no results higher than expected" but failed to evidence what the results were expected to be; failed to include a recent A1c (a measure of blood sugar), any recent daily blood sugars, or patients ability to accurately inject insulin. Psychosocial status evidenced that long and short-term memory, judgment, problem solving/reasoning, thought organization, and insight was minimally impaired, which was contrary to the history given during the interview with the clinician (see interview below). The assessment evidenced a reading evaluation result of minimally impaired/WFL [unknown definition] and the patient substituted and omitted words when reading. It failed to include how the patient safely reads/measured her insulin, identified medication bottles. and reordered her own medications. Interventions this visit included teaching body alignment and transfer techniques, but failed to evidence patient was assessed for alignment and transfer issues. The assessment failed to evidence a full medication reconciliation was completed for all medications and included current and correct dose, frequency, route, and name for all medications. A review of the nutritional status evidenced no changes but failed to evidence a nutritional assessment. The patient's appetite was good, which conflicted with the patient's appetite affected due to pain. The prescribed diet was for low cholesterol, low sodium, and no concentrated sweets but failed to specify sodium and cholesterol milligrams allowed and conflicted with the patient's statement that she counted carbohydrates per

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meal. Durable medical equipment/assistive devices were blank. Safety Precautions included ambulation, however, the patient was independent for ambulation. Discharge plans evidenced "Not addressed this visit. Patient needs post-discharge: None at this time." Further discharge plans evidenced "When goals are met." An OASIS narrative note evidenced "This patient is very pleasant but somewhat cognitively impaired due to CVA. She is also a brittle diabetic and on a treatment regimen. She knows when to take her medications, what they are for, but is unable to prefill a pill container by herself. I go weekly to fill her medications and have her work with me to hopefully be able to fill her medication by herself. It will take a lot of teaching to accomplish this goal." The narrative failed to be consistent with the assessment and failed to evidence why she required a pill set up when she was independent, understood, and took all medications..

11. During a home visit on 7/7/21 at 10:10 AM, patient #5 stated they have a past medical history of thyroid issues and had been diagnosed with diabetes mellitus, was to start insulin, but through weight loss, diet, and dietary supplements, their blood sugars are now "well controlled." The patient stated they have had an Inguinal Hernia Repair within the past year and a previous Left Total Knee Replacement within two years. Patient #5 stated they have numbness from the big toe to the side of their foot and expressed concerns over loss of sensation in the sole of the right foot making it difficult for them to make sure the right foot is placed appropriately while ambulating and doing the prescribed home exercise. The patient also stated a loss of sensation to their left knee from the left total knee

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replacement. The patient reported constant pain, with a level of 5 being intolerable, and is only able to exercise for 15 minutes and no longer. While observing the patient's physical therapy, the patient facial expressions indicated she was having pain during therapy. Patient #5 stated they get brain fog at times due to the amount of pain medication they are taking so her family checks in on her frequently and another family member has been assisting with their daycare business until she recovers. The home also has 2 steps and a small porch when entering the patient's home and an area rug in the kitchen where the patient ambulates for exercise.

The clinical record for patient #5 was reviewed on 7/8/21 and contained a physician order dated 6/8/21. This order indicated the patient's diagnosis is "presence of right artificial knee joint" and also indicated "status post total right knee replacement using cement." The record also contained the Operative report dated 6/7/21, which indicated a preoperative diagnosis of "Right knee primary osteoarthritis". The physician ordered skilled nursing, physical and occupational therapy.

A review of the start of care comprehensive assessment / OASIS (Outcomes and Assessment Information Set) dated 6/21/21, indicated the primary diagnosis listed is unilateral primary osteoarthritis. The registered nurse answered no to pre-existing conditions of Peripheral Vascular Disease or Diabetes Mellitus. The asked if the pain assessment was completed in which the response indicated "No" but "The frequency of pain" is documented as daily but not constantly. No further assessment of pain was indicated. It is noted that she is alert and oriented

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with an abnormal gait. The neurological assessment indicated "No neurological findings" and failed to identify the patient's numbness. The cognitive level was WNL (within normal limits). The Nutrition section indicated "None" to the prescribed diet. The Endocrine/ Metabolic status stated "WNL[within normal limits]/ No problems noted, however, no foot assessment was completed and the assessment failed to identify that the patient has a past medical history of diabetes that is being treated and how it was being treated/ managed. The assessment failed to identify that the patient has a past medical history of thyroid issues. The registered nurse documented patient had one observable surgical wound that was fully granulating but failed to evidence a complete assessment, such as what the incision looked like, the length of the incision, the number of staples, and the appearance of surrounding skin. The assessment failed to identify that the patient had an inguinal hernia near hernia with a repair within the last year. The assessment failed to identify a previous surgical event to the left knee (knee replacement). The Braden scale risk assessment indicated "No, not assessed this visit." The assessment asked if safety hazards were found in the patient's current place of residence, in which the note indicated "None noted or verbalized. The fall risk assessment indicated it was not completed, however when asked if the patient had a multi-factor falls risk assessment using a standardized, validated assessment tool, the question was answered as "Yes, and it does not indicate a risk for falls." The assessment indicated "Not attempted due to medical conditions or safety concerns" for questions of the ability to go up and down a curb and/ or up and down one step, ability to bend/ stoop from a

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standing position to pick up a small object from the floor, the ability to transfer in and out of care, walking 20 feet once standing, and the ability to roll from lying on back to left and right side and return to lying on back on the bed. The safety issues identified were difficulty with transfers, infection control concerns, and unsafe ambulation. The current payment source indicated the patient was Medicare Traditional and NA-Not applicable for Medicaid when the patient has managed care insurance through a Medicaid program. The Date of Physician-ordered start of care indicated the physician referred the patient to home health services on 6/21/21 when the patient was referred on 6/8/21.

The clinical record revealed that PT first evaluated the patient on 6/30/21 and OT never evaluated the patient. The assessment failed to include all therapies.

A review of a document titled "Verbal Order" dated 6/30/21, by physical therapist Employee C, revealed the patient lives in a one-story home with an uneven threshold leading in and out of the house. The patient is documented as presenting with decreased mobility, decreased safety with transfers, decreased strength in the right lower extremity, decreased ambulation ability needing assistance secondary to high risk of falls.

During a phone interview on 7/8/21 at 4:17 PM, the patient stated that while they are recovering and taking pain medicine, it helps to have family members present during home health visits to help them remember everything. Patient #5 stated that the family members who help her, take notes so they won't miss or forget anything.

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G 528	Continued From page 56 The patient expressed concerns that they are sleepier and less "aware" than normal while taking pain medicine.	G 528		
G 530	410 17-14-1(a)(1)(A)&(B) Strengths, goals, and care preferences CFR(s): 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients all patients received a comprehensive assessment that included the patient's strengths and care preferences, and included measurable and patient specific goals for 3 of 5 active patients reviewed. (Patients #3, 4, 5) Findings include: 1. Review of an agency policy titled "Initial and Comprehensive Assessment, C-145", evidenced that all baseline data to be used in measuring the patient's progress towards goals and other relevant information will be documented in the patient's clinical record, including "... Communication strengths and barriers ... Patient problems/needs/strengths ... Patient care preferences ...." The policy failed to mention patient stated and/or patient specific and measurable goals.	G 530		

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2. Review of the clinical record for patient #3 revealed a document titled "Skilled Nurse Visit Note, Home Health POC (plan of Care) Recertification" dated 7/2/21 at 10 AM, which revealed a section titled "Medical History - Patient Goals" and evidenced patient #3 would like to "Be able to care for herself." A section titled "Visit Plan - Status of Goals" evidenced "Goals partially met; patient continues to make progress according to plan of care." The assessment failed to include patient strengths or care preferences, including whether patient declined specific care preferences, and failed to include patient specific and measurable goals for care.

3. Review of the clinical record for patient #4 revealed a comprehensive assessment dated 5/31/21 at 11:30 AM. A section titled "Medical History - Patient Goals: Patient self stated goals/care preferences" evidenced the patient wanted to drive. The "Status of Goals - Progress Towards Goals" evidenced "goals partially met; patient continues to make progress according to the plan of care." Discharge plans evidenced "When goals are met." The assessment failed to evidence patient specific and measurable goals, including goals related to the reason for home care; and failed to evidence any specific care preferences, including whether the patient was consulted and declined care preferences.

4. During an interview on 7/14/21 at 3:30 PM, the administrator and alternate clinical manager were queried concerning what information should be obtained during a comprehensive assessment. The alternate clinical manager stated it should include an assessment of body systems. When queried concerning where and when goals are discussed and recorded on the comprehensive

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G 530	Continued From page 58 assessment, the alternate clinical manager had no further information. The administrator stated the goals were on the plan of care. The administrator and alternate clinical manager were unable to locate goals on the comprehensive assessments for patients #3 and 4. 5. The clinical record of patient #5, Start of Care (SOC) 6/21/21, was reviewed on 7/8/21. The record contained a start of care comprehensive assessment dated 6/21/21, which failed to evidence the patient's goals, patient strengths and care preferences. During a phone interview on 7/8/21 at 4:17 PM, patient #5 stated they run a daycare from their home and would like to get back to running the business independently.	G 530		
G 532	Continuing need for home care CFR(s): 484.55(c)(3) The patient's continuing need for home care; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure the comprehensive assessment included the reason for continued home health services in 2 of 5 active patients reviewed. (Patients #3, 4) Findings include: 1. Review of an undated agency policy titled "Initial and comprehensive Assessment, policy C-145" revealed "The assessment will be patient-specific and comprehensive to include the patient's need for home care, rehabilitative care, social, and discharge planning needs ... The comprehensive assessment shall reflect and	G 532		

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determine: ... The patient's continuing need for home care...."

2. Review of the clinical record for patient #3 revealed a "Skilled Nurse Visit Note - Plan of Care Recertification", dated 7/2/21 at 10 AM. The assessment evidenced patient #3 had a primary diagnosis of a fracture of the shaft of the right tibia, dated 1/16/20. The patient was ambulatory with an unsteady gait. (see home visit below), was a diabetic, had poor circulation, a risk for falls, poor strength and endurance, joint pain, only a fair knowledge and compliance with diet and diagnoses. However, the assessment also evidenced the patient was independent for ambulation, transfer, medication management, ADLs/IADs (activities of daily living/instrumental activities of daily living) and was continent of bowel and bladder. The assessment failed to include the need for a home health aide, including the frequency, duration, and patient specific interventions, a complete and accurate assessment that included health, psychosocial, functional, cognitive, status that made sense, and patient specific goals that supported the need for home health services. The assessment evidenced "Discharge Planning/ Coordination of Continued Care, Treatment, or Services - not addressed this visit. Patient needs post discharge: None at this time" but failed to evidence the current needs.

3. Review of the clinical record for patient #4 revealed a "Recert OASIS" (Recertification Outcome and Assessment Information Set) dated 5/31/21 at 11:30 AM. The assessment evidenced the patient was independent for self care, ambulation, and IADLs (Instrumental Activities of Daily Living), understood all medications,

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G 532	Continued From page 60 including how, when, and why to take them, but failed to evidence specific orders for continuing home health, why the patient needed pills set up in a pill box, why she couldn't take them out of the bottle, or how using a pill box ensured compliance. 4. During an interview on 7/14/21 at 3:30 PM, the administrator and alternate clinical manager were queried as to the content of the comprehensive assessment. The alternate clinical manager stated the assessment should include all body systems. No further information was available concerning the need for continuing home care services.	G 532		
G 534	Patient's needs CFR(s): 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients received a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs in 3 of 5 active records reviewed. (Patients #3, 4, 5) Findings include: 1. Review of an undated agency policy titled "Initial and comprehensive Assessment, policy C-145" revealed "The assessment will be patient-specific and comprehensive to include the patient's need for home care, rehabilitative care, social, and discharge planning needs ... The comprehensive assessment shall reflect and determine: ... the patient's continuing need for	G 534		

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home care...." and that the comprehensive assessment shall reflect and determine "Patient problems/needs/strengths; The patient's continuing need for home care; That the patient meets payment eligibility requirements ...; Patient prognosis; Patient care preferences; Baseline information to be used to measure the patient's progress ...; Plan of Care, including type of services, frequency, and duration; The ability of the organization to adequately meet the patient's medical, nursing, rehabilitation, social, and discharge planning needs ...."

2. Review of an undated agency policy titled "Client Discharge Process, policy C-500" revealed "Planning for discharge is provided as part of the ongoing assessment of needs. The client /family will participate in this process beginning with the initial assessment visit." and "Client's needs for continuing care to meet physical and psychological needs are identified ...."

3. Review of the clinical record for patient #3 revealed a form titled "Skilled Nursing Visit Note" dated 7/2/21 which evidenced a section titled "Discharge Plans - Not applicable". The patient's rehabilitative needs and prognosis were good, but failed to evidence what the needs were. The assessment failed to include a home health aide frequency or duration, or interventions the patient was currently receiving, and failed to evidence orders or collaboration with the clinician, patient, and physician concerning ongoing needs.

4. During a home visit on 7/2/21 at 2 PM, the patient stated she managed her own blood sugars and tested before meals using a glucometer. The patient reported a sliding scale

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for her insulin, and stated the dose increased by 1 unit if the blood sugar is greater that 150, 2 units if 151 - 200, 3 units if 201-250, 4 units if 251 - 300, 4 units if 301 - 350. The patient denied receiving instructions to notify the physician for high or low blood sugar. The nurse stated she was unaware of this sliding scale and "it didn't sound right." The patient stated she had frequent and severe migraines and received sample medications from the physician, and was receiving a monthly injection as well. The patient was unable to name any medications, including the injection. The patient's nurse was unaware of the medications but was aware that the patient had migraines.

Review of the clinical record for patient #4 revealed a referral which evidenced the following diagnosis: Cerebral infarction, unspecified, Type 2 diabetes mellitus without complications, Migraine, unspecified, Major depressive disorder, recurrent severe without psychiatric features, other idiopathic peripheral autonomic neuropathy, essential hypertension, other symptoms and signs with cognitive functions following other cerebral vascular disease, other symptoms and signs with cognitive functions following cerebral infarction, altered mental status, unspecified, feeding difficulties, other abnormalities of gait and mobility, unsteadiness on feet, other lack of coordination, cognitive communication deficit.

Review of a document titled "Recert OASIS (Recertification Outcome Assessment and Information Set), dated 5/31/21 at 11:30 AM revealed the assessment failed to include a complete and accurate assessment of the patient's health, psychosocial, functional, and cognitive status to accurately establish the

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patient's need for services. Discharge plans evidenced "Not addressed this visit. Patient needs post discharge: None at this time." Further discharge plans evidenced "When goals are met." An OASIS narrative note evidenced "This patient is very pleasant but somewhat cognitively impaired due to CVA(Cerebral Vascular Accident). She is also a brittle diabetic and on a treatment regiment. [sic] She knows when to take her medications, what they are for, but is unable to prefill a pill container by herself. I go weekly to fill her medications and have her work with me to hopefully be able to fill her medication by herself. It will take a lot of teaching to accomplish this goal." The narrative failed to be consistent with the assessment and the assessment failed to evidence why the patient required a pill set up it she was independent, understood and took all medications, and what her ongoing needs were.

5. On 7/14/21 at 3:30 PM, the alternate clinical manager was interviewed concerning patient #4. The alternate clinical manager agreed that the patient's migraines and brittle diabetes were not accurately and completely assessed on the comprehensive assessment. When queried concerning the needs of patients #3 and #4, the alternate clinical manager agreed the assessments were incomplete for both patients, and stated the patients had ongoing needs and would not be discharging so there was no discharge planning. When queried as to when discharge planning should start, the alternate clinical manager stated "when they are close to discharge."

6. The clinical record for patient #5, start of care (SOC) 6/21/21, was reviewed on 7/8/21. The record contained a start of care comprehensive

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G 534	Continued From page 64 assessment dated 6/21/21, in which the "Visit plan - Discharge Planning" section indicated "Not addressed this visit. Patient needs post discharge: None at this time." A review of skilled nursing visit notes for patient #5, dated 6/25/21, 7/2/21, and 7/6/21, revealed the section titled "Discharge Planning / Coordination of Continued Care, Treatment or Services" indicated "was not addressed at this visit" and "Patient needs post discharge" indicated "None at this time."	G 534		
G 536	410 IAC 17-14-1(a)(1)(B) A review of all current medications CFR(s): 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. This ELEMENT is not met as evidenced by: Based on observation, record review, and interview the agency failed to complete a review of all medications the patient was currently using, including potential adverse effects, drug reactions, ineffective drug therapy, side effects, duplicate therapy, and noncompliance in 4 of 5 active patients reviewed. (patients #3, 4, 5, 6) Findings include: 1. Review of an undated agency policy titled "Initial and Comprehensive Assessment, policy c-145" revealed "During the initial and	G 536		

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comprehensive patient assessment all baseline data ... will be documented in the patient's clinical record, including at least the following information ... Review of medication history ... and current medication use, including prescriptions, over-the-counter medications and herbal medications, and allergic reactions, identifying significant drug interactions, duplicative drug therapy, potential adverse effects and drug reactions, ineffective drug therapy, effectiveness of drug therapy ... significant side effects and noncompliance with therapy.

2. Review of an undated agency policy titled "Medication Management, policy c-705" revealed "Comprehensive client assessments performed at start of care and other defined points in time include review of all medication the client is taking." The policy also revealed "Medications in the home are reviewed with the client/family to determine current medications and client understanding ... actions and side effects. Specific instructions for how and when to take the medications will be reviewed and documented ... Medication storage areas will be inspected at least every 60 days and more often if medication changes occur or if the agency is managing and/or setting up the medications. If medications are being set up by the nurse for self administration or administration by family or other caregivers, a chart or other form or direction should be left in the home to assure medications are taken at the times ordered and to assess client compliance with the schedule." Medication orders should include the full name of the drug, dose and time (no unacceptable abbreviations), indication, special instructions, parameters for using PRN (as needed) medications, concentration and dose of medication devices

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such as nebulizers, orders will be obtained for herbal drugs, and over the counter medications taken as needed must be reviewed for potential side effects or adverse effects.

3. Review of an agency policy titled "Medication Orders, policy c-706" revealed "All medication orders, including herbal preparations, must contain dosage, route, and frequency. Orders for PRN medications must include name, dose, reason for use, and any specific time constraints for administration ... A new order is required to resume or restart medications. "Resume previous orders" or blanket reinstatement of previous medication orders is not acceptable.

