| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 157618 | A. BUILDING<br>B. WING | 10/28/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PARAGON HOME HEALTHCARE | 3601 HOBSON RD, SUITE 102, FORT WAYNE, IN, 46815 |

| (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 |
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| N0000 | Initial Comments<br><br>This visit was for a State Complaint Survey of a Deemed Home Health provider.<br><br>Complaint #: 93951: Unsubstantiated. Unrelated State deficiencies were cited.<br><br>Survey Dates: 10/27 – 10/28/2022<br><br>Census: 234 | N0000 | | 2022-11-18 |

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| N0514 | Patient Rights<br><br>410 IAC 17-12-3(c)<br><br>Rule 12 Sec. 3(c)<br>(c) The home health agency shall do the following:<br>(1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following:<br>(A) Treatment or care that is (or fails to be) furnished.<br>(B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency.<br>(2) Document both the existence of the complaint and the resolution of the complaint.<br><br>Based on record review and interview, the agency failed to evidence documentation of the existence of all complaints and the agency's investigation and resolution of patient complaints in 1 of 1 agency reviewed, with the potential to affect all patients.<br><br>Findings include:<br><br>1. Review of an agency policy titled “Complaint Resolution” indicated the purpose of the policy was to provide for a prompt and equitable resolution of complaints. The policy indicated the patient could contact the agency with any concern(s) related to care, | N0514 | **Corrective Action:**<br><br>In order to correct the abovedeficiency cited, the Administrator, Alternate Administrator and Director ofNursing held a management meeting on 11/11/2022 and reviewed, discussed theagency policy titled "Complaint Resolution" under Patient Rights andResponsibilities section. During this meeting, deficiencies cited under N-0514were reviewed, addressed and discussed in detail. It was concluded thateffective 11/11/2022, all complaints that are being investigated and resolved willbe documented irrespective the nature of the complaints.<br><br>An in-service meeting will beconducted by the Administrator and to be attended by Alternate Administratorand Director of Nursing, Alternate Director of Nursing, all clinicians, officestaff, marketers and liaisons including contracted personnel on 11/18/2022 todiscuss agency policy titled "Complaint Resolution" under PatientRights and Responsibilities section. The Administrator will reiterate the | 2022-11-18 |

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| | patient safety issues and that the agency maintained records of grievances / complaints and their outcome.<br><br>2. Review of the complaint log evidenced 3 complaints since the last state survey on 3/12/2019. A complaint dated 10/5/2022, concerned Patient #1, in which a family member complained about an appointment with the Social Worker. The complaint focused on the "... verbally abusive ..." language of the family member, who was "... upset about [a] miscommunication of appointment [sic] ...."<br><br>A complaint dated 9/17/2022 concerned Patient #6, in which a family member was upset with how long the Social Worker spent with the patient (3 hours) and the outcome of the evaluation, which was to put patient into "... a home ...." The complaint narrative indicated the family member called the agency with threatening language throughout the day.<br><br>A complaint dated 7/6/2021 indicated Patient #6 was a victim of verbal and physical | | importanceof accurately investigating, resolving and documenting all complaints as perAgency Policy and provide all staff copy of Agency Policy "Complaint Resolution"and "Complaint form". All clinicians, office staff, marketers and liaisonsincluding contracted personnel will be re-educated on accurately completing the"complaint form" as per policy. All staff will understand and acknowledge therequirement mentioned above.<br><br>This corrective action will be implemented on 11/18/22.<br><br>**Measures to assure Norecurrence:** | |

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| | Entity B and Entity C.<br><br>3. During an interview on 10/27/2022 at 12:10 PM, the Alternated Administrator (AA) indicated “serious complaints” were recorded in the complaint log. When queried how the decision was made if a complaint was serious, the Alternate Administrator indicated something that could be resolved with a phone call or two was not a serious complaint and was not recorded in the log.<br><br>4. During an interview on 10/28/2022 at 3:10 PM, the AA indicated only serious complaints were recorded. When queried about what was serious, the AA indicated any time there was profanity or abusive language (from the complainant to the agency), it was important and to be recorded. When asked if miscommunication about an appointment would be in the complaint log, the AA indicated this would not be a serious complaint as it could be resolved with a couple of phone calls. When queried if a patient would consider a missed appointment as a serious | | In order to ensure that there isno recurrence of this deficiency, the Office Manager will utilize a Complaintaudit tool to ensure that all complaints are being investigated, resolved anddocumented as per Agency policy. This process of utilizing Complaint audit toolfor staff will help us identify any discrepancies in the process ofinvestigation, resolution and documentation of complaints.<br><br>**Monitoring:**<br><br>In order to ensure implementation and effectiveness ofthis corrective action, the following monitoring process will be put in place;the Office Manager will utilize a Complaint audit tool and audit 100% of all complaintson a monthly basis to ensure that all complaints show evidence of investigation,resolution and documentation. The Director ofNursing will review Office Manager’s audit findings of all complaints. Monthlyreports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This | |

