STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHWEST HOME HEALTH CARE INC	9011 INDIANAPOLIS BOULEVARD, SUITE B, HIGHLAND, IN, 46322

(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
N0000	Initial Comments This visit was a State Re-licensure Revisit Survey of a Home Health provider. Survey Dates: 8/11/2022, 8/12/2022, 8/15/2022, 8/16/2022, and 8/24/2022 Census: 32 active	N0000		2022-09-19
G0000	INITIAL COMMENTS This visit was a Post-Condition Revisit Survey for a Federal Recertification and State Re-licensure Survey of a Home Health provider. Survey Dates: 8/11/2022, 8/12/2022, 8/15/2022, 8/16/2022, and 8/24/2022 Census: 32 active This post-condition revisit survey found the home health agency to be in compliance with	G0000		2022-09-19

	Care Planning, Coordination of Services, Quality of Care. The post-condition revisit found 11 standards corrected and 5 standards re-cited. Based on the Condition-level deficiencies during the recertification survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your 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 7/5/2022 and continuing through 7/4/2024. These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Quality Review Completed 09/09/2022			
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 for a Home Health Provider and Suppliers. Survey Date: 8/11/2022, 8/12/2022, 8/15/2022, 8/16/2022, and 8/24/2022 At this Emergency Preparedness survey the home health agency was found to be in compliance with Conditions of Participation 42 CFR 484.102 Emergency Preparedness requirements for Medicare Participating Providers and Suppliers, including staffing and the implementation of staffing during a pandemic.	E0000		2022-09-19

G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review and interview, the home health agency failed to ensure all OASIS assessments were accurate to reflect information relevant at the time of discharge for 1 of 2 closed records, from a total sample of 5 clinical records reviewed. (#4) The findings include: Record review of an undated policy titled "Comprehensive Patient Assessment" retrieved on 8/24/2022, stated "... Purpose ... To identify patients medical, nursing, rehabilitative, social and discharge planning needs ... Special Instructions ... 3. In addition to general health status/system assessment, NORTHWEST HOME HEALTH CARE, INC. comprehensive assessment tool with OASIS will include: ... k. Medications ...." Clinical record review on 8/24/2022, for patient #4, start of care 6/2/2022, evidenced an agency document titled	G0374	**During the emergency meeting of GB on September17, 2022 the Administrator/ Director ofNursing discussed and reviewed regarding Policy on ComprehensivePatient Assessment and Medication Management.** **The clinician accurately encoded anddocumented the OASIS data that reflects on the patient's status at the time ofassessment on the Patients who were admitted; Resumed and Discharged with datestarted on August 24 , 2022 which required an Oasis that was reviewed.** **The clinician made sure to conduct acomplete Drug Regimen Reviewincluding Drug-Drug Interactions and reviewed identifypotential clinically significant medication issues upon admission,Recertification, Resumption of care, new/ change of medication duringDischarge.** **Medications were reviewed with the Physician, Patient/PCG for Potential adverse effects, Drug**	2022-09-19

	was signed by Registered Nurse (RN) #1 on 7/29/2022. This document had an area subtitled "Medications" which stated "(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/ recommended actions by midnight of the next calendar day each time potentially clinically significant medication issues were identified since the SOC/ROC [start of care/resumption of care]? … 9 – NA [not applicable] - - There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications…." Record review of an agency document titled "Drug-Drug Interactions" retrieved on 8/24/2022, evidenced a major drug interaction between gabapentin (medication used to treat seizures and nerve pain) and tramadol (opioid pain medication used to treat moderate to severe pain). The severity description stated "MONITOR CLOSELY: Concomitant use of opioids with gabapentinoids (e.g. gabapentin, pregabalin) may		**interactions, Ineffective drug therapy, Significant side effects, Significant interactions, Duplicate drug therapy and Non compliance with drug therapy. The agency contacted a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues.** **To prevent the deficiency from recurringin the future the Administrator/ Director of Nursing shallensure that the clinician shall conduct a complete DrugRegimen Review including Drug-Drug Interactions and review identify potential clinicallysignificant medication issues upon admission, Recertification,Resumption of care, new/ change of medication during Discharge and shall ensurethat agency contacted aphysician (or physician-designee) by midnight of the next calendar day andcomplete prescribed/recommended actions in response to the**	

