STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157538	A. BUILDING B. WING	07/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROCARE HOME HEALTH SERVICES	8300 BROADWAY STREET STE F2A, MERRILLVILLE, IN, 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 6/22/2023, 6/23/2023, 6/26/2023 – 6/30/2023, and 7/3/2023 Active Census: 43 At this Emergency Preparedness survey, ProCare Home Health Services was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000	08/01/2023 Emergency Preparedness Requirements for Medicare andMedicaid Participating Providers and Suppliers is now complete.	
E0001	Establishment of the Emergency Program (EP)	E0001	Administrator and Clinical Manager reviewed the following	2023-07-28

	483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following		policy for reeducation and clarification of procedures. Emergency Preparedness Management Policy B-400 Agency will have an identified plan in place to ensure the safety and well-being of patients and employees during periods of an emergency or disaster that disrupts agency services. The plan considers the agency's commitment to provide service while ensuring the safety of its employees and patients. The Agency will implement this Emergency Management Policy as soon as the agency becomes aware of the existence of an emergency with emphasis on Sub Sections (SS) 2 & 4. 2. All team members will be oriented to the emergency management plan and their associated responsibilities. Reviews will be held at least annually. 4. A classification system will be identified within the agency to determine patient acuity and need for services during an emergency. This classification would be used to assure patient with immediate needs are seen	

	elements: Based on record review and interview, the home health agency failed to develop and maintain a comprehensive emergency preparedness plan. The findings include: Record review of the agency's emergency preparedness plan on 6/28/2023, with the Administrator at 10:52 AM, which was indicated to be the emergency preparedness plan for the agency, received on 6/23/2023, failed to evidence the following requirements for an emergency preparedness plan: A documented, facility-based and community-based risk assessment utilizing an all-hazards approach and included strategies for addressing emergency events identified by the risk assessment; included the high risk areas for the agency's patient population; they developed and maintained an emergency preparedness plan to include a process for cooperation and collaboration with local, State and Federal emergency preparedness officials and efforts to maintain an integrated response during a		during this time or alternate July 28th 2023: The home health agency now has a comprehensive emergency preparedness plan utilizing an all-hazards approach and has the elements required for an emergency preparedness plan: It is facility-based, and community-based risk assessment utilizing an all-hazards approach and includes strategies for addressing emergency events identified by the risk assessment; includes the high-risk areas for the agency's patient population; it includes a process for cooperation and collaboration with local, State and Federal emergency preparedness officials and efforts to maintain an integrated response during a disaster or an emergency. We now have an individualized emergency preparedness plan for patients which provides appropriate instructions, in the event of an emergency, to communicate with the agency. We current patient information to determine their immediate	

	disaster or emergency situation; they developed and implemented an individualized emergency preparedness plan for the patients which provided appropriate instructions, in the event of an emergency, to communicate with the agency (see tag E0017), Maintained current patient information to determine the immediate needs in the event of service interruption; Included a system where clinical documentation preserves patient confidentiality; Included the use of volunteers; they developed and maintained an emergency preparedness communication plan which included contact information for State, tribal, regional, and local emergency preparedness staff and other sources of assistance; they developed and maintained an emergency preparedness communication plan which included primary and alternate means for communicating with agency staff and Federal, State, tribal, regional and local emergency management agencies; Established an emergency preparedness training program for new employees; And failed to ensure they conducted exercises to test		needs in the event of service interruption, and a system where clinical documentation preserves patient confidentiality. The plan includes the process for the utilization of volunteers. We also now have an emergency preparedness communication plan which includes contact information for State, regional, and local emergency preparedness staff, and other sources of assistance. We also have an emergency preparedness communication plan which includes primary and alternate means for communicating with agency staff and Federal, State, regional and local emergency management agencies. We have now established an emergency preparedness training program for new staff members. The plan will be reviewed and maintained annually with a tabletop exercise, with sign-in sheets. The next annual tabletop exercise is scheduled for August 3rd, 2023.	

	the emergency plan annually. During an interview on 6/28/2023, from 10:52 AM – 11:33 AM, the administrator indicated the plan was developed to prepare for severe weather and to avoid overwhelming the medical systems in the area. The administrator indicated the agency did not utilize volunteers, did not have an emergency preparedness training program for new employees, and did not have a sign in sheet for the 2 outlined tabletop exercises. The administrator referred to another book with emergency preparedness information when queried about a hazard vulnerability assessment for the areas served, the process to collaborate with local/state/federal emergency officials, when/how to determine who would need immediate assistance in the event of service interruptions, primary and alternate means of communication for staff and emergency officials. The administrator indicated there was another book with information but could not find it due to it being misplaced with			

	the move at the end of May 2023 The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment and resulted in the agency being found out of compliance with the condition 42 CFR 484.102 Emergency preparedness.			
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on observation, record review and interview, the home	E0017	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. Emergency Preparedness Management Policy B-400 Agency will have an identified plan in place to ensure the safety and well-being of patients and employees during periods of an emergency or disaster that disrupts agency services. The plan considers the agency's commitment to provide service while ensuring the safety of its employees and patients. The Agency will implement this Emergency Management Policy as soon as the agency becomes aware of	2023-07-28

	health agency failed to ensure all patients had an individualized emergency preparedness plan for 3 of 3 home visits conducted. (Patients #3, #6, #8) The findings include: 1. During an observation of care on 6/23/2023, at 9:24 AM, at the home of Patient #3, an individualized emergency plan was not observed in the patient's home. Clinical record review on 6/22/2023 failed to evidence an individualized emergency plan. During an interview on 6/23/2023, at 3:02 PM, the Clinical Manager indicated there was no individual emergency plan for the patient in the hard chart or the electronic medical record. The Clinical Manager indicated the patient-specific emergency plan should be provided to the patient in the home. 2. During an observation of care on 6/23/2023, at 11:52 AM, at the home of Patient #6, the patient was observed to have		the existence of an emergency. With Emphasis on SS6 6. Patients categorized as high risk would include those who are: a. Receiving continuous infusion therapy. b. Dependent on medical equipment (monitors, ventilators, oxygen). c. Physically unable to provide self-care and without available caregiver. d. Medically unstable (diabetic, cardiac). e. Requiring continuous care. f. Residence is in at-risk location. The home health agency now has individualized emergency preparedness plans for all patients. The Clinical Manager and Administrator reviewed all active patients' clinical records and found that 25 out 35 patients did not have an emergency preparedness plan that was individualized to them. This situation has now been corrected. The home health agency now has individualized emergency preparedness plans for all patients which provide appropriate instructions, in the event of an emergency, to	

	wounds to both below the knee amputations and to the right middle finger. The Clinical Manager was observed applying a wound vacuum device (a wound treatment that applies suction to the wound) to the wounds to both below the knee amputations. During an interview on 6/23/2023, at 12:59 PM, Patient #6 indicated he received peritoneal dialysis (a medical procedure that filters the blood through a machine by adding a solution to and removing fluid from the abdomen) every night for 8 hours. Review of an agency document in the patient's home titled "Emergency Plan" dated 5/24/2023, failed to evidence the plan was individualized to include the patient's dialysis treatment and wound care. 3. During an interview on 6/27/2023, at 11:33 AM, the Clinical Manager indicated the emergency plan should be completed in its entirety for each patient to include specific supplies needed for each patient. 1. Review of an agency policy		We now have current patient information and are able to determine the immediate needs in the event of service interruption; including a system where clinical documentation preserves patient confidentiality; and the use of volunteers. We also have an emergency preparedness communication plan which includes contact information for State, regional, and local emergency preparedness staff and other sources of assistance. The clinical Manager and the quality assurance team will monitor all new assessments for complete individualized emergency preparedness plan and also review it as needed and with any patient hospitalization or change of condition and no later than each recertification period. The Clinical Manager is responsible to ensure that this situation does not recur	

	titled "Emergency Preparedness Management Policy" revised 6/28/2022, stated "Agency will have an identified plan in place to ensure the safety and well-being of patients and employees during periods of an emergency or disaster that disrupts agency services ...." 2. An observation of a home visit was conducted on 6/28/2023, from 1:21 PM to 2:17 PM, for a physical therapy (PT) visit with Patient #8, start of care 2/1/2023, pertinent diagnoses of chronic obstructive pulmonary disease (COPD; lung disease that blocks airflow and make it hard to breath) and type 2 diabetes with daily blood sugar checks. Upon arrival, the patient was observed resting in a hospital bed in the living room with a home health aide (HHA) from Entity J. During the visit, PT 1 and the HHA from Entity J, assisted the patient to the side of the bed for exercises, then to a standing position for exercises, then back to bed. During the visit, the HHA indicated the patient required 2 people to transfer and would not be able to help the patient transfer due to their own			

	mobility function issues. Observation of the information books (1 book for PT and 1 book for the Clinical Manager) provided by the agency failed to evidence an individualized emergency preparedness plan. Record review evidenced an undated agency document titled "Emergency Plan" initialed by the patient and signed by the Clinical Manager which indicated when to call ProCare, the doctor, or emergency services. This document had the name and phone number for the patient's physician, pharmacy, next of kin, and another relative. Review of the emergency plan failed to evidence individualized information and instructions to address mobility barriers, necessary medical equipment for COPD and diabetes, including but not limited to how to obtain a glucometer (machine to test concentrated glucose in a blood sample) or nebulizer (machine used to deliver medications to the respiratory system). Record review failed to evidence an individualized emergency preparedness to address all patient needs in the case of an			

	unforeseen event.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification, State re-licensure, and a complaint survey of a home health provider. Complaint: IN0099081 - substantiated. Federal deficiencies were cited. Survey Dates: June 22-23, 2023, June 26-30, 2023, July 3, 2023 Unduplicated Skilled Admissions for the last 12 Months: 233 An Immediate Jeopardy related to §484.105 Organization and Administration of Services was identified and announced on 6/30/2023 at 3:16 PM. The Immediate Jeopardy remained unabated at the time of exit on 7/3/2023.	G0000	08/01/2023 These deficiencies have now been corrected.	

	During this Federal Recertification Survey, ProCare Home Health Services was found to be out of compliance with Conditions of Participation 42 CFR §484.58 Discharge Planning; 42 CFR §484.60 Care Planning, Coordination of Services, and Quality of Care; 42 CFR §484.65 Quality Assessment/Performance Improvement; 42 CFR §484.75 Skilled Professional Services; and 42 CFR §484.105 Organization and Administration of Services. Based on the Condition-level deficiencies during the 7/3/2023 survey, ProCare Home Health Services was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 6/27/2023. 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			

	years beginning 7/3/2023 and continuing through 7/2/2025. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. **Quality Review completed 07/19/2023**			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the agency failed to ensure the patient's rights to participate in care and be informed	G0434	The Administrator and Clinical Manager reviewed the following policy for reeducation and clarification of procedures. Service Agreement/Plan C-160 A Service Agreement/Plan shall be developed with all patients upon admission before care is provided. The service agreement/plan will identify the services to be provided, disciplines providing care, charges and expected sources of reimbursement for services. The patient will be informed of their liability for payment. With emphasis on 4. The patient shall be advised, of any changes in type or frequency of services, coverage of services and any change in financial liability. Changes in	2023-07-27

	furnished, the disciplines providing the care, and the frequency of the care to be furnished in 7 of 9 clinical records reviewed. (Patient #1, #2, #3, #4, #6, #8, #9) The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Service Agreement/Plan" stated, "... The patient shall be advised, of any changes in type or frequency of services, coverage of services and any change in financial liability...." 2. Clinical record review on 6/23/2023, for Patient #1, evidenced a physician order from Person H (physician) signed 5/26/2023, indicating the patient was to be admitted for home care services to include a home health aide (HHA). Review failed to evidence the agency provided HHA services and failed to evidence the agency communicated with the patient on the provision of HHA services. During an interview on 6/26/2023, at 4:17 PM, Patient #1 indicated the agency told her they would look for an aide to provide personal care and		financial liability will be verbal and in writing as soon as possible, but no later than, 30 calendar days from the date the agency becomes aware of a change. July 27, 2023 The agency now ensures the patient's rights to participate in care and be informed in advance of the care to be furnished, the disciplines providing the care, and the frequency of the care to be furnished. The Clinical Manager and Administrator reviewed all active patients' clinical records and found that 13 out 35 patient's rights to participate in care and be informed in advance of the care to be furnished, the disciplines providing the care, and the frequency of the care to be furnished were not completely documented. The Administrator in-serviced the clinical manager on the importance of informing the patients in advance of the care to be furnished, the disciplines providing the care, and the frequency of the care to be	

	indicated she was never informed by the agency that they did not have any aide to service her. During an interview on 6/27/2023, at 10:23 AM, the Clinical Manager indicated the agency did not provide home health aide services because the agency did not have staffing. The Clinical Manager indicated she informed the patient at the time of admission that the agency would look for an aide to provide services to the patient and the patient agreed to admit to the agency in the meantime. The Clinical Manager indicated she did not have documentation of the communication with the patient regarding HHA services prior to 6/5/2023. 3. Clinical record review on 6/23/2023, for Patient #2, start of care 5/15/2023, evidenced a referral order for home health from Entity A which indicated the patient was to receive home health services to include HHA services. Review failed to evidence the agency provided HHA services and failed to evidence the agency		furnished. The Administrator and Clinical Manager will be responsible for all intakes and admissions to the agency. They will review all admissions to ensure that patients are informed in advance of the care to be furnished, the disciplines providing the care, and the frequency of the care to be furnished. The Administrator is responsible to ensure that this situation does not recur.	

	on the provision of HHA services. During an interview on 6/26/2023, at 3:53 PM, the patient's family member indicated the patient lived alone, had a history of falls, and could use an aide to assist with showers and personal care. The patient's family member indicated the patient had not been offered an aide by the agency. During an interview on 6/28/2023, at 1:07 PM, the Clinical Manager indicated the agency did not offer HHA services to the patient and HHA services were not provided because the agency did not have a HHA to provide the patient. 4. Clinical record review on 6/22/2023, for Patient #3, evidenced an agency document titled "Physician Order" dated 6/15/2023, which indicated the agency was to increase HHA services on every Saturday and Sunday to 8 hours a day. Review of an agency document titled "Admission Service Agreement Home Health" signed and dated by the Clinical			

	Manager and Patient #3 on 4/19/2022, indicated the agency was to provide 4 hours daily of HHA services. Review failed to evidence the patient was informed prior to the change frequency of the HHA services. During an interview on 6/23/2023, at 9:35 AM, Patient #3 indicated she received 4 hours daily of HHA services and was unaware of any changes to HHA services. During an interview on 6/27/2023, at 3:35 PM, the Clinical Manager indicated there was no documented communication with the patient regarding the increase in hours of HHA services. 5. Clinical record review on 6/23/2023, for Patient #4, start of care 6/13/2023, evidenced an agency document titled "Physician Order" dated 6/14/2023, indicated the agency was to provide HHA services 2 times a week for 8 weeks. Review failed to evidence the agency provided HHA services. Review of an agency document titled "Admission Service Agreement Home Health"			

	and the Clinical Manager, indicated the agency would provide HHA services. Review failed to evidence the agency communicated to the patient that HHA services would not be provided. During an interview on 6/27/2023, at 12:20 PM, the Clinical Manager indicated there was no HHA available to provide to the patient and indicated there was no documentation the patient was made aware there was no HHA available. *. Clinical record review on 6/23/2023, for Patient #6, start of care 5/24/2023, evidenced a document titled "Admission Service Agreement" signed by the Clinical Manager and patient, which indicated the agency would provide occupational therapy (OT) twice a week for 3 weeks. Record review failed to evidence the patient received an evaluation or subsequent visits from OT as indicated on the service agreement at admission. During an interview on 6/29/2023, at 1:04 PM, when queried why OT services had			

	not started, the Clinical Manager indicated the therapist could not reach the patient by phone. The Clinical Manager indicated communication with Entity L (contracted therapy agency) and the OT was not documented. *. Clinical record review on 6/26/2023, for Patient #8, start of care 2/1/2023, evidenced a document titled "Admission Service Agreement" signed by the Clinical Manager and the patient on 1/27/2023. This document indicated the agency was to provide 1 SN visit, and for PT and OT to evaluate and treat the patient based off their assessment. This document had a line through the OT direction to evaluate and treat that stated "Refused." An observation of a home visit was conducted on 6/28/2023, for patient #8 with PT 1. At 1:30 PM, the patient's admission book evidenced the "Admission Service Agreement" signed by the Clinical Manager and patient on 1/27/2023, did not have a line through the OT direction to evaluate and treat and "refused" written. Record			

	original copy differed from the agency's copy. Record review failed to evidence patient participation in their own care planning. During an interview on 6/28/2023, at 1:56 PM, Patient #8 indicated they did not refuse occupational therapy services. *. Clinical record review on 6/26/2023, for Patient #9, start of care 5/19/2023, pertinent diagnoses included but were not limited to right side hemiplegia (paralysis to one side) and dysphagia (difficulty swallowing), evidenced a document titled "Admission Service Agreement" signed by the Clinical Manager and the patient on 5/19/2023. This document indicated the agency was to provide PT and OT evaluation, speech therapy (ST) "once available" and all were to start once prior authorization was approved. Record review evidenced a PT evaluation on 5/24/2023, and OT evaluation on 6/12/2023. Review evidenced PT and OT services ceased without an explanation documented. Record review failed to			

	evidence ST evaluated the patient. Record review failed to evidence patient participation with the planning of care. During an interview on 6/29/2023, at 1:38 PM, when queried if the patient was notified of the delay of services, the Clinical Manager indicated the issue was only discussed at the start of care evaluation, but not documented.			
G0484	Document complaint and resolution 484.50(e)(1)(ii) (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the agency failed to document patient complaints and resolution in 1 of 1 clinical record reviewed with a patient complaint. (Patient #1) The findings include: Review of an agency policy revised 1/21/2021, titled "Patient/Caregiver Complaint/Grievance Policy" stated, "... A complaint is	G0484	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. PATIENT/CAREGIVER COMPLAINT/GRIEVANCE POLICY C-382 All patients admitted to the Agency will be informed of their right to voice grievances to the agency without fear of retaliation. Patients will be presented with a copy of the Home Care Bill of Rights and the Agency and State Contact numbers for voicing a complaint. PURPOSE To provide a mechanism for handling patient/caregiver complaints	2023-07-27

	defined as "any expression of dissatisfaction by a patient/caregiver regarding care or services that can be addressed at the time of complaint by team members present" … Patient complaints will be documented on a patient complaint form and filed with the complaint log in the ProCare Home Health Service Agency concerns administrative file…." Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Start of Care" identified as the initial assessment dated 6/1/2023, which indicated the patient had a new below the knee amputation to the left leg and was dependent for transfers from bed to wheelchair and toileting. Review indicated the patient lived alone without any available caregiver. Review evidenced an agency document titled "Physician Order" dated 6/5/2023, which indicated the agency informed the patient of no available home health aide at the time and the patient agreed to use privately paid caregivers until the agency was able to offer		and/or grievances in a timely and efficient manner. To allow patients/caregivers to express complaints or grievances to someone other than their direct caregiver. To establish a procedure for channeling complaints to the appropriate person for resolution, and to provide a response to the patient/caregiver. To provide a mechanism for patients/caregivers to complain and participate in the process without fear of retaliation. With emphasis on PATIENT COMPLAINT A complaint is defined as "any expression of dissatisfaction by a patient/caregiver regarding care or services that can be addressed at the time of complaint by team members present". This includes any agency team members present at the time of the complaint or who can quickly go to the patient location to resolve the complaint. GRIEVANCE A grievance is any formal or informal written or verbal expression of dissatisfaction with care or service that is expressed by the	

	home health aide services. Review of "Home Health Discharge Summary (Auto Generated)" dated 6/21/2023, indicated the last date of service provided by the agency was 6/12/2023. Review indicated the patient called the agency at 7:15 AM requesting an aide for personal care and at 9:00 AM the agency informed the patient there was no aide available. Review indicated at 11:30 AM, the patient called the agency again to report she needed an aide to assist her because she had diarrhea to which the agency informed the patient the agency would try to find an agency that could provide home health services since the agency did not have aide services available to which the patient agreed. During an interview on 6/26/2023, at 4:17 PM, Patient #1 indicated at time of admission to the agency, she was told by the agency that they would find her a home health aide in addition to the other services to be provided. Patient #1 indicated when after the agency did not provide home health aide services after		patient/caregiver that is not solved at that time by team members present. A written complaint is always considered a grievance; as are complaints alleging abuse, neglect, patient harm, charges/billing or non-compliance with state regulations. If a patient requests that a complaint be handled as a formal complaint or requests a written response, it must be considered a grievance. Any complaint that fits the grievance definition will require a written response to the person complaining. July 27, 2023 The agency now ensures that Complaints and Resolutions are documented on a Communication Note in patients chart and a copy of the complaint is in the Complaint book The Administrator and Clinical Manager will be responsible for all complaints. They will ensure all patients' complaints are documented and completed accurately. The Administrator and Clinical Manager are responsible to ensure that this situation does	

	a week or so, she requested the agency find her another agency that could provide home health aide services. Patient #1 indicated she expressed her complaint with the agency regarding the need for aide services and was not provided any resolution. Review of the agency complaint log on 6/22/2023, failed to evidence a complaint and resolution documented for Patient #1. During an interview on 6/28/2023, at 11:04 AM, the Clinical Manager indicated the agency did not document a complaint and resolution for Patient #1 and indicated the agency should have because the patient did have a complaint about her lack of aide staffing.		not recur.	
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant	G0536	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures, and revised it to reflect that ONLY Registered Nurses can review and reconcile	2023-08-14

	side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the agency failed to ensure all medications were reviewed for potential adverse effects and drug reactions and /or failed to follow the agency policy on reporting any identified problems to the physician in 5 of 9 clinical records reviewed. (Patient #1, #2, #3, #4, #6) The findings include: 1. Review of an agency policy revised 6/28/2022, titled "Medication Profile" stated, "... At the time of admission, the admission professional shall check all medication a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication. The clinician shall promptly report any identified problems to the physician...." 2. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/1/2023-7/30/2023, which indicated the patient's		Medications C-700 Medication Profile The Registered Nurse will complete a medication profile for each patient at the time of admission. The medication profile shall include all prescription and nonprescription drugs, including regularly scheduled medications and those taken intermittently or as needed. The profile will be reviewed and updated as needed to reflect current medications the patient is taking. PURPOSE To provide a complete list of ALL medications the patient is taking and an evaluation of the patient's knowledge of the effects of these medications. To provide documentation of the comprehensive assessment of all medications the patient is currently taking and identify discrepancies between patient profile and the physician and/or agency profile. To identify possible ineffective drug therapy, adverse reactions,	

	medications included, but were not limited to, Norco (a narcotic pain medication), Ambien (a medication to help with sleep), and Ativan (a medication used to treat anxiety). Review indicated 2 serious drug interactions between Norco and Ambien and Norco and Ativan, both causing respiratory depression and sedation. Review of an agency document titled "Start of Care" completed by the registered nurse (RN) and dated 6/1/2023, which indicated issues were identified during the drug review. Review failed to evidence the physician was notified of the serious drug interactions. During an interview on 6/27/2023, at 9:59 AM, the Clinical Manager indicated there was not any documentation of what was communicated to the physician regarding the drug review and indicated there was not a physician order faxed to the physician listing the major drug interactions per agency protocol. Review of an agency document titled "Skilled Visit Note" completed by the Clinical		allergies, and contraindicated medications. With emphasis on 1. At the time of admission, the Registered Nurse shall check all medications a patient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication. The clinician shall promptly report any identified problems to the physician. 2. The Nurse shall record on the Medication Profile all prescribed and over-the-counter (OTC) medications the patient is currently taking. The Clinical Manager and quality assurance (QA) team reviewed all active patients' clinical records and found that 15 out of 35 charts did not include Major Drug to Drug interactions and side effects reported to the Primary Physician. The Agency has now ensured that all medications were reviewed in the patient's home	

	Manager and dated 6/12/2023, indicated the patient had a pink area to the left vaginal area to which the RN applied ointment of the patient's choice to the area. Review failed to evidence the medication was reviewed for potential adverse effects. During an interview on 6/27/2023, at 11:05 AM, the Clinical Manager indicated she applied Neosporin (an antibiotic ointment) to the vaginal area since that is the ointment the patient had in the home. The Clinical Manager indicated the Neosporin was not reviewed because it was not added to the medication profile. The Clinical Manager indicated medication review is completed within the electronic health record when a medication is added to the medication profile and if the medication is not added to the medication profile, the medication was not reviewed. 3. Clinical record review on 6/23/2023, for Patient #2, evidenced an agency document titled "Resumption of Care" completed by the Clinical Manager and dated 6/5/2023, which indicated serious drug		and are on the medication profile list and in the patient's home. All clinicians have now submitted a list of the Major Drug to Drug Interactions and side effects to the Primary Care Physician on a Physician's order with request for any new medication changes. The Clinical Manager and quality assurance (QA) will review all medication profiles at admission, recertification and resumptions for Major Drug to Drug Interactions and side effects and ensure completeness and accuracy. The Clinical Manager is responsible to ensure that this situation does not recur.	

	the drug review. Review of an agency document titled "Drug-Drug Interactions" dated 6/26/2023, evidenced major drug interactions between zolpidem (medication to treat insomnia) and Tramadol (narcotic pain medication) causing an increased risk of sedation, respiratory depression, coma, and death and between gabapentin (medication to treat seizures) and Tramadol causing an increased risk of sedation, respiratory depression, fainting, and death. Review failed to evidence documentation the physician was notified of the major drug interactions per policy.			

