STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200852690A	A. BUILDING B. WING	07/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SERVANT'S HEART HOME HEALTH SERVICES	1714 DIVIDEND DRIVE, LOGANSPORT, IN, 46947

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: July 5, 6, 7, 8, and 11, 2022 Census: 23 At this Emergency Preparedness survey, Servant s Heart Home Health Services was found to have been in compliance with the Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers at 42 CFR 484.102. QA: A2 7/22/22	E0000	This plan of correction is a representation of Servants Heart Home Health Services, Inc.'s commitment to provide quality care to our patients and of our efforts to comply with federal regulations. Submission of this plan of correction does not constitute an admission by Servants Heart Home Health Services, Inc that the allegations contained in this survey report are a true and accurate portrayal of the provision of our services, nor does it represent an admission of the allegations of the deficiencies in this survey.	2022-08-10
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Relicensure survey of a Provider in conjunction with 1 complaint investigation. Survey Dates: July 5, 6, 7, 8, and 11, 2022	G0000	This plan of correction is a representation of Servants Heart Home Health Services, Inc.'s commitment to provide quality care to our patients and of our efforts to comply with federal regulations. Submission of this plan of correction does not constitute an admission by Servants Heart Home Health Services, Inc that the allegations contained in this survey report are a true and accurate portrayal of the provision of our services, nor does it represent an admission of	2022-08-10

	Complaint #: 31900 - Unsubstantiated: Federal and state deficiencies, unrelated, were cited. Census: 23 QA: A 2 7/22/22 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. During this Federal Recertification Survey, Servant s Heart Home Health Services was found to be out of compliance with Conditions of Participation 42 CR 484.60 Care planning, coordination of care and quality of care and 42 CFR 484.70 Infection Prevention and Control. Based on the Condition-level deficiencies during the 07/11/2022 survey, the home health agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 07/06/2022 at 2:37 PM. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, the agency is precluded from operating or being the site of a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning 07/11/2022 and continuing through 07/10/2024.		the allegations of the deficiencies in this survey.	
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet	G0570	Deficiency ID: G-0570 CORRECTIVE ACTION TAKEN: A nursing in-service regarding the Plan of Care will be provided to all nurses with a required completion date of 08/04/2022. (See Attachment D	2022-08-04

	the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review, and interview, the home health agency failed to ensure the plan of care included all pertinent diagnoses, a medication list with clear directions for administration for topical medication and indications for as needed medications, and parameters for contacting the physician for high or low vital signs (See Tag G574). Based on record review and interview, the home health agency failed to obtain physician orders prior to administering medications, treating wounds, and providing skilled nursing and home health aide services (See G580). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.60 Care planning, coordination, and quality of care.		- Agenda for Nurse's Staff Meeting) The in-service will include the necessity of having all the following elements in each Plan of Care: 1. All pertinent diagnoses 2. Medication list with clear directions for administration for topical medication and indications for all as needed (PRN) medications 3. Parameters for contacting the physician for high or low vital signs when indicated 4. Physician orders prior to administering medications, providing wound care, performing treatments, and providing skilled nursing and home health aide services. (Ensure all verbal orders are followed up with the physician or NP's signature.) Frequency must be ordered for all treatments (i.e., catheterizations, tube feedings, residual checks, etc.) 5. A statement indicating that "the next care period will be (starting date through ending date of next care period) and the patient will continue to receive services through those	

			dates unless discharge notice is sent." This will ensure that we have obtained a signed order to assess and re-certify the patient prior to the start of the next care period while we are waiting for the physician to sign the new Plan of Care. 6. All services provided should be noted on the Plan of care whether done through respite waiver, PA, private pay, or any payor source should be included on the Plan of Care. Each payor source and duration/frequency of services must be on the Plan of Care. Nurses will be instructed to check the patient's expiration dates for all medications at least once a month and more often as indicated. This includes medications that are to be administered in an emergency for seizures, low blood sugar, etc. This medication check should be documented in the narrative section of the patient's chart and confirmed by signing the medication profile monthly in the patient's chart. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be	

done on all patients starting 08/04/2022 by the QAPI Committee with the Administrator, DON, and ADON giving oversight to the audits. Charts will be monitored for all the above-mentioned elements being noted in every Plan of Care.

This audit will continue monthly for 3 months (through 11/04/2022) and evaluated during a QAPI meeting which is scheduled on that date. The QAPI Committee will evaluate the effectiveness of this plan based on trends identified. The QAPI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of patient POC's will continue until no further negative trends are identified for a period of 3 months.
After this 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area.

PERSON(S) RESPONSIBLE FOR

			The Administrator, Clinical Manager, and Alternate Clinical Manager will give oversight to this plan of correction to ensure no further deficiencies in this area occur.	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge;	G0574	Deficiency ID: G-0574 CORRECTIVE ACTION TAKEN: A nursing in-service regarding the Plan of Care will be provided to all nurses with a required completion date of 08/04/2022. (See Attachment D - Agenda for Nurse's Staff Meeting) This in-service will include the necessity of having all the following elements in each Plan of Care: 1. All pertinent diagnoses 2. Medication list with clear directions for administration for topical medication and indications for all as needed (PRN) medications 3. Parameters for contacting the physician for high or low vital signs when indicated 4. Physician orders prior to administering medications,	2022-08-04