	increase the risk of opioid overdose and serious adverse effects such as profound sedation, respiratory depression, syncope [temporary loss of consciousness], and death due to potentially additive depressant effects on the central nervous system ….” Record review failed to evidence the OASIS Discharge document identified a serious drug interaction. Record review failed to evidence the OASIS assessment reflected accurate information at the time of discharge. During an interview on 8/24/2022, at 3:26 PM, administrative staff #1 indicated the RN should have checked “Yes” instead of “NA” to the assessment question on the OASIS discharge assessment. .		**identified potentialclinically significant medication issues .The clinician shall accurately encode anddocument it in the OASIS data.** **The Administrator/ Director of Nursing conducted an In-service onSeptember 19, 2022 regarding Policy on Comprehensive Patient Assessment and Policy on Medication Managements.** **The Administrator/ Director of Nursing will be responsible forimplementing, maintaining and reinforcing these corrective actions to ensurethat these deficiencies are corrected and will not recur effective after theIn-Service meeting to all the staffs on September 19, 2022** **On September 19, 2022 The Administrator/ Director of Nursing/Clinical Manager made sure that the clinician shall accuratelyencode and document the OASIS data that reflects on the patient's status at thetime of assessment on 100 % of all active clinical records reviewed.**	

			(see attachments) **G0374 A1 – A3 :** **Policy Comprehensive Patient Assessment** **G0374 B1 – B7 :** **Policy on Medication Management** **G0374 C1 – C2 : GB meeting** **G0374 D1 – D2: Inservice**	
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the home health agency failed to ensure a functional assessment was completed in all comprehensive assessments for 1 of 2 closed records, from a total sample of 5 clinical records reviewed. (#4) The findings include: Record review of an undated policy titled "Comprehensive Patient Assessment" retrieved on 8/24/2022, stated "... Purpose ... To determine the appropriate care, treatment and	G0528	**During the emergency meeting of GB onSeptember 17, 2022 the Director of Nursing/ Administrator discussed andreviewed the Policy on Comprehensive Patient Assessment.** **The Director of Nursing/ Administratorshall ensure that the Clinician shall assess and document Musculoskeletalstatus . The patient's Functional status, Limitations and the patient's overallfunctional mobility will be included inthe comprehensive assessment and will be documented in the Oasis .** **The Director of Nursing/**	2022-09-19

	services to meet patient initial needs and his/her changing needs … To collect data about the patient's health history, (physical, functional, and psychological) and their needs as appropriate to the home care setting. To make care, treatment or service decisions based on information developed about each patient's needs and the individuals response to care … To identify patients medical, nursing, rehabilitative, social and discharge planning needs … Special instructions … 5. Functional status is assessed and documented using the OASIS [Outcomes and Assessment Information Set] data elements with NORTHWEST HOME HEALTH CARE, INC. specific assessment criteria ….” Clinical record review on 8/24/2022, for patient #4, start of care 6/2/2022, evidenced an agency document titled “OASIS-D1 Discharge” which was signed by Registered Nurse (RN) #1 on 7/29/2022. This document had an area subtitled “Functional Status” which stated “… Comments: SN [skilled nurse] reinforced safety/fall precautions. Patients overall		**In-service onSeptember 19, 2022 regarding Policy on Comprehensive Patient Assessment.** **The Director of Nursing/ Administrator will be responsible forimplementing, maintaining and reinforcing these corrective actions to ensurethat these deficiencies are corrected and will not recur effective after theIn-Service meeting to all the staffs on September 19, 2022 .**	