	During an interview on 6/28/2023, at 1:09 PM, the Clinical Manager indicated she checked the box on the resumption form that the physician was notified of the drug interactions because she planned to send the physician an order to include the drug interactions but did not do it. The Clinical Manager indicated the physician had not been notified of the major drug interactions.			

	4. During an observation of care at the home of Patient #3 on 6/23/2023, 9:38 AM, the patient's medications in individual dosing packs from the pharmacy were observed taped to the patient's bedroom wall. A medication list from the pharmacy was attached to the wall noting what medications were included in the dosing packs indicating the patient's medications included, but were not limited to, Duloxetine (an antidepressant), Tizanidine (muscle relaxer), and Midodrine 10 milligrams (mg) three times a day. A prescription bottle labeled Vitamin D was observed, which Home Health Aide 1 indicated the patient also took. Review of an undated agency document on 6/23/2023, titled "Medication Profile" for episode 6/13/2023-8/11/2023, failed to evidence the patient's medications had been reviewed for Duloxetine, Tizanidine, and Vitamin D. Review indicated Midodrine was to be taken two times a day. 5. Clinical record review on 6/23/2023 and 6/26/2023, for Patient #4, start of care			

	6/13/2023, failed to evidence a medication profile and a completed initial comprehensive assessment. Review of an agency document on 6/27/2023, titled "Start of Care" identified as the comprehensive assessment, indicated a major drug interaction between gabapentin and acetaminophen-hydrocodone (narcotic pain medication) which increased the risk of sedation, respiratory depression, fainting, and death. Review failed to evidence the physician was notified. During an interview on 6/27/2023, at 12:10 PM, the Clinical Manager indicated the nurse that performed the start of care assessment did not complete the documentation until 6/27/2023. The Clinical Manager indicated the medication was not reviewed at the time of the assessment because the medication review was completed when the medications were entered onto the medication profile and the review was conducted via the electronic health record. The Clinical Manager indicated the			

	physician was not notified of the major drug interaction but should have been by sending the drug interaction via a physician order for the physician to sign. 6. During an observation of care at the home of Patient #6 on 6/23/2023, at 11:52 AM, the patient's medications were observed on the kitchen counter to include, but not limited to, clopidogrel (a blood thinning medication to treat/prevent blood clots), midodrine (a medication used to treat low blood pressure), vitamin D2 (dietary supplement), and calcium acetate (used to control high levels of phosphorous). At 1:09 PM, a bottle labeled "Imodium [a medication used to treat diarrhea]" was noted on the patient's table next to the couch, which the patient indicated he took last night for diarrhea. Review of an agency document on 6/23/2023, titled "Medication Profile" failed to evidence the clopidogrel, midodrine, vitamin D2, calcium acetate, and Imodium was reviewed for potential adverse			

	effects. During an interview on 6/29/2023, at 3:18 PM, the Clinical Manager indicated she was unaware the patient had medications on the kitchen counter and indicated all the medications the patient takes should be reviewed. 7. During an interview on 6/27/2023, at 9:59 AM, the Clinical Manager indicated the agency's process for notifying the physician for drug interactions was to send the physician the major interactions on a physician order and fax to the physician.			
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; Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment included the availability, ability, and willingness of the caregiver in 3 of 9 clinical records reviewed.	G0538	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-145 Comprehensive Patient Assessment The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the patient's return home, or on the physician ordered start of care date. A thorough, well-organized, comprehensive, and accurate assessment,	2023-07-29

	(Patient #1, #3, #5) The findings include: 1. Review of an agency policy revised 6/28/2022, titled "Comprehensive Patient Assessment" stated, "... The assessment will identify the patient's primary caregiver(s), if any, and any other available supports, including their willingness and ability to provide care, and availability and schedules...." 2. During an interview on 6/26/2023, at 4:17 PM, Patient #1 indicated she lived at home with her husband who helps her in the evening and indicated he leaves for work early in the morning before she gets out of bed. Patient #1 indicated she hired a private caregiver to assist her in getting out of bed, providing incontinent care, and transferring into a wheelchair until the home health aide could come in the mornings. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Skilled Nurse Visit" dated 6/5/2023, which indicated the		consistent with the patient's immediate needs will be completed for all patients in a timely manner, but no later than five (5) calendar days after start of care. All skilled Medicare and Medicaid patients except pediatric and post-partum will have comprehensive assessments that include the OASIS data set specific to mandated time points. The Agency now ensures that at the time of the Comprehensive Assessment, the agency the ability, willingness and availability of the caregiver is verified and that coordination with any privately paid assistance is recorded. All clinicians are now including Caregiver abilities, willingness and availability in the Comprehensive Assessment. The Clinical Manager and quality assurance (QA) team reviewed all active patients' clinical records for caregiver abilities, willingness and availability in the Comprehensive Assessment and found 7 of 35 active patients did not have information . This deficiency has now been	

	caregiver assists with care when available. Review evidenced an agency document titled "Start of Care" completed by the Clinical Manager and dated 6/1/2023, which indicated the patient lived alone and had no available caregiver. Review failed to evidence the ability, willingness, and availability of the patient's husband and private caregiver. During an interview on 6/27/2023, at 10:18 AM, the Clinical Manager indicated the patient lived with a significant other. The Clinical Manager indicated the caregiver just gets her up out of bed in the mornings and was unsure who would provide incontinent care for the patient. The Clinical Manager indicated she did not verify the willingness and ability of the caregiver. 3. Clinical record review on 6/22/2023, for Patient #3, evidenced an agency document titled "Recertification" identified as the comprehensive assessment, completed by the Clinical Manager, and dated 6/12/2023. Review indicated the		corrected. The Clinical Manager and quality assurance (QA) will review all Comprehensive Assessments to ensure that caregiver status is included. The Clinical Manager is responsible to ensure that this deficiency does not recur.	

	willing and available caregiver and indicated the patient had a caregiver in the home to provide assistance with wound care when the nurse was not present. Review failed to evidence the nurse assessed the patient to include the availability, ability, and willingness of the caregiver. During an observation of care at the home of Patient #3 on 6/23/2023, at 9:24 AM, a family member was observed with the patient. During an interview on 6/23/2023, at 9:24 AM, Home Health Aide (HHA) 1 indicated the family member present at the patient's home assisted the patient with feeding and other activities of daily living (ADLs) and indicated the patient lived with her significant other. During an interview on 6/23/2023, 9:44 AM, Patient #3 indicated she lived with her significant other who performed straight catheterization (a procedure involving inserting a plastic tube into the urethra and into the bladder to drain urine from the body) for the patient. 4. Clinical record review on			

	6/26/2023, for Patient #5, evidenced an agency document titled "Recertification" dated 5/6/2023, which indicated the patient had a primary diagnosis of quadriplegia (paralysis of all 4 extremities) and had an abdominal stoma (an opening) which was used for catheterization for urine removal several times a day. Review indicated the patient lived alone and was catheterized several times a day by a family member but failed to identity the family member and their availability. During an interview on 6/29/2023, at 3:50 PM, the Clinical Manager indicated the patient's in-law did the catheterization.			
G0560	Discharge Planning 484.58 Condition of Participation: Discharge planning. Based on record review and interview, the home health agency failed to follow its policies for discharge planning, failed to establish an agency policy (see G560) and failed to send all necessary medical information	G0560	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C – 495 DISCHARGE POLICY Patients are discharged from treatment in the home when the expectations that the patient's medical, nursing, and social needs have been met adequately by Agency in the	2023-07-29

	pertaining to the patient's current course of illness and treatment to the receiving health care practitioner to ensure a safe and effective transition of care (see tag G0564). The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.58 Discharge Planning. Based on record review and interview, the agency failed to follow its policies for discharge planning to ensure the patient's needs have been met adequately upon discharge in 2 of 2 closed records reviewed (Patient #1, #2) and failed to establish an agency policy in accordance with federal regulation related to the discharge summary. The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Patient Discharge Process" stated, "... Discharge planning is initiated for every home care patient at the time of the patient's admission for home care ... The physician will be involved in the discharge plan and specific ongoing care needs		patient's place of residence, upon death of the patient, or for another reason. With emphasis on 1. Discharge planning shall begin at the time of admission with patients being advised as to the expected duration of treatment. Additional planning with the patient shall occur throughout the course of care and shall include documentation of specific plans and the expected date of discharge at least fifteen (15) calendar days before the services are stopped. C - 120 ADMISSION POLICY Patients are accepted for treatment in the home based on reasonable criteria and under the expectation that the patient's medical, nursing, and social needs can be met adequately by the Agency in the patient's place of residence. C-500 Patient Discharge Process Discharge Planning is initiated for every home care patient at the time of the patient's admission for home care. When patients are admitted for home	

	will be identified and addressed as part of the plan ... A Discharge Plan shall be developed that is documented in writing and includes all written/verbal instruction regarding the patient's ongoing care needs and available resources provided to the patient and family ... if unmet needs are present, appropriate referrals are made to agencies/institutions to meet continuing patient need ...." 2. Review of an agency policy revised 6/28/2022, titled "Comprehensive Patient Assessment" stated, "... A thorough, well-organized, comprehensive, and accurate assessment, consistent with the patient's immediate needs will be completed ... All skilled Medicare and Medicaid patients expect pediatric and post-partum will have comprehensive assessments that include the OASIS [Outcome and Assessment Information Set] specific to mandated time points...." 3. Review of an agency policy revised 6/28/2022, titled "Encoding and Reporting OASIS Data" stated, "... Discharge		is that the patient will be discharged to self-care or care of family when goals are met. Discharging a patient to another provider is permitted under limited circumstances that are documented in the admission notices. With emphasis on SS 2 & 6 2. Patient's needs for continuing care to meet physical and psychological needs are identified and patients are told in a timely manner of the need to plan for discharge or transfer to another level of care/organization. Patients are informed of the reason for discharge and anticipated needs for services after discharge. 6. The Registered Nurse/Therapist shall ensure that the treatment goals and patient outcomes have been met or, if unmet needs are present, appropriate referrals are made to agencies/institutions to meet continuing patient needs.. C-145 Comprehensive Patient Assessment	

	OASIS will be completed by the last skilled discipline whenever possible within 48 hours of the last visit ….” 4. Review of an agency policy revised 6/28/2022, titled “Discharge Policy” stated, “… Discharge planning … shall include documentation of specific plans and the expected date of discharge at least fifteen (15) calendar days before the services are stopped ….” 5. Review of an agency policy revised 6/28/2022, titled “Discharge Summary” stated, “… Discharge Summary … will be mailed to the physician upon request….” Review failed to evidence the policy included the discharge summary will be sent to the primary care practitioner or other health care professional responsible for providing care and services to the patient after discharge from the agency within 5 days of patient discharge per federal regulation. 6. Review of an agency policy revised 6/28/2022, titled “Home Health Change of Care Notice (HHCCN)” stated, “… The home health agency (HHA) must		The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the patient’s return home, or on the physician ordered start of care date. A thorough, well-organized, comprehensive, and accurate assessment, consistent with the patient’s immediate needs will be completed for all patients in a timely manner, but no later than five (5) calendar days after start of care. All skilled Medicare and Medicaid patients except pediatric and post-partum will have comprehensive assessments that include the OASIS data set specific to mandated time points. B-250 Encoding and Reporting Oasis Data The agency will electronically report all OASIS (Outcome and Assessment Information Set) data collected in accordance with State and Federal regulations. The agency and agents acting on behalf of the agency will ensure confidentiality of all patient specific information in the clinical record. PURPOSE To demonstrate	

	provide the HHCCN whenever they reduce or terminate a beneficiary's home health services ...." 7. Record review of an agency document titled "Discharged Patients" dated 6/22/2023, indicated Patient #1, start of care 6/1/2023, was discharged on 6/13/2023 due to patient refused service. During an interview on 6/26/2023, at 4:17 PM, Patient #1 indicated at time of admission to the agency, she was told by the agency that they would find her a home health aide in addition to the other services to be provided. Patient #1 indicated when after the agency did not provide home health aide services after a week or so, she requested the agency find her another agency that could provide home health aide services. Patient #1 indicated she did not refuse services from the agency in the meantime while the agency was to find her another agency to provide home health aide services and indicated she did not receive discharge notice from the agency. Patient #1 indicated the agency never		compliance with the Medicare Conditions of Participation. To transmit assessment data on all skilled (Medicare and Medicaid) patients receiving services from Agency (exceptions: pediatric and pre/post-partum patients). To provide aggregate data to be used in evaluating patient outcomes. To assure confidentiality of patient identifiable information. C-495 Discharge Policy Patients are discharged from treatment in the home when the expectations that the patient's medical, nursing, and social needs have been met adequately by Agency in the patient's place of residence, upon death of the patient, or for another reason. C-820 Discharge Summary A Discharge Summary will be completed for patients discharged from Agency. PURPOSE To record a summary of care received by the patient from the start of care through discharge. To document patient status at the time of discharge, identified unmet needs, and referrals initiated. To document	

	informed her they were going to stop coming for her skilled nursing and therapy services. Patient #1 indicated when after the agency did not show up, she contacted her physician's office who helped her find an alternative agency. Clinical record review on 6/23/2023, evidenced an agency document titled "Start of Care" completed by the registered nurse (RN) and dated 6/1/2023, which indicated the patient was a diabetic and had insulin (an injectable medication used to lower blood sugar) which was to be given based on her blood sugar level, and review indicated the patient did not have a glucometer (a medical device used to measure blood sugar). Review failed to evidence discharge planning included obtaining a glucometer for the patient or informing the physician of the need for a glucometer at time of discharge. Review evidenced an agency document titled "Physician Order" dated 6/5/2023, which indicated the agency informed the patient of no available		instructions given to the patient/caregiver regarding medications, treatment, referrals, and necessary follow-up. C-123 Home Health Change of Care Notice The home health agency (HHA) must provide the HHCCN whenever they reduce or terminate a beneficiary's home health services due to physician/provider orders or limitations of the HHA in providing the specific service. Notification is required for covered and non-covered services when a triggering event changes the beneficiary's plan of care (POC). Triggering events are reductions or terminations in care in accordance with Medicare COPs. The Agency now continues Home Care services while the patients care is transitioned to another Home Health Agency due to unavailable staffing	

	and the patient agreed to use privately paid caregivers until the agency was able to offer home health aide services. Review evidenced an agency document titled "Home Health Discharge Summary (Auto Generated)" dated 6/21/2023, which indicated the agency informed the patient they would assist the patient in finding an agency to provide home health services to which the patient agreed. Review indicated the social worker at Entity D (referring agency) made attempts to find the patient another home care agency. Review failed to evidence efforts made by the agency to find the patient home health aide services. Review failed to evidence communication to the patient's physician regarding the change in discharge plans with the patient being serviced by another home care agency. Review evidenced the last date of service by the agency was 6/12/2023. Review of a document from Entity I (home care agency) obtained 6/23/2023, titled "Home Health Certification and		The Clinical Manager now ensures that all active and recently discharged patients have obtained or plan to obtain supplies needed to monitor their health conditions For Patient #1, privately paid assistance was received before admission to the agency and continued after admission to ensure that the patient was assisted in her home due to caregiver working in the mornings The Agency now assists with finding a home care agency by phone or by supplying the patient or caregiver with a list of homecare agencies for patients that can not be staffed The Clinical Manager team now performs in person discharge visits as soon as possible to decrease interruption of care for the patient The Clinical Team now notifies the primary care physician of patients' lack of funds due to insurance changes by phone and documentation on a verbal order. The Agency now makes several	

	Plan of Care" indicated the patient was admitted for home health services with Entity I on 6/15/2023. Review of an agency document titled "Discharge Non-Visit" identified as the comprehensive assessment completed by the Clinical Manager and dated 6/13/2023, failed to evidence the patient was offered an in-person assessment. During an interview on 6/27/2023, at 10:02 AM, the Clinical Manager indicated the patient agreed to admission to the agency for skilled nursing and therapy services while the agency looked for home health aide services. At 10:47 AM, the Clinical Manager indicated the patient still did not have a glucometer at time of discharge. At 11:20 AM, the Clinical Manager indicated the agency stopped providing services for the patient because the patient's physician informed the agency Entity I (home health agency) would provide home care services to the patient. At 11:27 AM, the Clinical Manager indicated the patient did not refuse services from the agency and agreed to allow the agency		all caregivers listed of the need to perform an in person visit at the time of a discharge The Clinical Manager and quality assurance (QA) team reviewed all active patients' clinical records for patients care that is transitioned to another Home Health Agency, patients that need supplies, any assistance that is privately paid, need for another home care agency to provide care agency due to unavailable staffing, notification to the primary care physician of lack of funds due to insurance changes and need for in person discharge visits and found 13 of 35 active patients did not have information . This deficiency has now been corrected. The Clinical Manager is responsible to ensure that these situations do not recur.	

	to find another agency with home health aide services. At 11:27 AM, the Clinical Manager indicated the discharge assessment was not completed in-person and could not remember why. The Clinical Manager indicated the document was completed based on what she knew of the patient and not based on an assessment on the date of discharge. 8. Clinical record review on 6/28/2023, for Patient #2, evidenced an agency document titled "Home Health Discharge Summary (Auto-Generated)" completed by the Clinical Manager and dated 6/23/2023. Review indicated the patient was discharged due to lack of funds. Review indicated the date the agency last provided services was on 6/12/2023. Review failed to evidence the discharge summary was sent to the physician. Review failed to evidence the agency communicated the lack of funds and need to discharge the patient to the physician. Review failed to evidence the agency provided referrals to other agencies and provided the patient with contact information			

	of other agencies to provide services. Review failed to evidence the agency completed a comprehensive assessment at discharge. During an interview on 6/28/2023, at 1:05 PM, the Clinical Manager indicated the patient's insurance changed and the agency did not have authorization for services. The Clinical Manager indicated there was no documentation the agency notified the physician or the patient of the need for discharge. The Clinical Manager indicated there was no documentation the change of care notice was provided to the patient per agency policy and the discharge summary was not sent to the physician. The Clinical Manager indicated the agency did not provide the patient with contact information of other agencies to provide home health services but indicated the agency should do that. The Clinical Manager indicated the agency completed a comprehensive assessment after the patient's transfer to the hospital on 5/23/2023, but did not complete a comprehensive assessment at discharge after resuming the			

	patient's care on 6/5/2023, after hospitalization. The Clinical Manager indicated she would delete the documents related to the discharge on 5/31/2023, after the patient's transfer to the hospital and before the agency resumed services on 6/5/2023, and re-do them. 9. During an interview on 6/27/2023, at 11:27 AM, the Clinical Manager indicated she was unsure why the agency policy said the discharge summary was to be sent upon request to the primary care practitioner and not sent within 5 days of discharge.			
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. Based on record review and interview, the agency failed to ensure the discharge/transfer summary contained all necessary information regarding the patient's	G0564	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-820 Discharge Summary A Discharge Summary will be completed for patients discharged from Agency. PURPOSE To record a summary of care received by the patient from the start of care through discharge. To document patient status at the time of discharge, identified unmet needs, and	2023-07-29

	discharge including medications and post-discharge goals of care and failed to ensure the discharge summary was sent to the patient's physician responsible for the plan of care within 5 business days of the date of discharge and the transfer summary was sent to the receiving facility within 2 business days of transfer in 2 of 2 closed clinical record reviewed. (Patient #1, #2) The findings include: 1. Review of an agency policy revised 6/28/2022, titled "Discharge Summary" stated, "... The Discharge Summary ... shall include, but not be limited to: ... Status at time of discharge ...." 2. Review of an agency policy revised 1/21/2021, titled "Patient Transfer" stated, "... A Transfer Summary shall be completed by the Registered Nurse/Therapist. This summary ... shall include documentation of ... the patient's physical and psychosocial status, current medications, continuing symptom management needs, summery [sic] of care ... The original Transfer Summary form shall be sent to the new provider or facility ...." 3. Record review of an agency		referrals initiated. To document instructions given to the patient/caregiver regarding medications, treatment, referrals, and necessary follow-up. C-840 Patient Transfer Home care services shall not be arbitrarily terminated. A patient may be transferred as determined by the Director of Nursing or designated Registered Nurse/Therapist in response to the patient's request and/or identified need that cannot be met by the agency. A transfer from the agency to another provider will be documented as a discharge from the agency. PURPOSE To assure continuity of care by providing pertinent information to another home health care company or facility when a patient chooses another provider #4a). The Clinicians now revise the Plan of Care with new updated medications and skin care as soon as new orders are received	

	document titled "Discharged Patients" dated 6/22/2023, indicated Patient #1 was discharged on 6/13/2023. 4. Clinical record review on 6/23/2023, for Patient #1, start of care 6/1/2023, evidenced an agency document titled "Physician Order" dated 6/7/2023, which indicated the patient was to begin Lorazepam (a medication used to treat anxiety) 0.5 milligrams (mg) twice a day as needed. Review of an agency document titled "Skilled Visit Note" completed by the Clinical Manager and dated 6/12/2023, indicated the patient had a pink area to the left vaginal area to which the RN applied ointment of the patient's choice to the area. During an interview on 6/27/2023, at 11:05 AM, the Clinical Manager indicated she applied Neosporin (an antibiotic ointment) to the vaginal area since that is the ointment the patient had in the home. Review evidenced an agency document titled "Home Health Discharge Summary (Auto		b). Discharge Summaries now sent to the Physicians as soon as they are completed #5). Transfer summaries are now sent to the receiving facility with any previous conditions pertaining to why patient is sent to the facility The Administrator and Clinical Manager will be responsible for all Plan of Cares to ensure that medications are updated at time they are received The Administrator and Clinical Manager are responsible to ensure that this situation does not recur.	