4. Review of an agency policy titled "Medication Profile, policy c-706" [sic] revealed the registered nurse will complete a medication profile for each client at the time of admission which includes all prescription and nonprescription drugs. The profile will be reviewed and updated as needed. The policy evidenced "At the time of admission, the admission professional shall check all medications a client may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication.

5. Review of an agency policy titled "Medication Reconciliation, policy c-709" revealed "At the time of admission to the home care agency, the admitting professional will document a complete list of medications taken by the client prior to admission. this will include all over the counter, prescribed, and PRN medications ... Medications will be reviewed with the client on each home visit to determine if other prescriptions or non-prescription drugs are being taken.

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6. Review of the clinical record for patient #3 revealed a "Skilled Nurse Visit Note - Plan of Care Recertification" dated 7/2/21. The recertification assessment failed to evidence the clinician reviewed the patients medications for updates, compliance, reactions, side effects, and duplicate medications.

7. During a home visit on 7/2/21 at 1 PM, patient #4's medication profile was compared to the plan of care and medication profile in the home. The medication profile in the home evidenced it was printed on 7/2/21. When queried as to whether the medication and plan of care were brought to the patient's home today, the alternate clinical manager stated that it had been in the folder and was not brought today. Review of the medication bottles/insulin pens in the patient's home revealed the following: Aripiprazole 10 mg (milligrams) by mouth daily per then plan of care, however the bottle evidenced Repairable 5 mg by mouth daily; Adult Aspirin 81 mg oral tablet, chew 1 tablet once per day, however the patient stated she had no Aspirin because she could not afford it and needed a prescription to obtain through insurance; Admelog SoloStar 100units/ml (milliliter), inject 5 units is incorrectly documented as intravenous rather that subcutaneous; Cholecalciferol 1250 mcg (micrograms) 1 capsule orally once a day, however per the patient, the cholecalciferol was discontinued in April 2021; Tresiba Flex Touch 100 units/ml subcutaneous, inject 40 units once a day, however the patient stated the dose was changed to 30 units once per day and the plan of care did not specify how many milliliters to inject (30 units = ? milliliters) or what time during the day to inject. The patient medication box evidenced a bottle of Bystolic 20

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mg, 1 tablet po (by mouth) daily per bottle, however the plan of care did not include Bystolic in any dose. When queried as to whether the patient checked blood sugars, she stated she did so before meals. When asked of she would share the last few blood sugars from the glucometer, the patient was agreeable but was unable to locate the glucometer. The surveyor noted a cabinet with several medication bottles and queried the patient as to whether that was her medication as well. After hesitating, the patient stated they were family medications and declined for the surveyor access to them. Patient #4 stated she has migraines and obtains sample migraine medication "from the doctor". When queried as to the names of the samples, the patient stated "Nurtek, Ajovy, and Ubrelvy, but did not know the doses, frequencies, or times any of the samples were last taken. The patient also stated she received a monthly injection for migraines at the physician, but was unable to state which physician, the name and dose of the medication, or when it was last received. The alternate clinical manager stated the patient usually wore a Libre device, however it had fallen off. The device was not listed on the plan of care. When queried as to what the patient did if her blood sugars were high, the patient stated she took 5 units Admelog as ordered for blood sugars less than 150. She followed a sliding scale per her doctor which was 150 - 200 = 6 units, 201 - 250 = 7 units, 251 - 300 = 8 units, 301 - 350 = 9 units, 351 - 400 = 10 units, >400 call the physician. The alternate clinical manager stated she was unaware of the sliding scale for insulin as well as the migraine medication, though she was aware the patient had migraines.

Review of the clinical record for patient #4

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revealed a recertification assessment dated 5/31/21. the recertification assessment failed to evidence the clinician reviewed the patients medications for updates, compliance, reactions, side effects, and duplicate medications.

On 7/2/21 at 3:57 PM the alternate clinical manager was interviewed concerning the home visit. The administrator was present and answered for the alternate clinical manager. The alternate clinical manager was queried concerning the patient's ability to correctly take insulin based on continued non-compliance with preset oral medications and the administrator stated that the hospital wanted the patient to be admitted to long term care permanently because they felt she was not safe at home. The alternate clinical manager was queried as to the agency policy for updating medications, obtaining new medication orders. The administrator answered and stated that orders were obtained from the physician if new medications were ordered or a new bottle was in the home. The alternate clinical manager failed to answer how verbal orders were taken and transcribed for medications or how the plan of care was updated. The alternate clinical manager was queried as to whether the physician was contacted after every recertification or start of care to review medications or request an updated medication profile. The administrator stated the physician was contacted. The question was directed to the alternate clinical manager, who stated the physician was not contacted after an initial or recertification assessment. The alternate clinical manager stated that after a comprehensive assessment was completed, the plan of care was written by the alternate clinical manager, then sent to the physician for review and signature. When queried as to why the

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patient had gone 2 weeks without Aspirin and what the agency's responsibility was, the alternate clinical manager stated that she could not make the patient buy Aspirin if she didn't want to, and the patient felt like it was not affordable. The alternate clinical manager the physician had not yet been notified that the patient was not taking the aspirin, but she would do so. When queried whether the alternate clinical manager was concerned about the need for Aspirin related to the patient's history of a watershed stroke, the alternate clinical manager had no further information.

8. Review of the clinical record for patient #6 revealed the patient was placed on hold on 6/10/21 due to expired insurance authorization. A physician order dated The patient's services resumed 7/6/21. Review of the visit note for 7/6/21 revealed a "Skilled Nurse - follow up visit" and failed to include a comprehensive assessment and/or OASIS (Outcome Assessment and Information Set) was completed and included a review of all current medications potential adverse effects, drug reactions, ineffective drug therapy, side effects, duplicate therapy, and noncompliance.

9. A home visit for patient #5 was conducted on 7/7/21 at 10:10 AM. The patient was queried as to whether they had any allergies. The patient stated they have an allergy to Percocet, how it played with their mind and made them "suicidal". A review of the discharge instructions from the hospital included medications such as 81 mg of Aspirin daily for 2 weeks, Cefadroxil 500 mg for 14 days, Colace 100 mg twice a day, celecoxib 200 mg twice a day, and Dilaudid for pain. On 6/29/21, Cephalexin 500 mg twice a day, and on

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G 536	Continued From page 71 6/30/21, hydrocodone 10/325 mg 1 every 4 to 6 hours was added to the patient's medication list. The patient stated they also took over-the-counter medications such as CoQ10, Cyanocobalamin, flaxseed, Probiotic woman, Zinc, Vitamin C, Omega 3, Tumeric, levocarnitine, cholecalciferol. The clinical record for patient #5, the start of care date (SOC) 6/21/21 was reviewed on 7/8/21. The record contained a "Medication Profile" dated 6/21/21, in which the document failed to evidence the patient's allergy to Percocet. The medication list revealed only acetaminophen-benzhydrocodone 325 mg -4.08 mg oral tablet and Aspirin EC (enteric coated) 81 mg. The medication list failed to be accurate and include the most up-to-date medications the patient is taking and/ or prescribed, including over-the-counter medications. During an interview on 7/12/21 at 2:00 PM, when asked about medication reconciliation with the patient's OTC medications, the alternate clinical director stated the patient didn't tell her and she couldn't help that.	G 536		
G 564	410 IAC 17-14-1(a)(1)(B) Discharge or Transfer Summary Content CFR(s): 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to	G 564		

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ensure the safe and effective transition of care. This STANDARD is not met as evidenced by:
Based on record review and interview, the agency failed to send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals, and treatment preferences to the receiving facility or health care practitioner to ensure effective care transitions in 2 of 2 discharged patients reviewed. (patients #1, 2)

Findings include:

1. Review of an agency policy titled "Client Discharge Process, C-500" revealed "Discharge Procedure: ... The Registered Nurse ... shall ensure that the treatment goals and client outcomes have been met or ... appropriate referrals are made ... to meet continuing client needs; ... agency documentation will include ... Evidence that the decision was not made unilaterally. The client, family, and physician participated in the decision ... If there are unmet needs ... documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated; Documentation of a communication with the client, including the rationale for discharge, will be kept in the client file with copies sent to the primary physician." Discharge and transfer criteria included "The patient and/or family have threatened agency staff, have weapons in the home or the home is ... an unsafe environment for agency staff;... There is a threat to patient safety due to home environment; The patient ... will be informed of the change ...; Agency staff will complete a discharge summary that includes ... Patient status at the time of admission ...; Statement of care and interventions provided and outcomes of care;

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Status at discharge/last visit/current medications, therapies, and continuous care needs; Name of person or organization assuming responsibility for care; Instructions and referrals given to the patient ...; Reason for discharge and date of discharge; A copy of the discharge summary is mailed to the physician upon request." The agency failed to follow it's policy for discharge for cause, including documenting an unsafe environment, communication with the patient, physician, and other care entities, name of individuals assisting patient after discharge, assistance with transfer to another service provider, ongoing or unmet needs, and a detailed discharge summary.

2. Review of a "SN (skilled nurse) Discharge Summary", signed by the alternate clinical manager and dated 4/22/21, evidenced patient #1's reason for discharge was "unsafe environment", patient condition was "unchanged", and condition of discharge was "Pt. [patient] is in a poor environment. The police have been to the home on several occasions [sic] due to drugs, domestic disturbances. Pure's staff no longer feels safe in the home. CICOA (Area Agency on Aging and Disability) cm (case manager) notified. 4/22 was the last call made to pt (patient)." The discharge disposition was unknown, and discharge instructions evidenced "Notified pt (patient) via phone that staff were not feeling safe in the home. Instructed pt to remove son and DIL (daughter in law) to maintain a safe environment. Instructed pt to [illegible] f/u (follow up) w/ (with) CICOA." The discharge summary failed to evidence the patient's status at admission, care/interventions/outcomes provided, status at discharge, last visit, and current needs. The summary also failed to include if instructions were

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G 564	Continued From page 74 given to the patient, current medications, assistance with finding another care provider, and the name and number of the patient's contact at CICOA. 3. Review of the clinical record for patient #2 revealed a document titled "Transfer OASIS" (Outcome Assessment and Information Set) dated 2/26/21 at 10:30 AM, which evidenced patient #2 was transferred to a hospital and discharged from the agency. The OASIS failed to evidence why the patient was transferred to the hospital and why the patient was discharged from the agency. Further review of the clinical record for patient #2 revealed a discharge summary for dated 2/18/21. The discharge summary failed to include the reason home health care, the reason for discharge, the patient's condition at discharge, any instructions if given, goals/interventions/progress, treatment preferences, discipline orders, a summary of care provided by the agency; and failed to evidence a complete and accurate discharge summary was sent to the physician. 3. During an interview on 7/14/21 at 3:30 PM, the administrator and alternate clinical manager were queried as to the agency process for discharge. The administrator stated that patients are discharged for cause, if there is no payer, and if there is no available agency caregiver. A discharge summary should be sent. When queried as to the content of the discharge summary, the administrator and alternate clinical manager had no further information.	G 564		
G 570	Care planning, coordination, quality of care	G 570		

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G 570	Continued From page 75 CFR(s): 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. This CONDITION is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the needs of the patient was met for 1 of 1 newly admitted patient record reviewed (See G570); failed to ensure the registered nurse communicated/ collaborated with and received orders from the physician after the start of care evaluation visit (See G572); failed to ensure all patients received an individualized and patient specific plan of care, including all pertinent diagnoses, mental/ psychosocial/ cognitive status, types of services, equipment/ supplies needed, frequency, duration, activities, nutritional requirements, all medications and treatments, safety measures, risk for emergency department/hospital admission, interventions to address risk factors, patient/	G 570		

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caregiver education and training, patient-speechified interventions and education, measurable outcomes and goals identified by the patient and agency, advance directives, and any additional items necessary (See G574); failed to ensure all the physician orders were obtained, written, and sent to the correct ordering physician for signature (See G580); failed to ensure the plan of care was reviewed by the physician responsible for the home health plan of care (See G588); failed to ensure they promptly notified the ordering physician when the start of care is delayed, failed to notify the physician of the agency's inability to provide occupational services, and failed to ensure clinicians notified the physician when there is a possible change in condition (See G590); failed to ensure they documented their efforts in coordinating with all disciplines involved in a patients care (See G608); failed to ensure all patients received a copy of the visit schedule for home health staff (See G614); and failed to ensure a medication list was provided the patient in plain language (See G616).

The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care.

In regards to G570, the findings include:

During a home visit on 7/7/2021 at 10:10 a.m., patient #5 and a family member were discussing the delay of services and stated they had to go 3 weeks without therapy. Per the family member, they had expected someone to be there to do the admission on 6/9/21. The patient and family

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member stated that they had to go buy supplies to do dry dressings to the right knee incision and spoke with the hospice to find out what supplies to get and the ordering physician to see what treatment needed to be done. The family member stated initially when they called the agency to find out when they were coming to admit the patient, they were told that they had to run the patient's insurance and it would be a week. The family member stated they waited two weeks and called the agency back and a date/ time was set but then no one showed up. When they called the agency to inquire why no one showed up as scheduled, the agency told them the orders had been canceled. The family member stated no one canceled the orders. The family member stated they called Person B, the case manager with Entity F and Physician D, the surgeon/ order physician to verify that no one canceled the home health services. The family member stated a nurse finally showed up on 6/21/21, however, they were told that physical therapy was on vacation and wouldn't be able to see the patient for another week. Patient #5 stated they had their left knee done and this time it was so different because she was waiting on the home health company to start and felt alone. The patient also commented that this time was different because of the swelling and redness of her right knee and numbness of their right foot.

The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021. The clinical record revealed hospital discharge documents which revealed a diagnosis of right knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents revealed the patient received therapy post-operatively and was able to

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discharge home using a walker on 6/8/21. The referral and order for SN/PT/OT (Skilled Nurse/Physical Therapy/Occupational Therapy) were faxed to the agency which has a timestamp date and time of 6/8/21 at 11:51 AM.

A review of a typed document on a blank sheet of paper that contained documentation between the agency and Entity F's "case manager" and Person C. The note indicated that on 6/9/21 at 11:55 a.m., the agency "spoke with Case Management. Informed that patient had been accepted by another agency." The note was electronically signed by the Administrator. The note failed to evidence of who was the case manager was spoken to. Below the 6/9/21 entry, another note dated 6/18/21 at 1:36 p.m. indicated "18th [Name of Person C] called the office to ask where we were. Informed [Person C] we were told another home health care started services. He/she stated they did not and wanted us to admit his/ her [patient #5] on Monday. We asked when PT would be needed, stated that he/ she was not thinking she would need physical therapy. I told [name of Person C] that when the admission nurse is out on Monday she can evaluate and see if at that time if [patient] would be interested. [Name of Person C] agreed and scheduled SOC to begin Monday. Write called [Entity F] case management to ask where the referral originally was sent. The case manager stated she was not working that day and did not have the answer. I informed her that that [sic] [name of Person C] called and we have scheduled for SOC to be on Monday. Write called the MD office. Informed practice that [last name of patient] would be admitted on Monday per patient request. This note was electronically signed by the administrator and not by the Clinical

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Manager. The note failed to indicate which physician was notified and who the Administrator spoke to and failed to evidence that the physician-approved this change.

A review of the patient's face sheet revealed the patient's primary physician was Physician E and not Physician D, who was the ordering physician.

A review of the Prior Authorization Request Form indicated the "Rendering Provider" was Physician E and not Physician D.

The record revealed skilled nursing did not admit the patient until 6/21/21, which was 13 days after the referral was received.

Review of a skilled nursing visit note dated 7/6/21, the narrative note stated "He/she is very sore and PT is very difficult since it was started so late .... "

The record failed to evidence that an occupational therapist evaluated the patient, nor did the record evidence the agency notified the physician that an occupational therapist was unavailable and to discontinue the order or refer to another agency.

The record revealed the physical therapist evaluated the patient on 6/30/21, which was 9 days after the start of care and 22 days after the referral was received.

A review of the plan of care for the certification period of 6/21/21 to 8/19/21 indicated the primary physician listed was Physician E and not Physician D. The Plan of Care failed to evidence orders for Occupational Therapy (OT) nor did the

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clinical record evidence an order to discontinue the OT evaluation.

During an interview on 6/29/21 at 10:44 AM, when reviewing the entrance conference notes with the administrator, the administrator confirmed that the agency did not have an occupational therapist. However, on 7/14/21 at 4:01 PM, the administrator provider provided an active employee list from the Emergency Preparedness Plan which revealed the agency had 3 physical therapists and 1 occupational therapist on staff.

During an interview on 7/8/21 at 2:58 PM, when asked if they had canceled the referral for home health services with Pure Home Health, Person B, a discharge case manager with Entity F, stated they did not cancel with Pure and has had many conversations with the agency. Person B indicated the agency wanted a face with the face from Physician D and Person B had to educate the agency on what their face-to-face encounter looks like and it was tied into the order for home health services. Person B stated no one had sent patient #5's referral to another agency. Person B stated this agency was chosen because it was one of the few that would take this patient's insurance. The hospital case manager stated this was an ongoing issue with Pure Home Health for they have received multiple complaints from other families and other physicians who have ordered home health services with this agency and this agency's failure to start services timely after discharge.

On 7/8/21 at 1:28 PM, an Indiana Department of Health physician questionnaire was faxed to the ordering physician, Physician D. The document

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was returned to the surveyor on 7/16/21 and indicated Physician D was the primary care provider, the agency failed to notify the physician of their inability to admit the patient on or after 6/8/21, and failed to obtain orders to delay admission until 6/21/21. The document went on to state the physician's office was notified of the delay in admission by the patient's family member and that they did not give the agency approval to notify or obtain orders from the patient's primary care physician, Physician E in regards to the care of the patient right knee.

During an interview on 7/8/21 at 6:17 PM, Patient #5's family member, Person C, stated they had called the agency on 6/9/21 to inquire when someone would be out to start care. Person C stated they were told the agency was waiting on insurance verification. On 6/16/21, Person C had called again and was told that someone would be out on 6/18/21. When no one showed up, Person C stated they called the agency's office again but was told that "someone" canceled the appointment. Person C told the office that no one from the family canceled the appointment and the patient needed home health. Person C was queried if Physician E is still patient 5's primary care physician, in which Person C responded patient #5 goes to Entity G, a county health clinic. Person C stated Physician E started there about one year ago and has never seen the patient. Physician D, the patient's surgeon, has been handling the patient's recent health issues because they are related to his/her osteoarthritis.