	functional mobility improved ….” Review failed to evidence a functional assessment to include, but not limited to, specifics such as poor balance, weakness, joint stiffness, or unsteady gait. Review failed to evidence the patient’s functional mobility was assessed. During an interview on 8/24/2022, at 2:46 PM, administrative staff #1 indicated functional mobility should be included in a comprehensive assessment. During an interview on 8/24/2022, at 3:26 PM, administrative staff #1 indicated the discharge narrative should have explained the functional status but would incorporate moving forward.		**On September 19,2022 the Administrator/Director of Nursing/Clinicalmanager made sure that the Clinician assessed and documented the Musculoskeletal status . The patient’sFunctional status, Limitations and thepatient’s overall functional mobility were included in the comprehensive assessmentand documented in the Oasis at Start ofcare; Recertification of care, Resumption of care and Discharge OASIS on datestarted on August 24 , 2022 which required an Oasis on 100 % of all active clinicalrecords reviewed.** **(See attachments)** **G0528 A1-A3: Policy onComprehensive Patient Assessment** **G0528 B1 – B2: GB meeting** **G0528 C1- C2 : Inservice**	

G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Deficiency corrected 07/19/2022 Deficiency corrected 07/19/2022	G0538	**This deficiency has beencorrected on July 19, 2022.** During the emergencymeeting of GB on September 17, 2022 the Director of Nursing/Administrator discussed and reviewed the Policy on Comprehensive PatientAssessment. The Director of Nursing/Administrator shall continue to ensure that the Clinician shall document theSupportive assistance of the patient which will include the names offamily/Caregiver/available support which includes their availability orschedule and ability/willingness to provide care and assume responsibility forhealthcare needs . This will be documented in the Oasis and Plan of Care underCaregiver status. The Director of Nursing/Administrator conducted an In-service on September 19, 2022 regardingPolicy on Comprehensive Patient Assessment which includes In addition togeneral health status/system assessment,	2022-09-19

			Northwest Home Health Care Inc.Comprehensive Patient assessment will include to document the Supportiveassistance of the patient which will include the names offamily/Caregiver/available support which includes their availability orschedule and ability/willingness to provide care and assume responsibility forhealthcare needs and to ensure that the corrected deficiency will not recur. The Director of Nursing/Administrator will be responsible for implementing, maintaining and reinforcingthese corrective actions to ensure that these deficiencies are corrected andwill not recur effective after the In-Service meeting to all the staffs onSeptember 19, 2022 . **OnSeptember 19, 2022 The Director of Nursing/ Administrator/Clinical manager continuedto ensure that the Clinician shall document the Supportive assistance of thepatient which will include the names of family/Caregiver/available supportwhich includes their**	

			availability or schedule and ability/willingness toprovide care and assume responsibility for healthcare needs on100 % of all active clinical records reviewed. (see attachments) G0538 A1– A3: Policy onComprehensive Patient Assessment G0538 B1 – B2 : **GB meeting** G0538 C1 – C2: Inservice	
G0564	Discharge or Transfer Summary Content 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 ensure the safe and effective transition of care.	G0564	**During the emergency meeting of GB on September17, 2022 the Director of Nursing/ Administrator discussed and reviewedthe Policy on Discharge and Transfer Summary.** **The Director of Nursing/ Administrator shall ensure that the Patient'sDischarge or**	2022-09-19

	Based on record review and interview, the home health agency failed to ensure a discharge summary was completed to include all pertinent diagnoses for 1 of 2 closed clinical records reviewed. (#5) The findings include: Record review of an undated policy titled "Discharge Summary" retrieved on 8/24/2022, stated "Policy ... A Discharge Summary will be completed for patients discharged from NORTHWEST HOME HEALTH CARE, INC ... Special Instructions: ... 4. The discharge summary will include date of discharge, patient identifying information ... diagnosis ... any instructions given to patient/family or responsible party ...." Clinical record review on 8/24/2022, for patient #5, start of care 12/8/2021, diagnoses included but were not limited to enlarged prostate, retention of urine, urinary tract infection (UTI), and Klebsiella pneumoniae (common gram-negative bacterium associated with UTI and pneumonia), evidenced an agency document titled "SN [skilled nurse] Discharge		**Transfer Summary shall have all necessary medical informationpertaining to the patient's current course of illness and treatment to thehealth care practitioner which includes pertinent diagnosis of the patientwhich were included and addressed with interventions documented in the plan ofcare.** **The Director of Nursing/ Administrator conducted an In-service onSeptember 19,2022 regarding Policy on Discharge and Transfer Summary.** **The Director of Nursing/ Administrator will be responsible forimplementing, maintaining and reinforcing these corrective actions to ensurethat these deficiencies are corrected and will not recur effective after theIn-Service meeting to all the staffs on September 19, 2022 .** **On September 19, 2022 The Director of Nursing/ Administrator/Clinicalmanage r ensured that the Discharge or Transfer Summary of the**	