	(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to ensure the plan of care included all pertinent diagnoses, a medication list with clear directions for administration for topical medication and indications for as needed medications, and parameters for contacting the physician for high or low vital signs, for 3 of 4 active records reviewed of patients receiving skilled nursing services (Patients #1, 2, and 3). Findings include: 1. An agency policy #C-580, titled Plan of Care, indicated but was not limited to Policy: Home care services are furnished under the supervision and direction of the client s physician & Special Instructions: & 2. The Plan of Care shall be completed in full to include: a. All pertinent diagnosis(es) & l. Medications & t. Other appropriate items &. 2. An agency policy #C-705, titled Medication Management, indicated but was not limited to & Medication Orders & 1 & A complete medication order must include: & d. Special instructions for the use of the drug ... 2. Parameters for using PRN [as needed] medications including amount and frequency and any other time limitations &. 3. The review of Patient #1 s clinical record was completed on 07/08/2022 and included a plan of care [POC] for the recertification period of 06/29/2022 08/27/2022. The POC indicated a start of care date of 01/05/2021, patient diagnoses included, but not limited to, post traumatic seizures and hypoglycemia (low blood sugar), and included orders for skilled		performing treatments, and providing skilled nursing and home health aide services. (Ensure all verbal orders are followed up with the physician or NP's signature.) Frequency must be ordered for all treatments (i.e., catheterizations, tube feedings, residual checks, etc.) 5. A statement indicating that "the next care period will be (starting date through ending date of next care period) and the patient will continue to receive services through those dates unless discharge notice is sent." This will ensure that we have obtained a signed order to recertify the patient's services prior to the start of the next care period while we are waiting for the physician to sign the new Plan of Care. 6. All services provided should be noted on the Plan of care whether done through respite waiver, PA, private pay, or any payor source should be included on the Plan of Care. Each payor source and duration/frequency of services must be on the Plan of Care. Nurses will be instructed to	

	nursing services for 8 hours per day, 3 days a week for 1 week, and 8 hours per day, 5 days a week for 8 weeks. The POC indicated nursing interventions included monitor safety, [signs and symptoms] of impending seizure or hypoglycemia & For Blood sugars below 50, [nurse] to & call for emergency assistance as needed." The POC failed to evidence call parameters for high or low vital signs (basic measurements of body function, including blood pressure, heart rate, temperature, respiratory rate, and oxygen saturation (SpO2)) and high blood sugar levels, to direct when the agency nurse was to contact / alert the physician. A home visit observation was conducted on 07/06/2022 at 7:15 AM with Patient #1 and Licensed Practical Nurse (LPN) #1. During the visit, the patient obtained his own blood pressure, used an automatic blood pressure cuff, heart rate and oxygen saturation using an SpO2 monitor, temperature using a thermometer, and blood sugar using a home glucose monitor, and the nurse obtained the patient s respiratory rate through listening to the patient s lung sounds. LPN #1 reported the patient preferred to obtain his own vital signs, and the nurse would record them each day. 4. The review of Patient #2 s clinical record was completed on 07/07/2022 and included a POC for the recertification period of 06/13/2022 08/11/2022. The POC indicated a start of care date of 09/12/2016, diagnoses included, cerebral palsy, gastrostomy (surgically created opening into stomach), scoliosis (curving of the spine), and sleep apnea (condition where a person stops breathing for short intervals during sleep), and included orders for skilled nursing services for 4-8 hours per day for 5 days a week and a maximum of 60 respite skilled nursing hours per month to be used, as requested. The POC indicated nursing interventions included straight catheterization (temporary insertion of tube through urethra into bladder to drain urine, then remove tube) every 6 hours and monitor use of Triology 100 [ventilator] & when patient is asleep. The POC included parameters for a low oxygen saturation but failed to evidence high or low		check the patient's expiration dates for all medications at least once a month and more often as indicated. This includes medications that are to be administered in an emergency for seizures, low blood sugar, etc. This medication check should be documented in the narrative section of the patient's chart and confirmed by signing the medication profile monthly in the patient's chart. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all patients starting 08/04/2022 by the QAPI Committee with the Administrator, DON, and ADON giving oversight to the audits. Charts will be monitored for all the above-mentioned elements being noted in every Plan of Care. This audit will continue monthly for 3 months (through 11/04/2022) and evaluated during a QAPI meeting which is scheduled on that date. The QAPI Committee will evaluate the effectiveness of this plan based on trends identified. The QAPI Committee will adjust the plan if negative trends are	

	call parameters for other vital signs. The POC included medication orders, but not limited to, compression vest (percussion therapy administered to decrease secretions) twice a day and stated, can be done total of 3 4 [times were day] if needed, Desitin cream (used as a protective barrier to treat and prevent skin issues) to be applied topically (directly onto skin) as needed (PRN), Glycerin suppository (given to treat constipation) once a day as needed, Senna syrup (given to treat constipation) twice a day if second dose needed, acetaminophen (over-the-counter pain and fever reducer medication) every 4 hours as needed, Benadryl (over-the-counter allergy medication) every 4 hours as needed, Cetirizine (over-the-counter allergy medication) once a day, give two times a day if needed, dicyclomine (given to treat abdominal cramping) 4 times a day as needed, DuoNeb (given to treat shortness of breath or wheezing) 4 times a day as needed, Fleet Enema (given to treat constipation) once a day as needed, ibuprofen (over-the counter pain medication) every 6 hours as needed, and Polyethylene Glycol (given to treat constipation) daily or two times a day if needed. The POC failed to evidence directions on where to apply Desitin cream, failed to evidence indications for the administration for the as needed medications, Desitin, Glycerin, acetaminophen, Benadryl, dicyclomine, DuoNeb, Fleet Enema, and ibuprofen, and failed to evidence indications for administering additional doses of the compression vest, Senna syrup, Cetirizine, and Polyethylene Glycol. A home visit observation was conducted on 07/06/2022 at 8:30 AM with Patient #2 and Registered Nurse (RN) #1. During the visit, RN #1 reported the straight catheterization procedure was ordered to be done every 4 - 6 hours and they typically performed the procedure twice during an 8 hour shift. The nurse was observed administering medication to treat constipation due to slow bowel motility, GERD (Gastro-Esophageal Reflux Disease, the backflow of stomach acid into the		identified, and additional months of close observation and monitoring of patient POC's will continue until no further negative trends are identified for a period of 3 months. After this 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The Administrator, Clinical Manager, and Alternate Clinical Manager will give oversight to this plan of correction to ensure no further deficiencies in this area occur.	