During an interview on 7/12/21 at 2:00 PM, when asked why Patient #5's initial assessment/ admission occurred outside the 48 hours from the return home on 6/8/21 and referral, the

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G 570	Continued From page 82 administrator stated she called to talk to the hospital case manager, on 6/9/21 and was told at that time that the patient had been accepted by another home health company. When asked about the OT orders and accepting the patient knowing they had no OT, the administrator stated she was aware that they accepted the patient knowing they needed the service. When asked if Physician D, the ordering physician was made aware, the administrator responded she notified the hospital case manager only. The clinical record failed to evidence any documentation about this conversation. When asked if she obtained an order to discontinue the request for OT, the administrator and clinical manager stated they did not. During an interview on 7/13/21 at 12:21 PM, the 6/18/21 note written by the administrator was read to the patient's family member, Person C. When asked about the authenticity of the conversation, Person C denied stating that the patient was thinking of not having physical therapy for that was the reason for all the phone calls to the physician, hospital, and agency when was physical therapy coming.	G 570		
G 572	410 IAC 17-13-1(a) Plan of care CFR(s): 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	G 572		

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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.
This STANDARD is not met as evidenced by:
Based on record review and interview, the agency failed to ensure the registered nurse communicated/ collaborated with and received orders from the physician after the start of care evaluation or recertification visit for 3 of 5 active patients reviewed. (Patients #3, 4, 5)

Findings include:

1. Review of a policy titled "Plan of Care, policy c-580" revealed "Home care services are furnished under the supervision and direction of the client's physician ... the Plan of care is based on a comprehensive assessment and information provided by the client/family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that the client needs are et, and will be updated as necessary, bat at least every sixty (60) days." The policy evidenced a purpose "To assure that the plan meets state/federal guidelines, and all applicable laws and regulations." The policy failed to evidence that the physician must be contacted after the comprehensive assessment so that findings could be reviewed and further orders obtained to develop the plan of care.

2. Review of the clinical record for patient #3

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revealed a document titled " Skilled Nursing Visit Note - POC (Plan of Care) Recertification" dated 7/2/21, which failed to evidence the clinician contacted the physician to review findings and obtain orders for continued care and service.

3. Review of the clinical record for patient #4, titled "Recert OASIS (Recertification Outcome Assessment and Information Set), dated 5/31/21 at 11:30 AM which failed to evidence the clinician contacted the physician to review findings and obtain orders for continued care and service.

4. During an interview with the administrator and alternate clinical manager on 7/12/21 at 2:00 PM, the alternate clinical manager was queried concerning the agency policy for obtaining orders for the plan of care. The alternate clinical manager stated she obtains orders before going to complete the comprehensive assessment start of care or recertification, which are used to complete the patient's plan of care. She stated she does not contact the physician's office after the assessment is completed.

5. The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021. The clinical record contained hospital discharge documents which revealed a diagnosis of right knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents included an order from Physician D for SN/PT/OT (Skilled Nurse/Physical Therapy/Occupational Therapy) evaluation.

Review of the start of care comprehensive assessment dated 6/21/21. The visit plan/ communication section indicated "no one

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contacted as a result of this visit." The clinical record failed to evidence the admitting clinician notified the ordering physician to collaborate and develop the plan of care.

A review of the "Home Health Care Certification and Plan of Care" for the certification period of 6/21/21 to 8/19/21, revealed Physician E as the primary physician and not Physician D, the ordering physician. The clinical record failed to evidence any documentation that they collaborated with physician D.

On 7/8/21 at 1:28 PM, an Indiana Department of Health physician questionnaire was faxed to the ordering physician, Physician D. The document was returned to the surveyor on 7/16/21 and indicated Physician D was the primary care provider, and that they did not give the agency approval to notify or obtain orders from the patient's primary care physician, Physician E in regards to the care of the patient right knee.

During an interview on 7/8/21 at 6:17 PM, Person C was queried if Physician E is still patient 5's primary care physician. Person C stated the patient goes to Entity G, a county health clinic. Person C stated Physician E started there about one year ago and has never seen the patient. Physician D, the patient's surgeon, has been handling the patient's recent health issues because they are related to his/her osteoarthritis.

During an interview on 7/12/21 at 2:00 PM, when asked who is the physician for establishing the plan of care, the administrator answered "patient's primary care physician". When asked if she called the ordering physician, Physician D, upon the patient's admission to establish/

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G 572	Continued From page 86 collaborate on the development for the plan of care, the alternate clinical manager stated she had not.	G 572		
G 574	410 IAC 17-13-1(a) Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include.	G 574		

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This ELEMENT is not met as evidenced by:
Based on record review and interview, the agency failed to ensure all patients received an individualized and patient specific plan of care, including all pertinent diagnoses, mental/ psychosocial/ cognitive status, types of services, equipment/ supplies needed, frequency, duration, activities, nutritional requirements, all medications and treatments, safety measures, risk for emergency department/ hospital admission, interventions to address risk factors, patient/ caregiver education and training, patient-speechified interventions and education, measurable outcomes and goals identified by the patient and agency, advance directives, and any additional items necessary in 5 of 5 active patients reviewed. (Patients #3, 4, 5, 6, 7)

Findings include:

1. Review of an agency policy titled "Care Plans, policy c-660" revealed "Each client will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs ... a Care Plan shall be developed with the client and/or caregiver. The interventions shall correspond to the problems identified, services needed and the client goals for the episode of care... The Care Plan shall include, but not be limited to nursing diagnoses ... Reasonable, measurable, and realistic goals ... specific interventions with plans for implementation ... Indicators for measuring goal achievement and identified time frames."

2. Review of the clinical record for patient #3 revealed a plan of care for certification period 7/3/21 - 8/31/21, which evidenced a primary diagnosis of diabetes mellitus without

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complications, mixed hyperlipidemia, history of falling, pain in right leg, fractured shaft of right fibula, fractured shaft of right tibia, and deficiency of other specified B group vitamins. The patient's fractures occurred over 1 year ago and were currently healed, however the patient had difficulty walking due to pain and mobility related to the now healed fractures. Medications revealed the patient took Omeprazole, a medication for gastroesophageal reflux,neurontin, an medication for neuropathy, and amlodipine and Carvedilol, cardiac medications. However, the plan of care failed to evidence diagnoses consistent with those medications and failed to evidence all accurate and pertinent diagnoses. The plan of care evidenced an activity level of up as tolerated; wheelchair however during a home visit on 7/1/21 at 2 PM, the patient was observed ambulating independently. The plan of care listed a frequency of 5 wk 8 wk, 2 wk 1 wk, but failed to list the hours per day and failed to include all weeks of the certification period. The patient required assistance transferring in and out of the shower, and walked without a device, but held on to the wall for balance. The plan of care failed to include surgical procedures and all activities and restrictions permitted. The risk of emergency room/hospital admission evidenced the patient was currently taking 5 or more medications and reported exhaustion, but failed to include the risks related to the patients diabetes, fall risk, and infection control risk. The medications evidenced a medication for Metformin 500 milligrams. The plan of care failed to evidence patient specific and measurable goals and interventions, patient selected goals, strengths, and care preferences, and failed to include discharge planning.

3. Review of the clinical record for patient #4

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revealed a plan of care for certification period 6/2/21 - 7/31/21, revealed a primary diagnosis of cerebral infarction, unspecified and secondary diagnoses of idiopathic peripheral autonomic neuropathy, type 2 diabetes without complications, essential (primary) hypertension, and diabetes due to underlying condition with other circulatory complications. Functional limitations included ambulation, but failed to include the patient other mobility limitations and limitations related to memory loss and cognitive limitations due to the stroke, limitations related to right sided weakness from the stroke. Mental status evidenced the patient was oriented, but failed to include cognitive limitations related to the previous stroke. Supplies included gloves and pill boxes, but failed to include the patient's glucometer/supplies/needle bin. The medications failed to correctly list all medications, and failed to list all medications the patient was taking. Review of the medication bottles/insulin pens in the patient's home revealed the following: Aripiprazole 10 mg (milligrams) by mouth daily per then plan of care, however the bottle evidenced Repairable 5 mg by mouth daily; Adult Aspirin 81 mg oral tablet, chew 1 tablet once per day, however the patient stated she had no Aspirin because she could not afford it and needed a prescription to obtain through insurance; Admelog SoloStar 100units/ml (milliliter), inject 5 units is incorrectly documented as intravenous rather that subcutaneous; Cholecalciferol 1250 mcg (micrograms) 1 capsule orally once a day, however per the patient, the cholecalciferol was discontinued in April 2021; Tresiba Flex Touch 100 units/ml subcutaneous, inject 40 units once a day, however the patient stated the dose was changed to 30 units once per day and the plan of care did not specify how

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many milliliters to inject (30 units = ? milliliters) or what time during the day to inject. The patient medication box evidenced a bottle of Bystolic 20 mg, 1 tablet po (by mouth) daily per bottle, however the plan of care did not include Bystolic in any dose. Interventions evidenced "SN (skilled nurse) prepour/set-up medications, but failed to evidence interventions that included teaching, promoting patient independence, performing blood sugars. The plan of care failed to evidence orders related to the patient's diabetes, including blood sugar parameters, frequency of blood sugars, sliding scale for insulin, interventions for hypo/hyper glycemia. The plan of care evidenced a goal of "Patient/caregiver will demonstrate medication compliance with use of pill reminder" but failed to evidence the patient's progress towards the goal; failed to evidence patient specific and measurable goals or patient stated goals. Discharge planning evidenced "When goals are met." but failed to evidence a plan that was reasonable and pertinent for a patient who was noncompliant with medication and had no measurable or patient specific goals documented.

4. Review of the clinical record for patient #6, certification period 5/18/21 - 7/16/21 revealed a primary diagnosis of type 2 diabetes with other skin complications, other peripheral autonomic neuropathy, metabolic syndrome, heart disease, and morbid obesity. Patient #6 had difficulty with ambulation due to morbid obesity and endurance, and had difficulty with compliance. Medications included ferrous sulfate (iron), Guaifenesin and Loratadine (medications taken for allergies and/or increased secretions), psyllium (for constipation), and torsemide and spironolactone (for edema/swelling/fluid retention). The patient's diet evidenced "diet as tolerated" but failed to

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evidence orders appropriate for a diabetic with heart disease, fluid retention, and morbid obesity. The plan of care failed to evidence all pertinent and accurate diagnoses related to the home health episode and related to medications taken; failed to include patient specific and measurable goals; patient stated goals; all interventions; patient education related to monitoring fluid status (weigh daily, diet instruction, etc.); functional limitations such as fall risk, limited mobility and ambulation, inability to perform activities of daily living. Safety measures evidenced Oxygen precautions, but the plan of care failed to evidence the patient was receiving oxygen and/or how many liters. Goals included the patient would demonstrate healing, understanding of signs and symptoms of wound infection and measures to decrease infection, proper skin care, techniques to promote healing, causes of breakdown and care to prevent pressure ulcers, knowledge of wound care and what to report, and be free from infection. The plan of care failed to evidence teaching related to the goals, the current progress towards the goals, what measures decrease infection, how the patient would manage these measures if unable to reach body areas due to mobility and obesity, what proper skin care was, what techniques promote healing. Discharge plans included "When goals are met or progress plateaus" but failed to be patient specific and reasonable.

5. During a home visit on 7/7/21 at 10:10 AM, patient #5 stated they have a past medical history of thyroid issues and had been diagnosed with diabetes mellitus, was to start insulin, but through weight loss, diet, and dietary supplements, their blood sugars are now "well controlled." The patient and family member stated that they had to

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go buy supplies to do dry dressings to the right knee incision and spoke with the hospice to find out what supplies to get and the ordering physician to see what treatment needed to be done. The patient stated they have had an Inguinal Hernia Repair within the past year and a previous Left Total Knee Replacement within two years. Patient #5 stated they have numbness from the big toe to the side of their foot and expressed concerns over loss of sensation in the sole of the right foot making it difficult for them to make sure the right foot is placed appropriately while ambulating and doing the prescribed home exercise. The patient also stated a loss of sensation to their left knee from the left total knee replacement. The patient reported constant pain, with a level of 5 being intolerable, and is only able to exercise for 15 minutes and no longer. While observing the patient's physical therapy, the patient facial expressions indicated she was having pain during therapy. Patient #5 stated they get brain fog at times due to the amount of pain medication they are taking so her family checks in on her frequently and another family member has been assisting with their daycare business until she recovers. The home also has 2 steps and a small porch when entering the patient's home and an area rug in the kitchen where the patient ambulates for exercise. The patient was queried as to whether they had any allergies. The patient stated they have an allergy to Percocet, how it played with their mind and made them "suicidal". A review of the discharge instructions from the hospital included medications such as 81 mg of Aspirin daily for 2 weeks, Cefadroxil 500 mg for 14 days, Colace 100 mg twice a day, celecoxib 200 mg twice a day, and Dilaudid for pain. On 6/29/21, Cephalexin 500 mg twice a day, and on 6/30/21,

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hydrocodone 10/325 mg 1 every 4 to 6 hours was added to the patient's medication list. The patient stated they also took over-the-counter medications such as CoQ10, Cyanocobalamin, flaxseed, Probiotic woman, Zinc, Vitamin C, Omega 3, Tumeric, levocarnitine, cholecalciferol.

The clinical record of patient #5, start of care (SOC) 6/21/21, was reviewed on 7/8/21 and contained a physician order from physician D, surgeon, dated 6/8/21. This order indicated the patient's diagnosis is "presence of right artificial knee joint" and also indicated "status post total right knee replacement using cement." The record also contained the Operative report dated 6/7/21, which indicated a preoperative diagnosis of "Right knee primary osteoarthritis".

A review of the start of care comprehensive assessment / OASIS (Outcomes and Assessment Information Set) dated 6/21/21, indicated the primary diagnosis listed is unilateral primary osteoarthritis. The registered nurse answered no to pre-existing conditions of Peripheral Vascular Disease or Diabetes Mellitus. The assessment asked if the pain assessment was completed in which the response indicated "No" but "The frequency of pain" is documented as daily but not constantly. It is noted that the patient has an abnormal gait. The Nutrition section indicated "None" to prescribed diet. The registered nurse documented patient had one observable surgical wound that was fully granulating but failed to evidence a complete assessment, such as what the incision looked like, the length of the incision, the number of staples, and the appearance of surrounding skin. The assessment asked if safety hazards found in the patient's current place of residence, in which

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the note indicated "None noted or verbalized." The mobility section identified the patient needed supervision or touching assistance when lying to sitting on the side of the bed, chair/ bed to chair transfer, shower/ bathing self, and toileting indicated partial to moderate assistance. The safety issues identified were difficulty with transfers, infection control concerns, and unsafe ambulation. The safety/fall risk-safety consideration section indicated difficulty with transfers and unsafe ambulation.

On 7/8/21 at 1:28 PM, an Indiana Department of Health physician questionnaire was faxed to the ordering physician, Physician D. The document was returned to the surveyor on 7/16/21 and indicated Physician D was the primary care provider and that they did not give the agency approval to notify or obtain orders from the patient's primary care physician, Physician E in regards to the care of the patient right knee.

A review of the "Medication Profile" dated 6/21/21, in which the document failed to evidence the patient's allergy to Percocet. The medication list revealed only acetaminophen-benzhydrocodone 325 mg -4.08 mg oral tablet and Aspirin EC 81 mg. The medication list failed to be accurate and include the most up-to-date medications the patient is taking and/ or prescribed, including over-the-counter medications.

A review of the plan of care for the certification period of 6/21/21 - 8/19/21, indicated the patient's primary diagnosis of Unilateral primary osteoarthritis right knee. The plan of care failed to evidence the diagnosis provided by the ordering physician of right total knee replacement

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and failed to evidence all past medical history diagnoses. The document failed to identify ADLs (activities of daily living- eating, meal preparation, dressing, bathing) as a functional limitation7; failed to document the activities the patient is permitted (i.e. up with walker or cane); failed to evidence patient's risk for emergency department visits and hospital readmission related to possible infections or risk from falls; failed to evidence any patient and caregiver education and training to facilitate discharge; and failed to evidence a diet type (regular). The medication list on the plan of care revealed only acetaminophen-benzhydrocodone 325 mg -4.08 mg oral tablet and Aspirin EC 81 mg. The plan of care failed to document all current medications, including OTC (over-the-counter) medications, failed to evidence the correct name and dosage for the hydrocodone, and failed to evidence the patient's allergy to Percocet. Skilled nursing services on the plan of care were written for 1 time a week for 9 weeks for skincare, wound/ ulcer care, and teaching signs and symptoms of infection when the plan of care failed to evidence any patient-specific wound treatment orders or supplies to be used. The nursing intervention documented to teach signs and symptoms of infection failed to document patient-specific education and teaching (i.e watch for redness, warmth at the incision site, or COVID 19 related symptoms). The plan of care failed to evidence interventions for bleeding precautions, safety measures, education for bowel and pain management, and failed to evidence measurable outcomes and goals for skilled nursing for the patient to achieve. The plan of care failed to evidence pain management, family's involvement /assistance with the patient, failed to evidence any discharge planning. The plan of care listed

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Physician E as the primary responsible for the plan of care and failed to identify the Physician D as the correct primary physician responsible for the plan of care.

During an interview on 7/8/21 at 6:17 PM, Person C was queried if Physician E is still patient 5's primary care physician, in which Person C responded patient #5 goes to Entity G, a county health clinic. Person C stated Physician E started there about one year ago and has never seen the patient. Physician D, the patient's surgeon, has been handling the patient's recent health issues because they are related to his/her osteoarthritis.

During an interview on 7/12/21 at 2:00 PM, when asked about medication reconciliation with the patient's OTC medications, the alternate clinical director stated the patient didn't tell her and she couldn't help that. Need more on this interview in regards to missing items on the POC.

6. The clinical record for patient #7 was reviewed on 7/13/21, and contained a document titled "Home Health Care Certification and Plan of Care" for the certification period of 5/22/21 - 7/20/21. The diagnoses include primary hypertension, hemiplegia right dominant side intracerebral hemorrhage, chronic embolism and thrombus of deep vein of the lower extremity, nerve root and plexus disorder unspecified, and aphasia following other cerebrovascular diseases. The medications listed include amlodipine, clopidogrel, cranberry capsule, debrox, fentanyl, gabapentin, levetiracetam, lisinopril, magnesium chloride Mucinex D, Nitroglycerin, Tylenol, and vitamin D. The plan of care failed to evidence precautions (i.e. bleeding precautions) or side effects listed for clopidogrel.