	Summary" dated 8/3/2022. This document had an area which stated "REASON FOR ADMISSION TO HOME CARE: Patient is home bound and has medical condition requiring skilled assessment/observation and intervention. Patient has medical diagnosis of: Essential (primary) Hypertension (high blood pressure) … Other Diagnosis: …." This document failed to evidence diagnoses Klebsiella pneumoniae and UTI were communicated at discharge. Record review failed to evidence all pertinent diagnoses were documented at the time of patient's discharge. During an interview on 8/24/2022, at 2:48 PM, administrative staff #1 indicated the most recent and pertinent information should be included on the discharge summary. During an interview on 8/24/2022, at 3:19 PM, administrative staff #1 indicated they would want to include all diagnoses on the discharge summary and will make an addendum.		**Patient who aredischarged or transferred after August 24 , 2022 shall have all necessary medical information pertainingto the patient's current course of illness and treatment to the health carepractitioner which includes pertinent diagnosis of the patient which wereincluded and addressed with interventions documented in the plan of care on all 100% Discharge or Transfer clinicalrecords reviewed.** **This deficiency will be monitored using the Northwest Home Health CareDischarge and Transfer QA tool.** **(see attachments)** **G0564 A1 – A3:** **Policy on Discharge and Transfer Summary** **G0564 B1 – B2:** **Discharge and Transfer QATool** **G0564 C1 – C2:** **GB meeting**	

			G0564 D1 – D2 : Inservice	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the home health agency failed to ensure each patient received services that were written in an individualized plan of care to identify patient-specific measurable outcomes and goals for 1 of 1 clinical records reviewed where a home visit was conducted. (#1) The findings include: Record review of an undated policy titled "Plan of Care" retrieved on 8/24/2022, stated "... Purpose ... To provide guidelines for NORTHWEST	G0572	**During the emergency meeting conducted by GB on September 17, 2022, theDirector of Nursing/ Administrator discussed and reviewed the Policy on Plan ofcare.** **The Director of Nursing/ Administrator shall ensure that each patient admittedmust receive the home health services that are written in an individualizedplan of care that identifies patient-specific measurable outcomes and goals,and which is established, periodically reviewed, and signed by a doctor ofmedicine, osteopathy, or podiatry acting within the scope of his or her statelicense, certification, or registration; this individualized plan of care must be developed and completed by theadmitting clinician within 5 calendar days. If a physician or allowedpractitioner refers a patient under a plan of care that cannot be**	2022-09-19

	HOME HEALTH CARE, INC. staff to develop a plan of care individualized to meet specific patient needs ... Special Instructions 1. An individualized Plan of Care signed by a physician shall be required for each patient receiving home health and personal care service ... 2. The...Plan of Care shall be completed in full to include: ... j. All Medications, treatments, and procedures ... q. All patient care orders, including verbal orders, must be recorded in the plan of care ...." Clinical record review on 8/11/2022, for patient #1, start of care 8/3/2022, failed to evidence a plan of care for treatments and services to be provided by the agency. Record review evidenced the agency developed a plan of care 8 days after the start of care. During an interview on 8/11/2022, at 4:18 PM, administrative staff #1 was asked to provide the patient's plan of care in preparation for a home visit. Administrator #1 indicated the plan of care was not complete as the certification period just started recently.		**completeduntil after an evaluation visit, the physician or allowed practitioner isconsulted to approve additions or modifications to the original plan.** **The Director of Nursing/Administrator conducted an In-service on September19, 2022 regarding Policy on Plan of care.** **The Director of Nursing/ Administrator will be responsible forimplementing, maintaining and reinforcing these corrective actions to ensurethat these deficiencies are corrected and will not recur effective after theIn-Service meeting to all the staffs on September 19, 2022 .** **On September 19, 2022 The Director of Nursing/ Administrator/ClinicalManager ensured that the clinician has developed and completed an individualizedPlan of care for each patient receiving home health services on 100 % of all active clinical records reviewed.**	