	care failed to evidence the frequency of straight catheterization, as reported by the nurse and failed to evidence diagnoses for the medications administered by RN#1. 5. The review of Patient #3 s clinical record was completed on 07/08/2022 and included a plan of care for a recertification period of 06/04/2022 08/02/2022. The plan of care indicated a start of care date of 12/06/2021, patient diagnoses included but were not limited to Chronic Obstructive Pulmonary Disease (COPD, a long term lung disease) and high blood pressure, and included orders for skilled nursing for 1 visit per week for 1 week and 3 visits per week for 8 weeks and home health aide services for 3 visits per week for 9 weeks. The plan of care indicated skilled nursing tasks were to include [Nurse] to provide full body assessment including SpO2 and report and concerns [sic] or negative findings. The plan of care failed to evidence call parameters for high or low vital signs. 6. An interview with the Administrator and Chief Financial Officer #1 was conducted on 07/08/2022 at 2:05 PM. During the interview, the Administrator confirmed the plan of care should include all pertinent diagnoses and a medication list with instructions for administration of topical medications and indications for administration of as needed medications. The Administrator reported the plan of care should only include vital sign call parameters if a physician had indicated specific parameters. The Administrator reported the agency did not have a set standard of vital sign call parameters in the case the physician did not specify the parameters. When asked how the nurse would know when to notify the physician if a vital sign was potentially high or low, the Administrator stated the nurse would notify the physician of any changes in condition that would warrant concern. 17-13-1(a)(1)(B) 17-13-1(a)(1)(C)(ix)			

	17-13-1(a)(1)(C)(xiii)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to obtain physician orders prior to administering medications, treating wounds, and providing skilled nursing and home health aide services for 3 of 5 active records reviewed (Patients #1, 2, 3, and 4). Findings include: 1. An agency policy #C-635, titled Physician s Orders, indicated but was not limited to Policy: All medications, treatments and services provided to clients must be ordered by a physician & Special Instructions: 1. When the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given & The order must include the date, specific order & and be sent to the physician for signature & 7. If the client or caregiver initiates changes that have been communicated to them by the physician, the nurse or therapist will write and date the order the day he/she is informed of the change &. 2. The review of Patient #1 s clinical record was completed on 07/08/2022 and included a plan of care for the recertification period of 06/29/2022 08/27/2022. The plan of care indicated a start of care date of 01/05/2021, patient diagnoses included but were not limited to post traumatic seizures and hypoglycemia (low blood sugar), and included orders for skilled nursing services for 8 hours per day, 3 days a week for 1 week, and 8 hours per day, 5 days a week for 8 weeks. The record included visit notes for respite skilled nursing visits conducted on 06/29/2022 and	G0580	Deficiency ID: G-0580 CORRECTIVE ACTION TAKEN: A nursing in-service regarding the Plan of Care will be provided to all nurses with a required completion date of 08/04/2022. (See Attachment D - Agenda for Nurse's Staff Meeting) This in-service will include the necessity of having all the following elements in each Plan of Care: 1. All pertinent diagnoses 2. Medication list with clear directions for administration for topical medication and indications for all as needed (PRN) medications 3. Parameters for contacting the physician for high or low vital signs when indicated 4. Physician orders prior to administering medications, providing wound care, performing treatments, and providing skilled nursing and home health aide services. (Ensure all verbal orders are followed up with the physician or NP’s signature.) Frequency	2022-08-04

	07/05/2022. The record failed to evidence an order for respite skilled nursing services. An interview was conducted on 07/08/2022 at 2:57 PM with the Administrator. During the interview, the Administrator confirmed Patient #1 s current plan of care or clinical record did not evidence an order for the patient s respite skilled nursing hours. 3. The review of Patient #2 s clinical record was completed on 07/07/2022 and included a plan of care for the recertification period of 06/13/2022 08/11/2022. The plan of care indicated a start of care date of 09/12/2016, patient diagnoses included but were not limited to cerebral palsy, gastrostomy (surgically created opening into stomach), and scoliosis (curving of the spine), and included orders for skilled nursing services for 4-8 hours per day for 5 days a week and a maximum of 60 respite skilled nursing hours per month to be used as requested. The plan of care also indicated the skilled nurse was to assess skin integrity for breakdown/irritation every visit. The record indicated respite skilled nursing hours were provided on 6/13/2022, 06/14/2022, 06/15/2022, and 06/16/2022. The record failed to evidence a verbal or written physician order for recertification was obtained until 06/17/2022. The record included a respite skilled nursing visit conducted on 06/13/2022 by Registered Nurse (RN) #1. The visit note indicated Patient #2 s skin around a G/J tube (gastrostomy-jejunostomy tube, surgically placed in the stomach and small intestine for feeding and draining) was excoriated. The record indicated the nurse reported the excoriation to the patient s caregiver/family member, who reported the excoriation was due to a disconnection of the G/J tube which led to stomach contents draining onto the area. RN #1 documented the area was cleansed and the nurse applied Triple Antibiotic Ointment (a cream available		must be ordered for all treatments (i.e., catheterizations, tube feedings, residual checks, etc.) 5. A statement indicating that “the next care period will be (starting date through ending date of next care period) and the patient will continue to receive services through those dates unless discharge notice is sent.” This will ensure that we have obtained a signed order to recertify the patient’s services prior to the start of the next care period while we are waiting for the physician to sign the new Plan of Care. 6. All services provided should be noted on the Plan of care whether done through respite waiver, PA, private pay, or any payor source should be included on the Plan of Care. Each payor source and duration/frequency of services must be on the Plan of Care. Nurses will be instructed to check the patient’s expiration dates for all medications at least once a month and more often as indicated. This includes medications that are to be administered in an emergency	