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G 574	Continued From page 97 The patient is on two types of anti-epileptic medications gabapentin and levetiracetam that can be used for seizures or pain management. The plan of care failed to evidence any diagnosis of seizures when previous certifications revealed the diagnosis of Non-epileptic seizures. The plan of care failed to evidence any patient-specific outcomes; goals/outcomes comments were documented. and the discharge was documented as not applicable. During an interview on 7/12/21, when asked about patient #7's medications and any necessary precautions related to their side effects, the clinical manager responded that there should be precautions for bleeding, seizures, falls related to blood pressure medications. When viewing the plan of care, the administrator and alternate clinical manager indicated their surprise at how they were not listed.	G 574		
G 580	410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(i-xi, xiii) Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure all the physician orders were obtained, written, and sent to the correct ordering physician for signature in 4 of 5 active patient records reviewed. (Patient #3, 4, 5, 6)	G 580		

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Findings include:

1. The clinical record of patient #5, start of care (SOC) 6/21/21, was reviewed on 7/8/21. The clinical record contained a referral order from Physician D, surgeon, for Skilled Nursing (SN), Physical (PT), and Occupational Therapy (OT) evaluation and treat for home health services.

A review of the plan of care for the certification date of 6/21/21 to 8/19/21, failed to evidence Physician D as the ordering and primary physician while the patient is on home health services. The plan of care included orders for skilled nursing 1 time a week and physical therapy 2 times a week.

Review of the skilled nursing visit notes, the SN provided services on 6/21, 72, and 7/6/21 without a Physician's order from Physician D.

Review of the physical therapy notes, the PT provided services on 6/30, 7/7, and 7/8/21 without a Physician's order from Physician D.

A review of an agency document titled "Verbal Order" dated 6/30/21, written by the physical therapy, included orders for treatment. The order indicated Physician E as the ordering physician and not Physician D.

A review of an agency document titled "Verbal Order" dated 7/1/21, written by the alternate clinical manager, indicated 8 entries for the initiation of new medications such as acetaminophen-benzhydrocodone, aspirin, hydocodone [sic], hydrocodone. The order indicated Physician E as the ordering physician

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and not Physician D.

A review of an agency document titled "Verbal Order" dated 7/6/21, written by the alternate clinical manager, indicated 7 entries for aspirin, hydrocodone, and acetaminophen-benzydrocodone to be discontinued. The order indicated Physician E as the ordering physician and not Physician D.

On 7/8/21 at 1:28 PM, an Indiana Department of Health physician questionnaire was faxed to the ordering physician, Physician D. The document was returned to the surveyor on 7/16/21 and indicated Physician D was the primary care provider, and that they did not give the agency approval to notify or obtain orders from the patient's primary care physician, Physician E in regards to the care of the patient right knee.

During an interview on 7/8/21 at 6:17 PM, Person C was queried if Physician E is still patient 5's primary care physician. Person C stated the patient goes to Entity G, a county health clinic. Person C stated Physician E started there about one year ago and has never seen the patient. Physician D, the patient's surgeon, has been handling the patient's recent health issues because they are related to his/her osteoarthritis.

During an interview on 7/12/21 at 2:00 PM, when asked who is the physician for establishing the plan of care, the administrator answered "patient's primary care physician". When asked if she called the ordering physician, Physician D, upon the patient's admission to establish/ collaborate on the development for the plan of care, the alternate clinical manager stated she had not.

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2. Review of the clinical record for patient #3, certification period 7/3/21 - 8/31/21, failed to evidence documentation or physician's orders that confirmed the physician was contacted after the comprehensive assessment to review findings and obtain orders for further services.

3. Review of the clinical record for patient #4, certification period 6/2/31 - 7/31/21 failed to evidence documentation or physician's orders that confirmed the physician was contacted after the comprehensive assessment to review findings and obtain orders for further services.

4. Review of the clinical record for patient #6, certification period 5/18/21 - 7/16/21 failed to evidence documentation or physician's orders that confirmed the physician was contacted after the comprehensive assessment to review findings and obtain orders for further services.

Further review of the record revealed a document titled "Verbal Order" which evidenced "Skilled Nursing 5 wk 1 wk; 3 wk 1 wk; Resume pt (patient) from hold due to receiving authorization on June 30th, and patient requested to resume care on 7/6/21; Start date: 7/5/21 - End Date: 7/16/21; Total number of visits: 8" The document failed to evidence orders for care, which included specific wound/skin care orders with type, frequency, and treatment were obtained from the physician.

On 7/14/21 at 4:20 PM, the case manager for patient #6 was interviewed concerning the resumption of the patient's services. The case manager stated the patient did not receive a comprehensive assessment; however, a skilled

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G 580	Continued From page 101 nurse visit note was completed, and services were resumed as they had been prior to the hold. 5. During an interview on 7/12/21 at 2 PM, the administrator and alternate clinical manager, the alternate clinical manager were queried as to the agency policy concerning obtaining orders and was asked if she contacts the physician after the comprehensive assessment. The alternate clinical manager stated she obtained orders prior to making the visit and did not contact the physician after the visit.	G 580		
G 588	410 IAC 17-13-1(a) Reviewed, revised by physician every 60 days CFR(s): 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. This ELEMENT is not met as evidenced by: Based on record review and interview the agency failed to ensure the plan of care was reviewed by the physician responsible for the home health plan of care for 1 of 1 newly admitted patient record reviewed. (Patient #5) Findings include: 1. The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021. The clinical record contained hospital discharge documents which revealed a diagnosis of right	G 588		

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knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents included an order from Physician D for SN/PT/OT (Skilled Nurse/ Physical Therapy/ Occupational Therapy) evaluation and treat.

A review of the plan of care for the certification period 6/21/21 -8/19/21, failed to evidence Physician D as the ordering physician responsible for the plan of care but had Physician E listed as the primary physician responsible.

On 7/8/21 at 1:28 PM, an Indiana Department of Health physician questionnaire was faxed to Physician D. The document was returned to the surveyor on 7/16/21 and indicated Physician D was the primary care provider and Physician D did not give the agency approval to notify or obtain orders from Physician E in regards to the care of the patient right knee.

During an interview on 7/8/21 at 6:17 PM, Person C was queried if Physician E is still patient 5's primary care physician, in which Person C responded patient #5 goes to Entity G, a county health clinic. Person C stated Physician E started there about one year ago and has never seen the patient. Physician D, the patient's surgeon, has been handling the patient's recent health issues because they are related to his/her osteoarthritis.

During an interview on 7/12/21 at 2:00 PM, when asked who was the physician for establishing the plan of care, the administrator answered "the patient's primary care physician". When asked if Physician E was the ordering physician for patient #5, the administrator answered no, and the alternate clinical manager agreed.

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G 590	410 IAC 17-13-1(a)(2) Promptly alert relevant physician of changes CFR(s): 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. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure they promptly notified the ordering physician when the start of care is delayed, failed to notify the physician of the agency's inability to provide occupational services, and failed to ensure clinicians notified the physician when there is a possible change in condition for 2 of 5 active patient records reviewed. (Patient #5, 6) Findings include: 1. During a home visit on 7/7/2021 at 10:10 a.m., the patient's blood pressure was taken by the physical therapist (PT). The physical therapist reported the patient's blood pressure as being 179/83 and the patient reported that was high for her. The therapist asked the patient if she was having pain and the patient reported she was having warmth at the incision site, even after icing her knee. The patient expressed she can only tolerate 15 minutes of exercise. The patient expressed numbness from her big toe to the side of her foot since surgery and neuropathy to her left knee from a past left knee replacement. The patient reported taking pain medications such as	G 590		

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hydrocodone and Dilaudid and finished a coarse of Cephalexin (antibiotics). The patient #5 and a family member were discussing the delay of services and stated they had to go 3 weeks without therapy. Per the family member, they had expected someone to be there to do the admission on 6/9/21. The family member stated initially, when they called the agency to find out when they were coming to admit the patient, they were told that they had to run the patient's insurance and it would be a week. The family member stated they waited two weeks and called the agency back and a date/ time was set but then no one showed up. When they called the agency to inquire why no one showed up as scheduled, the agency told them the orders had been canceled. The family member stated no one canceled the orders. The family member stated they called the Person B, the case manager with Entity F and Physician D, the surgeon/ order physician to verify that no one canceled the home health services. The family member stated a nurse finally showed up on 6/21/21, however, they were told that physical therapy was on vacation and wouldn't be able to see the patient for another week.

The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021. The clinical record revealed a hospital discharge documents which revealed a diagnosis of right knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents revealed the patient received therapy post-operatively and was able to discharge home using a walker on 6/8/21. The referral and order for SN/PT/OT (Skilled Nurse/Physical Therapy/Occupational Therapy) was faxed to agency which has a time stamp that

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the agency received the fax on date and time of 6/8/21 at 11:51 AM.

The record revealed skilled nursing did not admit the patient until 6/21/21, which was 13 days after the referral was received.

Review of a skilled nursing visit note dated 7/6/21, the narrative note stated "He/she is very sore and PT is very difficult since it was started so late .... " The "visit plan - communication" indicated "No one contacted as a result of this visit."

The record failed to reveal evidence that the agency notified the physician that an occupational therapist was unavailable.

The record revealed the physical therapist evaluated the patient on 6/30/21, which was 9 days after the start of care and 22 days after the referral was received.

A review of the physical therapy visit note for 7/7/21, failed to evidence the actual blood pressure taken and reported during the home visit and failed to evidence that the physician was notified of the patient's elevated blood pressure, complaint of continued warmth at the incision site after icing, and patient's stating she can only tolerate 15 minutes of exercise.

During an interview on 7/8/21 at 2:58 PM, when asked if the they had canceled the referral for home health services with Pure Home Health, Person B, a discharge case manager with Entity F, stated they did not cancel with Pure and has had many conversations with the agency. Person B indicated the agency wanted a face to face

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from Physician D and Person B had to educate the agency on what their face to face encounter looks like and it was tied into the order for home health services. Person B stated no one had sent patient #5's referral to another agency. Person B stated this agency was chosen because it was one of the few that would take this patient's insurance. The hospital case manager stated this was an ongoing issue with Pure Home Health for they have received multiple complaints from other families and other physicians who has ordered home health services with this agency and this agency's failure to start services timely after discharge.

On 7/8/21 at 1:28 PM, an Indiana Department of Health physician questionnaire was faxed to the ordering physician, Physician D. The document was returned to the surveyor on 7/16/21 and indicated Physician D was the primary care provider, the agency failed to notify the physician of their inability to admit the patient on or after 6/8/21, and failed to obtain orders to delay admission until 6/21/21. The document also indicated the physician's office was notified of the delay in admission by the patient's family member. The note went on to indicate that the physician was not made aware of the patient's pain level, warmth at the site, and increase blood pressure.

During an interview on 7/8/21 at 6:17 PM, Patient #5's family member, Person C, stated they had called the agency on 6/9/21 to inquire when someone would be out to start care. He was told that they were waiting on insurance verification. On 6/16/21 he had called again and was told that someone would be out on 6/18/21. When no one showed up he called the agency's office again

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was told that "someone" canceled the appointment. Per patient's son he told the office that no one from the family canceled the appointment and she needed home health. Person C was queried if Physician E is still patient 5's primary care physician. Person C stated the patient goes to Entity G, a county health clinic. Person C stated Physician E started there about one year ago and has never seen the patient. Physician D, the patient's surgeon, have been handling the patient's recent health issues because they related to his/her osteoarthritis.

During an interview on 7/12/21 at 2:00 PM, when asked why Patient #5's initial assessment/ admission occurred outside the 48 hours from the return home on 6/8/21 and referral, the administrator stated she called to talk to the hospital case manager, on 6/9/21 and was told at that time that the patient had been accepted by another home health company. When asked about the OT orders and accepting the patient knowing they had no OT, the administrator stated she was aware that they accepted the patient knowing they needed the service, however, they did report to the physician that they didn't have OT but she didn't document the discussion she had and didn't obtain an order to discontinue the request. When asked if they informed the physician of PT being delayed, the administrator and clinical manager stated they did not.

6. Review of the clinical record for patient #6 revealed the patient was receiving skilled nurse services to apply medicated cream to excoriated (red, inflamed) areas to the abdominal folds and groin. The patient was unable to meet their own needs due to morbid obesity and mobility limitations. The patient lived with a daughter who

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attempted to help, when possible, but was not comfortable applying the cream to personal areas. (See interview below) The record evidenced the patient was placed on hold effective 6/10/21 due to no payor because of a cancelled authorization from the Veteran's Administration. The patient's services were resumed effective 7/6/21. The record failed to evidence the agency arranged for the patient to have the cream applied and failed to evidence the nurse completed a comprehensive assessment to determine if the patient had a change in condition during the hold period, and if the affected areas has worsened.

On 7/8/21 at 3:20 PM, the patient was interviewed concerning who helped with care during the time the patient was on hold. The patient stated the daughter tried to help but was not comfortable applying the cream due to the personal nature of the affected areas. (abdominal folds and groin.) The patient was queried as to whether the areas were worse, better, or the same as before being placed on hold. The patient stated they did not want to discuss the issue any further.

Further review of the record revealed a document titled "Verbal Order" which evidenced "Skilled Nursing 5 wk 1 wk; 3 wk 1 wk; Resume pt (patient) from hold due to receiving authorization on June 30th, and patient requested to resume care on 7/6/21; Start date: 7/5/21 - End Date: 7/16/21; Total number of visits: 8" The document failed to evidence orders for care, which included specific wound/skin care orders with type, frequency, and treatment were obtained from the physician.

On 7/14/21 at 4:20 PM, the case manager for

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G 590	Continued From page 109 patient #6 was interviewed concerning the resumption of the patient's services. The case manager stated the patient did not receive a comprehensive assessment; however, a skilled nurse visit note was completed, and services were resumed as they had been prior to the hold.	G 590		
G 608	410 IAC 17-13-1(a)(2) Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure they documented their efforts in coordinating with all disciplines involved in a patients care for 1 (Patient #5) of 1 newly admitted patient record reviewed and failed to ensure the all disciplines coordinated care delivery to meet the patient's needs. Findings include: 1. During a home visit on 7/7/21 at 10:10 AM, Employee C obtained patient #5's blood pressure and reported the reading as being 179/83, in which the patient reported that was high for her. Employee C asked the patient if she was having pain and the patient reported she was having warmth at the incision site, even after icing her knee. The patient expressed she can only tolerate 15 minutes of exercise. The patient expressed numbness from her big toe to the side of her foot since surgery and neuropathy to her	G 608		

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left knee from a past left knee replacement.

The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021. The clinical record contained hospital discharge documents which revealed a diagnosis of right knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents included an order from Physician D for SN/PT/OT (Skilled Nurse/ Physical Therapy/ Occupational Therapy) evaluation.

Review of the start of care comprehensive assessment dated 6/21/21. The visit plan/ communication section indicated "no one contacted as a result of this visit." The clinical record failed to evidence the admitting clinician notified the ordering physician to collaborate and develop the plan of care.

Review of a skilled nursing visit note dated 6/29/21, the visit plan/ communication section indicated "No one contacted as a result of this visit." The narrative note stated "A PT (physical therapist) also sees him/ her" however, PT has not been out to the home to initiate care at this time.

On 6/30/21, Employee C conducted an evaluation visit to determine the patient's ongoing physical therapy needs.

Review of a skilled nursing visit note dated 7/2/21 and 7/6/21, the visit plan/ communication section indicated "No one contacted as a result of this visit."

Review of a skilled nursing visit note dated

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7/6/21, the narrative note stated "He/she is very sore and PT is very difficult since it was started so late .... " The "visit plan - communication" indicated "No one contacted as a result of this visit."

A review of the physical therapy note dated 7/7/21, failed to evidence the elevated blood pressure and the pain assessment. The "visit plan - case communication" section asks if contacts were made as a result of the visit, in which Employee C answered "supervisor". However, the narrative note and clinical record failed to evidence if Employee C reported the patients continued pain and numbness, elevated blood pressure, or the patient's complaint of warmth at the incision site after icing to the administrator or the alternate clinical manager as well as failure to report these findings with the patient's physician.

A review of the physical therapy note dated 7/8/21, the "visit plan - case communication" section asks if contacts were made as a result of the visit, in which Employee C answered "supervisor". However, the narrative note and clinical record failed to evidence what was reported to the supervisor and which supervisor was spoken to (administrator or alternate clinical manager).