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| | complaint, the AA indicated a complaint regarding a missed visit / appointment was a "miscommunication" and further indicated if a patient with dementia called 4 times a day with confusion about an appointment, "... would it be worth my time to document it? I think not." | | month for the next 3 months until 100% compliance is achievedand to maintain this level of compliance, all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified within thenext 3 months, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 3 months, this process will continue to be monitored on aquarterly basis and will be included in the quarterly Complaint audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 100%of Complaint records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations.<br><br>The Administrator will be | |

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| | | | responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.<br><br>This deficiency will becorrected on 11/18/2022. | |
| N0522 | Patient Care<br><br>410 IAC 17-13-1(a)<br><br>Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:<br><br>Based on record review and interview, the agency failed to follow the physician ordered plan of care (POC) for 1 of 5 patient records reviewed (Patient #4).<br><br>Findings include:<br><br>1. Review of an agency policy titled "Plan of Care – CMS #485 [Centers for Medicare and Medicaid Services Plan of Care document] and Physicians Orders" indicated in part, | N0522 | **Corrective Action:**<br><br>In order to correct the abovedeficiency cited, the Administrator and Director of Nursing held a managementmeeting on 11/11/2022, reviewed and discussed agency policies titled 9.9.1"Care Planning Process" and 9.10.1 "Plan of Care – CMS #485 andPhysician Orders". During this meeting, deficiencies cited under N-0522citation were reviewed and discussed in detail.<br><br>An in-service meeting will beconducted by the Director of Nursing and to be attended by all staff, includingHome Health Aide staff on 11/18/22 to discuss policy of "Care Planning Process"and "Plan of Care – CMS #485 and Physician Orders". The Director of | 2022-11-18 |

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| | "…Each patient must receive the home health services that are written in an individualized plan of care."<br><br>2. Review of the clinical record for Patient #4 evidenced a POC for the certification period 9/16/22 to 11/14/22, with an order for Home Health Aide services with 2 visits per week ordered for the weeks of 10/2/22 to 10/8/22 and 10/9/22 to 10/15/22, and one visit the week of 10/16/22 to 10/22/22. The record failed to evidence documentation that aide services were provided after 10/3/2022 nor documentation of why the visits were not conducted.<br><br>3. During an interview on 10/28/22, the Alternate Clinical Supervisor indicated there was no documentation in the clinical record that explained why aide services were not provided as ordered and confirmed Patient #4 did not receive the services in accordance with the POC. | | Nursingwill emphasize that all Home Health Aide services must be provided in accordance with theplan of care (POC) and physician Orders. The Director of Nursing willspecifically address the Home Health Aide staff to discuss the issue of HomeHealth Aide services that were not provided as per Plan of Care or notificationof delay to the physician was not documented in the clinical record. All staffwill be re-educated on the requirement of timely providing Home Health Aideservices as per plan of care. Citations listed in the clinical recordreviews will be addressed. All staff will understand and acknowledge therequirement and the need to provide services that are ordered by thephysician as indicated in the plan of care and physician orders. Thiscorrective action will be implemented effective 11/18/22.<br><br>**Measures to assure Norecurrence:**<br><br>In order to ensure that there isno recurrence of this deficiency, the Director of | |

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| | | | tool to ensure that all active patient records for patients receivinghome health services show evidence of Home Health Aide services are beingprovided as per Plan of Care and Physician Orders. This process of utilizingactive chart audit tool on all active patients will help us ensure that thepolicy is being followed and identify any discrepancies in the clinical recordsand re-educate all staff of the above mentioned requirement.<br><br>**Monitoring:**<br><br>In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place, theClinical supervisor will utilize a chart audit tool and audit 100% of all activepatient records for patients receiving Home Health Aide Services on a weeklybasis to ensure that all Home Health Aide Services are being provided as perPlan of Care and Physician Orders. The Director of Nursing will review Clinicalsupervisor's audit findings of Home Health Aide Services being provided as | |