	treat infections of superficial skin wounds) and gauze to the area per request of Patient #2 s caregiver/family member. The record failed to evidence a verbal or written order for the medicated cream was obtained. The record included a respite skilled nursing visit conducted on 06/20/2022 by RN #2. The visit note indicated the nurse observed a new skin tear to Patient #2 s right elbow after the patient s percussion vest therapy. The note indicated RN #2 notified the patient s primary caregiver/family member, cleansed the wound, and applied Triple Antibiotic Ointment and a Band-Aid. The note also indicated during a doctor s visit later that same day, RN #2 notified Medical Provider #1 of the new wound and treatment provided, and the provider approved of the treatment. The record failed to evidence a signed written was later obtained to verify the verbal order received. 4. The review of Patient #3 s clinical record was completed on 07/08/2022 and included a plan of care for a recertification period of 06/04/2022 08/02/2022. The plan of care indicated a start of care date of 12/06/2021, included orders for home health aide services for 3 visits per week for 9 weeks, and indicated patient diagnoses included Chronic Obstructive Pulmonary Disease (COPD, a long term lung disease), high blood pressure, and high cholesterol. The record included a written order, dated 6/16/2022 and signed by Medical Provider #2, to evaluate and treat patient due to & pressure [wound] & of [right] buttock. The record included a new plan of care for an initial certification period of 06/17/2022 08/15/2022. The plan of care indicated a new start of care of 06/17/2022 and included orders for skilled nursing for 1 visit per week for 1 week and 3 visits per week for 8 weeks and home health aide services for 3 visits per week. The plan of care indicated Patient #3 s diagnoses included but were not limited to COPD, anxiety disorder, Stage 1 pressure ulcer (type of wound caused by prolonged pressure on a body part, classified as "stages" between 1-4; a Stage 1 pressure ulcer is reddened and does not blanch but has no open areas) to the		for seizures, low blood sugar, etc. This medication check should be documented in the narrative section of the patient's chart and confirmed by signing the medication profile monthly in the patient's chart. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all patients starting 08/04/2022 by the QAPI Committee with the Administrator, DON, and ADON giving oversight to the audits. Charts will be monitored for all the above-mentioned elements being noted in every Plan of Care. This audit will continue monthly for 3 months (through 11/04/2022) and evaluated during a QAPI meeting which is scheduled on that date. The QAPI Committee will evaluate the effectiveness of this plan based on trends identified. The QAPI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of patient POC's will continue until no further negative trends are identified for a period of 3	

	(wound is opened and layers of skin are affected) of the right buttock. The plan of care included wound care orders for the skilled nurse to cleanse [pressure ulcer] wounds with normal saline, pat dry with sterile gauze, and affix Optifoam border dressing [wound dressing] to affected area on buttock. The record failed to evidence a verbal or written order was obtained for the new plan of care, which included the new orders for skilled nursing visits and wound care. The record included visit notes for skilled nursing visits conducted by the Clinical Manager on 06/17/2022, 06/20/2022, 06/22/2022, 06/24/2022, 06/27/2022, and 07/01/2022. The visit notes indicated the nurse changed the patient s buttocks wounds without a physician order. The visit note dated 06/20/2022 indicated the assisted living facility s nurse wrote order for & calmoseptine [ointment available over-the-counter which acts as a moisture barrier and helps treat and prevent skin irritation] for the nurse practitioner to sign. The visit note dated 06/27/2022 indicated calmoseptine was applied to both buttock wounds but the record failed to evidence a verbal or written order for the ointment was obtained prior to administration. The record included a physician order dated 06/29/2022 and written by the Clinical Manager. The order indicated both buttocks wounds were to be treated and have dressing changes 3 times per week and the wound care included [cleanse] with wound cleanser, [pat] dry with sterile gauze and [cover] with Allevyn bordered foam [type of wound dressing]. The order also included wound care orders for a new abscess wound to the left hip. The order indicated the wound was to be packed with gauze, covered with ABD pads [type of wound dressing] and tape, and was to be changed ex [sic] times per week. The record failed to evidence the order was obtained verbally and failed to evidence the order was signed.		months. After this 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The Administrator, Clinical Manager, and Alternate Clinical Manager will give oversight to this plan of correction to ensure no further deficiencies in this area occur.	

	The record included a visit note for a skilled nursing visit conducted by the Clinical Manager on 07/01/2022. The note indicated the nurse provided wound care to both buttocks and the left hip wounds. An interview was conducted on 07/11/2022 at 2:41 PM with the Clinical Manager. During the interview, the Clinical Manager confirmed they did not obtain verbal or written orders for skilled nursing services or for the wound care to be provided to Patient #3 s buttocks and left hip wounds. The Clinical Manager reported the initial order for the home health agency to evaluate and treat the patient encompassed all subsequent orders and the nurse wrote the wound care treatment orders based on her clinical knowledge and experience. 5. The review of Patient #4 s clinical record was completed on 07/11/2022 and included a plan of care for the recertification period of 07/01/2022 08/29/2022. The plan of care indicated a start of care date of 04/27/2022, included orders for home health aide services 1 5 days per week as needed per caregiver s request for 9 weeks, and indicated patient diagnoses included but were not limited to vascular dementia and atrial fibrillation (irregular heart rhythm). The record indicated home health aide visits were conducted on 07/05/2022. The record failed to evidence a verbal or written order for recertification was obtained.			

	6. An interview with the Administrator and Chief Financial Officer #1 was conducted on 07/08/2022 at 2:05 PM. During the interview, the Administrator confirmed the agency s orders for recertification of services was obtained by receiving a physician-signed plan of care and the agency did not obtain verbal orders if the signed plan of care was not returned prior to the start of the new certification period. The Administrator reported a patient s initial order for services was considered the order for services until the patient was discharged. A follow up interview was conducted with the Administrator on 07/11/2022 at 2:10 PM. During the interview, the Administrator confirmed a verbal or written physician order should be obtained prior to administration of a medication or treatment. 17-13-1(a)(1)(B)			
G0680	Infection prevention and control 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. Based on record review and interview, the home health agency failed to develop policies and procedures regarding staff COVID-19 vaccination which included staff positions and roles for whom the COVID-19 vaccination was required, additional precautions	G0680	Deficiency ID: G-0680 CORRECTIVE ACTION TAKEN: Our infection control policy and procedure (see Attachment A - Policy and Procedure B401) was revised and updated with the mandatory COVID vaccine policy. This revision was approved by the Governing Body on 7/28/2022. (See Attachment C with signatures of the Governing Body's approval) A copy of this revised policy will be given to all employees no later than August 10, 2022. This policy requires all	2022-08-10

	for all staff not fully vaccinated for COVID-19 to mitigate the spread, a process for staff request and agency review of religious exemption to the COVID-19 vaccination requirement, and a process for tracking and securely documenting the status of fully vaccinated, partially vaccinated, medical or religious exempted, and temporary delayed vaccination status of all required staff (See G687). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.70.		employees to report and submit a written copy of their COVID vaccinations including any boosters received. If the employee requests an exemption for either medical or religious reasons, they must submit the appropriate exemption request. If the reason is medical, it must be substantiated with documentation signed and dated by a licensed practitioner. As of 07/2022, all staff members have either been fully vaccinated or have an exemption approved by the Administrator and the Alternate Administrator. PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: After July 28, 2022 all individuals being offered a position with the Agency, will be asked to provide proof that they are fully vaccinated. Individuals who cannot provide proof of Vaccination at time of hire will need to: - provide proof of having received a single dose COVID-19 Vaccine or the first dose of the Primary Vaccination	