2. During an interview with the alternate clinical manager and administrator 7/13/21 at 4:38 PM, the alternate clinical manager was queried as to how often the agency conducted IDG (Interdisciplinary Group) meetings. The alternate clinical manager stated the meetings were monthly. When queried "Can I have the minutes?" the alternate clinical manager did not

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G 608	Continued From page 112 initially answer, then stated, "I'll have to find them." When queried as to the date of the most recent IDG meeting, the alternate clinical manager and administrator stated they did not know the date. When queried as to who participated in the IDG meetings, the alternate clinical manager stated, "The clinicians." On 7/14/21 at 3:45 PM, Employee F, a physical therapist, was interviewed as to whether the agency had regular IDG or case conference meetings to discuss patient care, progress, and services. The physicial theapy stated he had never particpated in any case conferences. On 7/14/21 at 4:20 PM, Employee G, a registered nurse, was interviewed as to whether the agency had regular IDG or case conference meetings to discuss patient care, progress, and services. The nurse stated that they did not conduct or participate in any case conferences. On 7/14/21 at 4:30 PM, the alternate clinical manager submitted 19 documents titled "Case Conference Note", dated between 6/14/21 and 6/17/21, which evidenced the patient's primary diagnosis, certification period, and that patients liked their caregiver. These notes appeared to be about patient satisfaction, rather than the patients progress toward goals, if needs were met or not met, and future plans for any discharges.	G 608		
G 614	410 IAC 17-12-2(g) Visit schedule CFR(s): 484.60(e)(1)	G 614		

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G 614	Continued From page 113 Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure all patients received a copy of the visit schedule for home health staff for 2 of 3 home visits conducted. (Patient #4, 5) Findings include: 1. The review of the agency's admission folder revealed a document titled "Episode Manager" which contained spaces for the documentation of the home health services and their frequencies. 2. The clinical record of patient #5's, start of care (SOC) 6/21/21, was reviewed on 7/8/21, and failed to evidence an "Episode Manager" document. 3. During the home visit for patient #5 on 7/7/21 at 10:10 AM, the patient's admission folder failed to evidence the "Episode Manager" and failed to evidence a schedule of when the skilled nurse and physical therapist will be coming. During this time, when asked about clinician schedules, Patient #5 stated they are never sure when someone is coming. Patient was then queried as if she felt the registered nurse and physical therapist involved her and her family in setting up a schedule or what they wanted to accomplish, she stated no. They only know week to week when someone is coming but not always the time. Person C, a family member, stated the agency schedules 1 week at a time and another family member has to fill in during these appointments (daycare). Person C stated this was somewhat of an inconvenience due to their own jobs and	G 614		

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G 614	Continued From page 114 personal schedules. 4. During a home visit with patient #4 on 7/3/21 at 1 PM, the admission folder was reviewed and failed to evidence the patient received a schedule for the skilled nurse visits.	G 614		
G 616	Patient medication schedule/instructions CFR(s): 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. This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to ensure a medication list was provided the patient in plain language for 1 (Patient #5) of 1 newly admitted patient record reviewed and 2 of 3 home visits conducted. (Patient #5) Findings include: 1. During a home visit on 7/7/21 at 10:10 AM, patient #5's home folder was reviewed and revealed a medication list with ASA e.c. 81 mg 2 times a day. During this time, Patient #5 stated she wasn't sure what it was at first but realized it was her aspirin because of the dose amount. 2. During a home visit on 7/2/21 at 2:05 PM, the medication profile for patient #4 was reviewed and evidenced the following medications: Aripiprazole (medication for schizophrenia, bipolar disorder, depression, and Tourettes syndrome) 10 mg (milligrams) by mouth daily per the plan of care, however the bottle evidenced	G 616		

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G 616	Continued From page 115 Aripipazole 5 mg by mouth daily; Adult Aspirin 81 mg oral tablet, chew 1 tablet once per day, however the patient stated she had no Aspirin because she could not afford it and needed a prescription to obtain through insurance; Admelog SoloStar (insulin) 100 units/ml (milliliter), inject 5 units was incorrectly documented as intravenous rather that subcutaneous; Cholecalciferol (Vitamin D3) 1250 mcg (micrograms) 1 capsule orally once a day, however per the patient, the cholecalciferol was discontinued in April 2021; Tresiba (insulin) Flex Touch 100 units/ml subcutaneous, inject 40 units once a day, however the patient stated the dose was changed to 30 units once per day and the plan of care did not specify how many milliliters to inject (30 units = ? milliliters) or what time during the day to inject. The patient medication box evidenced a bottle of Bystolic (antihypertensive) 20 mg, 1 tablet po (by mouth) daily per bottle, however the plan of care did not include Bystolic in any dose. The medication list failed to evidence the patient had a list of medications with dose, route, and frequency that was correct and in plain language the patient could understand.	G 616		
G 640	Quality assessment/performance improvement CFR(s): 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	G 640		

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arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.
This CONDITION is not met as evidenced by:
Based on record review and interview, the administrator failed to ensure the agency implemented an active QAPI (Quality Assurance Performance Improvement) Program which identified measurable indicators for improving health outcomes, patient safety, and quality of care; failed to measure, analyze, and track quality indicators and other aspects of performance; failed to include adverse patient events and OASIS (Outcome Assessment and Information Set) indicators; failed to consider incidence, prevalence, and severity of problems; failed to focus on high risk, high volume, or problem-prone areas; failed to use measurable identifiers to immediately correct any identified problems that potentially or directly threatened the health and safety of patients; failed to ensure the agency took action through use of performance improvement plans (PIPs); failed to measure the success of the PIPs through tracking, analyzing, and implementing preventative actions; failed to PIPs that reflected the scope, complexity, and past performance of the agency; failed to ensure the administrator documented the number, reason for, and measurable progress of any PIPs; failed to ensure the governing body defined, implemented, and maintained oversight of an agency-wide QAPI program; failed to ensure the governing body regularly evaluated the program

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for effectiveness, that expectations for patient safety were clearly established, implemented, and maintained, and included addressing any findings of fraud or waste; and failed to implement an infection control program with an emphasis on the public health emergency related to COVID-19. The absence of an effective QAPI program impacted all 14 of the patients receiving services.

The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care.

Findings include:

1. A review of an undated agency policy titled "Incident Reporting B-340" revealed "The reporting of incidents and the investigation are part of the agency's Performance Improvement Program. Trends or problem areas will be brought to the attention of the appropriate committee." The policy also revealed "7. After the report is reviewed by the administrator, the leadership team determines opportunities for performance improvement or whether to continue monitoring; 8. Aggregated results are part of the annual Performance Improvement Program evaluation."

2. A review of an undated agency policy titled "Clinical Record Review, Policy B-220" revealed "Clinical records will be reviewed at least quarterly ... shall reflect the scope of the QAPI program to show measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of

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care ... shall be approved by the organization's governing body." The policy further revealed "The Performance Improvement Coordinator will incorporate the review and analysis ... reports as part of the organization's quarterly clinical record review... focus on case mix and adverse events report data, and include adverse events with the most clinical relevance to the organization ... Review findings will be documented and the data collated and analyzed ... Results will be utilized for improvements in patient care and incorporated into performance improvement plans ... A summary of the results and ... analysis will be presented to the ... QAPI Committee ...." The agency failed to evidence chosen indicators, quarterly record review and analysis, adverse even reports, PIPs, summaries, or meeting minutes showing analysis was presented to the QAPI committee, and failed to evidence who was on the QAPI committee.

3. A review of an undated agency policy titled "Governing Body, Policy B-100" revealed "The Governing Body will assume full ... accountability for ... its (QAPI) program ... Relevant findings of performance improvement activities are consistently provided to the Governing Body ... an ongoing program for quality improvement and patient safety is defined, implemented, and maintained ... will address priorities for improved quality of care and patient safety ... programs are evaluated for effectiveness ... clear expectations for safety are established, implemented, and maintained ,,, and any findings of fraud or waste are appropriately addressed ... The Governing Body will evaluate the organization's performance on a regular basis ... All actions taken by the Governing Body will be documented in meeting minutes ...." The agency failed to provide

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evidence that the governing body was notified of or participated in QAPI or PIPs.

4. Review of undated agency policies titled "Infection Control Precautions, Policy N-100", "Hand Hygiene, Policy N-100", and "Infection Control/ Expanded Precautions, Policy N-140" failed to evidence information specific to the screening, tracking, analyzing, and management of COVID-19 illness and/or pandemic.

6. On 7/12/21 at 1:11 PM the administrator was requested to provide all information related to the agency's QAPI plan. The administrator provided a 20 page untitled document which revealed "Pure Health has a QAPI program which meets monthly to systematically review and analyze data, processes, and trends with a goal of identifying root cause of any concerns potentially impacting the patient .... Performance improvement plans are developed, tracked, measured, and updated until the desired balance ... is obtained ... The administrator will assure that the QAPI plan is reviewed minimally on an annual basis by the QAPI committee." The document revealed the agency "focused on high risk, high volume, or problem-prone areas and tracked and ranked measures on a prioritization worksheet ... any identified problem that directly or potentially threatens the health and safety of our patients will lead to an immediate correction." The document detailed how QAPI was conducted, but failed to evidence any agency specific information obtained, including PIPs, tracking, analyzing, feedback, ranking, training, or audits.

A section titled "Annual assessment of the overall effectiveness of the QAPI program" evidenced "challenges due to the COVID-19 pandemic of

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PURE HOME HEALTH CARE LLC	1531 W OAK STREET ZIONSVILLE, IN 46077

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2020" and "goals of reduced falls, infections, hospitalizations, and deaths were difficult due to the virus ... staffing challenges, visit refusal, and isolation resulted in decreased social interaction/stimulation, deteriorating mental health, progressive weakness, increased falls and so forth ... we have continued to prioritize other data points including hospitalizations, timeliness of initiation of care, and patient satisfaction ... 2020 in some ways seems like a lost year for QAPI." The document revealed the following reports, all run on 7/5/21: "Home Health Data;" "Turnover Rate;" "PPS (Pay per Service) Trends by Case Manager" for Nov 2019 - Jan 2020; "PPS Trends by Case Manager" for Nov 11, 2019; "PPS Trends by Case Manager" for Dec 2019 - Feb 2020; "PPS Trends by Case Manager" for Dec 12, 2019; "PPS Trends by Case Manager" for Jan - Feb 2020; "PPS Trends by Case Manager" for Jan 1, 2020; "PPS Trends by Case Manager" for Feb 2020; "PPS Trends by Case Manager" for Feb 2, 2020; "Claim Delays by Clinician", undated; "PPS Gross Margin Report", undated; and "PPS Gross Margin Scheduled Visits", undated. All reports failed to evidence any data, analysis, or whether a PIP was established.

7. On 7/12/21 at 1:11 PM, the administrator provided a 20 page untitled document which she stated was the agency QAPI program. On 7/14/21 at 4:49 PM, during an interview with the administrator and alternate clinical manager to review findings, the administrator was queried as to whether there was any further QAPI documentation. The administrator provided a 4 page spreadsheet titled "Prioritization of Important Processes" which identified certain categories as a level 1, 2, or 3, but failed to include patient identifiers, dates, analysis, trends,

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goals, or a performance improvement plan specific to any of the categories listed. When queried as to what specific high risk, high volume, problem prone areas the agency was tracking and whether there were PIPs in place, the administrator stated, "It's in Brightree (the agency's electronic software). There are reports showing hospitalizations, missed visits, late submissions, and all the things we can track." When queried concerning what specifically the agency had identified for tracking, the administrator stated, "Coordination of care, orders, timely submission to IQIES (Internet Quality Improvement and Evaluation System), timeliness of OASIS (Outcome and Assessment Information Set) and documentation, audits - we do spot audits" but failed to provide any documentation showing data tracking, analysis, or PIPs. When queried as to the QAPI committee members and how often the committee met, the administrator stated the committee members were the administrator, the alternate clinical manager, and Individual G, an agency owner, but failed to evidence documentation showing the QAPI committee members. The administrator stated that she and the alternate clinical manager met monthly. When queried as to meeting minutes or a sign in sheet, the administrator stated there were no minutes or sign in sheets and for QAPI or governing body meetings. The agency failed to evidence Brightree reports were regularly monitored and analyzed for high risk, high volume, problem prone trends; failed to identify quality indicators and improvement projects, the reason for conducting specific projects, and any measurable success achieved; and failed to evidence the governing body's ongoing involvement with quality improvement and patient safety.

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G 682	410 IAC 17-12-2(a) Infection Prevention CFR(s): 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. This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure all staff were compliant with standard precautions, including hand hygiene and reprocessing of reusable medical equipment for 2 of 3 home visits conducted. (Patient #4, 5) Findings include: During a home visit observation for patient #5 on 7/7/21 at 10:10 AM, Employee C, physical therapist, was observed entering the home carrying a single pocket clear tote and tablet. They were observed removing a disposable barrier from the center of the single pocket bag and placed it down on a foot rest by patient. Employee failed to perform hand hygiene before entering bag. Employee C placed their tablet on the barrier before cleaning. Employee C removed gloves, blood pressure cuff, thermometer and hand sanitizer from the single pocket bag. Employee C failed to perform hand hygiene before reentering their bag. Employee C was observed going to the kitchen completing hand hygiene with soap and water and was timed <10 seconds of hand washing. Employee C then	G 682		

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used the hand towel on the counter to dry their hands. Employee C donned gloves, took patient's vital signs and documented on the tablet with gloved hands. Employee C was observed placing unclean equipment on the barrier (blood pressure cuff, pulse oximeter, and thermometer) without maintaining a clean and dirty area. At the end of the visit employee C doffed their gloves and disposed of them in the kitchen waste can. Employee failed to perform hand hygiene (hand washing or sanitizer) after removing their gloves. Employee C failed to clean the equipment prior to replacing it in the bag, and failed to have a designated "clean/dirty" area of the bag.

During an interview after the visit on 7/7/21 at 11:30 AM, Employee C was asked how long are they to wash their hands and the employee stated 20 seconds. When asked about her bag technique and cleaning the equipment before returning to the bag, Employee C stated they didn't have any antibacterial cleaning wipes with them.

2. During a home visit for patient #4, on 7/2/21 at 2 PM, the alternate clinical manager was observed donning gloves to complete the medication pre-fill. Upon completion, the alternate clinical manager removed the gloves and dropped them on the floor in front of the clinical bag she'd hung on the doorknob. She was observed reaching into the bag to obtain another pair of gloves, which she attempted to don but was unable to due to sweaty hands. The alternate clinical manager was observed removing the gloves and dropping them on the patient's floor as well, where both sets remained until the end of the visit. At the end of the visit, the nurse procured the gloves from the floor and placed

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G 682	Continued From page 124 them in the front pocket of the clinical bag. During an interview in the driveway, the nurse was asked to show the inside of the clinical bag. The surveyor observed a gym-bag type of bag, with one central large opening and a small open front pocket, which contained the soiled gloves. When queried as to whether the bag was an approved nursing bag, the alternate clinical manager stated that the administrator had approved the bag. The bag failed to evidence the ability to utilize a clean/dirty side that would separate hand sanitizer, pens, tablet, etc. from items for care and assessment, such as the stethoscope, thermometer. The alternate clinical manager stated the small front pocket with the dirty gloves was considered the dirty pocket. When queried as to why the alternate clinical manager dropped the gloves on the patient's floor, then picked them up and put them in the pocket, she stated she did not like to leave trash in the patient's home.	G 682		
G 706	410 IAC 17-12-1(m) Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the physical therapist and registered nurse failed to assess patient's pain, skin and bowel status during visits in 1 of 1 newly admitted records reviewed. (Patient #5) Findings include:	G 706		

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G 706	Continued From page 125 1. According to RN.com "Pain Assessment and Management" dated 12/31/2016, indicated " ... Pain is often referred to as the 'fifth vital sign,' and should be assessed regularly and frequently ... The assessment should include physical examination and the systems in relation to pain evaluation. Areas of focus should include site of the pain, musculoskeletal, and neurological system. Other components of history and physical assessment include: Patient's self-report of pain; Patient's behaviors and gestures that indicate pain; ... Specific aspects of pain: onset and duration, location, quality of pain [as described by the patient], intensity, aggravating and alleviating factors; Medication history; Disease or injury history; History of pain relief measures, including medications, supplements, exercise, massage, complementary and alternative therapies ... Functional and Psychosocial Assessment: ... Reports of patient's prior level of function; Observation of patient's behaviors while performing functional tasks; Patient or family's report of impact of pain on activities of daily living including work, self-care, exercise, and leisure; Patient's goal for pain management and level of function; Patient or family's report of impact of pain on quality of life; Cultural and developmental considerations; History of pain in relation to depression, abuse, psychopathology, chemical or alcohol use; Impact of pain on patient's cognitive abilities ... Pain management refers to the appropriate treatment and interventions developed in relation to pain assessment, and should be developed in collaboration with the patient and family...Pain management strategies include pharmacological and non-pharmacological approaches .... " 2. According to Nursing 2021 journal, when	G 706		

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documenting surgical incision site care, the professional journal states: " ... Document the anatomic location of the incision, including on which side of the body surgery was performed. Chart the length of the incision in centimeters and include the depth measurement whenever appropriate. Routine documentation helps you track healing. Note the appearance of the incision and surrounding skin. What does the site look like? Do you see erythema, edema, purulent drainage, or any other signs of infections? Provide detailed information if the site isn't healing well. If necrotic tissue appears, for example, you documentation should include when it appeared, who was notified, the interventions ordered and provided, and the patient's response to those interventions. Assess pain by having the patient routinely rate his pain intensity on a standard pain- scale. Indicate the type of materials used to keep the incision closed: sutures, staples or clips, retention sutures, or tape closure .... "

3. According to HHS article dated 11/11/07, "The Narcotic Bowel Syndrome: Clinical Features, Pathophysiology and Management" indicates " ... Potential Physiological Mechanisms for Pathological Pain Facilitation: It is recognized that morphine and other opiates act on opioid receptors in enteric neurons with a variety of GI [gastrointestinal] effects that includes reduced gastrointestinal and biliary motility and secretion producing nausea, vomiting, constipation, secondary intestinal pseudo-obstruction and gastroparesis [a condition that affects the stomach muscles and prevents proper stomach emptying] .... "

4. According to Nursing.connection.com dated

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2019, indicated " ... Nursing Considerations: Nurses are in an ideal position to identify patients at risk for constipation and to assess for signs and symptoms. Obtain the patient's health history, noting risk factors such as inadequate fluid intake, decreased mobility, and comorbid conditions. Assess the patient's diet, including fiber intake. Perform medication reconciliation, including the use of over-the-counter medications and herbal supplements. Look for anything that may contribute to constipation or be used for self-treatment, such as laxatives. Ask about the patient's oral health; changes in appetite; patterns of bowel movements; consistency, color, and size of the stool; seepage of stool; degree of straining during bowel movements; ignoring the urge to defecate; and nausea, vomiting, or other GI complaints. Ask about the patient living conditions ... eating or swallowing difficulties that may contribute to weight loss, changes in skin integrity [such as hemorrhoids, anal fissures, and skin ulcerations], and risk of falls in patient who use laxatives .... "

5. During the home visit for patient #5, Employee C asked the patient if she was having pain. The conversation got interrupted when a family member walked in, however, the patient talked about her pain issues throughout the visit. Towards the end of the visit, the physical therapist was asked about pain assessments, in which Employee C then asked the patient her pain level, however, Employee C failed adequately assess the patient's pain, such as inquiring about the frequency and severity of patient's pain and the effectiveness of current pain relief methods.

The clinical record for patient #5 was reviewed on 7/8/21. A review of skilled nursing (SN) visits

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for 6/25, 7/2, and 7/6/21, failed to evidence an assessment of patient's pain level using a measurable scale to assess level and frequency of pain, the efficacy of current pain relief methods and teaching for alternate methods of pain control, failed to evidence an assessment of patient's bowel status for possible constipation due to patient's use of pain medications after surgery and decreased mobility, and failed to evidence an assessment of patient's skin condition in relation to surgical incision site and surrounding wound area, for signs of infection (warmth, drainage,redness)

A review of a Physical Therapy (PT) note for 7/7/21, failed to evidence an assessment of patient pain level using a measurable scale to assess level and frequency, the efficacy of current pain relief methods and teaching for alternate methods of pain control, failed to evidence an assessment of patient's bowel status for possible constipation related to the use of pain medications and decreased mobility and failed to evidence an assessment of patient's right knee incision.

A review of a PT visit note on 7/8/21, failed to evidence an assessment of the patient's bowel status for possible constipation related to the use of pain medications and decreased mobility and failed to evidence an assessment of patient's right knee incision for indications of infection (increased warmth, drainage, redness).