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| | | | perPlan of Care and Physician Orders. Weekly reports will be generated and resultswill be compiled and sent to the Administrator to ensure that processes haveimproved. This process will continue for each week for the next 30 days until100% compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will continueto audit 20% of clinical records quarterly to ensure compliance is maintained.The Administrator and QAPI Committee will send a written | |

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| | | | report to theGoverning Body quarterly for their recommendations.<br><br>The Director of Nursing will be responsible for correctiveaction of this deficiency, measure to assure no recurrence and monitoring ofthis deficiency.<br><br>This deficiency will becorrected on 11/18/2022. | |
| N0524 | Patient Care<br><br>410 IAC 17-13-1(a)(1)<br><br>Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall:<br>(A) Be developed in consultation with the home health agency staff.<br>(B) Include all services to be provided if a skilled service is being provided.<br>(B) Cover all pertinent diagnoses.<br>(C) Include the following:<br>(i) Mental status.<br>(ii) Types of services and equipment required.<br>(iii) Frequency and duration of visits.<br>(iv) Prognosis.<br>(v) Rehabilitation potential.<br>(vi) Functional limitations. | N0524 | **Corrective Action:**<br><br>In order to correct the abovedeficiency cited, the Administrator and Director of Nursing held a managementmeeting on 11/11/2022, reviewed and discussed agency policy titled 9.10.1 "Planof Care – CMS #485 and Physician Orders". During this meeting, deficienciescited under N-0524 citation were reviewed and discussed in detail.<br><br>An in-service meeting will beconducted by the Director of Nursing and to be attended by all staff, on 11/18/22to discuss policy "Plan of Care – CMS #485 | 2022-11-18 |

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| | (vii) Activities permitted.<br>(viii) Nutritional requirements.<br>(ix) Medications and treatments.<br>(x) Any safety measures to protect against injury.<br>(xi) Instructions for timely discharge or referral.<br>(xii) Therapy modalities specifying length of treatment.<br>(xiii) Any other appropriate items.<br><br>Based on record review and interview, the agency failed to ensure the plan of care included orders for patient's wound dressing for 1 of 1 clinical record reviewed with orders for wound care / treatment (Patient #1).<br><br>Findings include:<br><br>Review of the clinical record for Patient #1 evidenced a Plan of Care (POC) for certification period 9/15/22 to 11/13/22, which included orders for wound care for a peripherally inserted central catheter (PICC, a thin tube inserted into a large vein to provide medications) site. The orders read, “Cleanse wound with, [sic] supplies sent from hospital in IV [intravenous] supply kit. Follow directions for changing sterile dressing for | | and Physician Orders”. The Directorof Nursing will emphasize that the plan of care (POC) must include specific woundcare orders. The Director of Nursing will specifically address the Nursingstaff to discuss the issue of insufficient and specific wound care orders thatwere not entirely documented in the Plan of Care. All staff will be re-educatedon the requirement of documenting sufficient and specific wound care orders inthe plan of care. Citations listed in the clinical record reviews will be addressed.All staff will understand and acknowledge the requirement and the need todocument specific wound care orders in the plan of care and to provide specificwound care services as ordered by the physician. This corrective action will beimplemented effective 11/18/22.<br><br>**Measures to assure Norecurrence:**<br><br>In order to ensure that there isno recurrence of this deficiency, the Director of | |

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| | PICC line using aseptic technique [a method to reduce contamination with bacteria].<br><br>During an interview on 10/28/2022 at 3:10 PM, the Alternate Clinical Supervisor confirmed the POC lacked sufficient and specific wound care orders. | | tool to ensure that all active clinical records for patients receivingwound care show evidence of sufficient and specific wound care ordersdocumentation in the plan of care and to provide specific wound care services asordered by the physician. This process of utilizing active chart audittool on all active patients will help us ensure that the policy is beingfollowed and identify any discrepancies in the clinical records and re-educateall staff of the above mentioned requirement.<br><br>**Monitoring:**<br><br>In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place, theClinical supervisor will utilize a chart audit tool and audit 100% of all activepatient records for patients receiving wound care services on a weekly basis toensure that all Plan of Care include documentation of sufficient and specificwound care orders. The Director of Nursing will review | |

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| | | | findings of specific wound care orders documentation in the Plan of Care.Weekly reports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified within 30days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. The Administratorand QAPI | |