			COVID-19 vaccine before they can start work; - provide proof of a need for a temporary delay due to clinical precautions and considerations as recommended by the CDC; - or request an exemption due to a Medical Contraindication or Disability or a Sincerely Held Religious Belief or Religious Practice. Any staff member who is not fully vaccinated will be required to complete a COVID screen on Axxess daily and prior to any contact with a patient as an additional precaution. Our agency will continue to maintain a list of Staff Members Vaccination Status. This list includes all Staff Members and documents: - Date of first vaccine dose - Date of second vaccine dose (if Staff Member received a multi-dose vaccine) - Date of Booster dose(s) received by Staff Member - Request for Delay for Clinical Precautions	

			- Date when individual may begin, or continue, pursuing becoming fully vaccinated - Request for Exemption for Medical or Religious Reasons - Basis for Exemption Request. Medical Contraindication, ADA or Sincerely Held Religious Beliefs - Date of Exemption Request (if one was submitted) - Status of Request and Date Exemption Request was Granted or Denied. a) Our agency will utilize this information to determine: - Percentage of Staff who are fully vaccinated - Percentage of Staff who are exempt - Percentage of Staff who are in the process of becoming fully vaccinated - Dates by which staff Members who have chosen to receive a multi-dose vaccine should have received their second dose. b) This list will ensure	

			timely follow up with staff, be stored securely, and maintained confidentially PERSON(S) RESPONSIBLE FOR THIS PLAN: The Administrator, Alternate Administrator and Alternate Clinical Manager	
G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and	G0687	**Deficiency ID: G-0680** **CORRECTIVE ACTION TAKEN: Our infection control policy and procedure (see attached Policy and Procedure B401) was revised and updated with the mandatory COVID vaccine policy. This revision was approved by the Governing Body on 7/28/2022. (See Attachment C with signatures of the Governing Body's approval)** **A copy of this revised policy will be given to all employees no later than August 10, 2022. This policy requires all employees to report and submit a written copy of their COVID vaccinations including any boosters received. If the employee requests an exemption for either medical**	2022-08-10

	(iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to		**or religious reasons, they must submit the appropriate exemption request. If the reason is medical, it must be substantiated with documentation signed and dated by a licensed practitioner.** **AnAny staff member who is not fully vaccinated will be required to complete a COVID screen on Axxess daily and prior to any contact with a patient as an additional precaution.** **AAs of 07/2022, all staff members have either been fully vaccinated or have an exemption approved by the Administrator and the Alternate Administrator.** **PREVENTION OF FUTURE DEFICIENCY IN THIS AREA:** **After July 28, 2022 all individuals being offered a position with the Agency, will be asked to provide proof that they are fully vaccinated. Individuals who cannot provide proof of Vaccination at time of hire will need to:** **provide proof of having received a single dose**	

	the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements;		**COVID-19 Vaccine or the first dose of the Primary Vaccination Series for a multi-dose COVID-19 vaccine before they can start work;** **provide proof of a need for a temporary delay due to clinical precautions and considerations as recommended by the CDC;** **or request an exemption due to a Medical Contraindication or Disability or a Sincerely Held Religious Belief or Religious Practice.** **Our agency will continue to maintain a list of Staff Members Vaccination Status. This list includes all Staff Members and documents:** **Date of first vaccine dose** **- Date of second vaccine dose (if Staff Member received a multi-dose vaccine)** **- Date of Booster dose(s) received by Staff Member** **- Request for Delay for Clinical Precautions**	

	(viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Based on record review and interview, the home health agency failed to develop policies and procedures regarding staff COVID-19 vaccination to include staff positions and roles for whom the COVID-19 vaccination was required, additional precautions for all staff not fully vaccinated for COVID-19 to mitigate the spread, a process for staff request and		**- Date when individual may begin, or continue, pursuing becoming fully vaccinated** **- Request for Exemption for Medical or Religious Reasons** **- Basis for Exemption Request. Medical Contraindication, ADA or Sincerely Held Religious Beliefs** **- Date of Exemption Request (if one was submitted)** **- Status of Request and Date Exemption Request was Granted or Denied.** **a) Our agency will utilize this information to determine:** **- Percentage of Staff who are fully vaccinated** **- Percentage of Staff who are exempt** **- Percentage of Staff who are in the process of becoming fully vaccinated**	

	COVID-19 vaccination requirement, and a process for tracking and securely documenting the status of fully vaccinated, partially vaccinated, medical or religious exempted, and temporary delayed vaccination status of all required staff, which had the potential to affect all patients and agency staff for 1 of 1 agency. Findings include: 1. An agency policy titled COVID-19 Infection Control Policy indicated but was not limited to 1 & Staff members will not be required to receive the COVID vaccine, but should maintain proper PPE [personal protective equipment, such as gloves, gowns, masks, etc] and infection control measures and complete the COVID screening questions daily on [electronic medical record (EMR) system] & If a staff member receives the COVID vaccine, they should notify the administrator for their health record. If a staff member has a medical or religious exemption reason for not taking the vaccine, this will be noted on their medical record by the administrator. If there is a medical reason for not having the vaccine, the staff member should have a copy of the vaccine medical exemption form completed by their physician &. The policy failed to evidence staff positions and roles for whom the COVID-19 vaccination was required additional precautions for all staff not fully vaccinated for COVID-19 to mitigate the spread, a process for staff request and agency review of a religious exemption to the COVID-19 vaccination requirement, and a process for tracking and securely documenting the status of fully vaccinated, partially vaccinated, medical or religious exempted, and temporary delayed vaccination status of all required staff. The policy also failed to evidence a date the policy was enacted by the agency. 2. A document titled Servant s Heart Home Health Services, Inc. Professional Advisory Board: Meeting Minutes October 2021, confirmed by the Administrator as the minutes from the agency s most recent governing body meeting, indicated but was not limited to & Infection control for Staff and Patients: & C.		**- Dates by which staff Members who have chosen to receive a multi-dose vaccine should have received their second dose.** **b) This list will ensure timely follow up with staff, be stored** **securely, and maintained confidentially** **PERSON(S) RESPONSIBLE FOR THIS PLAN:** **The Administrator, Alternate Administrator and Alternate Clinical Manager**	