	which failed to include the Lorazepam order. Review indicated the skilled nurse provided wound care and failed to evidence the frequency of the wound care to be provided. Review indicated the patient's medications included, but were not limited to, Protonix (a medication used to treat reflux), which indicated the patient was to take if blood sugar was between 150-200 and give 2 units of Novolog (an injectable medication used to treat high blood sugar). Review failed to evidence the pink area to the vaginal area and the ointment to be applied. Review failed to evidence the discharge summary was sent to the physician responsible for the plan of care. During an interview on 6/27/2023, at 10:18 AM, the Clinical Manager the Protonix medication order was not a correct order. At 10:23 AM, the Clinical Manager indicated the wound care frequency was not clear. At 10:57 AM, the Clinical Manager indicated it was not time for the plan of care to be revised yet and indicated the plan of care was revised at time of recertification every 60 days			

	as the reason why the Lorazepam was not included in the medication list and why the pink vaginal area and Neosporin application were not included on the discharge summary since the discharge summary was created by the plan of care. At 11:27 AM, the Clinical Manager indicated the discharge summary had not yet been sent to the physician. 5. Clinical record review on 6/23/2023, for Patient #2, start of care 5/15/2023, evidenced agency documents titled "Physician Order" which indicated the patient fell and was on the floor for several hours on document dated 5/22/2023. Review of document dated 5/23/2023, indicated the patient called the agency to report she fell onto the floor and indicated the agency contacted the physician who requested the patient go to the hospital for evaluation. Review of documents obtained from Entity 1 (hospital) on 6/28/2023, indicated the patient was admitted to the hospital from 5/23/2023 to 6/2/2023. Review of an agency document			

	titled "Home Health Transfer Summary (Auto-Generated)" completed by the Clinical Manager and dated 6/5/2023, failed to include the facility to which the patient was transferred to and failed to evidence the transfer summary was sent to the receiving facility. Review failed to evidence the transfer summary included the patient's recent falls and medication at time of transfer. During an interview on 6/27/2023, at 11:47 AM, the Clinical Manager indicated the agency had not yet sent the transfer summary to the hospital and indicated the hospital name of to where the patient was transferred should be included on the transfer summary.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including	G0570	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-120 Admission Policy Patients are accepted for treatment in the home based on reasonable criteria and under the expectation that the	2023-07-27

	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 agency met the patient needs (see G570); the plan of care was reviewed by the physician, individualized and followed by all agency staff (See tag G0572); the plan of care included all required information / elements for the treatment of the patient (See tag G0574); services and treatment were provided as ordered by a physician (See tag G0578); all treatments provided by agency staff were ordered by a physician (See tag G0580); the physician's verbal orders were documented in the patient's clinical record to include a signature, date and time of the order and failed to ensure the verbal orders were authenticated and dated by the physician (See tag G0584); the plan of care was reviewed by the patients primary care physician at least every 60 days (See tag G0588); physicians were promptly notified of a change in the patient's condition (See tag G0590); the plan of care was revised to reflect current health status and nursing needs (See tag		patient's medical, nursing, and social needs can be met adequately by Agency in the patient's place of residence. Agency shall make available and provide services to all persons without regard to race, color, creed, sex, national origin, handicap, sexual orientation, age, marital status, status with regard to public assistance or veteran status, in compliance with 45CFR parts 80, 84, 91, and other agency guidelines. All services are available without distinction to all program participants, regardless of diagnosis. Agency shall not deny admission to people with a contagious disease, including, but not limited to HIV, MRSA, Hepatitis, and COVID-19. All persons and organizations that either refer persons for services or recommend the agency's services shall also be advised of same. C-260 Medical Social Services ***As of January 11, 2005, ProCare Home Health Services is not licensed to provide the services of a Medical Social Worker. However, the DON is responsible for obtaining a referral to the appropriate	

	G0592); coordination of care for all services provided to the patient (See tag G0606); the written visit schedule was provided to patients (See tag G0614); written instructions were provided to the patient for the patient's medication schedule and instructions (See tag G0616); the treatments to be administered by agency personnel were provided to the patient and caregiver in writing (See tag G0618); and the name and contact information of the clinical manager were provided in writing to the patient and caregiver (See tag G0622). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care. Based on record review and interview, the agency failed to meet the patient's needs in 1 of 1 clinical record reviewed with MSW (medical social worker) needs. (Patient #1) The findings include: Based on record review and interview, the agency failed to meet the patient's needs in 1 of		Social Service Agency to meet the required need of the patient.*** POLICY Medical Social Services shall be provided by a qualified Social Worker or a Social Worker Assistant under the supervision of a Social Worker. These services shall be provided in accordance with a medically approved Plan of Care. The Agency now contacts a Medical Social Worker through the facility that they were discharged from or through Northwest Indiana Community Action for social needs such as unable to afford supplies or anxiety and depression The Clinical Manager and quality assurance (QA) team reviewed all active patients' clinical records for patients with social services requirements and found 9 of 35 active patients that were not supplied Social Services information. This deficiency has now been corrected. The Clinical Manager and QA team will monitor all visits notes and assessments to ensure that all active patients with social services requirements are	

	(Patient #1) The findings include: Review of an agency policy revised 6/28/2022, titled "Admission Policy" stated, "... Patients are accepted for treatment in the home based on reasonable criteria and under the expectation that the patient's medical, nursing, and social needs can be met adequately by Agency ...." Review of an agency policy revised 6/28/2022, titled "Medical Social Services" stated, "... the DON [director of nursing] is responsible for obtaining a referral to the appropriate Social Service Agency to meet the required need of the patient...." Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Start of Care" completed by the registered nurse (RN) and dated 6/1/2023, which indicated the patient had a recent amputation of her left leg and was feeling very anxious about her medications, had been feeling depressed or hopeless for several days, and sometimes had felt lonely or		provided a Social Service coordinator. The Clinical Manager will be responsible to ensure that this deficiency does not recur.	

	isolated from those around her. Review indicated the patient was a diabetic and had insulin (an injectable medication used to lower blood sugar) which was to be given based on her blood sugar level, and review indicated the patient did not have a glucometer (a medical device used to measure blood sugar). Review of agency documents titled "Skilled Nurse Visit" completed by the RN and dated 6/2/2023, 6/9/2023, and 6/12/2023, indicated the patient was anxious about her health. Review failed to evidence the agency made a referral to a medical social worker for the assessment of the patient's anxiety and depression. During an interview on 6/27/2023, at 9:57 AM, the Clinical Manager indicated the agency did not refer patient for social work services and indicated the patient needed social work services. At 10:33 AM, the Clinical Manager indicated the patient was doubling up on her anxiety medication and had run out. At			

	indicated the patient informed the Clinical Manager that she did not have any money for a glucometer, and the Clinical Manager indicated a medical social worker could have helped with obtaining medical supplies. The Clinical Manger indicated the skilled nurse did not obtain the patient's blood sugar level because the agency did not have a glucometer. *. Clinical record review on 6/23/2023, for Patient #6, start of care 5/24/2023, evidenced the patient was referred to the agency for skilled nursing (SN) and physical therapy (PT) services. Review evidenced a start of care assessment performed on 5/24/2023, identified a need for occupational therapy (OT) and incorporated OT services into the plan of care. Record review failed to evidence OT services were started to meet the patient's needs. During an interview on 6/29/2023, at 1:04 PM, when queried why OT failed to initiate services, the Clinical Manager indicated the therapist could not get a hold of the patient by phone, then indicated Procare			

	was able to reach the patient and make regular visits. *. Clinical record review on 6/26/2023, for Patient #8, start of care 2/1/2023, evidenced a document titled "Referral Form" from Person B (patient's referring physician) on 1/25/2023, which indicated the patient had frequent urinary tract infections and seizures and stated, "Order for PT and OT." Record review failed to evidence OT services were initiated for the patient. Record review failed to evidence the agency provided services to meet the patients' needs. During an interview on 6/28/2023, at 1:56 PM, Patient #8 indicated they were not offered OT services through the agency. During an interview on 6/28/2023, at 2:13 PM, PT 1 was queried if the patient would be appropriate for OT services based on their assessment and stated "Yes, it would be helpful." *. Clinical record review on 6/26/2023, for Patient #9, pertinent diagnoses included			

	but were not limited to right side hemiplegia (paralysis to one side) and dysphagia (difficulty swallowing), evidenced an order written on prescription paper by Person C (patient's referring physician) that indicated an order for HHA, ST, OT, and PT on 4/24/2023. Record review of the start of care assessment from 5/19/2023, evidenced the need for HHA, ST, OT, and PT services. Record review failed to evidence the agency provided ST services. Review evidenced HHA, PT and OT services ceased without an explanation. Record review failed to evidence the agency provided services to meet the patient's needs.			
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	G0572	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. Plan of Care C-580 ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a	2023-08-12

	completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to establish a plan of care and failed to ensure services were provided as directed in the plan of care in 5 of 9 clinical records reviewed. (Patient #1, #2, #4, #8, #9) The findings include: Based on record review and interview, the agency failed to establish a plan of care and that services were provided as directed in the plan of care in 3 of 9 clinical records reviewed. (Patient #1, #2 #4) The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Plan of Care" stated, "... The Plan of Care is based on a comprehensive assessment ... Planning for care is a dynamic process that addresses the care, treatment, and services to be provided...." 2. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Home Health		comprehensive assessment and information provided by the patient/caregiver and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. For Patient #2, The Physical Therapist was in-serviced 7/28/2023 on timely documentation of missed visits after all attempts were made. The Administrator and Clinical Manager in-serviced the clinicians on the importance of timely submission of all Comprehensive Assessments The Administrator and Clinical Manager in-serviced the Contracted disciplines on ensuring that all missed visits are documented after several attempts to provide care. The Administrator and Clinical Manager in-serviced the Contracted disciplines on ensuring that all Assessments are submitted in a timely	

	Certification and Plan of Care" for certification period 6/1/2023-7/30/2023, which indicated the agency was to notify the physician of a temperature greater than 100.4 degrees Fahrenheit. Review indicated the agency was to provide occupational therapy (OT) services 2 times a week for 3 weeks. Review failed to evidence OT provided services as directed in the plan of care 2 times during week of 6/4/2023. During an interview on 6/27/2023, at 10:30 AM, the Clinical Manager indicated OT should have provided services as directed in the plan of care. Review of agency document titled "HHA Visit" dated 6/9/2023, indicated the patient's temperature was 101.0 degrees Fahrenheit. Review failed to evidence the agency contacted the physician for the temperature outside of parameters as directed in the plan of care. During an interview on 6/27/2023, at 9:45 AM, the Clinical Manager indicated the physician should have been contacted and she did not see		authorization waiting periods The Clinical Manager now ensures that referral sources are informed at time of referral if Patients needs can be met, and the physicians are notified when frequencies for visits are not met and why The Agency now only accepts patients' whose needs can be met upon acceptance and now ensures that the Primary Care Physicians receive documentation for services that are on hold due to prior authorization approval or injury to staff members. The Clinical Manager and Intake team will monitor all referrals to ensure that Patients' need can be met upon acceptance, and if it cannot, the Patient will not be accepted for care. The Clinical Manager and QA team will monitor the plan of care daily to ensure that physicians are notified of vital signs that are not within Parameters designated for the patient.	

	that he was. 3. Clinical record review on 6/23/2023, for Patient #2, start of care 5/15/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/15/2023-7/13/2023, which indicated the agency was to provide physical therapy (PT) services 2 times a week for 4 weeks. Review failed to evidence the agency provided PT services and failed to evidence any documented communication regarding attempts to schedule the PT visits. During an interview on 6/27/2023, at 11:44 AM, the Clinical Manager indicated the PT had scheduling difficulties and indicated there was no documented communication with the PT regarding attempts to schedule the assessment. 4. Clinical record review on 6/26/2023, for Patient #4, start of care 6/13/2023, failed to evidence a plan of care was developed. During an interview on 6/27/2023, at 12:10 PM, the		The Clinical Manager is responsible to ensure that this deficiency does not recur.	

	plan of care was generated from the start of care assessment which Registered Nurse (RN) 1 did not complete until 6/27/2023. The Clinical Manger indicated RN 1 was a busy nurse and indicated the plan of care was completed as of 6/27/2023 when RN 1 completed the start of care assessment. Review on 6/29/2023, of an agency document titled "Speech Therapy [ST] Plan of Care" dated 6/15/2023, indicated the agency was to provide ST services 1 time a week for 2 weeks. Review failed to evidence ST services were provided the second week during the week of 6/18/2023. Review on 6/29/2023, of an agency document titled "Occupational Therapy Plan of Care" dated 6/21/2023, indicated the agency was to provide OT services 1 time a week for 1 week and then 2 times a week for 4 weeks. Review failed to evidence OT services were provided since the OT evaluation on 6/21/2023. During an interview on			

	Clinical Manager indicated the agency was waiting on insurance authorization for OT and would check on if the ST had made any additional visits. The Clinical Manager indicated the Office Manager submitted the requests for authorization. During an interview on 6/27/2023, at 12:21 PM, the Office Manager indicated due to the late completion of the OT evaluation, the document was still waiting to be reviewed by QA (quality assurance) before she could submit for additional authorization. During an interview on 6/29/2023, at 3:50 PM, the Clinical Manager indicated no additional visits had been made. *. Clinical record review on 6/26/2023, for Patient #8, start of care 2/1/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/1/2023 – 7/30/2023, which indicated PT services were ordered once a week for 8 weeks. Record review failed to evidence PT visits the first calendar week of the certification period (6/1/2023 –			

	6/3/2023). During an interview on 6/29/2023, at 2:01 PM, the Clinical Manager indicated the physical therapist was not scheduled to see the patient until 6/5/2023. *. Clinical record review on 6/26/2023, for Patient #9, start of care 5/19/2023, primary diagnosis of right-side hemiplegia (paralysis to one side), evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/19/2023 – 7/17/2023, indicated home health aide (HHA) services ordered twice a week for 6 weeks and physical therapy (PT) services ordered twice a week for 8 weeks. Record review evidenced a HHA visit completed on 6/14/2023. Review failed to evidence HHA services were provided as ordered in the plan of care.			

	Record review evidenced 4 PT visits completed on 6/9/2023, 6/12/2023, 6/16/2023, and 6/19/2023. Review failed to evidence PT services were provided as ordered on the plan of care. During an interview on 6/29/2023, at 1:22 PM, the Clinical Manager indicated the HHA hurt their back in the patient's home and never returned to work. During an interview on 6/29/2023, at 1:38 PM, the Clinical Manager indicated the PT was injured and they were looking for a new therapist to service the patient.			
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;	G0574	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-580 Plan of Care ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a comprehensive assessment and information provided by the patient/caregiver and health	2023-07-27

	(vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the agency failed to ensure the plan of care was individualized to include interventions, medications, medical supplies, measurable outcomes and goals, and discharge plans for 9 of 9 clinical records reviewed. (Patient #1, #2, #3, #4, #5, #6, #7, #8, #9) The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Plan of Care" stated, "... An individualized Plan of Care written and signed by a physician shall be required for each patient ... The Plan of Care		team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. The agency now ensures the Plan of Care is individualized to include interventions, medications, medical supplies, measurable outcomes and goals and discharge plans The Clinical Manager and Administrator reviewed all active patients' clinical records and found that 9 out 35 patient's Plan of Cares were not updated with medications, medical supplies, measurable outcomes, goals, and discharge plans The Clinical Manager and Administrator reviewed all active patients' clinical records and found that 16 out 35 patients are at risk for falls that were not notated. The Administrator in-serviced the clinical manager on the importance of ensuring that all	

	shall be completed in full to include: ... Medications, treatments, and procedures ... Medical supplies and equipment required ... Treatment goals ... Discharge Plans ...." 2. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/1/2023-7/30/2023, which indicated the skilled nurse was to provide wound care. Review failed to evidence the frequency of the wound care to be provided and the wound care supplies failed to be included in the durable medical equipment (DME) and supplies on the plan of care. Review indicated the patient's diagnoses included, but were not limited to, diabetes (a chronic condition which affects the way the body processes blood sugar) and indicated the physician was to be notified of random blood sugar levels greater than 200 and less than 70. Review indicated the patient's medications included, but were not limited to, Protonix (a medication used to treat reflux),		medication changes, medical supplies, measurable outcomes, goals and discharge plans The Administrator in-serviced the clinical director on the importance of ensuring that interventions for fall prevention, pain, bleeding precautions, parameters and diagnosis related to individualized care and wound care orders is included in the Plan of Care 3a). The Clinical Manager now ensures that Interventions and goals relate to the Primary diagnosis of 100% of all the charts b). Interventions for fall precautions are now evident on 100% of the charts for patients listed with fall risks c). The Clinical Manager now ensures that all measurable goals related to pain are included in the Plan of Care d). The Clinical Manager now ensures that Bleeding Precautions are included in the Safety Measures e). The Clinical Manager now ensures that all Parameters and diagnosis related to the	

	which indicated the patient was to take if blood sugar was between 150-200 and give 2 units of Novolog (an injectable medication used to treat high blood sugar), Lantus (an injectable medication used to treat high blood sugar), and Novolog (an injectable medication used to treat high blood sugar). Review indicated the patient's goals included, but were not limited to, patient was to have optimal effectiveness of pain management and failed to evidence an individualized, measurable goal related to pain. Review failed to evidence the plan of care included interventions and goals related to diabetes. Review indicated the patient lived alone with no willing or able caregiver and indicated the discharge plans were for the patient to discharge to the caregiver when the caregiver demonstrated necessary skills to assist the patient. During an interview on 6/27/2023, at 10:18 AM, the Clinical Manager indicated the wound care supplies should be included in the supplies on the plan of care. The Clinical Manager indicated the Protonix		individualized patients care are listed on the Plan of Care f). The Clinical Manager now ensures that wound care orders are included in the Plan of Care with frequency and type of dressing. The Clinical Manager and QA team will review all Plan of Cares whenever created to ensure that updates are included in the Plans of Care. The Clinical Manager will be responsible for all Plan of Cares and for all updates.	

	medication order was not a correct order. At 10:23 AM, the Clinical Manager indicated the wound care frequency and the discharge plans were not clear. At 10:25 AM, the Clinical Manager indicated the individual goal related to pain level should be included in the plan of care. At 10:48 AM, the Clinical Manager indicated the plan of care should include interventions and goals related to diabetes. 3. Clinical record review on 6/23/2023, for Patient #2, start of care 5/15/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/15/2023-7/13/2023, which indicated the primary diagnosis was dehydration. Review failed to evidence the plan of care included interventions and goals related to the primary diagnosis. Review indicated the patient was admitted to the agency after a hospitalization after a recent fall and indicated the patient's safety measures included fall precautions. Review failed to evidenced the plan of care included skilled nursing interventions related to fall prevention. for Review			

	indicated the patient's goals included, but were not limited to, patient was to have optimal effectiveness of pain management and failed to evidence an individualized, measurable goal related to pain. Review included the patient's medications included, but were not limited to, Plavix (a medication used to thin the blood to treat/prevent blood clots). Review failed to evidence the plan of care included bleeding precautions in the safety measures. Review indicated blood sugar parameters and failed to evidence the patient had a diagnosis of diabetes. During an interview on 6/27/2023, at 11:37 AM, the Clinical Manager indicated the plan of care did not include interventions and goals related to the primary diagnosis and indicated assessing fluid intake and assessing the skin for tenting should have been included in the plan of care. The Clinical Manager indicated the plan of care should include an individualized goal related to the patient's pain. At 11:53 AM, the Clinical Manager indicated			

included bleeding precautions as a safety measure.

During an interview on 6/28/2023, at 12:53 PM, the Clinical Manager indicated the patient was not diabetic and the blood sugar parameters were automatically entered from the program used to create the plans of care.

Review of an agency document titled "Home Health Certification and Plan of Care (Resumption of Care Following Hospital Stay)" for certification period 5/15/2023-7/13/2023, indicated the skilled nurse was to perform wound care to the coccyx (lower back above the buttocks) to include applying a dressing. Review failed to evidence the plan of care was individualized to include the frequency of the wound care and the type of dressing which was to be applied.

During an interview on 6/28/2023, at 12:57 PM, the Clinical Manager indicated she was unsure what the wound care frequency was and indicated she did it at every visit. The Clinical Manager

should be a gauze dressing but had not called the physician to get wound care orders and had not seen any wound care orders from the hospital.

4. During an observation of care at the home of Patient #3 on 6/23/2023, at 9:38 AM, the patient's medications in individual dosing packs from the pharmacy were observed taped to the patient's bedroom wall. A medication list from the pharmacy was attached to the wall noting what medications were included in the dosing packs indicating the patient's medications included, but were not limited to, Midodrine 10 milligrams (mg) three times a day. At 10:05 AM, HHA 1 was observed applying an abdominal binder, compression socks, and foot splints.

During an interview on 6/23/2023, at 10:05 AM, home health aide 1 indicated the patient was supposed to wear the abdominal binder, compression socks, and foot splints. 9:38 AM, the patient's medications in individual dosing packs from the pharmacy were observed taped to the patient's bedroom wall. A medication list

	from the pharmacy was attached to the wall noting what medications were included in the dosing packs indicating the patient's medications included, but were not limited to, Midodrine 10 milligrams (mg) three times a day. Clinical record review on 6/22/2023, evidenced an agency document titled "Recertification" identified as the comprehensive assessment, completed by the Clinical Manager, and dated 6/12/2023. Review indicated the patient needed straight catheterization (a procedure used to drain urine from the body by inserting a plastic tube into the bladder) every 4 hours. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/13/2023-8/11/2023, which evidenced blanks for to whose care the patient was to be discharged as part of the discharge plan. Review indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged			

	hip and failed to evidence wound treatment orders in the plan of care. Review indicated the plan of care contained the wrong street address for the patient. Review failed to evidence the plan of care included the straight catheter to include the size of the catheter and frequency. Review failed to evidence the plan of care included the abdominal binder, compression socks, and foot splints. Review indicated the medication in the plan of care included the correct frequency as review indicated Midodrine was to be taken twice a day. During an interview on 6/27/2023, at 2:57 PM, the Clinical Manager indicated she left it blank since the patient required ongoing care. The Clinical Manager indicated the patient moved over a year ago and the correct patient address was not included in the plan of care. At 3:00 PM, the Clinical Manager indicated she was unsure what the wound treatment order was for the left hip, because Entity I (home health agency) did the wound care. At 3:11 PM, the Clinical Manager indicated the size of			

	the unit of measure for catheters) and the catheter should be included in the plan of care to include the type, size, and frequency. At 3:54 PM, the Clinical Manager indicated the abdominal binder, compression socks, and foot splints should be included in the plan of care if the patient needed them. At 3:24 PM, the Clinical Manager indicated medications should be reviewed at every skilled nurse visit and added to the plan of care once clarified with the physician. 5. Clinical record review on 6/27/2023, for Patient #4, indicated an agency document titled "Start of Care" dated 6/13/2023, indicated the patient had a feeding tube with the feeding running during the assessment. Review indicated the tube feeding was Jevity 1.5 (type of formula) 60 milliliters continuous and flush with water after medication administration. Review indicated the patient denied being a diabetic, did not take any medications for diabetes, and failed to evidence the patient checked blood sugar levels. Review of an agency document			

	titled "Home Health Certification and Plan of Care" for certification period 6/13/2023-8/11/2023, failed to evidence the plan of care included the size of the feeding tube, the type, amount, and frequency of feedings, and the amount of water flush. Review failed to evidence the plan of care included the type and frequency of feeding tube site care. Review indicated fasting and random blood sugar parameters for when to call the physician and failed to evidence how often the patient was to check the blood sugar. Review indicated the patient was to take glucose gel for a low blood sugar. Review failed to evidence the glucose was included in the patient's list of medications on the medication profile. Review indicated the nurse was to instruct the patient on the bowel retraining program but failed to include the specifics to what the program was.			