During an interview on 7/7/21 11:30 AM, after patient 5's home visit, Employee C was queried about pain assessment, in which Employee C stated that generally she uses one of the pain scales.

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G 708	Development and evaluation of plan of care CFR(s): 484.75(b)(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); This ELEMENT is not met as evidenced by: Based on record review and interview, the skilled nurse failed to ensure the plan of care was developed with the patient and caregivers in 1 of 1 newly admitted patient records reviewed. (Patient #5) Findings include: The clinical record of patient #5 was reviewed on 7/8/21. The clinical record failed to evidence the document "Episode Manager" nor did the clinical record evidenced that the patient was informed verbally and in writing of the services and frequency of services to be provided. A review of the plan of care for the certification period 6/21/21 to 8/19/21, revealed the patient was receiving skilled nursing services 1 time a week and physical therapy services 2 times weekly. During a home visit on 7/7/21 at 10:10 AM, when asked to review the patient's admission packet, the patient provided two folders and stated the patient stated that on 6/21/21, the admission paperwork provided was difficult to read due to the faded ink but the agency provided a newer folder with readable documents on 7/6/21, the day prior to the surveyor home visit. A review of both folders verified the patient's statement. During another interview with patient #5 on 7/8/12 at 4:17 PM, when asked if she was informed of	G 708		

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G 708	Continued From page 130 her rights and if she was involved in the development of her plan of care, the patient stated that he/she and another family member asked the nurse what they were signing and the registered nurse informed them it was for billing and so the agency could take care of them. Patient #5 stated that they didn't have anything discussed with them about when people were coming or time of day. Patient #5 stated that they had no idea of what to expect.	G 708		
G 710	410 IAC 17-14-1(a)(1)(G) Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on record review and interview, the agency failed to provide occupational services as ordered in 1 of 1 record reviewed of a patient needing occupational therapy services. (Patient #5). Findings include: 1. A review of the clinical record for patient #5 on 7/8/21 revealed referral orders dated 6/8/21. The referral orders state " Please evaluate and treat for PT (physical therapy), OT (occupational therapy) and SN (skilled nursing) status post right total knee replacement." A plan of care for certification period 6/21/21 to 8/19/2021 failed to have orders for Occupational therapy. The record failed to evidence communication with the	G 710		

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G 710	Continued From page 131 physician for a change in occupational therapy orders. 2. During the interview on 7/12/21 at 2:00 PM, When asked about the OT orders and accepting the patient knowing they had no OT, the administrator stated she was aware that they accepted the patient knowing they needed the service. When asked if Physician D, the ordering physician was made aware, the administrator responded she notified the hospital case manager only. The clinical record failed to evidence any documentation about this conversation. When asked if she obtained an order to discontinue the request for OT, the administrator and clinical manager stated they did not.	G 710		
G 718	410 IAC 17-14-1(c) Communication with physicians CFR(s): 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; This ELEMENT is not met as evidenced by: Based on record review and interview, the physical therapist and clinical manager failed to ensure they communicated with the ordering physician when the start of care is delayed, inability to provide occupational therapy services, and failed to ensure clinicians notified the physician when there is a possible change in condition for 1 out of 1 newly admitted patient record reviewed. (Patient #5)	G 718		

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G 718	Continued From page 132 Findings include: 1. During a home visit on 7/7/2021 at 10:10 a.m., the patient's blood pressure was taken by Employee C, a physical therapist (PT). Employee C reported the patient's blood pressure as being 179/83 and the patient reported that was high for her. The therapist asked the patient if she was having pain and the patient reported she was having warmth at the incision site, even after icing her knee. The patient expressed she can only tolerate 15 minutes of exercise. The patient expressed numbness from her big toe to the side of her foot since surgery and neuropathy to her left knee from a past left knee replacement. The patient reported taking pain medications such as hydrocodone and Dilaudid and finished a coarse of Cephalexin (antibiotics). The patient #5 and a family member were discussing the delay of services and stated they had to go 3 weeks without therapy. Per the family member, they had expected someone to be there to do the admission on 6/9/21. The family member stated initially, when they called the agency to find out when they were coming to admit the patient, they were told that they had to run the patient's insurance and it would be a week. The family member stated they waited two weeks and called the agency back and a date/ time was set but then no one showed up. When they called the agency to inquire why no one showed up as scheduled, the agency told them the orders had been canceled. The family member stated no one canceled the orders. The family member stated they called the Person B, the case manager with Entity F and Physician D, the surgeon/ order physician to verify that no one canceled the home health services. The family member stated a nurse finally showed up on	G 718		

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6/21/21, however, they were told that physical therapy was on vacation and wouldn't be able to see the patient for another week.

The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021. The clinical record revealed a hospital discharge documents which revealed a diagnosis of right knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents revealed the patient received therapy post-operatively and was able to discharge home using a walker on 6/8/21. The referral and order for SN/PT/OT (Skilled Nurse/Physical Therapy/Occupational Therapy) was faxed to agency which has a time stamp that the agency received the fax on date and time of 6/8/21 at 11:51 AM.

The record revealed skilled nursing did not admit the patient until 6/21/21, which was 13 days after the referral was received.

Review of a skilled nursing visit note dated 7/6/21, the narrative note stated "He/she is very sore and PT is very difficult since it was started so late .... " The "visit plan - communication" indicated "No one contacted as a result of this visit."

The record failed to reveal evidence that the agency notified the physician that an occupational therapist was unavailable.

The record revealed the physical therapist evaluated the patient on 6/30/21, which was 9 days after the start of care and 22 days after the referral was received.

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A review of the physical therapy visit note for 7/7/21, failed to evidence the actual blood pressure taken and reported during the home visit and failed to evidence that the physician was notified of the patient's elevated blood pressure, complaint of continued warmth at the incision site after icing, and patient's stating she can only tolerate 15 minutes of exercise.

During an interview on 6/29/21 at 10:44 AM, when reviewing the entrance conference notes with the administrator, the administrator confirmed that the agency did not have an occupational therapist.

During an interview on 7/8/21 at 2:58 PM, when asked if the they had canceled the referral for home health services with Pure Home Health, Person B, a discharge case manager with Entity F, stated they did not cancel with Pure and has had many conversations with the agency. Person B indicated the agency wanted a face to face from Physician D and Person B had to educate the agency on what their face to face encounter looks like and it was tied into the order for home health services. Person B stated no one had sent patient #5's referral to another agency. Person B stated this agency was chosen because it was one of the few that would take this patient's insurance. The hospital case manager stated this was an ongoing issue with Pure Home Health for they have received multiple complaints from other families and other physicians who has ordered home health services with this agency and this agency's failure to start services timely after discharge.

On 7/8/21 at 1:28 PM, an Indiana Department of Health physician questionnaire was faxed to the

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ordering physician, Physician D. The document was returned to the surveyor on 7/16/21 and indicated Physician D was the primary care provider, the agency failed to notify the physician of their inability to admit the patient on or after 6/8/21, and failed to obtain orders to delay admission until 6/21/21. The document also indicated the physician's office was notified of the delay in admission by the patient's family member. The note went on to indicate that the physician was not made aware of the patient's pain level, warmth at the site, and increase blood pressure.

During an interview on 7/8/21 at 6:17 PM, Patient #5's family member, Person C, stated they had called the agency on 6/9/21 to inquire when someone would be out to start care. He was told that they were waiting on insurance verification. On 6/16/21 he had called again and was told that someone would be out on 6/18/21. When no one showed up he called the agency's office again was told that "someone" canceled the appointment. Per patient's son he told the office that no one from the family canceled the appointment and she needed home health. Person C was queried if Physician E is still patient 5's primary care physician. Person C stated the patient goes to Entity G, a county health clinic. Person C stated Physician E started there about one year ago and has never seen the patient. Physician D, the patient's surgeon, have been handling the patient's recent health issues because they related to his/her osteoarthritis.

During an interview on 7/12/21 at 2:00 PM, when asked why Patient #5's initial assessment/ admission occurred outside the 48 hours from the return home on 6/8/21 and referral, the

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G 718	Continued From page 136 administrator stated she called to talk to the hospital case manager, on 6/9/21 and was told at that time that the patient had been accepted by another home health company. When asked about the OT orders and accepting the patient knowing they had no OT, the administrator stated she was aware that they accepted the patient knowing they needed the service. When asked if Physician D, the ordering physician was made aware, the administrator responded she notified the hospital case manager only. The clinical record failed to evidence any documentation about this conversation. When asked if she obtained an order to discontinue the request for OT, the administrator and clinical manager stated they did not.	G 718		
G 940	410 IAC 17-14-1(a)(1)(G) Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished.	G 940		

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G 940	Continued From page 137 This CONDITION is not met as evidenced by: Based on record review, the Administrator failed to ensure they were responsible for the day to day operation of the home health agency in regards to incomplete documentation on comprehensive assessments and medication profiles, lack of individualization of care plans, coordination of care, and services being provided to meet the patient's needs, lack of competency, training, documentation, and services being provided beyond scope of practice, ensuring staff hired is qualified to provide services, an effective Quality Assessment Performance Improvement Program (QAPI), an effective Infection Control Program, and clinical records are complete and contain accurate information, legible signatures, dates, and correct spellings. (See G948); failed to ensure they had a pre-designated person, authorized in writing by the Administrator and Governing body, to assume the same responsibilities and obligations as the Administrator. (See G954); failed to ensure they had employed a Clinical Manager and/or a qualified Alternate Clinical Manager to provide oversight on making patient and personnel assignments, coordinating patient care, coordinating referrals, assuring that patient needs are continually assessed, and assuring the development, implementation, and updates of the individualized plan of care. (See G958); the Alternate Clinical Manager failed to ensure they documented their efforts in coordinating with all disciplines involved in a patients care for 1 (Patient #5) of 1 newly admitted patient record reviewed and failed to ensure the all disciplines coordinated care delivery to meet the patient's needs. (See G962); failed to ensure referrals received are appropriately reviewed to ensure the agency is able to meet the patient needs upon	G 940		

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G 940	Continued From page 138 admission and that there is no delay in services (G964); failed to ensure all patients received a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs. (See G966); failed to ensure they communicated/ collaborated with and received orders from the physician after the start of care evaluation or recertification visits. (See G968); failed to ensure all disciplines failed to follow professional standards when assessing a patient's pain, skin, and bowel status. (See G984). The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care.	G 940		
G 948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is not met as evidenced by: Based on record review, the Administrator failed to ensure they were responsible for the day to day operation of the home health agency in regards to incomplete documentation on comprehensive assessments and medication profiles, lack of individualization of care plans, coordination of care, and services being provided to meet the patient's needs, lack of competency, training, documentation, and services being provided beyond scope of practice, ensuring staff hired is qualified to provide services, an effective Quality Assessment Performance Improvement Program (QAPI), an effective Infection Control Program,	G 948		

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and clinical records are complete and contain accurate information, and an effective and updated Emergency Preparedness Program.

Findings include:

1. In regards to incomplete comprehensive assessment and medication reconciliation by Registered Nurses

Based on record review, and interview the agency failed to ensure the comprehensive assessments were completely filled out, accurately reflected the patients current health status and past medical history, failed to ensure assessments included patient's strengths, goals, and care preferences, failed to ensure assessments included the patient's medical, nursing, rehabilitative, social, and discharge planning needs, failed to ensure all medications were appropriately reconciled with the patient, health care representative, outside agencies and ordering physicians to ensure drug interactions and duplication is identified, failed to ensure a qualified clinical manager and alternate clinical manager were employed, failed to ensure a qualified alternate administrator was employed.

2. In regards to lack of individualized care planning, coordination of services, and quality of care

The Administrator failed to ensure they accepted patients on the reasonable expectation that they were able to meet pediatric patients nursing needs; failed to ensure services were provided per the plan of care and failed to ensure each patient received an individualized care plan that identified patient specific and measurable outcomes and goals that was periodically

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reviewed and signed by a physician; failed to ensure the individualized plan of care included all pertinent diagnoses, all supplies and equipment, specific frequency and duration of visits, nutritional requirements, all accurate medications and treatments, all safety measures to protect against injury, patient specific interventions, measurable outcomes and goals identified by the home health agency and patient; failed to ensure the plan of care was created in conjunction with the primary care physician after an assessment, verbal start of care and recertification orders obtained from the physician; failed to ensure verbal orders were complete and contained included duties/ services that the home health aides were to provide and the specific education the nurses were to educate to whom, and date and time of when orders when verbal orders were received; failed to ensure the physician was notified of the agency's inability to provide services; failed to ensure patients received all services, failed to ensure they communicated with the prescribing physician, and failed to ensure they coordinated care delivery to meet the patient's needs.

3. In regards to lack of qualified staff: The agency failed to ensure a clinical manager was responsible for all clinical care and activities, failed to ensure the alternate clinical manager was qualified and had sufficient knowledge of home health to meet patient needs and follow state and federal regulations for home health, and failed to ensure a qualified alternate administrator was available in the absence of the administrator.

4. In regards to an effective QAPI Program

The Administrator failed to ensure they

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implemented and maintained an effective Quality Assessment and Performance Improvement (QAPI) program, involved all agency services, utilized quality indicators data, including data from OASIS data, failed to focus on high risk, high volume, or problem prone areas, considered incidence, prevalence, and severity of problems in those area, take immediate corrective actions identified that could directly or potentially threaten the health and safety of patients; failed to ensure performance improvement projects analyze their causes and implemented appropriate actions and tracked the performance to ensure improvements are achieved; failed to ensure they conducted an annual performance improvement projects to ensure measurable progress has been achieved.

6. In regards to an effective Infection Control Program

The Administrator failed to ensure all staff followed standard precautions for patient care, including hand hygiene and disposal of trash, followed infection control and best practice guidelines for use of a clinical bag, and have a Covi-19 specific infection control plan.

The findings were reviewed with the administrator and alternate clinical manager on 7/14/21 at 3 PM. They had no further information or documentation to provide.

7. In regards to Discharge Summaries

The Administrator failed to ensure that they maintain a clinical record containing current and accurate information, as well as adhere to current clinical record documentation standards; failed to ensure an accurate and complete discharge

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G 948	Continued From page 142 summary was written. 8. In regards to the Emergency Preparedness Plan The Administrator failed to ensure an emergency preparedness plan included a documented, facility and community based risk assessment, including an all hazards approach, failed to include strategies for addressing emergency events identified by the risk assessment, failed to include a process for cooperation and collaboration with local, regional, state, and federal emergency preparedness officials, failed to develop and implement emergency preparedness policies and procedures, based on the agency's emergency plan. The agency failed to include individual plans for each patient as part of the comprehensive assessment, failed to include a process for the procedure to inform state and local emergency preparedness officials about agency patients in need of evacuation due to an emergency situation, failed to reflect the procedure 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 due to an emergency, failed to include a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records, failed to include a process for use of volunteers or other emergency staffing strategies, including integration of state of federally designated health care professionals, failed to maintain a communication plan that complied with federal, state, and local laws and was reviewed and updated at least annually, failed to maintain updated names and contact information for all staff, physicians, failed to	G 948		

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G 948	Continued From page 143 establish a primary and alternate means for communication with the agency's patients and their physicians, failed to establish a method for sharing information and medical documentation for patients, failed to establish a means of providing information about the general condition and location of patients, failed to establish a means of providing information about the agency's needs and ability to provide assistance, failed to update the training and testing program at least annually, including documentation of table top exercises, drills, emergency events, that included a group discussion and an analysis of the agency's response to in case the agency's emergency plan needed revised.	G 948		
G 954	410 IAC 17-12-1(c) 410 IAC 17-12-1(e) Ensures qualified pre-designated person CFR(s): 484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. This ELEMENT is not met as evidenced by: Based on record review and interview, the Administrator failed to ensure they had a pre-designated person, authorized in writing by the Administrator and Governing body, to assume the same responsibilities and obligations as the Administrator.	G 954		

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Findings include:

A review of the presurvey reports from the Indiana State Department of Health database, revealed Former Employee H resigned as the agency's Clinical Supervisor/ Manager and Alternate Administrator effective 7/5/19.

On 10/10/19, Former Employee I became the Clinical Supervisor/ Manager and Alternate Administrator until 11/1/20.

On 2/24/20, Former Employee J became the Alternate Clinical Supervisor/ Manager.

On 11/3/20, IDOH received a letter indicating Employee B became the Alternate Clinical Supervisor/ Manager effective 9/1/20, however on 11/4/20, IDOH sent the agency a request for additional information before Employee B would be accepted as the Alternate Clinical Supervisor/ Manager.

On 1/27/21, IDOH sent a 2nd letter to the agency requesting the additional information before Employee B would be accepted as the Alternate Clinical Supervisor/ Manager.

On 3/22/21, IDOH sent a 3rd letter to the agency requesting the additional documentation for Employee B in order to be accepted as the Alternate Clinical Supervisor/ Manager.

On 3/29/21, IDOH received a letter indicating to remove former Employee I from the Clinical Manager position effective 11/1/20. The letter also stated the agency has been recruiting for a Clinical Manager since 11/1/2019 but has not been successful. Former Employee I was also

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listed as the Alternate Administrator in IDOH database and was removed from that position as well.

On 5/27/21, IDOH sent a 3rd letter to the agency requesting the additional documentation for Employee B in order to be accepted as the Alternate Clinical Supervisor/ Manager.

On 6/28/21, IDOH received the requested documentation for Employee B, however the Criminal background checks was from 2019 and did not meet the State requirement of criminal background checks to be no later than 90 days from employment, therefore, Employee B was denied.

On 6/28/21 at 8:30 AM, surveyors arrived at the agency to conduct a recertification survey, however the office was not open and when a call was made to the office number on file, no one answered the phone. At 8:37 AM, Employee B opened the door and stated her "boss" was not there, she needed to be in the field to see patients, and she couldn't let the surveyors in the office. Employee B then stated she would have to call her "boss", closed the door and wouldn't let the surveyors in. At 8:40 AM, Employee B stated her "boss" wouldn't answer the phone. When asked what her position was, Employee B stated she was an RN liaison. Employee B went on to state that the agency didn't have a Clinical Manager and they only have 3 people working. Employee B stated she is working for everyone at this time and may have to get in her car to go to her "boss'" house to get her. When asked who was the alternate, Employee stated "I am but I am not" and further stated that "the documents have been sent in, I have been a nurse for 26 years,

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my "boss" broke her neck this summer, and this was a horrible time for you to come in." At 8:45 AM, Employee B stated she would try calling her "boss" again. At 8:55 AM, Employee B stated her "boss" was not answering the phone, and further stated "On Monday's, my boss comes in later and I come in early to answer to phone." Employee B went on to state that her "boss" takes calls on the weekends, and she knows that she is there on Monday mornings. Employee B stated she would call her "boss" husband. At 9:00 AM, Employee B stated "still no response to calls, [Name of Administrator] is the boss and she needs to be here. I can go and get her for she lives 10 minutes from the office." Employee B walked out the back doors while the surveyors stepped out the front doors, leaving the office unlocked. At 9:10 AM, Individual G came out the front doors and introduced himself as the Administrator's husband and stated the Administrator would be there shortly for she had to take her car into the dealership. Individual G led the surveyors to a conference room. At 9:25 AM, the Administrator arrived. During the entrance conference, when queried who was the individuals for Alternate Clinical Manager, Clinical Manager, Alternate Administrator, the Administrator stated they were all "pending" and stated IDOH was aware of the Alternate Clinical Manager, Employee B.