	Vaccine mandate concerns have caused some staff members to have anxiety over losing their jobs versus refusing the vaccine. At this time we have no mandate in place and we are waiting to see if these mandates are enforced by CMS &. 3. An interview was conducted on 07/05/2022 at 2:42 PM with the Administrator. During the interview, the Administrator reported there was no formal process for staff request and agency review of COVID-19 vaccine religious exemptions. The Administrator reported staff wanting a religious exemption would tell her verbally they wanted a religious exemption and she documented this on the agency s vaccination log. The Administrator was unsure of the process for agency review of medical exemption for the COVID-19 vaccine, 4. An interview was conducted on 07/05/2022 at 4:18 PM with the Administrator who confirmed the governing body was responsible for reviewing and approving all new policies and any policy changes. The Administrator reported the governing body last reviewed the agency s COVID-19 Infection Control policy for updates regarding the vaccine mandate at the October 2021 meeting. The Administrator reviewed the meeting minutes from the October 2021 meeting but was unable to state where the review and approval of the policy changes was documented. The Administrator confirmed the agency had no other policies regarding COVID-19 or vaccination requirements of staff. The Administrator reported the agency had no additional precautions in place for non-vaccinated staff to mitigate the spread of COVID-19. The Administrator reported they were not familiar with the regulation requiring COVID-19 vaccination of agency staff or the regulation s requirements regarding agency policies and procedures on employee COVID-19 vaccination. 17-12-1(m)			

G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on record review and interview, the Registered Nurse (RN) failed to perform a complete comprehensive and skilled nurse visit assessment for 1 of 2 active pediatric patient records reviewed (RN #2). Findings include: 1. An agency policy #C-148, titled Pain Assessment/Management, indicated but was not limited to & Special Instructions: & 3. Pain is assessed on every home visit and documented & 4. The nurse & will use a standardized agency accepted pain assessment tool that evaluates the & severity (rating scale) [of pain] &. 2. An agency job description for the role of RN indicated but was not limited to & II & the registered nurse shall do the following: & h. Accept and carry out physician & orders & i. Assist the physician & in evaluating level of function &. 3. The review of Patient #5 s clinical record was completed on 07/11/2022 and included a plan of care for the recertification period of 06/22/2022 08/20/2022. The plan of care indicated a start of care date of 03/04/2020, patient diagnoses including but not limited to shaken infant syndrome, encephalopathy (disease resulting in impaired brain function), and other disorders of psychological development, and included orders for skilled nursing services of up to 8 hours per visit, 3 times a week for 1 week, then 5 times a week for 8 weeks, with a maximum limit of 45 hours	G0706	Deficiency ID: G-0706 CORRECTIVE ACTION TAKEN: A Nursing in-service regarding the Comprehensive Nursing Assessments and patient medication management will be given to all nursing staff on 8/4/2022. (See Attachment D - Agenda for Nurse's Staff Meeting) This in-service will include the following: 1. All nursing staff will be required to check medication expiration dates for their patients' medications at least once a month and more often as indicated. This includes medications that are not given regularly but as needed for adverse reactions or during an emergency (i.e., seizure medications, etc.) In the event that emergency medications are kept in the home, the location of the medication and proper storage guidelines will be identified and documented. This medication check should be documented regularly in the narrative section of the patient's chart as well confirmed with the nurse's signature on Axxess for monthly signed medication	2022-08-04

	tasks were to include GT [G-tube, a tube surgically placed into the stomach for feeding and/or draining] feedings & and safety in the absence of [the primary caregiver]. The plan of care included parameters for MD notification for a high or low temperature, high or low pulse, high or low respiratory rate, and low oxygen saturation level. The record included a recertification comprehensive assessment completed on 06/20/2022 and skilled nurse visits completed on 06/27/2022, 06/28/2022, 06/29/2022, and 07/01/2022 by RN #2. The comprehensive assessment and visit notes failed to evidence an assessment of the patient s pain and the amount of tube feeding residual (volume remaining in the stomach after artificial feeding administered). The skilled nurse visit notes indicated the nurse assessed the patient s respiratory rate but failed to evidence the nurse assessed the patient s other vital signs (basic measurements of body function) of temperature, pulse, and oxygen saturation. An interview was conducted on 07/11/2022 at 1:45 PM with RN #2. During the interview, RN #2 reported there really isn t a way to assess Patient #5 s pain using a standardized pain rating scale. The nurse reported she assessed the patient for the presence or absence of pain by [paying] attention if giving physical cues & the way [the patient s] acting. The nurse reported Patient #5 had an order for as needed Tylenol for pain relief, but when asked how the nurse determined when to administer the medication, the nurse reported only if [the patient was] running a fever. RN #2 also reported she could only assess Patient #5 s respiratory rate, as the patient was not compliant with other vital sign assessments and Patient #5 s primary caregiver refused tube feeding residual checks. When asked if the primary caregiver s refusal of tube feeding residual checks was documented within the clinical record, RN #2 reported she was unsure. 4. An interview was conducted on 07/11/2022 at 2:10 PM with the Administrator. During the		profiles. 2. Nursing assessments must include vital signs or documentation when the patient defers having them done. This also applies to documenting residuals after tube feedings. If the patient or patient's POA does not want residuals checked or VS taken, this must be clearly noted on each assessment. 3. No areas of the nursing assessment should be left blank. Vital signs, pain assessments, and all other body system assessments must be addressed appropriately. If the patient does not want an area assessed, note that it was deferred by the patient on the assessment form. 4. Parameters regarding when to contact the physician will be noted for any vital signs that are indicated (i.e. SPO2 < 90% for patients who have COPD, temperature >100 for patients with high risk of infection, etc.). PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all patients starting	