	During an interview on 6/27/2023, at 12:10 PM, the Clinical Manager indicated RN 1 was a very busy nurse and indicated she was aware the note was not done until 6/27/2023. During an interview on 6/29/2023, at 3:42 PM, the Clinical Manager indicated the documentation should include the type, size, patency, placement, and appearance of the feeding tube and site. At 3:46 PM, the Clinical Manager indicated the blood sugar parameters and glucose should not be included in the plan of care but was probably automatically included in the plan of care from the software used to create the plan of care. The Clinical Manager indicated she was unsure what the bowel retraining program was and the plan of care should be more specific. 6. Clinical record review on 6/26/2023, for Patient #5, evidenced an agency document titled “Recertification” dated 5/6/2023, which indicated the patient had a primary diagnosis of quadriplegia (paralysis of all			

	abdominal stoma (an opening) which was used for catheterization for urine removal several times a day. Review indicated the patient lived alone and was catheterized several times a day by a family member but failed to identity the family member and their availability. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 5/7/2023-7/5/2023, indicated the interventions included, but were not limited to, the nurse was to instruct the patient on self-catheterization. Review indicated the nurse was to perform catheterization every morning but failed to evidence the frequency of the catheterizations throughout the day. Review failed to evidence the size of the catheter to be used and to where the nurse was to perform catheterization. Review failed to evidence goals related to the catheterization. During an interview on 6/29/2023, at 3:56 PM, the Clinical Manager indicated the patient can not self-catheterize and the plan of care was not			

	individualized. The Clinical Manager indicated the plan of care should be specific to the size of the catheter and that the patient should be catheterized through a stoma on the patient's side of the abdomen. At 4:06 PM, the Clinical Manager indicated the plan of care should include goals related to the catheter such as the bladder will be drained and the stoma would be intact. Review of an agency document titled "Skilled Nurse Visit" dated 6/25/2023, indicated the patient had a foot drop support in place to both feet. Review failed to evidence the foot drop supports were included in the plan of care. During an interview on 6/29/2023, at 4:09 PM, the Clinical Manager indicated the supports should be included in the plan of care. 7. During an observation of care at the home of Patient #6 on 6/23/2023, at 11:52 AM, the patient's medications were observed on the kitchen counter to include, but not limited to, clopidogrel (a blood			

	treat/prevent blood clots). Review of an agency document on 6/23/2023, titled "Home Health Certification and Plan of Care" for certification period 5/24/2023-7/22/2023, failed to evidence the plan of care included bleeding precautions in the safety measures. During an interview on 6/23/2023, at 12:59 PM, Patient #6 indicated he/she self-administered 35 units of insulin twice a day. During an interview on 6/29/2023, at 3:18 PM, the Clinical Manager indicated bleeding precautions should be included in the patient's plan of care. *. Clinical record review on 6/23/2023, for Patient #6, start of care 5/24/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/24/2023 – 7/22/2023, which indicated the patient was prescribed Rivaroxaban (blood thinning medication used to treat and prevent blood clots) and failed to evidence the patient was placed on bleeding			

	indicated the patient was prescribed Insulin Glargine (medication used to treat diabetes that is injected into the skin) as "50 Units 30 Units twice a day..." which evidenced 2 different doses. Review of this document evidenced the frequency and duration for skilled nursing services was ordered as 2 - 3 times per week, which failed to evidence indications for when to provide more than 2 visits a week. Review of this document indicated wound care was ordered for the patient's right and left legs to treat below the knee amputation incision care which included but was not limited to "...Cleanse wound with SALINE IF NEEDED ...." Review of the wound care instructions on the plan of care failed to evidence indications for when saline would be needed. During an interview on 6/29/2023, at 12:26 PM, the Clinical Manager indicated the patient was supposed to take 30 Units of Insulin Glargine. At 12:28 PM, the Clinical Manager indicated the patient was taking Rivaroxaban to prevent blood clots due to the surgical			

	incisions on the patient's legs and should have been placed on bleeding precautions under the safety measures on the plan of care. At 12:29 PM, the Clinical Manager indicated the patient's incisions might require saline if the wound had drainage. At 12:58 PM, the Clinical Manager indicated the patient might require more than 2 visits per week if there were complications with the wounds. *. Clinical record review on 6/22/2023, for Patient #7, start of care 6/1/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/1/2023 – 7/30/2023, that indicated the patient was prescribed Acetaminophen-Codeine (medication to treat moderate to severe pain) 1 tablet every 6 hours for 7 days and failed to evidence a start/end date. Review evidenced the patient was prescribed Furosemide (diuretic/water pill) 1 tablet in the morning for 30 days and failed to evidence a start/end date. Review evidenced the			

	3350 (MiraLAX/laxative powder mix with liquid) 1 pack, 1 time. Review of this document indicated the skilled nurse (SN) orders for stage 1 wound care as needed were to cleanse with saline, apply gauze, cover and secure with tape OR apply a barrier cream, which failed to evidence which procedure to perform and when. Review evidenced the patient was on continuous oxygen and failed to evidence oxygen safety precautions on the plan of care. Record review evidenced the patient utilized an external ventilator at night. Review failed to evidence the external ventilator listed under the durable medical equipment (DME) section, contact information for the DME company, or individualized setting failed to evidence the patient Review failed to evidence the plan of care was individualized to specific patient information. During an interview on 6/27/2023, from 4:02 PM – 4:04 PM, the Clinical Manager indicated the patient was still taking the acetaminophen-codeine as needed for pain and had a			

	couple pills left in the prescription bottle. The Clinical Manager indicated the Furosemide did not have an end date. The Clinical Manager indicated PEG 3350 was not supposed to be a one-time order and the patient is still taking it daily as needed for constipation. During an interview on 6/27/2023, from 4:13 PM – 4:19 PM, the Clinical Manager indicated the skilled nurse would determine which treatment for the family to perform for the stage 1 wound. Based on if there were open areas or not on the patient's skin. The Clinical Manager indicated the agency should have obtained a specific stage 1 treatment order from the physician. The Clinical Manager indicated oxygen safety precautions was not listed on the Plan of Care but should teach the patient oxygen is flammable. During an interview on 6/27/2023, at 4:22 PM, when queried the type of external ventilator the patient had, the Clinical Manager indicated the were not sure of the name of			

	the machine, device settings, or where the machine came from. The Clinical Manager indicated the external ventilator went over the nose, the family manages the settings and the patient wears it at night. *. Clinical record review on 6/26/2023, for Patient #8, start of care 2/1/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/1/2023 – 7/30/2023, that indicated the patient was to take Linezolid (antibiotic) twice a day for 10 days. Review failed to evidence a start and end date for the medication. This document evidenced the patient was taking pantoprazole (medication to decrease acid production in the stomach) one tablet daily before meals. Review failed to evidence how many tablets per day or how many meals to take pantoprazole with. Review evidenced the patient was taking Clopidogrel (anti-platelet medication used to prevent the formation of blood clots) and			

	Aspirin (pain reliever with anti-platelet properties) daily. Review failed to evidence the patient was placed on bleeding precautions for safety measures. During an interview on 6/29/2023, at 1:48 PM, with the Clinical Manager indicated the patient was not currently taking Linezolid and should have had an end date listed, and the patient should only take the Pantoprazole once a day with breakfast. At 1:49 PM, the Clinical Manager indicated a patient should be placed on bleeding precautions when taking any anti-platelet medication. *. Clinical record review on 6/26/2023, for Patient #9, start of care 5/19/2023, pertinent diagnosis of dysphagia (difficulty swallowing), evidenced an agency document titled "Home Health Certification and Plan of Care" which indicated the patient's only nutritional requirement was no added salt. Review failed to evidence a diet consistent with the patient's diagnosis of dysphagia. Review failed to evidence swallowing			

	measures. During an interview on 6/29/2023, at 1:19 PM, the Clinical Manager indicated the patient was on a regular diet and was not told the patient had difficulty swallowing.			
G0578	Conformance with physician orders 484.60(b) Standard: Conformance with physician or allowed practitioner orders. Based on record review and interview, the agency failed to ensure conformance with physician orders in 3 of 3 clinical records reviewed with wounds. (Patient #3, #6, #7) The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Plan of Care" stated, "... ProCare Home Health services are furnished under the general supervision and direction of the patient's physician...." Clinical record review on 6/22/2023, for Patient #3, evidenced an agency document titled "Physician Order" dated 6/15/2023, which indicated the	G0578	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. Plan of Care C-580 ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a comprehensive assessment and information provided by the patient/caregiver and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days.	2023-07-29

	agency was to increase home health aide (HHA) services on every Saturday and Sunday to 8 hours a day. Review failed to evidence the agency conformed to physician orders and indicated the agency provided only 4 hours of HHA services on 6/17/2023, 6/18/2023, 6/24/2023, and 6/25/2023. During an interview on 6/27/2023, at 3:35 PM, the Clinical Manager indicated the agency had not provided the patient with 8 hours of HHA services on every Saturday and Sunday yet because the agency was still waiting on insurance authorization. *. Clinical record review for patient #6, start of care 5/24/2023, pertinent diagnosis of recent bilateral below the knee amputations (BKA), evidenced faxed documents that contained a discharge summary from Entity A (referring hospital). This document indicated the patient was admitted to the hospital on 6/3/2023 for wound dehiscence (the separation of wound edges) of the bilateral BKA's. This document evidenced the		#2). As of 7-5-2023, patient #3 Home Health Aide hours are now increased to 8 hours daily #3). The Clinical Manager now ensures that ordered Antibiotics and Labs are administered according to physician's orders at time of discharge The Clinical Manager reviewed 100% of active Patients' Charts and noted that 35% did not show the agency conforming with all orders. The Clinical Manager and the Administrator are now also the intake coordinators. They now review all orders to ensure they are completed in a timely manner. The Clinical Manager is responsible to ensure that this situation does not recur.	

	Entity A on 6/13/2023, with new medications ordered including but not limited to 2 new antibiotics (Ciprofloxacin and Linezolid), and a complete blood count (CBC) and comprehensive metabolic panel (CMP) via blood draw, weekly for 2 weeks, and then fax results to Person Q (infectious disease physician). Record review evidenced on the agency's activity log evidenced the medication profile was signed on 6/26/2023, when the antibiotic medications Ciprofloxacin and Linezolid were added, 13 days after they were ordered. Record review evidenced an agency document titled "Physician Order" electronically signed by the Clinical Manager on 6/26/2023, that stated "... Orders for labs for CBC and CMP weekly for two weeks to be started on 7-3-23 ...." Review evidenced labs would start 20 days after they were ordered. Record review failed to evidence conformance of physician orders. During an interview on			

	queried if the ordering physician was made aware of delay in lab draws, the Clinical Manager indicated they did not reach out to Person Q yet. The Clinical Manager indicated when they realized the patient was not taking the antibiotics, they wrote an order. *. Clinical record review on 6/29/2023, for patient #7, start of care 6/1/2023, evidenced faxed documents from the office of Person X (patient's physician) dated 6/19/2023, which indicated blood draw labs were ordered for a CMP, a CBC and a TSH (test to measure the thyroid stimulating hormone in the blood) on 6/5/2023. Record review of Entity A's (hospital) laboratory indicated the CMP, CBC and TSH blood tests resulted on 6/23/2023, 18 days after the tests were ordered. Record review of patient #7's discharge documents retrieved from Entity A on 6/27/2023, evidenced the after visit summary had instructions to complete the laboratory blood			

	panel) by 6/6/2023 and a CBC by 6/7/2023, from Person Y, patient #7's hematologist (physician who specializes in the study of blood and its diseases). Review evidenced Person Y ordered the results to be faxed to their office when the BMP and CBC resulted. Review failed to evidence the orders from Person Y for the CBC and BMP were carried out. Record review failed to evidence the agency conformed to the patients discharge orders. During an interview on 6/29/2023, from 12:13 PM – 12:18 PM, the Clinical Manager indicated they performed the blood draw order when it was received, even though it was ordered on 6/5/2023. The clinical manager indicated they did not review the patients after visit summary when discharged from Entity A and stated the agency "goes by what information is given by the hospital on the referral."			
G0580	Only as ordered by a physician 484.60(b)(1)	G0580	The Director of Nursing and Administrator reviewed the following policy for reeducation	2023-07-29

	Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on observation, record review, and interview, the agency failed to ensure the services and treatments were provided only as ordered by a physician in 6 of 9 clinical records reviewed. (Patient #1, #2, #3, #5, #6, #7) The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Physician Orders" stated, "... All medications, treatments, and services provided to patients must be ordered by a physician...." 2. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Skilled Visit Note" completed by the Clinical Manager and dated 6/12/2023, which indicated the patient had a pink area to the left vaginal area to which the nurse applied ointment of the patient's choice to the area. Review failed to evidence a treatment order for the vaginal area. At 11:05 AM, the Clinical Manager indicated she applied Neosporin (an antibiotic		and clarification of procedures. C-635 Physician Orders All medications, treatments and services provided to patients must be ordered by a physician. The orders may be initiated via telephone or in writing and must be countersigned by the physician in a timely manner. Orders may be received via facsimile; however, the agency is responsible for obtaining an original signature if it would be required by surveyors or other regulatory personnel. All medications and treatments that are part of the patient's plan of care, must be ordered by the physician. Verbal orders must be taken by a PHHS Registered Nurse and in accordance with applicable State and Federal law and organization policy. All verbal orders must be "read back" to the physician to verify the accuracy of the orders and to decrease errors to inaccurate documentation of verbal orders. Orders will be accepted only from physicians who have a current license in the state of operation. The Agency now ensures that all	

	ointment) to the vaginal area since that is the ointment the patient had in the home. The Clinical Manager indicated there was no order from the physician for the application of Neosporin to skin breakdown on the vaginal area. 3. Clinical record review on 6/23/2023, for Patient #2, evidenced an agency document titled "Resumption of Care" completed by the Clinical Manager and dated 6/5/2023, which indicated the patient had an open area to the coccyx (lower back above the buttocks) and indicated the nurse cleansed the area with normal saline (wound cleanser) and applied a bordered gauze. Review failed to evidence an order for the wound care to the coccyx. During an interview 6/28/2023, at 12:57 PM, the Clinical Manager indicated she had not called the physician to get wound care orders and had not seen any wound care orders from the hospital. 4. Clinical record review on 6/22/2023, for Patient #3, evidenced an agency document		patient care is performed with a verbal or signed Physician order before implementing care. The Clinical manager and the Administrator in-serviced all field staff on physician orders. The Clinical Manager and QA team will monitor all documentation daily to ensure that patients' needs are met through physician orders that are requested or received before care is rendered. The Clinical Manager is responsible to ensure that this problem does not recur.	

	titled "Home Health Certification and Plan of Care" for certification period 6/13/2023-8/11/2023, which evidenced the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) to the left hip and failed to evidence wound treatment orders. Review of an agency document titled "Recertification" identified as a comprehensive assessment completed by the Clinical Manager and dated 6/12/2023, which indicated the nurse cleansed the wound with saline (wound cleanser), lightly packed the wound with gauze, and cover with gauze. Review failed to evidence an order for the wound. During an interview on 6/27/2023, at 3:00 PM, the Clinical Manager indicated she did complete wound care at the visit on 6/12/2023 and was unsure what the wound treatment order was for the left hip, because Entity I (home health agency) did the wound care. The Clinical Manager indicated she provided the			

	patient and the home health aide told her the nurse was doing from Entity I. 5. Clinical record review on 6/26/2023, for Patient #5, evidenced agency documents titled "Skilled Nurse Visit" completed by the RN and dated 6/24/2023, 6/25/2023, and 6/26/2023, which indicated the nurse performed digital stimulation (a medical procedure where a finger is inserted into the rectum to trigger a bowel movement). Review failed to evidence an order for the procedure. During an interview on 6/29/2023, at 4:23 PM, the Clinical Manager indicated the patient has had the procedure done for years and was surprised the order was not included in the plan of care. 6. During an observation of care at the home of Patient #6, on 6/23/2023, at 12:23 PM, the Clinical Manager was observed cleansing the wounds to both below the knee amputations with a bottle labeled "wound cleanser" and then applying a wound vacuum dressing			

	indicated to be 125 mmHg (millimeters of Mercury; unit of measure for pressure). At 12:55 PM, the Clinical Manager was observed removing a dressing to the right middle finger, cleansing with wound cleanser, applying a lubricated gauze and wrapping with dry gauze. During an interview on 6/29/2023, at 3:27 PM, the Clinical Manager indicated there was no order for wound treatment to the right middle finger wound. *. Clinical record review on 6/23/2023, for patient #6, start of care 5/24/2023, pertinent diagnosis of a recent bilateral below the knee amputation (BKA), evidenced an agency document titled "Physician Order" electronically signed by the Clinical Manager on 6/20/2023, stated "Dear doctor, Skilled Nurse to see patient 2 times a week for wound care with wound vac therapy (wound is attached to a vacuum assisted device to promote healing and wound closure) …." Record review failed to evidence an order for wound vac settings to include but not limited to			

	vacuum pressure amount and frequency. Review of an agency document titled "OASIS-E Resumption of Care" performed by the Clinical Manager on 6/15/2023, evidenced a section titled "Wound Care Flowsheet" that indicated the assessments and wound care performed to the right and left BKA. This documentation of the assessment indicated the vacuum setting was continuously set to 125 mm/hg (millimeters of mercury) and stated, "Cleansed wounds with saline and applied black foam to wounds and attached wound vac with no leaks noted after application …." Record review failed to evidence an order for wound care as it was documented. Review of an agency document titled "Skilled Nurse Visit" electronically signed by the Clinical Manager on 6/20/2023, had an area subtitled "Interventions" that indicated wound vac care was provided to BKA's which included a Y-shaped connection tube to assist drainage from both lower extremity surgical wounds to			

	the device. Review failed to evidence an order for wound care to be performed as it was documented. During an interview on 6/29/2023, at 12:42 PM, when queried if the agency had a copy of the wound vac orders, the Clinical Manager indicated they asked the hospital but never received them. *. Clinical record review on 6/23/2023, for patient #7, start of care 6/1/2023, evidenced an agency document titled "OASIS-E Start of Care" electronically signed by the Clinical Manager on 6/1/2023, which indicated the patient received wound care on the patient's coccyx (tailbone) which indicated they cleansed the wound with saline and then the caregiver "applied cream of [his/her] choice to area and left open to air …." Review failed to evidence which cream applied to the patient during a skilled nurse visit. Record review failed to evidence an order for the wound care provided. During an interview on 6/27/2023, at 4:25 PM, the Clinical Manager indicated the			

	cream used was already in the patient's home and did not have an order for it.			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the agency failed to have the physician review and revise the plan of care no less than every 60 days for 2 of 3 clinical records reviewed receiving services greater than 60 days. (Patient #5, #8) The findings include: Clinical record review on 6/26/2023, for Patient #5, evidenced agency documents titled "Home Health Certification and Plan of Care". Review indicated the plan of care for certification period 3/8/2023-5/6/2023 was reviewed and signed by the physician on 3/22/2023. Review indicated the document for certification period	G0588	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. Medical Supervision C-645 Physicians will be informed, at the time their patients are admitted to the agency, of each parties' responsibilities in managing patient care. All patients must be under the care of a licensed, practicing physician, podiatrist, or osteopath when receiving home care services through a Medicare certified agency. The patient's primary physician shall be responsible for providing signed orders, and for establishing and reviewing the patient's Plan of Care throughout the time the patient is receiving services The Clinical Manager reviewed 100% of all the active patient charts and noted 25% of the charts had incomplete End of Episode Summaries and Plan of Cares that were not reviewed by	2023-07-29

	5/7/2023-7/5/2023 indicated the physician reviewed and signed the plan of care on 6/5/2023 and evidenced the plan of care was not reviewed by the physician no less than every 60 days. During an interview on 6/29/2023, at 3:58 PM, the Clinical Manager indicated she believed the plan of care was sent to the physician late because the agency was waiting on quality assurance (QA) review. *. Record review of an agency policy titled "Physician Summary" revised on 6/28/2022, stated "A summary report will be provided to the physician no less than every sixty (60) days. The summary will provide a written report of the patient's current condition, the treatment/services provided, and the patient's response to the current treatment and/or medications, and pertinent changes in the patient's physical, emotional, or environmental condition since the last report ... The progress note/physician summary will be completed by the professional		the Primary Care Physician. These have now been completed and sent to the physician. The Agency now ensures that the End of Episode Summary is completed for each patient The Clinical Manager and QA Team now monitors the Plan of Cares daily to ensure that the Primary Care Physician reviews the POCs and End of Episode Summaries no less than every 60 days. The Clinical Manager is responsible to ensure that this deficiency does not recur.	