	During an interview on 8/24/2022, at 2:44 PM, administrative staff #1 indicated clinicians would use the Plan of Care as a guide to know which tasks and treatments to provide to a patient.		**(See attachments)** **G0572 A1 – A3: Policy on Plan of care** G0572 B1 – B2 : GB meeting **G0572 C1 – C2: Inservice**	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and	G0574	**This deficiency has been corrected on July19, 2022.** During the emergencymeeting of GB on September 17, 2022 the Director of Nursing/Administrator discussed and reviewed the Policy on Plan of care. TheDirector of Nursing/ Administrator shall continue to ensure that a completePlan of Care formulated to include: All pertinent diagnosis(es), The patient'sMental status, psychosocial, and cognitive status, Type of services, supplies,equipment required , The frequency, and duration of all visits to made ,Prognosis , Rehabilitation potential , Functional limitations , Activities permitted , Specific dietary or nutritional requirements orrestrictions , All Medications, treatments, and procedures , Safetymeasures to protect	2022-09-19

	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. Deficiency corrected 07/19/2022. Deficiency corrected 07/19/2022		against injury. **The Director of Nursing/ Administratorconducted an In-service on September 19, 2022 regarding Policy on Plan ofcare and to make sure that the corrected deficiency will not recur on100 % of all active clinical records reviewed.** The Director of Nursing/Administrator will be responsible for implementing, maintaining and reinforcingthese corrective actions to ensure that these deficiencies are corrected andwill not recur . (see attachments) G0574 A1 – A3: Policy onPlan of Care **G0574 B1 – B2: GB meeting** **G0574 C1 – C2: Inservice**	
G0576	All orders recorded in plan of care	G0576	**This deficiency has been corrected on July19, 2022.**	2022-09-19

	484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Deficiency corrected 07/19/2022 Deficiency corrected 07/19/2022.		**During the emergencymeeting of GB on September 17, 2022 the Director of Nursing/Administrator discussed and reviewed the Policy on Plan of Care.** **The Director of Nursing/Administrator shall continue to ensure that the Clinician shall include all patient careorders, including verbal orders, must be recorded in the plan of care.** **TheDirector of Nursing/ Administrator shall continue to ensure that all patient ordersare recorded in the plan of care by the clinician. For any new or changes of anycare ,treatment , medications orders a verbal/telephone orders shall beobtained from the patient's physician .** **The Director of Nursing/Administratorconducted an In-service on September 19, 2022 regarding Policy on Plan ofCare and to ensure that the corrected deficiency will not recur on 100 %of all active clinical records reviewed.** **The Director of Nursing/Administrator will be responsible for implementing, maintaining and reinforcingthese corrective actions to ensure that these deficiencies are corrected andwill not recur.** **On September 19, 2022 the Director of Nursing/ Administrator/ClinicalManager continued to ensure that all patient care ,treatment, medicationorders are recorded in the plan of care. Verbal/telephone orders were obtainedfrom the patient's physician for new or any changes of care , treatment**	