	interview, the Administrator reported the agency had a standardized pain rating scale built in to the Electronic Medical Record (EMR) that all staff should complete with every visit. The Administrator reported Patient #5 s medical history prevents staff from using the standardized pain rating scale, so staff should use nonverbal cues such as crying or fussiness to assess if pain is present. The Administrator confirmed the presence or absence of the non-verbal cues should be documented by staff. The Administrator also reported tube feeding residual should be assessed as ordered by the physician and if the patient or caregiver refused this assessment, this should be documented in the record. The Administrator confirmed vital signs should be assessed and documented with every skilled nurse visit.		08/03/2022 by the QAPI Committee with the Administrator, DON, and ADON giving oversight to the audits. Charts will be monitored for medication profile information and all body systems assessed in Comprehensive Assessments. This audit will continue monthly for 3 months (through 11/03/2022). The QAPI Committee will evaluate the effectiveness of this plan based on trends identified. The QAPI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of patient charts will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR THIS PLAN: The nursing managers (the Administrator, Clinical Manager, and Alternate Clinical Manager) will give oversight to this plan of correction to ensure no	

			further deficiencies in this area occur.	
G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; Based on observation, record review, and interview, the Licensed Practical Nurse (LPN) failed to ensure all patient medications were not expired for 1 of 1 home visit observations of an agency licensed practical nurse (LPN #1). Findings include: 1. An agency policy #C-705, titled Medication Management, indicated but was not limited to & Program Specifics: & Medications in the home are reviewed with the client/family & All expired, damaged, or contaminated medications will be removed from the home & In the event that emergency medications are kept in the home, location of the medication and proper storage guidelines will be identified and documented &. 2. The review of Patient #1 s clinical record was completed on 07/08/2022 and included a plan of care for the recertification period of 06/29/2022 08/27/2022. The plan of care indicated a start of care date of 01/05/2021, patient diagnoses included but were not limited to post traumatic seizures and hypoglycemia (low blood sugar), and included orders for skilled nursing services for 8 hours per day, 3 days a week for 1 week, and 8 hours per day, 5 days a week for 8 weeks. The plan of care included nurse tasks and interventions included but were not limited to Hours to be provided while [patient s family member] is at work in order to keep [Patient #1] safe. [Skilled	G0710	Deficiency ID: G-0710 CORRECTIVE ACTION TAKEN: A Nursing in-service regarding the Comprehensive Nursing Assessments and patient medication management will be given to all nursing staff on 8/4/2022. (See Attachment D - Agenda for Nurse's Staff Meeting) This in-service will include the following: 1. All nursing staff will be required to check medication expiration dates for their patients' medications at least once a month and more often as indicated. This includes medications that are not given regularly but as needed for adverse reactions or during an emergency (i.e., seizure medications, etc.) In the event that emergency medications are kept in the home, the location of the medication and proper storage guidelines will be identified and documented. This medication check should be documented regularly in the narrative section of the patient's	2022-08-04

	& of impending hypoglycemia. Nurse to administer emergency medications & for blood sugars below 50, [skilled nurse] to give 1 [milligram subcutaneous] of Glucagon [medication given to increase blood sugar quickly] .... A home visit observation was conducted on 07/06/2022 at 7:15 AM with Patient #1 and Licensed Practical Nurse (LPN) #1. During the visit, a backpack with emergency medications and supplies was observed. LPN #1 reported the patient took the backpack whenever they were outside of the house in case of emergencies. One single-dose vial of Glucagon with an expiration date of 01/2021 was observed in the backpack. Patient #1 reported a refill was requested from the pharmacy yesterday when the patient and nurse discovered the medication was expired. 3. An interview was conducted on 07/06/2022 at 2:22 PM with the Administrator who confirmed the skilled nurse should periodically check all of Patient #1 s emergency medications to ensure there are no expired medications. 17-14-1(a)(1)(H)		chart as well confirmed with the nurse's signature on Axxess for monthly signed medication profiles. 2. Nursing assessments must include vital signs or documentation when the patient defers having them done. This also applies to documenting residuals after tube feedings. If the patient or patient's POA does not want residuals checked or VS taken, this must be clearly noted on each assessment. 3. No areas of the nursing assessment should be left blank. Vital signs, pain assessments, and all other body system assessments must be addressed appropriately. If the patient does not want an area assessed, note that it was deferred by the patient on the assessment form. 4. Parameters regarding when to contact the physician will be noted for any vital signs that are indicated (i.e. SPO2 < 90% for patients who have COPD, temperature >100 for patients with high risk of infection, etc.).	

			PREVENTION OF FUTURE DEFICIENCY IN THIS AREA: Monthly chart audits will be done on all patients starting 08/03/2022 by the QAPI Committee with the Administrator, DON, and ADON giving oversight to the audits. Charts will be monitored for medication profile information and all body systems assessed in Comprehensive Assessments. This audit will continue monthly for 3 months (through 11/03/2022). The QAPI Committee will evaluate the effectiveness of this plan based on trends identified. The QAPI Committee will adjust the plan if negative trends are identified, and additional months of close observation and monitoring of patient charts will occur until no further problems are identified for a period of 3 months. After a 3 month period of no negative trends being identified, the audits will continue quarterly for the next year to ensure no further problems have occurred in this area. PERSON(S) RESPONSIBLE FOR	