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| | | | Committee will send a written report to the Governing Body quarterlyfor their recommendations.<br><br>The Director of Nursing will be responsible for correctiveaction of this deficiency, measure to assure no recurrence and monitoring ofthis deficiency.<br><br>This deficiency will becorrected on 11/18/2022. | |
| N0546 | Scope of Services<br><br>410 IAC 17-14-1(a)(1)(G)<br><br>Rule 14 Sec. 1(a) (1)(G) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:<br><br>(G) Inform the physician and other appropriate medical personnel of changes in the patient's condition and needs, counsel the patient and family in meeting nursing and related needs, participate in inservice programs, and supervise and teach other nursing personnel.<br><br>Based on record review and interview, the agency failed to evidence the attending physician was notified of a significant change | N0546 | **Corrective Action:**<br><br>In order to correct the abovedeficiency cited, the Administrator and Director of Nursing held a managementmeeting on 11/11/2022, reviewed and discussed agency policies titled 9.10.1"Plan of Care – CMS #485 and Physician Orders", 9.13.1 "Coordination of PatientCare" and 9.16.1 "Nursing Services". During this meeting, deficiencies citedunder N-0546 citation were reviewed and discussed in detail.<br><br>An in-service meeting will | 2022-11-18 |

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| | in patient status in 2 of 2 charts with documentation of significant changes (Patient #4 and 5).<br><br>Findings include:<br><br>1. Review of the clinical record for Patient #4 evidenced a skilled nursing note, dated 10/11/22, completed by registered nurse [RN] 3, that indicated Patient #4 fell in the bathroom on 10/10/22. RN 3 indicated Patient #4 had "… persistent bouts of orthostatic hypotension [low blood pressure upon standing] …." The note further indicated Patient #4 and daughter were to follow – up with the cardiologist regarding "… possible dehydration versus over – medication with anti-hypertensives."<br><br>During an interview on 10/28/22 at 3:10 PM, the Alternate Clinical Supervisor confirmed the nurse was expected to contact Patient #4's physician rather than expecting the family to call.<br><br>2. Review of the clinical record for Patient #5 evidenced a skilled nurse visit note, dated 9/26/22, completed by RN 2, which indicated Patent #5 | | Nursing and to be attended by all staff, on 11/18/22to discuss Agency Home Health policies "Plan of Care – CMS #485 and PhysicianOrders", "Coordination of Patient Care" and "Nursing Services". The Director ofNursing will emphasize that the attending physician must be notified of asignificant change in patient status. The Director of Nursing willspecifically address the Nursing staff to discuss lack of documentation of attendingphysician notification in patient records of a significant change in patientstatus with documentation of significant changes. All staff will be re-educatedon the requirement of documenting attending physician notification of any significantchanges in patient status in the patient record. Citations listed in the clinicalrecord reviews will be addressed. All staff will understand andacknowledge the requirement and to document attending physician notification ofany significant changes in patient status. This corrective action will beimplemented effective 11/18/22. | |

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| | reported "… feeling hot … daily diarrhea x 7 episodes today, chills / shaking at night, poor appetite past 3 days …." RN 2 documented "… Pt [patient] planning to present to ER for evaluation and treatment." The record failed to evidence documentation that the attending physician was notified of the change in the their condition / status or if Patient #5 sought other medical care.<br><br>Review of a nursing visit note dated 10/1/22 and completed by RN 2, indicated Patient #5 reported ongoing issues with diarrhea, new symptoms of shortness of breath, cough, and chest pain. RN 2 documented "… Pt has appt [appointment] with infections [sic] disease tomorrow at 11 am. Writer will follow up …." The record failed to evidence the attending physician was notified of Patient #5's symptoms.<br><br>During an interview on 10/28/22 at 3:10 PM, the Alternate Clinical Supervisor confirmed there was no follow – up nor was there evidence that the attending physician was notified of Patient #5's status | | **Measures to assure Norecurrence:**<br><br>In order to ensure that there isno recurrence of this deficiency, the Director of Nursing will utilize a chartaudit tool to ensure that all active clinical records show evidence of documentationof the attending physician notification of any significant changes in patientstatus. This process of utilizing active chart audit tool on all activepatients will help us ensure that the policy is being followed and identify anydiscrepancies in the clinical records and re-educate all staff of the abovementioned requirement.<br><br>**Monitoring:**<br><br>In order to ensure implementationand effectiveness of this corrective action, the following monitoring processwill be put in place, the Clinical supervisor will utilize a chart audit tooland audit 100% of all active patient records on a weekly basis to ensure that patientrecords include | |