	The summary note will include: … Clinical summary of the care, treatment and services provided during the previous sixty (60) day episode of care … Patient response to the services and progress toward established goals. Summary of current needs and involvement of other community/family caregivers or services … Date sent to physician and the name of the physician ….” *. Record review of an agency policy titled “Medical Supervision” revised 6/28/2023, stated “The Physician responsibilities include … Management of medical problems … Review/update of Plan of Care at least every sixty (60) days … Evaluation of Quality of Care ….” *. Clinical record review on 6/26/2023, for patient #8, start of care 2/1/2023, evidenced an agency document titled “Home Health End of Episode Summary” from the certification period 4/2/2023 – 5/31/2023, indicated treatments and goals provided by skilled nursing (SN). This document failed to evidence a medication profile,			

	provided with their frequencies. Record review failed to evidence the patient received SN services from ProCare. Record review failed to evidence other agencies involved with the patient's care on the summary per the agency policy.			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to ensure physician notification for services not provided as ordered on the plan of care for 3 of 6 clinical records reviewed with therapy services ordered. (Patient #1, #2, #4). The findings include: 1. Review of an agency policy revised 6/28/2022, titled "Patient Admission Process" stated, "... If the agency cannot fulfill the required health care	G0590	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-645 Medical Supervision Physicians will be informed, at the time their patients are admitted to the agency, of each parties' responsibilities in managing patient care. All patients must be under the care of a licensed, practicing physician, podiatrist, or osteopath when receiving home care services through a Medicare certified agency. The patient's primary physician shall be responsible for providing signed orders, and for establishing and reviewing the patient's Plan of Care throughout the time the patient	2023-07-27

	need, ... referral source will be notified...." 2. Clinical record review on 6/23/2023, for Patient #1, start of care 6/1/2023, evidenced a physician order from Person H (physician) signed 5/26/2023, indicating the patient was to be admitted for home care services to include a home health aide. Review failed to evidence the agency provided home health aide services and failed to evidence the agency notified the physician that home health aide services were not provided. During an interview on 6/27/2023, at 10:23 AM, the Clinical Manager indicated the agency did not provide home health aide services because the agency did not have staffing and indicated the agency was unable to contact Person H (ordering physician) and indicated there was no documentation of the efforts made to reach Person H. 3. Clinical record review on 6/23/2023, for Patient #2, start of care 5/15/2023, evidenced a physician order from Person M (physician) dated 5/8/2023, indicated the patient was to be		is receiving services As of 7-3-2023, The Physician is now aware that patient #1, #2, and #4 were not provided services for Home Health Aide and Physical Therapy services due to staff unavailability for patient #1, and caregiver stated they would assist the patients care for patient #4, and patient #2 was unable to be reached for Physical Therapy services at time of admission. The Administrator In-Serviced the Clinical Manager on ensuring that physicians are notified when ordered services are not provided. The Clinical Manager and the Administrator now review all of the new referrals to ensure that all orders are done in a timely manner The Administrator is responsible to ensure that this situation does not recur.	

	admitted for home care services to include physical therapy (PT) services. Review failed to evidence the agency provided PT services and failed to evidence the agency notified the physician that PT services were not provided. During an interview on 6/27/2023, at 11:44 AM, the Clinical Manager indicated the agency did not notify the physician that PT services were not provided as ordered. 4. Clinical record review on 6/23/2023, for Patient #4, start of care 6/13/2023, evidenced an agency document titled "Physician Order" dated 6/14/2023, which indicated the agency was to provide HHA services 2 times a week for 8 weeks. Review failed to evidence the agency provided HHA services. During an interview on 6/27/2023, at 12:18 PM, the Clinical Manager indicated the agency did not provide HHA services because the agency did not have a HHA available. The Clinical Manager indicated the agency did not inform the			

unable to provide HHA services as ordered.

Review of an agency document on 6/29/2023, titled "Occupational Therapy Plan of Care" dated 6/21/2023, indicated the agency was to provide OT services 1 time a week for 1 week and then 2 times a week for 4 weeks. Review failed to evidence OT services were provided since the OT evaluation on 6/21/2023.

During an interview on 6/27/2023, at 12:20 PM, the Clinical Manager indicated the agency was waiting on insurance authorization for OT and indicated the physician had not been notified that the agency could not provide services per patient need due to an authorization issue.

*. Record review of an agency policy titled "Medical Supervision" revised 6/28/2023, stated "Physician will be contacted when any of the following occurs ... Any change in patient condition or agency services, including non-compliance of the patient related to the plan of care ...."

*. Clinical record review on

	6/26/2023, for Patient #9, start of care 5/19/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/19/2023 – 7/17/2023, which had speech therapy (ST) ordered twice a week for 5 weeks, physical therapy (PT) ordered once a week for one week and twice a week for 8 weeks, occupational therapy (OT) ordered twice a week for 3 weeks, and home health aide (HHA) ordered twice a week for 6 weeks. This document indicated OT and HHA would start once prior authorization was approved. Record review evidenced a PT evaluation on 5/24/2023, and 4 subsequent visits. Record review evidenced an OT evaluation on 6/12/2023, and no further visits. Record review evidenced a HHA visit completed on 6/14/2023, and no other visits. Record review failed to evidence ST visits. Record review failed to evidence the physician was notified of ordered services not being provided by the agency. During an interview 6/29/2023, at 1:22 PM, the Clinical Manager indicated the HHA hurt their			

	back, then quit, and the patient's caregiver agreed to wait for another HHA. The Clinical Manager indicated the physician was not notified of the HHA services not provided. During an interview 6/29/2023, at 1:35 PM, the Clinical Manager indicated the physician was not made aware of OT services not being provided and must have been an oversight. During an interview 6/29/2023, at 1:40 PM, the Clinical Manager indicated PT 2 was injured and was looking for another therapist for the patient. The Clinical Manager indicated there was not documentation of physician notification. During an interview on 6/29/2023, at 1:43 PM, the Clinical Manager indicated the physician was not made aware of the agency not providing ST services.			
G0592	Revised plan of care 484.60(c)(2)	G0592	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures.	2023-08-12

	A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on record review and interview, the agency failed to ensure the plan of care was revised as needed with any changes in 3 of 9 clinical records reviewed. (Patient #1, #2, #3) The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Plan of Care" stated, "... Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary ...." 2. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Physician Order" dated 6/7/2023, which indicated the patient was to begin Lorazepam (the generic name for Ativan, a medication used to treat anxiety) 0.5 milligrams (mg) twice a day as needed. Review evidenced an agency document titled "Home Health		C-580 Plan of Care ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a comprehensive assessment and information provided by the patient/caregiver and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. In cases where patient care is provided in a clinical setting with rotating team members of physicians, orders shall be processed in accordance with Agency policy and the agency shall accept the signature and date of the physician assigned to the clinic at the time orders are presented for signature as the attending physician for the patient The Clinical Manager now ensures that the plan of care will be consistently reviewed, revised and updated as needed	

	Certification and Plan of Care" for certification period 6/1/2023-7/30/2023, which indicated the patient's medications included, but were not limited to, Ativan 0.5mg three times a day. Review failed to evidence the plan of care was updated to include the change in medication. During an interview on 6/27/2023, at 10:57 AM, the Clinical Manager indicated it was not time for the plan of care to be revised yet and indicated the plan of care is revised at time of recertification every 60 days. 3. Clinical record review on 6/23/2023, for Patient #2, evidenced an undated document titled "After Visit Summary" from Entity A (hospital) from hospital discharge date of 6/2/2023, which indicated the patient was to stop taking Losartan (a medication used to control high blood pressure) as ordered by the patient's primary physician. Review of an agency document titled "Home Health Certification and Plan of Care (Resumption of Care Following		and will reflect the patient's current progress, outcomes and goals and all physicians involved in the patient's plan of care are approved by the patient's primary care practitioner and notated on the plan of care. The Clinical Manager and the Administrator are now also the intake coordinators. They now review all orders to ensure they are completed in a timely manner. The Clinical Manager and QA team now review all plans of care for consistency, and update as needed and to reflect the patient's current progress, outcomes and goals and all physicians involved in the patient's plan of care are approved by the patient's primary care practitioner and notated on the plan of care. G0592 Revised plan of care 08/12/2023 The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-580 Plan of Care	

	Hospital Stay) for certification period 5/15/2023-7/13/2023, and signed by the Clinical Manager on 6/5/2023, indicated the patient's medications included Losartan and failed to evidence the plan of care was revised to include medication changes. During an interview on 6/28/2023, at 1:11 PM, the Clinical Manager indicated the plan of care should have been revised to include the discontinuation of the Losartan but was not due to an oversight. 4. Clinical record review on 6/22/2023, for Patient #3, evidenced an agency document titled "Physician Order" dated 6/15/2023, which indicated the agency was to increase home health aide (HHA) services on every Saturday and Sunday to 8 hours a day. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 6/13/2023-8/11/2023, indicated the agency was to provide HHA services 4 hours a day and failed to be revised to include the		ProCare Home Health services are furnished under the general supervision and direction of the patient's physician. The Plan of Care is based on a comprehensive assessment and information provided by the patient/caregiver and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that patient needs are met, and will be updated as necessary, but at least every sixty (60) days. In cases where patient care is provided in a clinical setting with rotating team members of physicians, orders shall be processed in accordance with Agency policy and the agency shall accept the signature and date of the physician assigned to the clinic at the time orders are presented for signature as the attending physician for the patient The Clinical Manager now ensures that the plan of care will be consistently reviewed, revised and updated as needed and will reflect the patient's current progress, outcomes and	

	provision of HHA services of 8 hours of HHA services every Saturday and Sunday. During an interview on 6/27/2023, at 3:35 PM, the Clinical Manager indicated the agency had not provided HHA services for 8 hours on Saturday and Sunday, so the agency had not yet revised the plan of care.		goals and all physicians involved in the patient's plan of care are approved by the patient's primary care practitioner and notated on the plan of care. The Clinical Manager and the Administrator are now also the intake coordinators. They now review all orders to ensure they are completed in a timely manner. The Clinical Manager and QA team now review all plans of care for consistency, and update as needed and to reflect the patient's current progress, outcomes and goals and all physicians involved in the patient's plan of care are approved by the patient's primary care practitioner and notated on the plan of care. The Clinical Manager is responsible to ensure that this situation does not recur. The Clinical Manager is responsible to ensure that this situation does not recur.	
G0606	Integrate all services	G0606	The Director of Nursing and Administrator reviewed the following policy for reeducation	2023-07-27

	484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on observation, record review and interview, the home health agency failed to coordinate care with between disciplines and with other entities providing care to the patient in 6 of 9 clinical records reviewed. (Patient #2, #3, #5, #6, #8, #9) The findings include: 1. Clinical record review on 6/23/2023, for Patient #2, start of care 5/15/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/15/2023-7/13/2023, which indicated orders for skilled nursing and physical therapy (PT) services 2 times a week for 4 weeks. Review evidenced an agency document titled "Skilled Visit Note" completed by the Clinical Manager and dated 5/22/2023, which indicated the patient was found on the floor incontinent of bowel and bladder. Review indicated the patient was at		and clarification of procedures. C-360 Coordination of Patient Services The agency will integrate services, whether they are provided directly or under contract, to assure the identification of patient needs and factors that could affect patient safety and the effectiveness of treatment. The coordination of care is provided by all disciplines and included communication with physicians. The Administrator and Clinical Manager In-Serviced all Procare and contracted clinical staff on coordination of care between disciplines and all other entities providing care to the patient The Agency now Coordinates care with all agencies, physicians and disciplines that are involved in active patients care #2a). For Patient #6, The Clinical Manager has ensured that there is now Coordination of Care with the Dialysis Center for patients Hemodialysis at time of recertification and as needed. b). The Agency was made aware	

	weakness, poor balance, and had impaired decision making. Review failed to evidence the nurse coordinated care with the PT regarding the patient's fall. During an interview on 6/27/2023, at 11:55 AM, the Clinical Manager indicated she did not notify the PT of the patient's falls. 2. Clinical record review on 6/22/2023, for Patient #3, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/13/2023-8/11/2023, which indicated Entity I (home care agency) provided skilled nursing services for wound care. Review failed to evidence care coordination with Entity I to include what services were provided and the frequency since 12/15/2022. Review indicated Person S was the patient's attending physician. During an interview on 6/23/2023, at 9:44 AM, Patient #3 indicated Entity I provided skilled nursing and PT services each 2 times a week. Review of a document obtained from Entity I on 6/23/2023,		of the patient's hospitalization once contact was made for a visit by the Occupational Therapy on 6-30-23. The Skilled Nurse had a visit with patient on 6-26-23 with no indication that patient may be hospitalized soon The Administrator and Clinical Manager will be responsible to ensure that all Coordination of Care is documented for all agencies, physicians and disciplines involved in each patients care The Clinical Manager and QA team will review all active patients charts shared with other agencies and service providers for care coordination weekly. The Clinical Manager is responsible to ensure that this situation does not recur	

	titled "Home Health Certification and Plan of Care" for certification period 6/3/2023-8/1/2023, indicated Entity I was providing skilled nursing and PT services. Review indicated Person T was the patient's attending physician. Review indicated the patient's medications included, but were not limited to, Tizanidine (muscle relaxant), Duloxetine (antidepressant), and Belsomra (a medication to aid in sleep) which were not included in the agency's list of medications in the plan of care. Review indicated the patient's permitted activities were partial weight bearing which was not included in the agency's plan of care. During an interview on 6/27/2023, at 3:17 PM, the Clinical Manager indicated she was unsure what services and the frequency of services that Entity I was providing and indicated the last coordination with Entity I that indicated what services they were providing was in December 2022 which indicated Entity I provided skilled nursing only. The Clinical Manager indicated the agency			

	with Entity I to clarify the differences in the plan of caer such as the medications and attending physicians. 3. Clinical record review on 6/26/2023, for Patient #5, evidenced an agency document titled “Recertification” dated 5/6/2023, which indicated the patient lived alone and had a primary diagnosis of quadriplegia (paralysis of all 4 extremities). Review failed to evidence the patient received services from another agency and failed to evidence care coordination with another agency. During an interview on 6/29/2023, at 3:52 PM, when queried how the patient was safe to live at home alone and how the patient’s personal care needs were met in the absence of the agency, the Clinical Manager indicated Entity U (home health agency) provided services to the patient. The Clinical Manager indicated there was not any documented care coordination with Entity U. 1. Record review of an agency policy titled “Coordination of			

	6/28/2023, stated "Policy ... The agency will integrate services, whether they are provided directly or under contract, to assure the identification of patient needs and factors that could affect patient safety and the effectiveness of treatment. The coordination of care is provided by all disciplines and included communication with physicians ... Special Instructions ... Coordination of care means assuring that the patient needs are continually assessed, addressed in the Plan of Care, that care is delivered in a timely and effective manner, and that goals are achieved. The agency will coordinate the nursing, therapy, aide and social work services ...Involvement of the care team must be apparent in the record either in an electronic health record or a paper document. How and when communication happens must be documented ... The agency Clinical Manager of their designee will develop and implement the coordination plan ... Coordination will include providers of care who are not part of the agency assisted living team members, outpatient wound clinics or privately hired caregivers ... The			

	agency will identify a communication system to assure that all disciplines and departments are informed of changes to plan and/or need for modifications ... Reports can be used to identify changes in frequency of services, notice of hospitalization or to communicate status changes ...." 2. Clinical record review for patient #6, start of care 5/24/2023, evidenced a resumption of care assessment performed by the Clinical Manager on 6/15/2023, indicated the patient was on peritoneal dialysis; A method of dialysis that uses the lining of the abdomen via a surgically inserted catheter to remove waste products from the blood and can be done at home usually with multiple exchanges daily. Record review failed to evidence care coordination with the dialysis facility who provided supplies and oversight of the patient's peritoneal dialysis. During an interview on 6/29/2023, at 9:23 AM, with Person P, nurse case manager at			

	discuss Patient #6's peritoneal dialysis orders. Person P indicated the patient's specific fluids to be infused totaled 14,500 milliliters (ml), over 10 hours and 20 minutes daily. They indicated the patient infuses the fluid 4 times daily, each time the fluid dwelled for 1 hour and 45 minutes, and then emptied the fluid into a drainage bag. Person P indicated the patient came into Entity O 3 days prior because the patient needed peritoneal dialysis supplies. Person P indicated the drainage bag for the patient was cloudy and was instructed by the physician to draw labs from the bag and send the patient to the hospital. Person P indicated the patient was admitted to Entity Q, and provided the patient's room number. Record review evidenced a skilled nurse visit was scheduled on 6/27/2023 and 6/29/2023. Record review failed to evidence the agency was aware of the patient's hospitalization. During an interview on 6/29/2023, at 12:49 PM, the Clinical Manager indicated that			

	peritoneal dialysis and coordinated care via phone but was not documented. When queried about the amount of fluid to infuse/pull, number of exchanges per day, dwelling time, and where the patient received supplies for peritoneal dialysis, the Clinical Manager indicated he performed peritoneal dialysis on thier own and did not tell the agency specific information about it. 3. An observation of a home visit with patient #8, was conducted on 6/28/2023, from 1:21 PM to 2:17 PM, for a physical therapy visit. The patient was in a hospital bed in the front room of the home, accompanied by a home health aide (HHA) from Entity J. At 2:03 PM, Patient #8 indicated they had around the clock HHA services provided by 2 home health agencies. Entity J provided a HHA from 8:00 AM – 4:00 PM. Entity K provided HHA services from 4:00 PM to 8:00 AM, split into 2 shifts.			

	Record review failed to evidence coordination of care between Procare and Entity K, which made up 16 hours of care for the patient daily. During an interview on 6/29/2023, at 2:04 PM, the Clinical Manager indicated they did not coordinate care with Entity K. 4. Clinical record review on 6/26/2023, for Patient #9, start of care 5/19/2023, diagnoses included but were not limited to hemiplegia (paralysis to one side of the body) and dysphagia (difficulty swallowing), evidenced an agency document titled "Home Health Certification and Plan of Care" which indicated occupational therapy (OT) services were ordered as twice a week for 3 weeks and speech therapy (ST) services ordered twice a week for 5 weeks. Record review evidenced an OT evaluation conducted on 6/12/2023, with no subsequent visits. Record review failed to evidence ST services were provided at time of review. Record review failed to			

	OT or ST clinicians regarding lack of patient care or reason for delay of services provided. During an interview on 6/29/2023, at 1:35 PM, the Clinical Manager indicated they were trying to get therapy services from other places but failed to document in the clinical record. During an interview on 6/29/2023, at 1:43 PM, the Clinical Manager indicated ST should have been notified to start treatment with the patient but did not see documentation of care coordination in the clinical record. 5. During an interview on 6/29/2023, at 1:31 PM the Clinical Manager indicated the process after a therapy evaluation on an agency patient, the therapist should coordinate with the doctor, and sometimes the Clinical Manager or Administrator.			

G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation and interview, the agency failed to provide the patient a written visit schedule in 3 of 3 home visits. (Patient #3, #6, #8) The findings include: 1. During an observation at the home of Patient #3 on 6/23/2023, at 9:24 AM, the agency home folder and the visit schedule were not observed in the patient's home. During an interview on 6/23/2023, at 9:35 AM, after looking for the agency folder, Home Health Aide (HHA) 1 indicated she could not find the agency folder. 2. During an observation of care at the home of Patient #6 on 6/23/2023, at 1:01 PM, the visit schedule to contain the visits to be provided by the agency was not observed in the patient's home. 3. During an interview on	G0614	The Agency now ensures that a visit schedule is utilized in the patient's home for upcoming visit dates by the disciplines. 1). For Patient #3, The Agency has now provided a folder in the patients home. The Administrator and Clinical Manager In-serviced the field staff on ensuring that the patient has a folder in the home with an updated visit schedule for each discipline. The Clinical Manager and the Administrator are now also the intake coordinators. They now review all Admissions to ensure that the patient has a folder in the home with a visit schedule. The QA team will follow up with the new patient after the 1st week to confirm the schedule is completed in the folder and there will be a quarterly follow up of 10% of the active patients. The Administrator and the Clinical Manager are responsible to ensure that this deficiency does not recur.	2023-07-28

	6/27/2023, at 9:31 AM, the Clinical Manager indicated the visit schedule should be included in the agency home folder. The Clinical Manager indicated staff should check for the agency folder at every visit since they have to record their vital signs in the agency home folder at every visit and they should let the office know if another folder needs to be provided to the patient. *. An observation of a home visit was conducted on 6/28/2023, from 1:21 PM to 2:17 PM, for a physical therapy visit with Patient #8, start of care 2/1/2023. Observation failed to evidence the patient was provided with a visit schedule for PT services provided by the agency.			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation and interview, the agency failed to	G0616	The Agency now ensures that folders are in each patient's home with updated Medication profiles and Plan of Cares. The Clinical Manager and the QA team reviewed all active patients' home folders and found that 26 out 35 patients did not have updated	2023-07-27

	provide the patient a written medication schedule and instructions in 3 of 3 home visits. (Patient #3, #6, #8) The findings include: 1. During an observation at the home of Patient #3 on 6/23/2023, at 9:24 AM, the agency home folder and the written medication schedule and instructions were not observed in the patient's home. During an interview on 6/23/2023, at 9:35 AM, after looking for the agency folder, Home Health Aide (HHA) 1 indicated she could not find the agency folder. 2. During an observation of care at the home of Patient #6 on 6/23/2023, at 1:01 PM, the written medication schedule and instructions were not observed in the patient's home. 3. During an interview on 6/27/2023, at 9:31 AM, the Clinical Manager indicated the medication profile should be included in the agency home folder. The Clinical Manager indicated staff should check for the agency folder at every visit since they have to record their		in their home folders. 1). For Patient #3, The patient now has a folder in the home with updated list of medications and Plan of Care 2). For Patient #6, The patient now has an updated Medication Profile and Plan of Care in his home. 3). Patient #8 was admitted to the hospital for management of UTI symptoms. 7-09-2023, The Clinical Manager and the Administrator are now also the intake coordinators. They now review all Admissions to ensure that Medication profiles and Plans of Care are in the patients folders in the home. The QA team will follow up with the new patient after the 1st week to confirm that medication profile and plan of care are in the folder and there will be a quarterly follow up of 10% of the active patients. The Clinical Manager is responsible to ensure that this deficiency does not recur.	

	vital signs in the agency home folder at every visit and they should let the office know if another folder needs to be provided to the patient. *. An observation of a home visit was conducted on 6/28/2023, from 1:21 PM to 2:17 PM, for a physical therapy visit with Patient #8, start of care 2/1/2023. Observation failed to evidence a current medication list in the patient's home managed by the agency.			
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation and interview, the agency failed to provide the patient in writing the services and treatments to be provided by the agency in 3 of 3 home visits. (Patient #3, #6, #8) The findings include: 1. During an observation at the home of Patient #3 on 6/23/2023, at 9:24 AM, the	G0618	The agency now provides all patients in writing the services and treatments to be provided at the start of care and ongoing. The agency home folder now has the written services and treatments to be provided. The Clinical Manager and Administrator reviewed all active patients' clinical records and found that 15 out 35 patients did not have the complete written services and treatments to be provided. The agency folder in the patient's home is now updated with the written services and treatments to be provided as well as a copy of a current plan of treatment	2023-07-31

	agency home folder and the written services and treatments to be provided by the agency were not observed in the patient's home. During an interview on 6/23/2023, at 9:35 AM, after looking for the agency folder, Home Health Aide (HHA) 1 indicated she could not find the agency folder. 2. During an observation of care at the home of Patient #6 on 6/23/2023, at 1:01 PM, the written services and treatments to be provided by the agency were not observed in the patient's home. 3. During an interview on 6/27/2023, at 9:31 AM, the Clinical Manager indicated the agency provided a copy of the consent form but indicated it did not have the treatments included. When queried if the agency provided a copy of the agency's plan of care to the patient, the Clinical Manager stated, "We can give them that?" *. An observation of a home visit was conducted on 6/28/2023, from 1:21 PM to		for the patient. The clinical Manager and the quality assurance team will monitor all clinicians admitting patients for home health and staff visiting the patients for ensuring that the written services and treatments to be provided as well as a copy of a current plan of treatment for the patient are in the patient's home folder. The clinical Manager is responsible to ensure that this situation does not recur.	

	visit with Patient #8, start of care 2/1/2023. Observation failed to evidence the patient was provided with a copy of a current plan of treatment for the patient.			
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. Based on observation and interview, the agency failed to provide in writing the name and contact information of the clinical manager to the patient in 1 of 1 home visit with a home health aide (HHA). (Patient #3) The findings include: During an observation at the home of Patient #3 on 6/23/2023, at 9:24 AM, the agency home folder and the name and contact information for the clinical manager were not observed in the patient's home. During an interview on 6/23/2023, at 9:35 AM, after looking for the agency folder,	G0622	The name/contact information of the clinical manager is now being provided in writing to the patient in the agency home folder. 1). For Patient #3, The Agency has now provided a folder in the patients home with contact information of each discipline involved with the patients care The Clinical Manager and Administrator reviewed all active patients' clinical records and found that 26 out 35 patients were not being provided with the name/contact information of the clinical manager, and 12 out of 35 patients did not record their vitals at every visit in the agency folder. Staff now check the agency folder at every visit to record their vitals at every visit and they let the office know if it is missing and another folder	2023-07-31

	HHA 1 indicated she could not find the agency folder. During an interview on 6/27/2023, at 9:31 AM, the Clinical Manager indicated the name of the clinical manager should be included in the agency home folder by writing it on the outside of the folder. The Clinical Manager indicated staff should check for the agency folder at every visit since they have to record their vital signs in the agency home folder at every visit and they should let the office know if another folder needs to be provided to the patient.		needs to be provided to the patient. The clinical Manager and the quality assurance team will monitor all clinicians admitting patients to ensure that the name/contact information of clinical manager is provided in writing to the patient in the agency home folder, and that Staff are recording the patient's vitals at every visit, and they let the office know if the folder is missing. The clinical Manager and the quality assurance team will monitor all new patients' to ensure that contact information for each discipline is included on the Home Care folders in each patient's home. The QA team will follow up with the new patient after the 1st week to confirm that contact information for each discipline is included on the Home Care folders in each patient's home and there will be a quarterly follow up of 10% of the active patients. The Administrator and the Clinical Manager are responsible to ensure that this situation does not recur.	