			,medication orders and are documented on 100 % of all active clinical recordsreviewed. **(See attachments) for :** G0576 A1 –A3: **Policyon Plan of Care.** **G0576 B1 –B2: GB meeting** **G0576 C1 – C2: Inservice**	
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on observation, record review, and interview, the home health agency failed to ensure coordination of care was demonstrated by all clinicians for 1 of 1 clinical records reviewed where a home visit was conducted. (#1) The findings include: Record review of an agency policy titled "Certified Home Health Aide Services" effective	G0608	**During the emergency meeting of GB on September 17, 2022 theDirector of Nursing/ Administrator discussed and reviewed the Policy onCoordination of Patient Services and Certified Home Health Aide Services .** **The Director of Nursing/ Administratorshall ensure that the Home health aide shall observe, report and document thepatient's status and shall coordinate with the Nurse or Director ofNursing/Clinical Manger the following:refusal of care; red or broken skin; no bm greater than 3**	2022-09-19

	1/13/2018, stated "Policy: To ensure that Certified Home Health Aide services are provided to patients by competent home health aides based on their job description ... Procedure: ... 4. The following items are part of the competency training and require direct observation of task being performed with a patient: ... Communication skills, including ability to read, write and verbally report clinical information to patients, representatives and caregivers as well as to other agency staff ... 5. The following items are part of the competency training and may be evaluated through written examination, oral examination or after observation of a Home Health Aide with a patient ... Observation, reporting and documentation of patient status and care or service furnished ...." An observation of a home visit was conducted on 8/12/2022, from 12:05 PM to 1:03 PM, with patient #1 and home health aide (HHA) #1. At 12:10 PM, person #1, caregiver, indicated the patient slept well the previous night and stated "They		**patient's condition; medication issues (anychange or new medications/ treatment); the Nurse or Director ofNursing/Clinical Manger will document itin the Coordination of Care form .** **If the patient/PCG reported to the Homehealth aide of the new medication or any of changes in medications The Clinician shall : Review MedicationReconciliation, verify the new order by Physician. Medications shall bereviewed with MD, Patient/PCG for Potential adverse effects, Drug interactions,Ineffective drug therapy, Significant side effects, Significant interactions,Duplicate drug therapy and Non compliance with drug therapy.** **On September 19, 2022 The Director of Nursing/ Administrator/ClinicalManage r ensured that the Home health aide will coordinate to the Nurse orDirector of Nursing/Clinical Manger any additional information regardingpatient's condition and issues inmedication and**	

	have her on a sleeping pill now." At 12:27 PM, person #1 indicated the patient's doctor recently prescribed the patient MiraLAX [laxative] to take daily. Person #1 indicated they did not understand how a person could have a bowel movement if they were not eating. At 1:00 PM, person #1 showed the box of MiraLAX prescribed as well as the prescription sleeping pills on the kitchen table. Clinical record review on 8/24/2022, for patient #1, start of care 8/3/2022, evidenced an agency document titled "HHA Care Plan" for the episode/period of 8/3/2022 – 10/1/2022. This document had an area subtitled "Comments/ Additional Instructions" which stated, "Things To Report: … Medication Issues …." Record review failed to evidence HHA #1 notified the primary nurse of new or changes in medications, as instructed on the HHA care plan. Record review failed to evidence communication from HHA #1 to the primary nurse about new medications in the home per the agency's policy. During an interview on 8/24/2022, at 2:59 PM,		**will be documented in the Care Coordination in all 100 % ofall active clinical records reviewed.** **The Director of Nursing/ Administrator conducted an In-service on September19, 2022 regarding Policy on Coordination of Patient Services andCertified Home Health Aide Services .** **The Director of Nursing/ Administrator will be responsible forimplementing, maintaining and reinforcing these corrective actions to ensurethat these deficiencies are corrected and will not recur effective after theIn-Service meeting to all the staffs on September 19, 2022 .** **(see attachments)** **G0608 A1 – A2: Policy on Coordination of Patient Services** **G0608 B1 : Coordination of Care form** **G0608 C1 – C3:** Certified Home Health Aide Services **G0608 D1- D2: GB**	

	administrative staff #1, indicated a communication note from HHA #1 on 8/12/2022, reported the patient slept well. When queried if the communication note reported the patient slept well due to a new sleeping medication, administrative staff indicated the communication note failed to mention new medications.		**meeting** **G0608 E1 – E2: Inservice**	

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