During an interview on 6/29/21 at 4:13 PM, the administrator stated she had been on an extended leave in February 2021, due to an injury, which occurred around February 2, 2021. When queried concerning who was the alternate administrator, the administrator stated she worked from home, and remained in contact with the alternate clinical administrator "constantly." When queried as to the availability of an alternate

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administrator and clinical manager, the administrator stated the alternate administrator and clinical manager were the same person previously, but that person was terminated August 2020. The administrator stated recruiting was ongoing on Indeed, Ziprecruiter, and Facebook but she has been unable to fill the positions so far.

On 7/2/21 at 4:12 PM, when queried as to who had access to the M-drive, the Administrator stated she was the only person who had access. When queried as to whether the alternate clinical manager had access to the M-drive, the administrator stated she was the only one with access. When queried as to how the alternate clinical manager accessed the policies if needed, the administrator stated the policies could be printed if needed. When queried as to what would happen if the administrator was not available, the administrator stated the agency was small, and the administrator and alternate clinical manager were constantly in touch with each other and were always present at the agency. When queried as to how that applied when the administrator was off for several weeks with a recent injury, the administrator had no further comment.

A review of the Indeed and and Zip Recruit website failed to evidence any active job needs for this agency. A review of the agency's Facebook webpage revealed arequest for an RN supervisor was 7/17/2019, a need for a "Director of Nursing (Clinical Manager) on 3/22/21, and a request for Administration Management on 5/12/21.

On 7/14/21 at 1:35 PM, the Governing Body

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G 954	Continued From page 148 minutes was requested, however, none was provided by the exit date on 7/14/21 at 7:24 PM. During an interview on 7/14/21 at 3 PM, the alternate clinical manager was queried concerning her ability to access the policies and procedures and her general understanding of home health care. The alternate clinical manager stated, "I'm just filling in right now. I'm just learning."	G 954		
G 958	410 IAC 17-12-1(c)(8) 410 IAC 17-12-1(d)(1-4) Clinical manager CFR(s): 484.105(c) Standard: Clinical manager. One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following-- This STANDARD is not met as evidenced by: Based on record review and interview, the Administrator failed to ensure they had employed a Clinical Manager and/or a qualified Alternate Clinical Manager to provide oversight on making patient and personnel assignments, coordinating patient care, coordinating referrals, assuring that patient needs are continually assessed, and assuring the development, implementation, and updates of the individualized plan of care. Findings include: Review of an agency policy titled "Director of Clinical Services Backup, policy A-130" evidenced "In compliance with established policy, in the event that the Director of Clinical Services is not	G 958		

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available, a designate, qualified alternate will assume his or her duties and responsibilities and be available to respond to emergencies. In the event that the Director of Clinical Services leave employment, the designated alternate will assume the Director's responsibilities until a replacement is hired and oriented.

A review of the presurvey reports from the Indiana State Department of Health database, revealed Former Employee H resigned as the agency's Clinical Supervisor/ Manager and Alternate Administrator effective 7/5/19.

On 10/10/19, Former Employee I became the Clinical Supervisor/ Manager and Alternate Administrator until 11/1/20.

On 2/24/20, Former Employee J became the Alternate Clinical Supervisor/ Manager.

On 11/3/20, IDOH received a letter indicating Employee B became the Alternate Clinical Supervisor/ Manager effective 9/1/20, however on 11/4/20, IDOH sent the agency a request for additional information before Employee B would be accepted as the Alternate Clinical Supervisor/ Manager.

On 1/27/21, IDOH sent a 2nd letter to the agency requesting the additional information before Employee B would be accepted as the Alternate Clinical Supervisor/ Manager.

On 3/22/21, IDOH sent a 3rd letter to the agency requesting the additional documentation for Employee B in order to be accepted as the Alternate Clinical Supervisor/ Manager.

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On 3/29/21, IDOH received a letter indicating to remove former Employee I from the Clinical Manager position effective 11/1/20. The letter also stated the agency has been recruiting for a Clinical Manager since 11/1/2019 but has not been successful. Former Employee I was also listed as the Alternate Administrator in IDOH database and was removed from that position as well.

On 5/27/21, IDOH sent a 3rd letter to the agency requesting the additional documentation for Employee B in order to be accepted as the Alternate Clinical Supervisor/ Manager.

On 6/28/21, IDOH received the requested documentation for Employee B, however the Criminal background checks was from 2019 and did not meet the State requirement of criminal background checks to be no later than 90 days from employment, therefore, Employee B was denied.

On 6/28/21 at 8:30 AM, surveyors arrived at the agency to conduct a recertification survey, however the office was not open and when a call was made to the office number on file, no one answered the phone. At 8:37 AM, Employee B opened the door and stated her "boss" was not there, she needed to be in the field to see patients, and she couldn't let the surveyors in the office. Employee B then stated she would have to call her "boss", closed the door and wouldn't let the surveyors in. At 8:40 AM, Employee B stated her "boss" wouldn't answer the phone. When asked what her position was, Employee B stated she was an RN liaison. Employee B went on to state that the agency didn't have a Clinical Manager and they only have 3 people working.

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Employee B stated she is working for everyone at this time and may have to get in her car to go to her "boss'" house to get her. When asked who was the alternate, Employee stated "I am but I am not" and further stated that "the documents have been sent in, I have been a nurse for 26 years, my "boss" broke her neck this summer, and this was a horrible time for you to come in." At 8:45 AM, Employee B stated she would try calling her "boss" again. At 8:55 AM, Employee B stated her "boss" was not answering the phone, and further stated "On Monday's, my boss comes in later and I come in early to answer to phone." Employee B went on to state that her "boss" takes calls on the weekends, and she knows that she is there on Monday mornings. Employee B stated she would call her "boss" husband. At 9:00 AM, Employee B stated "still no response to calls, [Name of Administrator] is the boss and she needs to be here. I can go and get her for she lives 10 minutes from the office." Employee B walked out the back doors while the surveyors stepped out the front doors, leaving the office unlocked. At 9:10 AM, Individual G came out the front doors and introduced himself as the Administrator's husband and stated the Administrator would be there shortly for she had to take her car into the dealership. Individual G led the surveyors to a conference room. At 9:25 AM, the Administrator arrived. During the entrance conference, when queried who was the individuals for Alternate Clinical Manager, Clinical Manager, Alternate Administrator, the Administrator stated they were all "pending" and stated IDOH was aware of the Alternate Clinical Manager, Employee B.

During an interview on 6/29/21 at 4:13 PM, the administrator stated she had been on an extended leave in February 2021, due to an

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injury, which occurred around February 2, 2021. When queried concerning who was the alternate administrator, the administrator stated she worked from home, and remained in contact with the alternate clinical administrator "constantly." When queried as to the availability of an alternate administrator and clinical manager, the administrator stated the alternate administrator and clinical manager were the same person previously, but that person was terminated August 2020. The administrator stated recruiting was ongoing on Indeed, Ziprecruiter, and Facebook but she has been unable to fill the positions so far.

On 7/2/21 at 4:12 PM, when queried as to who had access to the M-drive, the Administrator stated she was the only person who had access. When queried as to whether the alternate clinical manager had access to the M-drive, the administrator stated she was the only one with access. When queried as to how the alternate clinical manager accessed the policies if needed, the administrator stated the policies could be printed if needed. When queried as to what would happen if the administrator was not available, the administrator stated the agency was small, and the administrator and alternate clinical manager were constantly in touch with each other and were always present at the agency. When queried as to how that applied when the administrator was off for several weeks with a recent injury, the administrator had no further comment.

A review of the Indeed and and Zip Recruit website failed to evidence any active job needs for this agency. A review of the agency's Facebook webpage revealed arequest for an RN

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G 958	Continued From page 153 supervisor was 7/17/2019, a need for a "Director of Nursing (Clinical Manager) on 3/22/21, and a request for Administration Management on 5/12/21. On 7/14/21 at 1:35 PM, the Governing Body minutes was requested, however, none was provided by the exit date on 7/14/21 at 7:24 PM. During an interview on 7/14/21 at 3 PM, the alternate clinical manager was queried concerning her ability to access the policies and procedures, whether she contacted the physician after a comprehensive assessment, and her general understanding of home health care. The alternate clinical manager stated, "I'm just filling in right now. I'm just learning."	G 958		
G 962	410 IAC 17-12-1(d) Coordinate patient care CFR(s): 484.105(c)(2) Coordinating patient care, This ELEMENT is not met as evidenced by: Based on record review and interview, the Alternate Clinical Manager failed to ensure they documented their efforts in coordinating with all disciplines involved in a patients care for 1 (Patient #5) of 1 newly admitted patient record reviewed and failed to ensure the all disciplines coordinated care delivery to meet the patient's needs. Findings include: 1. During a home visit on 7/7/21 at 10:10 AM,	G 962		

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Employee C obtained patient #5's blood pressure and reported the reading as being 179/83, in which the patient reported that was high for her. Employee C asked the patient if she was having pain and the patient reported she was having warmth at the incision site, even after icing her knee. The patient expressed she can only tolerate 15 minutes of exercise. The patient expressed numbness from her big toe to the side of her foot since surgery and neuropathy to her left knee from a past left knee replacement.

The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021. The clinical record contained hospital discharge documents which revealed a diagnosis of right knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents included an order from Physician D for SN/PT/OT (Skilled Nurse/ Physical Therapy/ Occupational Therapy) evaluation.

Review of the start of care comprehensive assessment dated 6/21/21. The visit plan/ communication section indicated "no one contacted as a result of this visit." The clinical record failed to evidence the admitting clinician notified the ordering physician to collaborate and develop the plan of care.

Review of a skilled nursing visit note dated 6/29/21, the visit plan/ communication section indicated "No one contacted as a result of this visit." The narrative note stated "A PT (physical therapist) also sees him/ her" however, PT has not been out to the home to initiate care at this time.

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On 6/30/21, Employee C conducted an evaluation visit to determine the patient's ongoing physical therapy needs.

Review of a skilled nursing visit note dated 7/2/21 and 7/6/21, the visit plan/ communication section indicated "No one contacted as a result of this visit."

Review of a skilled nursing visit note dated 7/6/21, the narrative note stated "He/she is very sore and PT is very difficult since it was started so late .... " The "visit plan - communication" indicated "No one contacted as a result of this visit."

A review of the physical therapy note dated 7/7/21, failed to evidence the elevated blood pressure and the pain assessment. The "visit plan - case communication" section asks if contacts were made as a result of the visit, in which Employee C answered "supervisor". However, the narrative note and clinical record failed to evidence if Employee C reported the patients continued pain and numbness, elevated blood pressure, or the patient's complaint of warmth at the incision site after icing to the administrator or the alternate clinical manager as well as failure to report these findings with the patient's physician.

A review of the physical therapy note dated 7/8/21, the "visit plan - case communication" section asks if contacts were made as a result of the visit, in which Employee C answered "supervisor". However, the narrative note and clinical record failed to evidence what was reported to the supervisor and which supervisor was spoken to (administrator or alternate clinical

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G 962	Continued From page 156 manager). 2. During an interview with the alternate clinical manager and administrator 7/13/21 at 4:38 PM, the alternate clinical manager was queried as to how often the agency conducted IDG (Interdisciplinary Group) meetings. The alternate clinical manager stated the meetings were monthly. When queried "Can I have the minutes?" the alternate clinical manager did not initially answer, then stated, "I'll have to find them." When queried as to the date of the most recent IDG meeting, the alternate clinical manager and administrator stated they did not know the date. When queried as to who participated in the IDG meetings, the alternate clinical manager stated, "The clinicians." On 7/14/21 at 1:35 PM, the alternate clinical manager submitted 19 documents titled "Case Conference Note", dated between 6/14/21 and 6/17/21, which evidenced the patient's primary diagnosis and that patients liked their caregiver. On 7/14/21 at 3:45 PM, Employee F, a physical therapist, was interviewed as to whether the agency had regular IDG or case conference meetings to discuss patient care, progress, and services. The physicial theapy stated he had never particpated in any case conferences. On 7/14/21 at 4:20 PM, Employee G, a registered nurse, was interviewed as to whether the agency had regular IDG or case conference meetings to discuss patient care, progress, and services. The nurse stated that they did not conduct or participate in any case conferences.	G 962		
G 964	Coordinate referrals;	G 964		

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G 964	Continued From page 157 CFR(s): 484.105(c)(3) Coordinating referrals, This ELEMENT is not met as evidenced by: Based on record review and interview, the Alternate Clinical Manager failed to ensure referrals received are appropriately reviewed to ensure the agency is able to meet the patient needs upon admission and that there is no delay in services for 1 of 1 newly admitted patient record reviewed. (Patient #5) Findings include: During a home visit on 7/7/2021 at 10:10 a.m., patient #5 and a family member were discussing the delay of services and stated they had to go 3 weeks without therapy. Per the family member, they had expected someone to be there to do the admission on 6/9/21. The family member stated initially, when they called the agency to find out when they were coming to admit the patient, they were told that they had to run the patient's insurance and it would be a week. The family member stated they waited two weeks and called the agency back and a date/ time was set but then no one showed up. When they called the agency to inquire why no one showed up as scheduled, the agency told them the orders had been canceled. The family member stated no one canceled the orders. The family member stated they called the Person B, the case manager with Entity F and Physician D, the surgeon/ order physician to verify that no one canceled the home health services. The family member stated a nurse finally showed up on 6/21/21, however, they were told that physical therapy was on vacation and wouldn't be able to see the patient for another week.	G 964		

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G 964	Continued From page 158 The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021. The clinical record revealed a hospital discharge documents which revealed a diagnosis of right knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents revealed the patient received therapy post-operatively and was able to discharge home using a walker on 6/8/21. The referral and order for SN/PT/OT (Skilled Nurse/Physical Therapy/Occupational Therapy) was faxed to agency which has a time stamp that the agency received the fax on date and time of 6/8/21 at 11:51 AM. The record revealed skilled nursing did not admit the patient until 6/21/21, which was 13 days after the referral was received. The record failed to evidence that the agency informed the hospital that they did not have an occupational therapist on staff. The record revealed the physical therapist evaluated the patient on 6/30/21, which was 9 days after the start of care and 22 days after the referral was received. During an interview on 6/29/21 at 10:44 AM, when reviewing the entrance conference notes with the administrator, the administrator confirmed that the agency did not have an occupational therapist. However, on 7/14/21 at 4:01 PM, the administrator provider provided an active employee list from the Emergency Preparedness Plan which revealed the agency had 3 physical therapists and 1 occupational therapist on staff.	G 964		

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G 964	Continued From page 159 During an interview on 7/8/21 at 2:58 PM, when asked if the they had canceled the referral for home health services with Pure Home Health, Person B, a discharge case manager with Entity F, stated they did not cancel with Pure and has had many conversations with the agency. Person B indicated the agency wanted a face to face from Physician D and Person B had to educate the agency on what their face to face encounter looks like and it was tied into the order for home health services. Person B stated no one had sent patient #5's referral to another agency. Person B stated this agency was chosen because it was one of the few that would take this patient's insurance. The hospital case manager stated this was an ongoing issue with Pure Home Health for they have received multiple complaints from other families and other physicians who has ordered home health services with this agency and this agency's failure to start services timely after discharge. On 7/8/21 at 1:28 PM, an Indiana Department of Health physician questionnaire was faxed to the ordering physician, Physician D. The document was returned to the surveyor on 7/16/21 and indicated Physician D was the primary care provider, the agency failed to notify the physician of their inability to admit the patient on or after 6/8/21, and failed to obtain orders to delay admission until 6/21/21. The document also indicated the physician's office was notified of the delay in admission by the patient's family member. The note went on to indicate that the physician was not made aware of the patient's pain level, warmth at the site, and increase blood pressure.	G 964		

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G 964	Continued From page 160 During an interview on 7/8/21 at 6:17 PM, Patient #5's family member, Person C, stated they had called the agency on 6/9/21 to inquire when someone would be out to start care. He was told that they were waiting on insurance verification. On 6/16/21 he had called again and was told that someone would be out on 6/18/21. When no one showed up he called the agency's office again was told that "someone" canceled the appointment. Per patient's son he told the office that no one from the family canceled the appointment and she needed home health. Person C was queried if Physician E is still patient 5's primary care physician. Person C stated the patient goes to Entity G, a county health clinic. Person C stated Physician E started there about one year ago and has never seen the patient. Physician D, the patient's surgeon, have been handling the patient's recent health issues because they related to his/her osteoarthritis. During an interview on 7/12/21 at 2:00 PM, when asked why Patient #5's initial assessment/ admission occurred outside the 48 hours from the return home on 6/8/21 and referral, the administrator stated she called to talk to the hospital case manager, on 6/9/21 and was told at that time that the patient had been accepted by another home health company. When asked about the OT orders and accepting the patient knowing they had no OT, the administrator stated she was aware that they accepted the patient knowing they needed the service, however, they did report to the physician that they didn't have OT but she didn't document the discussion she had and didn't obtain an order to discontinue the request. When asked if they informed the physician of PT being delayed, the administrator and clinical manager stated they did not.	G 964		

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G 966	Assure patient needs are continually assessed CFR(s): 484.105(c)(4) Assuring that patient needs are continually assessed, and This ELEMENT is not met as evidenced by: Based on record review and interview, the Alternate Clinical Manager failed to ensure all patients received a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs in 3 of 5 active records reviewed. (Patients #3, 4, 5) Findings include: 1. Review of an undated agency policy titled "Initial and comprehensive Assessment, policy C-145" revealed "The assessment will be patient-specific and comprehensive to include the patient's need for home care, rehabilitative care, social, and discharge planning needs ... The comprehensive assessment shall reflect and determine: ... the patient's continuing need for home care...." and that the comprehensive assessment shall reflect and determine "Patient problems/needs/strengths; The patient's continuing need for home care; That the patient meets payment eligibility requirements ...; Patient prognosis; Patient care preferences; Baseline information to be used to measure the patient's progress ...; Plan of Care, including type of services, frequency, and duration; The ability of the organization to adequately meet the patient's medical, nursing, rehabilitation, social, and discharge planning needs ...." 2. Review of an undated agency policy titled "Client Discharge Process, policy C-500" revealed "Planning for discharge is provided as	G 966		

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G 966	Continued From page 162	G 966		

part of the ongoing assessment of needs. The client /family will participate in this process beginning with the initial assessment visit." and "Client's needs for continuing care to meet physical and psychological needs are identified ...."