G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the home health agency failed to develop and maintain a QAPI (quality assessment performance improvement) program that included aggregation of data, identification of issues, projects to address issues, and measurable patient outcomes related to health and safety. The findings include: Record review with the Administrator on 6/28/2023, from 4:03 PM – 4:33 PM, of the	G0640	The Administrator and the Clinical Manager reviewed the following policy for reeducation and clarification of procedures. B-100 GOVERNING BODY POLICY The Governing Body (or designated persons so functioning) shall assume full legal authority and responsibility for the overall management and operation of Agency. This includes the provision of home health services, fiscal operations, review of the agency's budget and its operational plans as well as the Quality Assessment and Performance Improvement Program. New governing body members/designees are oriented to the agency as appropriate to responsibilities. The roles of the Governing Body may not be delegated. B-260 Quality Assessment and Performance Improvement (QAPI) Agency will develop, implement, evaluate, and maintain an effective, ongoing agency wide, data driven QAPI program. This plan will be based on the organization's mission and	2023-07-29

	agency's QAPI binder, evidenced a QAPI policy and indicated there were no incidents in quarter 1 of 2023. The QAPI binder evidenced a "Quality Measures Analysis & Improvement Plan" from April 2023, which indicated the data collection period for the report was 4/1/2021 – 3/31/2022. The plan assessed data related to including but not limited to managing daily activities, preventing harm, and quality of patient care. Review of the QAPI binder failed to evidence the following requirements: Measurable improvement in indicators; Utilization of quality indicator data to identify opportunities for improvement, the QAPI data focused on high risk, high volume, or problem prone areas; Considered incidence, prevalence, and severity of problems in the high risk or high volume areas; the QAPI data led to an immediate correction of any identified problems that directly or potentially threaten the health and safety of patients; Performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventive actions; The agency		goals and designed to improve patient outcomes and the perceptions of patients/families about the quality and value of services. We laid emphasis on the authority and responsibility of the Administrator for the day-to-day operations of the agency; to include provision of home care services in accordance with state and federal regulations, accreditation standards, and the Agency mission. Also, the Administrator's responsibility, to provide direction and leadership and be directly involved in the agency's Quality Assessment and Performance Improvement Program (QAPI). We have now elicited the Services of a QAPI consultant to review, monitor and recommend actions to improve Patient survey outcomes. We are also migrating to a new EHR and will further improve charting, OASIS and patient Education resources.	

took action aimed at performance improvement and measured its success and tracked performance to ensure that improvements are sustained; Conducted a performance improvement project annually; Ensured the governing body was responsible for the implementation and maintenance of the QAPI program.

During an interview on 6/28/2023, from 4:03 PM – 4:33 PM, the Administrator indicated the agency went through OASIS reports and review all charts to identify improvements in patient outcomes. The administrator indicated the agency tracked adverse events such as falls and hospitalizations then compared data with the previous OASIS to monitor the effectiveness of services. The administrator indicated the agency's performance improvement activities focused on high risk, high volume, and problem prone areas by coming up with solutions once a problem was identified, then review and reassess. During the interview, at 4:16 PM, the Administrator indicated the agency was

	working with old data and re-hospitalizations were a problem within the patient population. The Administrator indicated the agency should have provided more therapies to assist with patient's daily activities. At 4:28 PM, when queried what the agency's performance improvement project (PIP) focused on, the administrator indicated there was a book for that. At 4:33 PM, the PIP evidenced shortness of breath was the project for the period of 10/14/2022 – 10/24/2022, and the administrator indicated there was not a current PIP documented. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR §484.65 Condition: Quality Assessment/Performance Improvement. 410 IAC 17-12-2(a)			

G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review and interview, the home health agency failed to ensure all employees practiced standard/universal precautions to prevent the transmission of infections and failed to follow agency infection control policies and procedures in 2 of 3 home visits. (Patient #3, #6) The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Handwashing/Hand Hygiene" stated, "... Indications for hand washing and hand antisepsis: Before touching a wound ... After removing gloves ... Hands are washed ... immediately after gloves are removed ... Decontaminate hands after ... contact with body fluids, excretions ... contact with inanimate objects including equipment in the immediate vicinity of the patient ...."	G0682	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. D-330 HANDWASHING/HAND HYGIENE In an effort to reduce the risk for infection in patients and team members, thorough hand washing/hand antisepsis is required of all employees. The agency will establish guidelines for all team members and will provide education and direction on accepted practices. The Clinical Manager reviewed 100% of all employee files and noted that 15% required updated in-services on Infection Control measures. The Clinical Manager and Administrator In-serviced all field staff on Standard Precautions to prevent the transmission of infections and communicable diseases. The Human Resource and Personnel Team will monitor all employees files for timeliness of In-Services on a monthly basis. The Administrator and Clinical Manager are responsible to ensure that this situation does	2023-07-28

	2. During an observation of care at the home of Patient #3 on 6/23/2023, at 9:35 AM, Home Health Aide (HHA) 1 was observed applying gloves after washing hands. HHA 1 was observed looking for home health agency folder in the patient's bedroom to include on the dresser and under the tv stand and then was observed looking for the patient's thermometer and blood pressure cuff. At 9:50 AM, HHA 1 was observed starting the patient's bath wearing gloves and was not observed performing hand hygiene after touching objects in the patient's room and before beginning patient's bath. HHA 1 was observed washing the patient's pubic area with gloved hands while the patient was lying on her back, then washing the patient's legs, in between the patient's labia and upper thighs, and upper chest and shoulders. At 9:55 AM, HHA 1 was observed rolling the patient to the right side and HHA 1 was observed washing the patient's back and buttocks without glove removal. HHA1 was observed applying Vaseline to		not recur.	

	buttocks, legs, and arms without glove removal. HHA 1 was not observed to have removed the gloves and perform hand hygiene after washing the patient's pubic area and before moving to other parts of the body. During an interview on 6/27/2023, at 9:30 AM, the Clinical Manager indicated staff should change gloves and perform hand hygiene after washing the pubic and buttock area and before washing other parts of the body. 3. During an observation of care at the home of Patient #6, on 6/23/2023, at 12:05 PM, the Clinical Manager was observed wearing gloves and cleaning the wound to the patient's left below the knee amputation with a liquid sprayed onto gauze from a bottle labeled "wound cleanser" and then observed cleaning the wound on the right below knee amputation with a new gauze. The Clinical Manager was not observed to have removed gloves and			

	cleaning the wound on the left leg and before cleaning the wound on the right leg. During an interview on 6/29/2023, at 3:29 PM, the Clinical Manager indicated staff should change gloves after cleaning one wound and before cleaning another.			
G0686	Infection control education 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). Based on record review and interview, the agency failed to ensure the staff was educated per agency policy on infection prevention and control. The findings include: Review of an agency policy revised 1/21/2021, titled "Infection Control Education/Training" stated, "... For each twelve (12) months of employment, all employees and contractors who have contact with the patients in the patients' residence shall complete	G0686	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. D-325 Infection Control Education and Training For each twelve (12) months of employment, all employees and contractors who have contact with the patients in the patients' residence shall complete in-service training about infection control practices to be used in the home. We now ensure that Infection Control and all required In-services are done within 12 months of employment for all employees The Clinical Manager reviewed	2023-07-28

	in-service training about infection control practices to be used in the home ... Training records will include dates, contents of the training sessions, names and qualifications of instructors, and the names and job titles of attendees." Review of an agency binder labeled "Inservice" on 6/29/2023, failed to evidence any documentation regarding infection control training/education. During an interview on 6/29/2023, at 2:14 PM, the Administrator indicated the last in-service provided by the agency to staff was in October 2022. The Administrator indicated there was no documentation of any staff education related to infection control in the last 12 months.		all employee files and noted 65% out of the 100% employees had not received inservice on infection control education and training in 12 months The Clinical Management Team will monitor all employees files for timeliness of In-Services on a monthly basis The Human Resource and Personnel Team will monitor all employees files for timeliness of In-Services on a monthly basis. The Administrator and Clinical Manager are responsible to ensure that this situation does not recur.	
G0700	Skilled professional services 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy,	G0700	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. Skilled Professional Services C-200 Skilled professional services	2023-07-29

	speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. Based on record review and interview, the skilled professional failed to provide the services as indicated in the plan of care (See tag G0710); failed to provide the patient and caregiver education (See tag G0714); failed to prepare clinical notes (See tag G0716); and failed to communicate with the physician and other health care practitioners (See tag G0718). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.75 Skilled Professional Services.		include skilled nursing services, physical therapy, speech-language pathology services and occupational therapy, as specified in the §409.44 of this chapter. Skilled professionals who provide services to home health agency patients directly or under contract must participate in the coordination of care. With emphasis on SS e, f e. Patient and caregiver education. f. Preparing clinical notes C-360 COORDINATION OF PATIENT SERVICES The agency will integrate services, whether they are provided directly or under contract, to assure the identification of patient needs and factors that could affect patient safety and the effectiveness of treatment. The coordination of care is provided by all disciplines and included communication with physicians. With emphasis on SS 4 4. Agency will communicate with ALL physicians who are	

			writing orders regarding the plan of care. The Agency is now able to provide quality home health services based on the corrections noted in G0710, G0714, G0716 & G0718. The Administrator, Clinical Manager and QA team will comply with the monitoring measures that have been instituted for these deficiencies. The Administrator is responsible to ensure that this situation does not recur.	
G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; Based on observation, record review, and interview, the skilled professional failed to provide services as directed in the plan of care in 5 of 9 clinical records reviewed. (Patient #1, #2, #3, #4, #6) The findings include:	G0710	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. Skilled Professional Services C-200 Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services and occupational therapy, as specified in the §409.44 of this chapter. Skilled professionals who provide	2023-08-12

	Based on observation, record review, and interview, the skilled professional failed to provide services as directed in the plan of care in 5 of 9 clinical records reviewed. (Patient #1, #2, #3, #4, #6) The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Skilled Professional Services" stated, "... Skilled professionals must assume responsibility for, but not be restricted to the following: ... Providing services that are ordered by the physician as indicated in the plan of care...." 2. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/1/2023-7/30/2023, which evidenced the agency was to notify the physician for a systolic blood pressure (the pressure against the arteries		patients directly or under contract must participate in the coordination of care. The clinical manager and administrator in-serviced (08/12/2023) all procare and contracted clinical staff on following the plan of care parameters listed for each patient and to report abnormal values to the physician The Clinical Manager now ensures that vital signs and pain management parameters are reported to the physician when they are not within range. The Clinical Manager and Administrator reviewed all active patients' clinical records and found that 15 out 35 patient's had vital signs out of parameter range not reported to the physician. These have now been reported to the physicians as well as patients, #1, 2, 3, 4 and 6 The Quality Assurance (QA) team will review clinical notes daily to ensure that all of the Home Health Aides are reporting abnormal vital signs and pain management parameters that are out of	

	during contraction of the heart and represented by the top number of a blood pressure reading) greater than 160 and of a diastolic blood pressure (the pressure against the arteries when the heart is at rest and represented by the bottom number of a blood pressure reading) greater than 90. Review of an agency document titled "Skilled Nurse Visit" completed by the registered nurse (RN) and dated 6/5/2023, indicated the patient's blood pressure was 174/101. Review failed to evidence the RN notified the physician as directed in the plan of care. During an interview on 6/27/2023 at 10:51 AM, the Clinical Manager indicated the physician was only notified of the patient's complaint to the left leg and not about the blood pressure that visit. 3. Clinical record review on 6/23/2023, for Patient #2, start of care 5/15/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/15/2023-7/13/2023, which		range are reported to the Clinical Manager and all clinicians are reporting such to the physicians. The Clinical Manager is responsible to ensure that this deficiency does not recur.	

	notify the physician for pain greater than 6 on a scale of 0-10 (0 being the least amount and 10 being the worst amount). Review evidenced an agency document titled "Start of Care" completed by the Clinical Manager and dated 5/15/2023, which indicated the patient reported pain at 7 on a scale of 0-10 to the patient's lower back and feet. Review failed to evidence the nurse notified the physician as directed in the plan of care. During an interview on 6/28/2023, at 12:50 PM, the Clinical Manager indicated she did not call the physician. 4. Clinical record on 6/22/2023, for Patient #3, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/14/2023-6/12/20223, which indicated the physician would be notified of a pulse less than 60 beats per minute. Review of an agency document titled "Recertifciation" completed by the Clinical Manager and dated 6/12/2023, indicated the patient's pulse			

	was 56 beats per minute and failed to evidence the nurse notified the physician per the plan of care. During an interview on 6/27/2023, at 3:54 PM, the Clinical Manager indicated she did not notify the physician of the pulse less than the ordered parameter. 5. Clinical record review on 6/26/2023, for Patient #4, start of care 6/13/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/13/2023-8/11/2023, which indicated the physician was to be notified of a pulse greater than 100 beats per minute and a diastolic blood pressure greater than 90. Review of an agency document titled "Occupational Therapy Assessment/Evaluation" completed by the OT and dated 6/21/2023, indicated the patient's pulse was 118 beats per minute and a diastolic blood pressure of 96. Review failed to evidence the OT notified the physician of the pulse and blood pressure			

directed in the plan of care.

During an interview on 6/27/2023, at 12:27 PM, the Clinical Manager indicated there was no documentation the OT notified the physician and indicated the OT should have notified the RN and the physician.

6. Clinical record review on 6/23/2023, for Patient #6, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/24/2023-7/22/2023, which indicated the skilled nurse was to perform a complete assessment at every visit. Review indicated the nurse was to review medications at every visit.

During an observation at the patient's home on 6/23/2023, at 1:16 PM, the Clinical Manager left the patient's home and was not observed to have placed a stethoscope on the patient's chest, back, or abdomen. The Clinical Manager was not observed palpating the patient's abdomen or lifting the patient's shirt to observe the patient's

	were observed on the patient's kitchen counter in prescription bottles, and the Clinical Manager was not observed to have reviewed the patient's medications and was not heard to ask the patient about any medication changes. During an interview on 6/23/2023, at 12:59 PM, Patient #6 indicated he received peritoneal dialysis (a medical procedure that filters the blood through a machine by adding a solution to and removing fluid from the abdomen) every night for 8 hours by hooking the dialysis machine to a tube in his stomach. During an interview on 6/29/2023, at 3:10 PM, the Clinical Manager indicated the nurse should use a stethoscope to listen to the patient's breathing, heart, and abdomen. The Clinical Manager indicated she did not lift the patient's shirt to observe and assess the patient's abdomen and the peritoneal dialysis site. At 3:18 PM, the Clinical Manager indicated she was not aware the patient had medications on the kitchen counter and indicated			

	reviewed. *. Clinical record review on 6/26/2023, for Patient #6, start of care 5/24/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/24/2023 – 7/22/2023, indicated the skilled nurse (SN) was to provide wound care to the bilateral (right and left) below the knee amputations (BKA). The Plan of Care also ordered the SN to perform a medication review with each visit and reconcile medications as indicated. Record review failed to evidence the SN notified the physician of interactions as indicated in the agency policy. Record review of agency documents titled "Skilled Nurse Visit" electronically signed by the Clinical Manager on 5/30/2023, 6/1/2023, and 6/20/2023, which indicated wound care performed to the left BKA according to the plan of care. Review of these documents failed to evidence wound care was provided to the			

	right BKA as ordered on the plan of care. During an interview on 6/29/2023, at 12:31 PM, the Clinical Manager indicated may have been an oversight or might not have needed to treat the right BKA wound.			
G0714	Patient and caregiver education 484.75(b)(5) Patient and caregiver education; Based on record review, and interview, the skilled professional failed to educate the patient/caregiver in 1 of 1 clinical record reviewed with parameters for blood sugar levels without a glucometer (a device used to check blood sugar) (Patient #1) and 1 of 1 clinical record reviewed with a fall (Patient #2). The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Skilled Professional Services" stated, "... Skilled professionals must assume responsibility for, but not be restricted to the following: ... Patient and caregiver education...."	G0714	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-200 Skilled Professional Services Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services and occupational therapy, as specified in the §409.44 of this chapter. Skilled professionals who provide services to home health agency patients directly or under contract must participate in the coordination of care. The Clinical Manager now ensures that patients requiring supplies for management of	2023-07-29

	2. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Start of Care" completed by the registered nurse (RN) and dated 6/1/2023, which indicated the patient's diagnoses included diabetes (a chronic condition which affects the way the body processes blood sugar) and had insulin (an injectable medication used to lower blood sugar) which was to be given based on blood sugar level, and review indicated the patient did not have a glucometer (a medical device used to measure blood sugar). Review failed to evidence the RN educated the patient on when to take the insulin and for what signs and symptoms the patient should call the physician since the patient was unable to check her blood sugar. During an interview on 6/27/2023, at 10:47 AM, the Clinical Manager indicated the patient was not taking her insulin and indicated the nurse should have educated the patient on when to take the insulin and signs and symptoms to report to the physician. 3. Clinical record review on		of admission and that the Primary Care Physician is notified of the need for supplies. The Clinical Manager now ensures that the patients are educated on Caregiver support for fall risks The Clinical Manager now ensures that all orders on hospital discharges are implemented The Clinical Manager reviewed 100% of the charts and found that in 30% of patients requiring supplies and Caregiver support, the Primary Care Physician was not notified of shortage of supplies and caregiver status. The Clinical Manager and the Quality Assurance (QA) team will monitor charts of patients requiring supplies and Caregiver support, monthly to ensure that there are no supply shortages and when it occurs, the Primary Care Physician will be notified of such. The Clinical Manager is responsible to ensure that this situation does not recur.	

	6/23/2023, for Patient #2, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/15/2023-7/13/2023, which indicated the patient used a walker, was incontinent of bladder, and lived alone. Review of an undated agency document titled "Patient Profile" indicated Person N (patient's family member) was the patient's emergency contact. Review evidenced an agency document titled "Communication Note" dated 5/22/2023, which indicated the patient fell and was on the floor for several hours. Review indicated the patient's family member arrived at the patient's home at which point the nurse left the home. Review evidenced an agency document titled "Skilled Visit Note" completed by the Clinical Manager and dated 5/22/2023, which indicated the patient was found on the floor incontinent of bowel and bladder. Review indicated the patient was at high risk of falls, had muscle weakness, poor balance, and			

	had impaired decision making. Review indicated the nurse educated the patient to have someone nearby for transfers to help prevent falls. Review failed to evidence the nurse provided education to the patient on who the patient was to have nearby for transfers since the patient lived alone. Review failed to evidence the nurse verified the patient's understanding of the education given the patient's impaired decision making. Review failed to evidence the nurse provided education to Person N regarding the patient's need for assistance during transfers for patient's safety. During an interview on 6/27/2023, at 11:48 AM, the Clinical Manager indicated the nurse should have educated on keeping pathways clear. At 11:50 AM, the Clinical Manager indicated the patient lived alone and believed the patient was more appropriate in an assisted living facility. The Clinical Manager indicated she did not communicate the assessment of the patient's safety needs with the patient and patient's family.			