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| | follow – up with the physician should have occurred and been documented. | | documentation of the attending physician notification of any significantchanges in patient status. The Director of Nursing will review Clinicalsupervisor's audit findings of the attending physician notification of any significantchanges in patient status. Weekly reports will be generated and results will becompiled and sent to the Administrator to ensure that processes have improved.This process will continue for each week for the next 30 days until 100%compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, | |

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| | | | the QAPI Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations.<br><br>The Director of Nursing will be responsible for correctiveaction of this deficiency, measure to assure no recurrence and monitoring ofthis deficiency.<br><br>This deficiency will becorrected on 11/18/2022. | |
| N0547 | Scope of Services<br><br>410 IAC 17-14-1(a)(1)(H)<br><br>Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following:<br><br>(H) Accept and carry out physician, chiropractor, podiatrist, dentist and optometrist orders (oral and written).<br><br>Based on record review and interview, the agency failed to | N0547 | **Corrective Action:**<br><br>In order to correct the abovedeficiency cited, the Administrator and Director of Nursing held a managementmeeting on 11/11/2022, reviewed and discussed agency policies titled 9.10.1"Plan of Care – CMS #485 and Physician Orders", 9.13.1 "Coordination of PatientCare" and 9.16.1 "Nursing Services". During this meeting, | 2022-11-18 |

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| | obtaining blood for lab work in 1 of 2 patients with lab draws performed by the agency (Patient #5).<br><br>Findings include:<br><br>Review of the clinical record for Patient #5 evidenced orders for weekly blood draws for labs. A communication note dated 9/15/2022 indicated Patient #5 needed labs "...on Monday [9/19/2022]."<br><br>Review of the nurse visit note for Patient #5 on 9/20/22, failed to evidence documentation of the blood draw.<br><br>During an interview on 10/28/22 at 3:10 PM, the Alternate Clinical Supervisor confirmed there was no documentation of a blood draw. The Alternate Clinical Supervisor further indicated there were no lab results in Patient #5's, which indicated the blood draw was not done. | | deficiencies citedunder N-0547 citation were reviewed and discussed in detail.<br><br>An in-service meeting will beconducted by the Director of Nursing and to be attended by all staff, on 11/18/22to discuss Agency Home Health policies "Plan of Care – CMS #485 and PhysicianOrders", "Coordination of Patient Care" and "Nursing Services". The Director ofNursing will emphasize that the agency must follow physician orders forobtaining blood for lab work and document blood draws and lab results inpatient records. The Director of Nursing will specifically address theNursing staff to discuss the issue of lack of blood draw/lab resultsdocumentation in patient records. All staff will be re-educated on the requirementof following orders and documenting blood draw/labs results in the patientrecord. Citationslisted in the clinical record reviews will be addressed. All staff will understandand acknowledge the requirement and to document blood draw/lab results in thenursing visit note. This corrective action will be | |

implemented effective 11/18/22.

**Measures to assure Norecurrence:**

In order to ensure that there isno recurrence of this deficiency, the Director of Nursing will utilize a chartaudit tool to ensure that all active clinical records for patient requiring labwork for blood draws show evidence of documentation of following physicianorders for blood draws/lab results in nursing visit note. This process of utilizingactive chart audit tool on all active patients will help us ensure that thepolicy is being followed and identify any discrepancies in the clinical recordsand re-educate all staff of the above mentioned requirement.

**Monitoring:**

In order to ensure implementationand effectiveness of this corrective action, the following monitoring processwill be put in place, the Clinical supervisor, on a weekly

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| | | | basis will utilize a chart audit tool and audit 100% of all activepatient records for patients requiring lab draws to ensure presence of blooddraws/labs documentation in nursing note. The Director of Nursing will reviewClinical supervisor's audit findings of blood draws/lab results documentationin the nursing visit notes. Weekly reports will be generated and results willbe compiled and sent to the Administrator to ensure that processes haveimproved. This process will continue for each week for the next 30 days until100% compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart | |

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| | | | audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations.<br><br>The Director of Nursing will be responsible for correctiveaction of this deficiency, measure to assure no recurrence and monitoring ofthis deficiency.<br><br>This deficiency will becorrected on 11/18/2022. | |

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 |
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| Muhammad Chaudhry | Administrator | 11/11/2022 7:42:37 PM |