			The nursing managers (the Administrator, Clinical Manager, and Alternate Clinical Manager) will give oversight to this plan of correction to ensure no further deficiencies in this area occur.	
G0942	Governing body 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the governing body failed to ensure the agency adhered to its Medicare agreement to accept and bill Medicare-covered patients, which had the potential to affect all referred and current patients for 1 of 1 agency. Findings include: 1. An agency policy #B-100, titled Governing Body, indicated but was not limited to Policy: The Governing Body shall assume full legal authority and responsibility for the operation of Servant s Heart Home Health Services & Special Instructions: The duties and responsibilities of the Governing Body shall include: & Oversee the management and fiscal affairs of the agency. This shall include & organizational operations &. 2. The survey Entrance Conference was	G0942	**Deficiency ID: G-0942 -Governing Body** **CORRECTIVE ACTION TAKEN:** **On July 28, 2022 we obtained verification of written approval from the Governing Body to continue the hold on Medicare referrals. (See Attachment C.)** **PREVENTION OF FUTURE DEFICIENCY IN THIS AREA:** **We will report all referral sources and Medicare related information to our Advisory Board at every annual meeting and as needed to ensure that we adhere to all of our agreements and policies.** **PERSON(S) RESPONSIBLE FOR THIS PLAN: The Administrator, CFO, and Advisory Board Members**	2022-07-25

	the Administrator, Branch Manager #1, and Chief Financial Office (CFO) #1. During the conference, the Administrator reported the agency was certified by Medicare but the agency did not have any Medicare patients on their current census. 3. An interview was conducted on 07/06/2022 at 2:22 PM with the Administrator and CFO #1. During the interview, the Administrator reported the agency had attempted to provide home health services to Medicare patients, was unable to provide these services and remain financially viable, therefore decided in 2014 to no longer accept referrals for Medicare services. The Administrator relayed the agency did report their no utilization of Medicare benefits to their Medicare Administrative Contractor (MAC) yearly. 4. A letter dated 01/05/2021 written on agency letterhead, addressed to the agency s MAC and signed by the Administrator, indicated the agency notified the MAC there had been no utilization of Medicare during the last year and the agency had not had any Medicare patients for more than 3 years. 5. A follow-up interview was conducted on 07/08/2022 at 10:20 AM with the Administrator and CFO #1. During the interview, the Administrator confirmed if the agency received a referral for home care services, to be billed under Medicare, the agency would not accept the patient and would refer the patient to another agency. The Administrator and CFO #1 were unsure if any of their current patients were eligible for Medicare benefits. The Administrator stated if a patient was receiving home health services from Servant s Heart and started to receive Medicare home health services from another agency, Servant s Heart Home Health Services would discharge the patient. When asked if the agency had received any referrals for home care services to be billed to Medicare, the Administrator was unable to answer definitively. The Administrator confirmed the list of referred patients within the last 12		**We respectfully request an IDR for this citation.** **The survey letter states:** **“This STANDARD is NOT MET as evidenced by:** **Based on record review and interview, the governing body failed to ensure the agency adhered to its Medicare agreement to accept and bill Medicare-covered patients, which had the potential to affect all referred and current patients for 1 of 1 agency.”** **Additionally, the following segment of the survey letter (on page 22 states) “The Administrator stated the Governing Body had not discussed the agency’s inability accept Medicare patients since 2015.” This is an inaccurate quote. The Administrator stated that the Governing Body approved the decision to stop taking Medicare for several reasons during a meeting held on October 19, 2016. (Our agency was not able to remain viable if we continued to accept Medicare patients due to the many issues we had with reimbursement and**	

	months was not up-to-date. The Administrator stated the Governing Body had not discussed the agency s inability to accept Medicare patients since 2015. 6. The meeting minutes from the agency s Governing Body meetings held on 10/25/2019, 10/20202, and 10/2021, confirmed by the Administrator as the minutes from the agency s last 3 governing body meetings, were reviewed on 07/08/2022. The minutes failed to evidence the governing body discussed the agency s Medicare agreement and denial of all Medicare-insured patients to determine if the agreement terms were met. 7. The review of Patient #1 s clinical record was completed on 07/08/2022 and included a plan of care for the certification period of 06/29/2022 08/27/2022. The plan of care indicated a start of care date of 01/05/2021 and included orders for skilled nursing services for 8 hours per day, 3 days per week for 1 week then 8 hours per day, 5 days per week for 8 weeks. The record included a copy of a fax dated 10/27/2020 sent by the Administrator to Home Health Agency #2. The fax included a Coordination of Care for Facilities or Other Providers document, signed by the Administrator on 10/27/2020 and the clinical manager of Home Health Agency #1 on the same day, which indicated the agency was to provide skilled nursing services through Medicaid and Home Health Agency #2 was to provide physical therapy visits only through Medicare to Patient #1. The fax also included a copy of the agency s plan of care for the certification period of 10/18/2020 12/16/2020, which indicated a start of care of 07/05/2017. 17-12-1(b)(3)		**not receiving enough Medicare referrals to cover the cost of staffing services. At the time when we were providing Medicare services, we only received one or two referrals in a month, and most of them were from the VA. Our local hospital gave all the Medicare referrals to another agency unless the patient insisted on ours.) (See Attachment B - PAB minutes 10/19/2016) When the Administrator offered to submit the minutes from the PAB meeting when these issues were discussed, the surveyor stated it wasn't necessary. These minutes are now being submitted with this IDR response for your consideration. (See Attachment B)** **There is nothing in the CoPs or the SOM that addresses "adherence to the Medicare Provider Agreement" or a requirement to accept all Medicare beneficiaries. The issue of accepting Medicare patients or billing Medicare is a billing issue. CMS has directed MACs to deactivate a provider number that has not billed in 12 months. Not**	

			billing for patients in 12 months implies that the provider has not admitted a Medicare patient in that time. Servant's Heart's lack of Medicare patients is not a survey issue. It is an issue dealt with by Medicare contractors. The Medicare Program Integrity Manual specifically states, "The deactivation of Medicare billing privileges does not affect a provider/supplier's participation agreement." Medicare Program Integrity Manual, Chapter 10, Section 10.4.8.G. This directly contradicts the statement that we have violated our provider agreement. CMS has clearly stated that this billing issue will not impact our provider agreement/enrollment. Servant's Heart may be eligible to have its Medicare billing privileges deactivated, but this should not impact its certification or provider agreement. This issue is not properly addressed in a survey issue, because the Program Integrity Manual specifically states that the deactivation will not impact the provider agreement Therefore, this should not be	

			a survey/certification/enrollment issue and this tag should be removed.	

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

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