	Review of an undated document titled "After Visit Summary" from Entity A (hospital) from hospital discharge date of 6/2/2023, indicated the patient was to have lab work of a basic metabolic panel (type of blood test) completed by 6/9/2023 and was to stop taking Losartan (a medication used to control high blood pressure) as ordered by the patient's primary physician. Review of an agency document titled "Medication Profile" signed and dated by the Clinical Manager on 6/5/2023, failed to evidence the Losartan was discontinued and indicated the patient was to take daily. Review of an agency document titled "Resumption" signed and dated by the Clinical Manager on 6/5/2023, failed to evidence the nurse instructed the patient on the discontinuation of the Losartan and the ordered blood work. During an interview on 6/28/2023, at 1:11 PM, the Clinical Manager indicated she should have contacted the hospital for discharge			

	instructions and did not educate the patient to the discontinuation of Losartan and the ordered blood work.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on observation, record review, and interview, the skilled professional failed to accurately, completely, and timely prepare clinical notes in 8 of 9 clinical records reviewed. (Patient #1, #2, #3, #4, #5, #6, #7, #8) The findings include: 1. Review of an agency policy revised 1/21/2021, titled "Skilled Professional Services" stated, "... Skilled professionals must assume responsibility for, but not be restricted to the following: ... Preparing of	G0716	The Director of Nursing and Administrator reviewed the following policies for reeducation and clarification of procedures. C-200 Skilled Professional Services Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services and occupational therapy, as specified in the §409.44 of this chapter. Skilled professionals who provide services to home health agency patients directly or under contract must participate in the coordination of care C-680 Clinical Documentation	2023-07-28

	clinical notes…." 2. Review of an agency policy revised 6/28/2022, titled "Clinical Documentation" stated, "… Documentation of services ordered on the plan of care will be completed the day service is rendered …." 3. Review of an agency policy revised 6/28/2022, titled "Pain Assessment/Management" stated, "… The assessment includes a measure of pain intensity and quality (character, frequency, location, and duration)…." 4. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/1/2023-7/30/2023, evidenced the patient's diagnoses included diabetes (a chronic condition which affects the way the body processes blood sugar) and the patient's medications included Glipizide (a medication used to lower blood sugar). Review of an agency document titled "Start of Care" completed by the registered nurse (RN)		7/28/2023 Agency will document each direct contact with the patient. This documentation will be completed by the direct caregivers and monitored by the skilled professional responsible for managing the patient's care With emphasis on SS 4 4. Documentation of services ordered on the plan of care will be completed the day service is rendered and incorporated into the clinical record within fourteen (14) days after the care has been provided C-148 Pain Assessment and Management All patients admitted to the Agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment. The Agency will work with the patient, family, and physician, as well as other members of the health care team, to establish a goal for pain relief and develop and implement a plan to achieve that goal. The plan will	

	the patient had not had a bowel movement in over 2 weeks. Review failed to evidence the RN completed the clinical note to include the assessment of the patient's bowel sounds and any distention and tenderness of the abdomen. Review failed to indicate the RN prepared the clinical document to include the patient's use of an oral hypoglycemic (a medication used to lower blood sugar). Review indicated the patient was assessed to have pain to the left leg and the right shoulder and failed to evidence the RN completed the visit note to assess each pain location separately. Review of agency documents titled "Skilled Nurse Visit" completed by the RN, indicated the patient was constipated and had not had a bowel movement since 6/3/2023 on document dated 6/5/2023. Review failed to evidence the RN completed the clinical note to include an assessment of the abdomen to include bowel sounds and any abdominal distention and tenderness. Review of document dated 6/12/2023, indicated the patient had pain to the left leg and the buttocks		be reviewed and modified if the patient does not have pain relief. Poorly managed pain delays healing and recovery time, alters the body's immune system and increases stress, anxiety, and depression. Patients will be informed that they have the rights to have pain evaluated and effectively treated. Pain will be treated as a "vital sign" and agency will strive to ensure that pain is measured and treated. Catheter flushes type and amount for patient #5 now included in each Skilled Nurse note. Coordination of care now included with all patients for patient #8 The Clinical Manager and Administrator reviewed all active patients' clinical records and found that 9 out 35 patients had discrepancies with full and accurate assessments, communication notes, and all notes. These discrepancies have now been corrected. The Administrator and Clinical Manager in-serviced the field	

	and failed to evidence the RN completed the visit note to assess each pain location separately. During an interview on 6//27/2023, at 9:53 AM, the Clinical Manager indicated the document should include the assessment of bowel sounds and any abdominal distention and tenderness. At 9:58 AM, the Clinical Manager indicated the oral hypoglycemic use should have been checked. 5. Clinical record review on 6/23/2023, for Patient #2, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/15/2023-7/13/2023, which indicated the patient's medications included, but were not limited to, Plavix (a medication used to thin the blood to treat/prevent blood clots). Review evidenced an agency document titled "Start of Care" completed by the RN and dated 5/15/2023, which indicated the patient was constipated and		staff on the importance of timely submission of Comprehensive Assessments and to address all systems, including tubing sizes, appearance of area tubing lies in along with placement of tubings The Administrator and Clinical Manager in-serviced the Contracted Therapy staff on timely and accurate submission of Assessments The Clinical Manager now includes a full assessment for constipation including checking for bowel sounds, abdominal distention and tenderness. The Clinical Manager now ensures that all diagnoses are assessed and documentation of systems included with each assessment. All Communication notes are now authenticated with the clinicians signature and title. Physical Therapy now completes their notes accurately Integumentary sections on Assessments now accurately state patients skin conditions The Clinical Manager now accurately addresses all systems	

	since 5/12/2023. Review failed to evidence the RN completed the clinical note to include an assessment of the abdomen to include bowel sounds and any abdominal distention and tenderness. Review failed to evidence the RN completed the clinical note to include bleeding precautions in the safety measures. Review indicated the patient reported pain to the patient's lower back and feet and failed to evidence the RN completed the visit note to assess each pain location separately. Review of an agency document titled "Skilled Nurse Visit" completed by the Clinical Manager and dated 6/7/2023, indicated the patient was constipated and last bowel movement was on 6/3/2023. Review failed to evidence the RN completed the clinical note to include an assessment of the abdomen to include bowel sounds and any abdominal distention and tenderness. During an interview on 6/27/2023, at 11:40 AM, the Clinical Manager indicated the documentation should have included the assessment of the		of each patient on the Assessment forms The Clinical Management Team now accurately documents on all wound care to each wound with weekly measurements, all equipment and supplies used, and infection control measures followed with hand sanitizing between each extremity of wound care. The Clinical Manager and the Quality Assurance (QA) team will monitor all visit notes and Assessments daily for accuracy and timeliness. The Clinical Manager is responsible to ensure that this situation does not recur.	

abdomen to include bowel sounds, distention, and tenderness. At 11:53 AM, the Clinical Manager indicated the assessment should have included bleeding precautions as a safety measure.

Review of an agency document titled "Communication Note" dated 5/22/2023, failed to be authenticated with the clinician's signature and title.

During an interview on 6/27/2023, at 11:54 AM, the Clinical Manager indicated she had completed the communication note and it should have her signature.

Review of an agency document titled "Missed Visit" signed and dated by Physical Therapist (PT) 1 on 5/27/2023, indicated the PT missed a visit with the patient on 5/17/2023 due to patient was hospitalized. Review indicated the patient was not transferred to the hospital until 5/23/2023. Review failed to evidence the PT completed the visit note accurately.

During an interview on 6/27/2023, at 11:46 AM, the Clinical Manager indicated the

on 5/17/2023 and indicated the PT made a mistake on the missed visit note.

During an interview on 6/27/2023, at 9:38 PM, PT 1 indicated he did not attempt to provide a visit to the patient before the patient's hospitalization because he was not aware of the PT referral until the patient was in the hospital.

Review of documents obtained from Entity 1 (hospital) on 6/28/2023, indicated the patient was admitted to the hospital from 5/23/2023 to 6/2/2023 and evidenced the assessment from the emergency room on 5/23/2023 included 3 open areas to the patient's coccyx (lower back above the buttocks).

Review of an agency document titled "Resumption of Care" completed by the Clinical Manager and dated 6/5/2023, indicated the assessment included no identified problems with the integumentary system (the body system including the skin).

During an interview on 6/28/2023, at 12:52 PM, the

	resumption of care assessment was not correct and because the patient had areas of shearing on her coccyx, the integumentary system assessment should have not been checked as no identified problems. 6. Clinical record review on 6/22/2023, for Patient #3, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/13/2023-8/11/2023, signed by the Clinical Manager on 6/12/2023, which indicated the diagnoses included, but were not limited to, quadriplegia (paralysis of all 4 limbs) and diabetes (a chronic disease which affects the body's ability to regulate blood sugar), was incontinent of bladder, and the patient had 3 medications to include, but not limited to, Metformin (a medication used to treat diabetes). Review evidenced an agency document titled "Recertification" identified as the comprehensive assessment, completed by the Clinical Manager, and dated 6/12/2023. Review indicated the nurse			

	risk of hospitalization due to being on 5 or more medications. Review indicated the patient had a wound to the left hip and failed to indicate wounds as a risk of infection and failed to indicate the assessment was completed to include the patient was at risk for skin breakdown. Review indicated the nurse accurately completed the clinical note regarding the patient's caregiver status as review indicated the patient lived alone without a willing and available caregiver and indicated the patient had a caregiver in the home to provide assistance with wound care when the nurse was not present. Review indicated the patient was bedbound and failed to evidence the nurse checked poor mobility as a risk of infection. Review failed to evidence the nurse accurately completed the document to include the patient's risk of falls. Review failed to evidence the risk assessment for pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) development was accurately completed as the document indicated the patient's mobility was slightly impaired and the			

patient was not incontinent. Review indicated the nurse did not complete the endocrine (the body system that pertains to hormones) assessment accurately because oral hypoglycemic (a medication used to lower blood sugar) medication was not checked. Review indicated the patient needed straight catheterization (a procedure used to drain urine from the body by inserting a plastic tube into the bladder) and failed to evidence the nurse completed the note to include the size of the catheter.

During an interview on 6/27/2023, at 3:07 PM, the Clinical Manager indicated the documentation should be clear and accurate regarding the caregiver and indicated the risk of infection should have included the wound and poor mobility. The Clinical Manager indicated the document was completed incorrectly regarding the patient being on 5 or more medications. The Clinical Manager indicated she should have completed the document to include the patient's risk of skin breakdown and falls. The Clinical Manager indicated the

	was not accurately completed because the patient's mobility was "definitely impaired" and the patient had bladder incontinence at times. At 3:13 PM, the Clinical Manager indicated oral hypoglycemic medication should have been checked under the endocrine assessment. The Clinical Manager indicated the patient used a 14 French (Fr; unit of measure for catheters) catheter and should have been included in the assessment. 7. Clinical record review on 6/23/2023, for Patient #4, start of care 6/13/2023, indicated the document titled "Start of Care" identified as the comprehensive assessment was assigned to RN 1 and had not yet been started. Review of the activity log in the electronic medical record on 6/27/2023, indicated RN 1 did the assessment on 6/13/2023 and completed the document on 6/27/2023. Review failed to evidence the RN prepared the note timely per agency policy. Review indicated the patient had a feeding tube with formula running at time of assessment. Review failed to include in the documentation the type and size of the feeding tube,			

verification of placement, and the appearance of the feeding tube site to include dressing if applicable.

During an interview on 6/27/2023, at 12:10 PM, the Clinical Manager indicated RN 1 was a very busy nurse and indicated she was aware the note was not done until 6/27/2023.

During an interview on 6/29/2023, at 3:42 PM, the Clinical Manager indicated the documentation should include the type, size, patency, placement, and appearance of the feeding tube and site.

Review on 6/23/2023 indicated an agency document titled "Occupational Therapy Assessment/Evaluation" was not yet completed. Review of the activity log on 6/27/2023, indicated the visit was conducted on 6/21/2023 by the occupational therapist (OT) and was not completed until 6/25/2023 and failed to evidence the OT prepared clinical documentation timely per agency policy. Review indicated the OT documented

	with parents. During the interview on 6/27/2023, at 12:28 PM, the Clinical Manager indicated the OT documented in error that the patient lived with the parents. Review on 6/23/2023 indicated an agency document titled "Speech Therapy Assessment/Evaluation" was not yet completed. Review of the activity log on 6/27/2023 indicated the visit was conducted on 6/15/2023, and indicated the ST completed the visit note on 6/25/2023 and failed to evidence the ST prepared the clinical documentation timely per agency policy. Review of the activity log on 6/29/2023 for an agency document titled "Physical Therapy Assessment/Evaluation" with a visit date of 6/20/2023, indicated the PT had not yet completed the visit note.			

During an interview on 6/29/2023, at 3:33 PM, the Clinical Manager indicated the therapy assessments were documented late.

8. Clinical record review on 6/26/2023, for Patient #5, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/7/2023-7/5/2023, indicated the patient's bladder was to be irrigated after each catheterization with 180 milliliters (ml) of normal saline (flush solution).

Review of an agency document titled "Recertification" completed by the RN and dated 5/6/2023, failed to evidence the nurse completed the document to include the catheter flushes.

During an interview on 6/29/2023, at 4:01 PM, the Clinical Manager indicated the RN should have included the catheter flushes in the recertification assessment.

Review of an agency document titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" completed by LPN 1 dated 6/27/2023,

	which indicated the nurse included her credentials to be LPN and HHA (home health aide). During an interview 6/29/2023, at 4:22 PM, the Clinical Manager indicated LPN 1 used to be a HHA and was now a nurse. 9. During an observation at the home of Patient #6 on 6/23/2023, at 11: 52 AM, medication were observed in prescription bottles with the patient's name on the kitchen counter. At 12:18 PM, the Clinical Manager was observed measuring the length and width of an open wound to the patient's left below the knee amputation (BKA). The wound base was observed to 100% covered with a yellow, dry, stringy substance, and the Clinical Manager was not observed to have measured the depth of the wound. At 12:18 PM, the Clinical Manager was observed measuring 2 open wounds to the patient's right BKA, one wound at the distal (furthest away) end of the BKA and one wound to the lateral (away from midline on the body) side of the BKA. The two wounds to the right BKA were			

	observed to have skin intact between the wounds and were observed to have a wound base 100% covered with a dry yellow substance. The Clinical Manager indicated the measurements to the distal wound on the right BKA were 4 cm in length and 1.0 cm in width and the measurements to the lateral wound on the right BKA were 6 cm in length and 2.5 cm in width. The Clinical Manager was not observed to measure the depth of the wounds to the right BKA. At 12:55 PM, the Clinical Manager was observed removing a dressing to the patient's right middle finger, cleaning it with gauze sprayed with liquid from a bottle labeled "wound cleanser", and then applying a new dressing. The Clinical Manager was not observed to have measured the wound to the right middle finger. At 1:16 PM, the Clinical Manager left the patient's home and was not observed to have reviewed the patient's medications and was not heard to ask the patient about any medication changes. Clinical record review on 6/29/2023, evidenced an agency document titled "Skilled			

	Nurse Visit" completed by the Clinical Manager and dated 6/23/2023 for the home visit. Review indicated the nurse reconciled medications. Review indicated the depth to the left BKA wound was 0 centimeters (cm) and indicated only one wound to the right BKA with measurements of 2.5 cm in length, 0.5 cm in width, and 0.1 cm in depth. Review indicated the wound measurements to the right middle finger were 2.0 cm in length, 2.0 cm in width, and 0 cm in depth and failed to evidence the wound treatment provided to the right middle finger was documented. Review failed to evidence the nurse accurately documented the visit conducted on 6/23/2023. During an interview on 6/29/2023, at 3:18 PM, the Clinical Manager indicated she was not aware the patient had medications on the kitchen counter and indicated all of the medication should be reviewed. The Clinical Manager indicated the wounds to both BKA were covered in slough (dead tissue) and there should not be any depth documented for those wounds since depth was not			

	the Clinical Manager indicated she just "eye-balled" the measurements to the wound on the right middle finger and indicated the wound treatment should have been documented. When queried why the documented wound measurements to the right BKA were different than what the Clinical Manager indicated they were at the time of the visit, the Clinical Manager remained silent. At 3:30 PM, the Clinical Manager indicated there were 2 wounds on the right BKA and indicated the wounds were separated by skin and should be documented separately. 10. During an interview on 6/27/2023, at 10:43 AM, the Clinical Manager indicated each pain location should be assessed separately. 11. During an interview on 6/23/2023, at 1:01 PM, Patient #6 indicated he did not take antibiotics because he did not know he was supposed to take them. *. Clinical record review on 6/26/2023, for Patient #6, start			

	agency document titled "OASIS-E Resumption of Care" completed by the Clinical Manager on 6/15/2023, indicated the patient had recent below the knee amputations to the right and left leg, and surgical removal of the right middle fingertip at the most recent hospitalization. An area subtitled "Plan of Care: Psychosocial Assessment" indicated there were no problems identified, including but not limited barriers to health status. Review failed to evidence the skilled nurse prepared clinical notes that were accurate to the patient's current condition to reflect recent changes in health. During an interview on 6/29/2023, at 12:25 PM, when queried if the patient had barriers related to their health status, the Clinical Manager indicated the patient had psychosocial issues. Record review of an agency document titled "Skilled Nurse Visit" electronically signed by the Clinical Manager on			

	coordination was performed with the physician because the patient's surgical wounds to their left and right lower extremities dehisced (when the edges of an incision have pulled apart) which was draining with an odor. An area subtitled "Wound Care Flowsheet" indicated minimal to moderate drainage without odor to the lower extremities. Review of this skilled nurse visit evidenced contradictory documentation regarding the same wounds. During an interview on 6/29/2023, at 12:33 PM, the Clinical Manager indicated the contradictory wound documentation was an oversight. Record review of an agency document titled "Skilled Nurse Visit" electronically signed by the Clinical Manager on 6/20/2023, had an area subtitled "Health Management" that stated "Educated on antibiotic LINEZOLID 600 MG TABLET used for infection to BKA surgical wounds. Patient voices no complaints of			

	medication …" Review evidence the medication was added to the medication profile on 6/26/2023, 6 days after the visit. An area of the Plan of Care subtitled "Interventions" indicated wound care provided to the patient was via vacuum therapy (wound vac –wound is attached to a vacuum assisted device to promote healing and wound closure) and the patient tolerated the wound vac dressing change well. An area subtitled "Wound Care Flowsheet" indicated the assessments of the right and left lower extremities indicated minimal to moderate drainage without odor. Review of the wound assessments failed to indicate the presence of wound vac therapy including but not limited to the seal around the wound, the color of the occlusive foam, or the rate and frequency of the vacuum assistance. Review of this document evidenced contradictory assessments of the same wounds. Review of this document failed to evidence wound care for the right middle finger. Record review evidenced the			

	accurate clinical documentation for the patient's current condition at the time of assessment. *** HV interview about ABT *** During an interview on 6/29/2023, at 12:38 PM, when queried the reason for education and assessment of side effects for a medication the patient was not yet taking, the Clinical Manager indicated they had found out later the patient was not able to get the antibiotic. During an interview on 6/29/2023, at 12:41 PM, the Clinical Manager indicated the wound care performed on the right middle finger was not documented. During an interview on 6/29/2023, at 1:00 PM, the Clinical Manager indicated drainage amount, seal, and if the device is working properly should be included in an assessment of a wound vac dressing.			

	*. Clinical record review on 6/23/2023, for Patient #7, evidenced a document titled "OASIS-E Start of Care" electronically signed by the Clinical Manager on 6/1/2023, which indicated the patient was bedbound and caregivers assisted with care daily but failed to evidence what type of care was provided and the frequency of the day. This document indicated the patient's psychosocial status had no issues assessed including but not limited to barriers to health status. Review failed to evidence a complete comprehensive assessment was documented by the skilled nurse. Record review of an agency document titled "Home Health Certification and Plan of Care" for certification period 6/1/2023 – 7/30/2023, which indicated the patient had a pressure ulcer on their coccyx (tailbone) and the skilled nurse was ordered to cleanse and irrigate the wound with saline, apply gauze to cover, and secure with tape. A section subtitled "Homebound Narrative" indicated the patient had a surgical incision to the left hip from a recent femur			

	fracture. The Plan of Care failed to evidence wound care orders for the left hip incision. Record review of an agency document titled "Skilled Nurse Visit" electronically signed by the Clinical Manager on 6/5/2023, evidenced wound care treatment provided to the left hip indicated the dressing was changed and the patient tolerated the procedure well. Review failed to evidence the steps performed during the treatment to the left hip. Record review failed to evidence wound care performed to the pressure ulcer on the coccyx as ordered. During an interview on 6/27/2023, at 4:29 PM, the Clinical Manager indicated they removed the old dressing, did not cleanse, and then covered the left hip surgical incision with adhesive dressings. The Clinical Manager indicated the pressure ulcer on the patient's coccyx had healed since the plan of care was initiated 5 days prior to the visit. Record review of an agency document titled "Skilled Nurse Visit" electronically signed by			

	6/9/2023, which indicated the dressing to the left hip was changed by the patient's family member. Review failed to evidence the skilled nurse assessed the patient's left hip surgical wound or stage 2 coccyx pressure ulcer. During an interview on 6/27/2023, at 4:32 PM, the Clinical Manager indicated the patient's caregiver changed the dressing on the 7th (2 days before the visit occurred) and the stage 2 coccyx pressure ulcer was healed. Record review of an agency document titled "Skilled Nurse Visit" electronically signed by the Clinical Manager on 6/12/2023, which indicated 48 staples were removed from the patient's left hip surgical incision, cleansed with saline and covered with an adhesive bordered dressing. Review failed to evidence the wound was assessed to include drainage, odor, and how the patient tolerated wound care during the visit. Record review failed to evidence the skilled nurse			

	document all pertinent assessments performed. During an interview on 6/27/2023, the Clinical Manager indicated a wound assessment should include the type of dressing, location of the wound, drainage, odor, and pain. *. Clinical record review on 6/26/2023, for Patient #8, evidenced an agency document titled "OASIS-E Start of Care (PT)" completed by PT 2 on 2/1/2023, indicated the patient was bedbound due to weakness of the legs and recent fall with a transfer, and the patient had no willing or available caregiver. An area subtitled "Plan of Care: Psychosocial Assessment" indicated there were no problems identified, including but not limited to an altered home environment, barriers to health status, or community resources needed. Review failed to evidence the skilled professional prepared clinical notes that were accurate to the patient's current condition. Record review evidenced an			

	agency document titled "OASIS-E Resumption of Care" completed by the Clinical Manager on 5/26/2023, indicated the patient was at risk for falls due to lower extremity weakness, incontinent of urine, and in need of assistance with all ADL's. An area subtitled "Plan of Care: Psychosocial Assessment" indicated community resources aided the patient but did not specify a service or agency. This section failed to evidence the skilled professional assessed the patient had to have barriers to health status. Review failed to evidence the skilled nurse prepared complete clinical notes to document an accurate description of the patient's current condition.			
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on observation, record review, and interview, the skilled professionals failed to ensure changes in patient conditions were	G0718	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-645 Medical Supervision Physicians will be informed, at the time their patients are admitted to the agency, of each parties' responsibilities in managing patient care. All	2023-08-12

	reported to the physician for 5 of 9 clinical records reviewed (Patient #1, #2, #5, #6, #7). The findings include: 1. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "Start of Care" completed by the registered nurse (RN) and dated 6/1/2023, which indicated the patient had not had a bowel movement in over 2 weeks. Review failed to evidence the RN notified the physician of the patient's lack of bowel movements. Review of agency documents titled "Skilled Nurse Visit" completed by the Clinical Manager, indicated the patient had diarrhea on document dated 6/2/2023. Review failed to evidence the RN notified the physician. Review of document dated 6/12/2023, indicated the patient had a pink area to the left vaginal area to which the RN applied ointment of the patient's choice to the area. Review failed to evidence the physician was notified of the pink area and application of antibiotic ointment. During an interview on		patients must be under the care of a licensed, practicing physician, podiatrist, or osteopath when receiving home care services through a Medicare certified agency. The patient's primary physician shall be responsible for providing signed orders, and for ESTABLISHING and reviewing the patient's Plan of Care throughout the time the patient is receiving services The Clinical Manager reviewed 100% of active patients' charts and noted that 35% had more than 1 physician following the patient's care and both physicians were not notified of changes or pertinent information with the patients' care. The physicians have now been notified. The Clinical Manager now ensures that the primary care physician approves of all physicians involved in the patient's plan of care and this is noted on the patient's plan of care. The primary care physician and all physicians involved in the patient's care are now notified of any significant	

	6/27/2023, at 10:25 AM, the Clinical Manager indicated she should have notified the physician and could not find any documentation of communication with the physician regarding the lack of bowel movements and diarrhea. At 11:05 AM, the Clinical Manager indicated she applied Neosporin (an antibiotic ointment) to skin breakdown to the vaginal area since that is the ointment the patient had in the home and indicated she did not notify the physician of the skin breakdown and application of Neosporin. 2. Clinical record review on 6/23/2023, for Patient #2, evidenced an agency document titled “Resumption of Care” completed by the Clinical Manager and dated 6/5/2023, which indicated a foley catheter (a plastic tube inserted into the bladder to drain urine and held in place with a small, inflated balloon) was noted dangling from the patient’s walker with an intact balloon tip. Review indicated the patient informed the nurse she pulled out the catheter herself. Review failed to evidence the nurse notified		changes in the patient's condition. The Clinical Manager and the Quality Assurance (QA) team will monitor all visit notes and Assessments daily for changes in the patient’s condition and ensure that the primary care physician and all physicians involved in the patient's care are now notified of any significant changes in the patient's condition. The Clinical Manager is responsible to ensure that this deficiency does not recur.	

discontinuing the foley catheter and to clarify if the foley catheter was needed.