3. Review of the clinical record for patient #3 revealed a form titled "Skilled Nursing Visit Note" dated 7/2/21 which evidenced a section titled "Discharge Plans - Not applicable". The patient's rehabilitative needs and prognosis were good, but failed to evidence what the needs were. The assessment failed to include a home health aide frequency or duration, or interventions the patient was currently receiving, and failed to evidence orders or collaboration with the clinician, patient, and physician concerning ongoing needs.

4. During a home visit on 7/2/21 at 2 PM, the patient stated she managed her own blood sugars and tested before meals using a glucometer. The patient reported a sliding scale for her insulin, and stated the dose increased by 1 unit if the blood sugar is greater that 150, 2 units if 151 - 200, 3 units if 201-250, 4 units if 251 - 300, 4 units if 301 - 350. The patient denied receiving instructions to notify the physician for high or low blood sugar. The nurse stated she was unaware of this sliding scale and "it didn't sound right." The patient stated she had frequent and severe migraines and received sample medications from the physician, and was receiving a monthly injection as well. The patient was unable to name any medications, including the injection. The patient's nurse was unaware of the medications but was aware that the patient had migraines.

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G 966	Continued From page 163	G 966		

Review of the clinical record for patient #4 revealed a referral which evidenced the following diagnosis: Cerebral infarction, unspecified, Type 2 diabetes mellitus without complications, Migraine, unspecified, Major depressive disorder, recurrent severe without psychiatric features, other idiopathic peripheral autonomic neuropathy, essential hypertension, other symptoms and signs with cognitive functions following other cerebral vascular disease, other symptoms and signs with cognitive functions following cerebral infarction, altered mental status, unspecified, feeding difficulties, other abnormalities of gait and mobility, unsteadiness on feet, other lack of coordination, cognitive communication deficit.

Review of a document titled "Recert OASIS (Recertification Outcome Assessment and Information Set), dated 5/31/21 at 11:30 AM revealed the assessment failed to include a complete and accurate assessment of the patient's health, psychosocial, functional, and cognitive status to accurately establish the patient's need for services. Discharge plans evidenced "Not addressed this visit. Patient needs post discharge: None at this time." Further discharge plans evidenced "When goals are met." An OASIS narrative note evidenced "This patient is very pleasant but somewhat cognitively impaired due to CVA(Cerebral Vascular Accident). She is also a brittle diabetic and on a treatment regiment. [sic] She knows when to take her medications, what they are for, but is unable to prefill a pill container by herself. I go weekly to fill her medications and have her work with me to hopefully be able to fill her medication by herself. It will take a lot of teaching to accomplish this goal." The narrative failed to be consistent with the assessment and the assessment failed to

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G 966	Continued From page 164 evidence why the patient required a pill set up it she was independent, understood and took all medications, and what her ongoing needs were. 5. On 7/14/21 at 3:30 PM, the alternate clinical manager was interviewed concerning patient #4. The alternate clinical manager agreed that the patient's migraines and brittle diabetes were not accurately and completely assessed on the comprehensive assessment. When queried concerning the needs of patients #3 and #4, the alternate clinical manager agreed the assessments were incomplete for both patients, and stated the patients had ongoing needs and would not be discharging so there was no discharge planning. When queried as to when discharge planning should start, the alternate clinical manager stated "when they are close to discharge." 6. The clinical record for patient #5, start of care (SOC) 6/21/21, was reviewed on 7/8/21. The record contained a start of care comprehensive assessment dated 6/21/21, in which the "Visit plan - Discharge Planning" section indicated "Not addressed this visit. Patient needs post discharge: None at this time." A review of skilled nursing visit notes for patient #5, dated 6/25/21, 7/2/21, and 7/6/21, revealed the section titled "Discharge Planning / Coordination of Continued Care, Treatment or Services" indicated "was not addressed at this visit" and "Patient needs post discharge" indicated "None at this time."	G 966		
G 968	Assure implementation of plan of care CFR(s): 484.105(c)(5)	G 968		

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G 968	Continued From page 165 Assuring the development, implementation, and updates of the individualized plan of care. This ELEMENT is not met as evidenced by: Based on record review and interview, the Alternate Clinical Manager failed to ensure they communicated/ collaborated with and received orders from the physician after the start of care evaluation or recertification visits for 3 of 5 active patients reviewed. (Patients #3, 4, 5) Findings include: 1. Review of a policy titled "Plan of Care, policy c-580" revealed "Home care services are furnished under the supervision and direction of the client's physician ... the Plan of care is based on a comprehensive assessment and information provided by the client/family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that the client needs are et, and will be updated as necessary, bat at least every sixty (60) days." The policy evidenced a purpose "To assure that the plan meets state/federal guidelines, and all applicable laws and regulations." The policy failed to evidence that the physician must be contacted after the comprehensive assessment so that findings could be reviewed and further orders obtained to develop the plan of care. 2. Review of the clinical record for patient #3 revealed a document titled " Skilled Nursing Visit Note - POC (Plan of Care) Recertification" dated 7/2/21, which failed to evidence the clinician contacted the physician to review findings and obtain orders for continued care and service.	G 968		

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G 968	Continued From page 166	G 968		

3. Review of the clinical record for patient #4, titled "Recert OASIS (Recertification Outcome Assessment and Information Set), dated 5/31/21 at 11:30 AM which failed to evidence the clinician contacted the physician to review findings and obtain orders for continued care and service.

4. During an interview with the administrator and alternate clinical manager on 7/12/21 at 2:00 PM, the alternate clinical manager was queried concerning the agency policy for obtaining orders for the plan of care. The alternate clinical manager stated she obtains orders before going to complete the comprehensive assessment start of care or recertification, which are used to complete the patient's plan of care. She stated she does not contact the physician's office after the assessment is completed.

5. The clinical record of patient #5 chart, Start of Care (SOC) 6/21/21, was reviewed on 7/8/2021. The clinical record contained hospital discharge documents which revealed a diagnosis of right knee primary osteoarthritis and the patient had a right total knee replacement on 6/7/21. The discharge documents included an order from Physician D for SN/PT/OT (Skilled Nurse/Physical Therapy/Occupational Therapy) evaluation.

Review of the start of care comprehensive assessment dated 6/21/21. The visit plan/ communication section indicated "no one contacted as a result of this visit." The clinical record failed to evidence the admitting clinician notified the ordering physician to collaborate and develop the plan of care.

A review of the "Home Health Care Certification

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and Plan of Care" for the certification period of 6/21/21 to 8/19/21, revealed Physician E as the primary physician and not Physician D, the ordering physician. The clinical record failed to evidence any documentation that they collaborated with physician D.

On 7/8/21 at 1:28 PM, an Indiana Department of Health physician questionnaire was faxed to the ordering physician, Physician D. The document was returned to the surveyor on 7/16/21 and indicated Physician D was the primary care provider, and that they did not give the agency approval to notify or obtain orders from the patient's primary care physician, Physician E in regards to the care of the patient right knee.

During an interview on 7/8/21 at 6:17 PM, Person C was queried if Physician E is still patient 5's primary care physician. Person C stated the patient goes to Entity G, a county health clinic. Person C stated Physician E started there about one year ago and has never seen the patient. Physician D, the patient's surgeon, has been handling the patient's recent health issues because they are related to his/her osteoarthritis.

During an interview on 7/12/21 at 2:00 PM, when asked who is the physician for establishing the plan of care, the administrator answered "patient's primary care physician". When asked if she called the ordering physician, Physician D, upon the patient's admission to establish/ collaborate on the development for the plan of care, the alternate clinical manager stated she had not.

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G 968	Continued From page 168 410 IAC 17-14-1(a)(1)	G 968		
G 984	In accordance with current clinical practice CFR(s): 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. This ELEMENT is not met as evidenced by: Based on observation, record review, and interview, the Alternate Clinical Manager failed to ensure all disciplines failed to follow professional standards when assessing a patient's pain, skin, and bowel status in 1 of 1 newly admitted records reviewed. (Patient #5) Findings include: 1. According to RN.com "Pain Assessment and Management" dated 12/31/2016, indicated " ... Pain is often referred to as the 'fifth vital sign,' and should be assessed regularly and frequently ... The assessment should include physical examination and the systems in relation to pain evaluation. Areas of focus should include site of the pain, musculoskeletal, and neurological system. Other components of history and physical assessment include: Patient's self-report of pain; Patient's behaviors and gestures that indicate pain; ... Specific aspects of pain: onset and duration, location, quality of pain [as described by the patient], intensity, aggravating and alleviating factors; Medication history; Disease or injury history; History of pain relief measures, including medications, supplements, exercise, massage, complementary and alternative therapies ... Functional and Psychosocial Assessment: ... Reports of patient's prior level of function; Observation of patient's	G 984		

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behaviors while performing functional tasks; Patient or family's report of impact of pain on activities of daily living including work, self-care, exercise, and leisure; Patient's goal for pain management and level of function; Patient or family's report of impact of pain on quality of life; Cultural and developmental considerations; History of pain in relation to depression, abuse, psychopathology, chemical or alcohol use; Impact of pain on patient's cognitive abilities ... Pain management refers to the appropriate treatment and interventions developed in relation to pain assessment, and should be developed in collaboration with the patient and family...Pain management strategies include pharmacological and non-pharmacological approaches .... "

2. According to Nursing 2021 journal, when documenting surgical incision site care, the professional journal states: " ... Document the anatomic location of the incision, including on which side of the body surgery was performed. Chart the length of the incision in centimeters and include the depth measurement whenever appropriate. Routine documentation helps you track healing. Note the appearance of the incision and surrounding skin. What does the site look like? Do you see erythema, edema, purulent drainage, or any other signs of infections? Provide detailed information if the site isn't healing well. If necrotic tissue appears, for example, you documentation should include when it appeared, who was notified, the interventions ordered and provided, and the patient's response to those interventions. Assess pain by having the patient routinely rate his pain intensity on a standard pain- scale. Indicate the type of materials used to keep the incision closed: sutures, staples or clips, retention sutures, or

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G 984	Continued From page 170 tape closure .... " 3. According to HHS article dated 11/11/07, "The Narcotic Bowel Syndrome: Clinical Features, Pathophysiology and Management" indicates " ... Potential Physiological Mechanisms for Pathological Pain Facilitation: It is recognized that morphine and other opiates act on opioid receptors in enteric neurons with a variety of GI [gastrointestinal] effects that includes reduced gastrointestinal and biliary motility and secretion producing nausea, vomiting, constipation, secondary intestinal pseudo-obstruction and gastroparesis [a condition that affects the stomach muscles and prevents proper stomach emptying] .... " 4. According to Nursing.connection.com dated 2019, indicated " ... Nursing Considerations: Nurses are in an ideal position to identify patients at risk for constipation and to assess for signs and symptoms. Obtain the patient's health history, noting risk factors such as inadequate fluid intake, decreased mobility, and comorbid conditions. Assess the patient's diet, including fiber intake. Perform medication reconciliation, including the use of over-the-counter medications and herbal supplements. Look for anything that may contribute to constipation or be used for self-treatment, such as laxatives. Ask about the patient's oral health; changes in appetite; patterns of bowel movements; consistency, color, and size of the stool; seepage of stool; degree of straining during bowel movements; ignoring the urge to defecate; and nausea, vomiting, or other GI complaints. Ask about the patient living conditions ... eating or swallowing difficulties that may contribute to weight loss, changes in skin integrity [such as hemorrhoids, anal fissures, and	G 984		

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skin ulcerations], and risk of falls in patient who use laxatives .... "

5. During the home visit for patient #5, Employee C asked the patient if she was having pain. The conversation got interrupted when a family member walked in, however, the patient talked about her pain issues throughout the visit. Towards the end of the visit, the physical therapist was asked about pain assessments, in which Employee C then asked the patient her pain level, however, Employee C failed adequately assess the patient's pain, such as inquiring about the frequency and severity of patient's pain and the effectiveness of current pain relief methods.

The clinical record for patient #5 was reviewed on 7/8/21. A review of skilled nursing (SN) visits for 6/25, 7/2, and 7/6/21, failed to evidence an assessment of patient's pain level using a measurable scale to assess level and frequency of pain, the efficacy of current pain relief methods and teaching for alternate methods of pain control, failed to evidence an assessment of patient's bowel status for possible constipation due to patient's use of pain medications after surgery and decreased mobility, and failed to evidence an assessment of patient's skin condition in relation to surgical incision site and surrounding wound area, for signs of infection (warmth, drainage,redness)

A review of a Physical Therapy (PT) note for 7/7/21, failed to evidence an assessment of patient pain level using a measurable scale to assess level and frequency, the efficacy of current pain relief methods and teaching for alternate methods of pain control, failed to evidence an assessment of patient's bowel status

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G 984	Continued From page 172 for possible constipation related to the use of pain medications and decreased mobility and failed to evidence an assessment of patient's right knee incision. A review of a PT visit note on 7/8/21, failed to evidence an assessment of the patient's bowel status for possible constipation related to the use of pain medications and decreased mobility and failed to evidence an assessment of patient's right knee incision for indications of infection (increased warmth, drainage, redness). During an interview on 7/7/21 11:30 AM, after patient 5's home visit, Employee C was queried about pain assessment, in which Employee C stated that generally she uses one of the pain scales.	G 984		
E 000	Initial Comments An Emergeny Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 102 for a Home Health Provider and Suppliers. Survey Date: 6/28/21 - 7/14/21 Facility #: 012680 Provider #: 157645 Medicaid #: 201083120 At this Emergency Preparedness survey, Pure Home Health Care, LLC was found to be out of compliance with Conditions of Participation 484.102 Emergency Preparedness requirements for Medicare Participating Providers and	E 000		

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E 000	Continued From page 173 Suppliers, including staffing and the implementation of staffing during a pandemic.	E 000		
E 001	Quality Review Completed on 8/16/21 by Area Establishment of the Emergency Program (EP) CFR(s): 484.102 §403.748, §416.54, §418.113, §441.184, §460.84, §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	E 001		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157645	A. BUILDING _____ B. WING _____	07/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PURE HOME HEALTH CARE LLC	1531 W OAK STREET ZIONSVILLE, IN 46077

(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
E 001	Continued From page 174	E 001		

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:
This CONDITION is not met as evidenced by:
Based on record review and interview, the agency failed to ensure an emergency preparedness plan included a documented, facility and community based risk assessment, including an all hazards approach, failed to include strategies for addressing emergency events identified by the risk assessment, failed to include a process for cooperation and collaboration with local, regional, state, and federal emergency preparedness officials, failed to develop and implement emergency preparedness policies and procedures, based on the agency's emergency plan. The agency failed to include individual plans for each patient as part of the comprehensive assessment, failed to include a process for the procedure to inform state and local emergency preparedness officials about agency patients in need of evacuation due to an emergency situation, failed to reflect the procedure 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 due to an emergency, failed to include a system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the

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E 001	Continued From page 175	E 001		

availability of records, failed to include a process for use of volunteers or other emergency staffing strategies, including integration of state of federally designated health care professionals, failed to maintain a communication plan that complied with federal, state, and local laws and was reviewed and updated at least annually, failed to maintain updated names and contact information for all staff, physicians, failed to establish a primary and alternate means for communication with the agency's patients and their physicians, failed to establish a method for sharing information and medical documentation for patients, failed to establish a means of providing information about the general condition and location of patients, failed to establish a means of providing information about the agency's needs and ability to provide assistance, failed to update the training and testing program at least annually.

Findings include:

1. Review of the agency's emergency preparedness plan revealed a document titled "Emergency Preparedness Plan" which evidenced an outline and instructions for the agency's plan should an emergency occur. The plan evidenced on admission, the staff will assign each patient a priority code that dictates the patient's emergency rating. "The code will be the colors Red (highest priority) ... Yellow (moderate priority) ... Green (low priority) ...." Review of the clinical records for active patients #3, 4, 5, 6, 7 and discharged patients #1, 2 failed to evidence any code was assigned or the code was assigned at admission. The document evidenced "If phone lines are down, listen to radio station _____ [blank space]." but failed to give the radio station

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E 001	Continued From page 176	E 001		

used. The document listed instructions for the safety officer, information officer, liaisons officer, operations officer, planning and intelligence officer, logistics, and finance/administration but failed to identify who those individuals were. The document evidenced "If a patient is injured or needs transport, contact the Operations Officer for arrangements to be made through the county emergency planners ..." but failed to list the name of the officer, the number to call, or who were the emergency planners. Further review evidenced potential hazards such as earthquake and tornado but failed to include a plan specific to Covid-19 and failed to give instructions specific to each hazard. The plan included a document titled "Patient Emergency Preparedness Plan", however, review of the clinical records in 3 home visits for patients 3, 4, 5 failed to evidence a copy of the plan in the patient's home. A review of a document titled "Pure Home Health Emerging Infectious Diseases (EID) Addendum" evidenced a plan for general preparedness but failed to include instructions specific to Covid-19. The agency emergency preparedness plan failed to include plan for staffing during an emergency, including staffing and the implementation of staffing during a pandemic, policy for utilizing volunteers during an emergency, failed to include updated phone lists for employees and staff, and also failed to include lists for city, county, state, and federal numbers for emergency assistance and contact.

The agency failed to provide any documentation of table top exercises, drills, emergency events, that included a group discussion and an analysis of the agency's response to in case the agency's emergency plan needed revised.

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E 001	Continued From page 177 During an interview on 6/29/21 at 10:44 AM, when reviewing the entrance conference notes with the administrator, the administrator confirmed that the agency did not have an occupational therapist. However, on 7/14/21 at 4:01 PM, the administrator provider provided an active employee list from the Emergency Preparedness Plan which revealed the agency had 3 physical therapists and 1 occupational therapist on staff. On 7/14/21 at 3 PM, the administrator was queried concerning the agency emergency preparedness plan and stated this was the complete plan and there was no further information available.	E 001		