During an interview on 6/28/2023, at 12:53 PM, the Clinical Manager indicated she did not notify the physician of the patient's removal of the catheter because it was already out and hanging on her walker.

3. Clinical record review on 6/26/2023, for Patient #5, evidenced an agency document titled "Skilled Nurse Visit" completed by the RN and dated 6/26/2023, which indicated the patient was complaining of severe pain to the left hip and the RN contacted Person V (physician) who ordered the patient to go the emergency room. Review failed to evidence the RN notified the patient's physician responsible for the plan of care, Person W, of the patient's transfer to the emergency room.

During an interview on 6/29/2023, at 4:26 PM, the Clinical Manager indicated the nurse called Person V who was the patient's orthopedic physician for fear the patient's hip was dislocated. The Clinical

Manager indicated the nurse should have notified the physician responsible for the plan of care, Person W, of the order from Person V to go to the emergency room.

4. During an observation at the home of Patient #6 on 6/23/2023, at 1:09 PM, a bottle labeled "Imodium [a medication used to treat diarrhea]" was noted on the patient's table next to the couch, which the patient indicated he took last night for diarrhea.

Clinical record review on 6/29/2023, evidenced an agency document titled "Skilled Nurse Visit" completed by the Clinical Manager and dated 6/23/2023 for the home visit. Review indicated the nurse indicated the patient complained of loose bowels and took Imodium. Review failed to evidence the patient's plan of care included Imodium in the patient's list of medication. Review failed to evidence the physician was notified of the patient's loose stool and use of Imodium.

During an interview on

	6/29/2023, at 3:12 PM, the Clinical Manager indicated she did not notify the physician of the patient's report of diarrhea and use of Imodium. The Clinical Manager indicated she wrote a physician order for the Imodium but did not call the physician for the order. 1. Record review of an agency policy titled "Medical Supervision" revised 6/28/2023, stated "Physician will be contacted when any of the following occurs ... Condition changes ... Expected response to treatment or medication changes ... Any change in patient condition or agency services, including non-compliance of the patient related to the plan of care ...." 2. Clinical record review on 6/26/2023, for Patient #6, start of care 5/24/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification 5/24/2023 – 7/22/2023, indicated the physician should be notified if the systolic blood pressure (top number) was greater than 160 mmhg (millimeters of mercury).			

	Record review of an agency document titled "Skilled Nurse Visit" electronically signed by the Clinical Manager on 5/30/2023, evidenced the patient's blood pressure was 165/66 mmhg. Review failed to evidence the skilled nurse re-checked the blood pressure. Review failed to evidence the physician was notified of the out-of-range systolic blood pressure. During an interview on 6/29/2023, at 12:30 PM, the Clinical Manager indicated they did not re-check the blood pressure or notify the physician. 3. Clinical record review on 6/23/2023, for Patient #7, start of care 6/1/2023, recent diagnosis of a left hip surgical incision evidenced a document titled "Home Health Certification and Plan of Care" for certification period 6/1/2023 – 7/30/2023, which ordered the skilled nurse to provide wound care to the coccyx (tailbone) to treat a stage 2 (Partial thickness skin loss) pressure ulcer. Record review failed to evidence the skilled nurse documented on			

	the stage 2 coccyx pressure ulcer in any of the skilled nurse visit notes. Record review of an agency document titled "Skilled Nurse Visit" electronically signed by the Clinical Manager on 6/15/2023, indicated the patient had 3 surgical incisions (wound 1, wound 2 and wound 3) to the left hip. Record review of an agency document titled "Skilled Nurse Visit" electronically signed by the Clinical Manager on 6/19/2023, indicated the patient had 2 surgical incisions (wound 2 and wound 3) to the left hip. Record review failed to evidence wound 1 addressed within the visit. Record review failed to evidence physician notification for the non-treatment of the stage 2 pressure ulcer on the patient's coccyx. Record review failed to evidence physician notification for the non-treatment of wound 1. During an interview on 6/27/2023, at 4:29 PM, the Clinical Manager indicated the patient's pressure ulcer on the coccyx was healed and			

	communication with the physician was not documented. During an interview on 6/29/2023, at 12:06 PM, the Clinical Manager indicated wound 1 healed and the physician was not made aware.			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the agency failed to ensure the home health aide (HHA) was oriented to the HHA care plan as assigned by the registered nurse for 3 of 3 clinical records reviewed with home health aide (HHA) services. (Patient #3, #5, #9) The findings include: 1. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document	G0798	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-780 Home Health Aide Assignment The need for home health aide services is determined during the assessment by the nurse or therapist. When the services are ordered by the physician, the designated Registered Nurse/Therapist will assign and orient the aide to the care plan. The Clinical Manager reviewed 100% of all active charts with Home Health Aide services and noted that 4 of 35 did not have written or verbal discussion of the HHA Care Plan with a the Home Health Aides The clinical manager and	2023-08-12

	titled "Home Health Certification and Plan of Care" signed by the physician for certification period 6/1/2023-7/30/2023, which indicated the agency was to notify the physician of a temperature greater than 100.4 degrees Fahrenheit. Review indicated the patient's diet included no added salt and no concentrated sweets and indicated the patient's allergies included cephalosporins (a class of antibiotics) and penicillin (antibiotic). Review of an agency document titled "HHA [home health aide] Care Plan" signed by the registered nurse (RN) and dated 6/9/2023, indicated the HHA was to notify the nurse for a temperature greater than 101 degrees Fahrenheit. Review failed to evidence the RN completed the HHA care plan to include the patient's diet and allergies. Review failed to evidence the RN assigned the HHA per the orders from the physician. 2. Clinical record review on 6/22/2023, for Patient #3, evidenced an agency document		administrator in-serviced (08/12/2023) all procare and contracted clinical staff on orientation of the aide to the home health aide care plan. The Clinical Manager now ensures that the Home Health Aide Care Plan is discussed with the HHA by phone or in person and documentation to be indicated on the Care Plan The Clinical Manager and the QA team review and ensure that every initial health aide care care plan is completed and discussed with the home health aide. The Clinical Manager and the QA team will follow up with review and ensure that every recertification and update of the home health aide care plan is completed and discussed with the home health aide. The Clinical Manager is responsible to ensure that this situation does not recur.	

	Certification and Plan of Care" signed by the physician for certification period 4/14/2023-6/12/2023, which indicated the agency was to notify the physician of a temperature greater than 100.4 degrees Fahrenheit. Review indicated the patient's diet included no added salt and no concentrated sweets. Review indicated the patient's primary diagnosis was quadriplegia (paralysis of all 4 limbs), and the patient's functional limitations included ambulation. Review of an agency document titled "HHA Care Plan" signed and dated by the RN on 4/10/2023, for episode period 4/14/2023 – 6/12/2023, indicated the HHA was to notify the nurse for a temperature greater than 101 degrees Fahrenheit. Review failed to evidence the RN completed the HHA care plan to include the patient's diet and allergies. Review failed to evidence the RN assigned the HHA per the orders from the physician. Review failed to evidence ambulation as a functional limitation and failed to evidence fall risk as a safety precaution.			

RN reviewed the HHA Care Plan every 60 days per agency policy since the HHA Care Plan dated 4/10/2023 was the most recent HHA Care Plan in the clinical record.

During an interview on 6/27/2023, at 3:04 PM, the Clinical Manager indicated ambulation should have been included on the HHA Care Plan as a functional limitation and fall risk should have been included as a safety precaution.

3. Clinical record review on 6/26/2023, for Patient #5, evidenced an agency document titled “HHA Care Plan” dated 3/6/2023. Review failed to evidence the HHA care plan was reviewed by the RN no less than every 60 days.

During an interview on 6/29/2023, at 4:08 PM, the Clinical Manager indicated there was no other HHA care plan since the document dated 3/6/2023 and indicated that it should have been reviewed at every recertification.

4. During an interview on 6/27/2023, at 9:45 AM, the Clinical Manager indicated the

	in the HHA care plan should match the parameters in the medical plan of care. At 11:01 AM, the Clinical Manager indicated the RN just tells the HHAs verbally of the patient's diet and allergies. 1. Record review of an agency policy titled "Home Health Aide Assignment" revised 6/28/2022, stated "... Purpose ... To orient the aide to the patient and to the care plan ... Special Instructions ... 8. Home Health Aide Visit Protocol includes: ... Receive verbal/written instructions for patient care from the Registered Nurse/Case Manager ... Clarify the patient assignment with Registered Nurse/Case Manager ... The Home Health Aide Care Plan shall be reviewed and updated by the Registered Nurse minimally every sixty (60) days...." 2. Clinical record review on			

	of care 5/19/2023, diagnoses included but were not limited to hemiplegia (paralysis to one side of the body) and dysphagia (difficulty swallowing), evidenced an agency document titled "HHA Care Plan" electronically signed by the Clinical Manager on 6/14/2023. This document indicated the patient's plan details which included but was not limited to personal care, nutritional needs, and functional limitations. Review failed to evidence the patient's diet and allergies listed on the HHA care plan. Review evidenced a section subtitled "Notifications" which had an area that had an empty box next to the statement "Reviewed with Home Health Aide" that remained unchecked. Review failed to evidence the care plan was reviewed with the HHA assigned to the patient. During an interview on 6/29/2023, at 1:30 PM, the Clinical Manager indicated a care plan is reviewed with the HHA individually either by phone or in person. The Clinical Manager indicated the unchecked box was an oversight because the care plan			

	the agency's office.			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review, and interview, the agency failed to ensure all home health aides (HHA) followed the plan of care for 1 of 3 patients who received HHA services, from a total sample of 7 clinical records reviewed with orders for an HHA (patient #9). The findings include: Record review of an agency policy titled "Home Health Aide Documentation" revised 6/28/2022, stated "Policy ... Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan ... Special Instructions ...The Home Health Aide shall be responsible for reporting any changes in the	G0800	The Clinical Manager and Administrator reviewed the following policy for reeducation and clarification of procedures. C-800 Home Health Aide Documentation Home Health Aides will document care/services provided on the home health aide charting form. Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan. The Clinical Manager now ensures that the Home Health Aides report abnormal vital signs listed on the Parameter list The Clinical Manager reviewed 100% of all charts with Home Health Aide services and noticed 15 out of 35 charts had vital signs out of range on the Parameter listing and not reported to the Clinical Manager team. The Clinical Manager Inserviced the Home Health Aide staff on reporting vital signs that are not	2023-07-28

	pertinent observations to the Supervising Nurse ... The designated Registered Nurse is responsible for reviewing the Home Health Aide's charting before it is placed in the chart ...." Clinical record review on 6/26/2023, for Patient #9, start of care 5/19/2023, evidenced an agency document titled "HHA Care Plan" which indicated the specific vital sign parameters for the blood pressure were to stay between 90/60 mmhg (millimeter of mercury) and 160/90 mmhg. The parameters for respirations were to stay between 14 to 22 breaths per minute.		in the Parameter range to the Clinical Manager Team. The Quality Assurance (QA) team will review clinical notes daily to ensure that all of the Home Health Aides are reporting abnormal vital signs to the Clinical Manager. The Clinical Manager is responsible to ensure that this situation does not recur.	

	Record review of an agency document titled "HHA Visit" from 6/14/2023, evidenced the patient's blood pressure was 132/100 mmhg and respirations were 36 breaths per minute. Review evidenced the patient's blood pressure and respirations were elevated above the given parameters on the HHA care plan. Record review failed to evidence the HHA reported the abnormal findings to the supervising nurse per agency policy. During an interview on 6/29/2023, at 1:28 PM, the Clinical Manager indicated the HHA should utilize the care plan to know when to report vitals that were out of normal range.			
G0822	Ensuring the overall quality of care provided 484.80(h)(5)(i) Ensuring the overall quality of care provided by an aide; Based on observation, record review, and interview, the agency failed to ensure the overall quality	G0822	The Administrator and Clinical Manager reviewed the following policy for reeducation and clarification of procedures. C-300 Clinical Supervision Skilled nursing and other therapeutic services are provided under the supervision	2023-07-28

	of care provided by a home health aide (HHA) in 1 of 1 home visit conducted with a HHA. (Patient #3) The findings include: Review of an agency policy revised 6/28/2022, titled "Clinical Supervision" stated, "... The Director of Nursing/Nursing Supervisor shall be responsible for the quality of care provided ...." Clinical record review on 6/22/2023, for Patient #3, evidenced an agency document titled "Communication Note" completed by the Clinical Manager and dated 12/19/2023, which indicated the pulse and temperature were noted to be the same on recent HHA notes. Review indicated the Clinical Manager informed HHA 1 of the findings. Review indicated the patient then called the Clinical Manager to report HHA 1 did obtain her vital signs which run low and the same for the aide, the therapist, and the hospital. Review indicated HHA 1 informed the Clinical Manager of accurate documentation of		of a Registered Nurse. The Director of Nursing or a designated qualified Registered Nurse will be available to provide ongoing supervision during the operating hours of the Agency. Under no circumstances will the administrative or supervisory responsibilities be delegated to another organization. The Clinical Manager team now ensures that the Home Health Aides are documenting accurate vital signs The Administrator and Clinical Manager in-serviced the field staff on the importance of ensuring that all vital signs are recorded as soon as they are taken and not to rely on memory to document on vitals after the visit. The Clinical Manager will be responsible to ensure that vital signs are documented accurately with monthly onsite supervisory visits stating vitals checked in the presence of a clinician and documented once obtained.	

	vital signs. Review failed to evidence the Clinical Manager assessed the quality of care provided by the aide to include obtaining and recording vital signs. Review evidenced agency documents titled "HHA Visit" completed by HHA 1indicated HHA 1 documented the same temperature, pulse, respirations, and blood pressure on visit notes dated 5/23/2023, 5/24/2023, 5/28/2023, 5/29/2023, 6/2/2023, 6/3/2023, 6/7/2023, 6/8/2023, 6/11/2023, 6/12/2023, 6/13/2023, 6/16/2023, 6/17/2023, 6/18/2023, and 6/21/2023 to include a temperature of 99.6 degrees Fahrenheit, pulse of 100 beats per minute, respirations of 17 breaths per minute, and a blood pressure of 100/70. During an observation at the home of Patient #3 on 6/23/2023, at 9:38 AM, HHA 1 was observed obtaining the patient's temperature which she indicated was 97.8 degrees Fahrenheit. HHA 1 was observed obtaining the patient's pulse and blood		The Clinical Manager is responsible to ensure that this situation does not recur.	

	blood pressure cuff on the patient's right wrist which was observed to indicate the pulse was 60 beats per minute and the blood pressure was 138/84. HHA 1 was not observed obtaining the patient's respirations and was not observed looking at a watch or clock to count the respirations. Review of an agency document titled "HHA Visit" completed by HHA and dated 6/23/2023, the date of the observation, indicated HHA 1 documented the temperature to be 99.6 degrees Fahrenheit, pulse of 100 beats per minute, respirations of 17 breaths per minute, and a blood pressure of 100/70. Review failed to evidence HHA 1 documented the vital signs accurately as observed. During an interview on 6/27/2023, at 3:44 PM, the Clinical Manager indicated she was made aware of HHA 1 documenting the same vital signs at the last survey, and the Clinical Manager has observed HHA 1 in the home obtaining vital signs but did not verify the aide documented the vital signs correctly. The Clinical Manager			

	indicated HHA 1 needs more on-site supervision.			
G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on observation, record review, and interview, the home health agency failed to ensure the organization and management of the home health agency as follows: the administrator failed to maintain the day-to-day operations of the agency (see tag G0948); the clinical manager failed to coordinate referrals (see tag G0964); the clinical manager failed to assure implementation of plan of care (see tag G0968); and failed to assure services were provided in accordance with current clinical practice (see tag G984).	G0940	Governing Body B-100 Comprehensive Patient Assessment C-145 Provision for 24-Hour RN Availability C-180 Personnel Records D-180 Job Descriptions D-110 Performance Evaluations D-260 Employee Orientation Program D-300 Competency Evaluation of Home Care Team Members D-220 Physician Summary C-650 Clinical Manager B-105 Patient Admission Process C-140 Clinical Manager B-105 Patient Referral and Acceptance C-139	2023-07-29

	The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.105 Organization and Administration of Services.		Admission Policy C-120 July 29, 2023 The Administrator and Clinical Manager reviewed all the afore-mentioned policies for reeducation and clarity. The agency now has the Administrator and Clinical Manager fully responsible for all day-to-day operations of the Home Health Agency. The Administrator and Clinical Manager performed a total program review and are now compliant with all aspects of the Agency management and operations. The Agency now organizes, manages, and administers its resources to attain and maintain the highest practicable functional capacity; including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. We have in writing our organizational structure,	

			including lines of authority, and services furnished. The administrator now maintains the day-to-day operations of the agency; the clinical manager and administrator now coordinate referrals; the clinical manager following in-serviced by the administrator now assure implementation of plan of care; and assure services are being provided in accordance with current clinical practice. The organizational chart has been revised to clearly show the lines of authority and roles. A tool has been created for logging and following up on referrals with referral sources and assigned services, clinical disciplines, and staff. The agency has signed a contract with another agency for HHA for services it is unable to provide. The Administrator and Clinical Manager will monitor the day-to-day operations of the Home Health Agency by being actively involved in the patient intake process and staff employment (for new staff as needed) on a daily basis.	

			The Administrator is responsible for ensuring that this deficiency does not recur.	
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to provide oversight of the day-to-operations of the agency to include ensuring the initial assessments were completed within 48 hours of the referral date, ensuring adequate staffing for the services the agency offered, ensuring protection of patient information, ensuring the availability of the nurse on-call, and ensuring the physician was provided a written summary at least every 60 days per agency policy in 1 of 1 agency. The findings include: 1. Review of an agency policy revised 6/28/2022, titled "Governing Body" stated, "... a qualified Administrator ... delegate to that individual the	G0948	The Administrator and the Clinical Manager reviewed the following policies for reeducation and clarification of procedures. B-100 Governing Body The Governing Body (or designated persons so functioning) shall assume full legal authority and responsibility for the overall management and operation of Agency. This includes the provision of home health services, fiscal operations, review of the agency's budget and its operational plans as well as the Quality Assessment and Performance Improvement Program. New governing body members/designees are oriented to the agency as appropriate to responsibilities. The roles of the Governing Body may not be delegated. C-145 Comprehensive Patient Assessment	2023-07-29

	the day to day operations of the agency to include provision of home care services in accordance with state and federal regulations, accreditation standards, and Agency mission…." 2. Review of an agency policy revised 6/28/2022, titled "Comprehensive Patient Assessment" stated, "… The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the patient's return home, or on the physician ordered start of care date…." 3. Review of an agency policy revised 1/21/2021, titled "Provision for 24-Hour RN [registered nurse] Availability" stated, "… A Registered Nurse shall be accessible at all times, 24 hours per day, by telephone and/or pager to meet patient needs…." 4. Review of an agency policy revised 6/28/2022, titled "Personnel Records" stated, "… The personnel record for an employee will include, but not be limited to: … Criminal history and background checks as required by law … Competency		The initial assessment visit must be held either within 48 hours of referral or within 48 hours of the patient's return home, or on the physician ordered start of care date. A thorough, well-organized, comprehensive, and accurate assessment, consistent with the patient's immediate needs will be completed for all patients in a timely manner, but no later than five (5) calendar days after start of care. All skilled Medicare and Medicaid patients except pediatric and post-partum will have comprehensive assessments that include the OASIS data set specific to mandated time points. C-180 Provision for 24-Hour RN Availability Hours of operation are from 8:00 a.m. to 4:30 p.m., Monday through Friday. A Registered Nurse shall be accessible at all times, 24 hours per day, by telephone and/or pager to meet patient needs. The Registered Nurse will be available to make a home visit, if necessary. If medical emergencies occur and there is not an agency team member in the home, patients	

	testing for home health aides … Signed job description … Orientation checklist … Performance appraisals … Updated license/certifications ….” 5. Review of an agency policy revised 1/21/2021, titled “Job Descriptions” stated, “… All personnel will receive a copy of their Job Descriptions during the onboarding process. A signed copy will be kept in their personnel file.” 6. Review of an agency policy revised 1/21/2021, titled “Performance Evaluations” stated, “… A competency-based performance evaluation will be conducted for all employees after one (1) year of employment and at least annually thereafter….” 7. Review of an agency policy revised 1/21/2021, titled “Employee Orientation Program” stated, “… All team members … will participate in a general orientation program before beginning any job responsibilities … orientation specific to team member’s needs and specific responsibilities will be provided		physicians or 911 for treatment. D-180 Personnel Records Personnel files will be established and maintained for all personnel. All information will be considered confidential and made available to authorized personnel only. All patient-identifying data will be removed from employee personnel records. Personnel records may not be removed from Agency unless ordered by subpoena D-110 Job Descriptions All personnel will receive a copy of their Job Description during the onboarding process. A signed copy will be kept in their personnel file. D-260 Performance Evaluations A competency-based performance evaluation will be conducted for all employees after one (1) year of employment and at least annually thereafter. The evaluation will be objectively based on criteria that are established in the position description for each employee. Job performance will be	

	after the general orientation…." 8. Review of an agency policy revised 1/21/2021, titled "Competency Evaluation of Home Care Team Members" stated, "… Home Health Aide Competency: … Skills competency is evaluated by observing the aide with patient … A Home Health Aide will not be permitted to provide Home Health Aide services until evidence of adequate training and/or competency has been determined by the designated professional in the agency…." 9. Review of an agency policy revised 1/21/2021, titled "Physician Summary" stated, "… A summary report will be provided to the physician no less than every sixty (60) days. The summary will provide a written report of the patient's current condition, the treatment/services provided … The summary note will include: … Date sent to physician …." 10. Clinical record review on 6/23/2023, for Patient #2, start of care 5/15/2023, evidenced a referral order for home health from Entity A, dated 5/9/2023, which indicated the patient was		documented on the appropriate form by the evaluator and will become a permanent part of the employee personnel file. Contracted organizations/personnel are expected to adhere to these requirements as part of the contractual agreement and to submit completed documentation of competency and performance evaluations to the agency. D-300 Employee Orientation Program All team members, volunteers, students, and members of the Board of Directors new to the Agency, will participate in a general orientation program before beginning any job responsibilities. D-220 Competency Evaluation of Home Care Team Members The agency will establish a program that allows for objective, measurable, assessment of the person's ability to perform required activities. Individuals working in the agency must be licensed, registered, or certified as required by law, policy, or	

	to receive home health services to include skilled nursing, physical therapy (PT), and home health aide (HHA) services. Review indicated the agency completed the initial assessment on 5/15/2023, which was greater than 48 hours. Review failed to evidence any documented communication regarding attempts to schedule the initial assessment with the patient. During an interview on 6/27/2023, at 11:35 AM, the Clinical Manager indicated she called the patient on 5/12/2023 and could not reach the patient and indicated the patient returned the call on 5/13/2023 and requested the start of care on 5/15/2023. The Clinical Manager indicated there was no documentation of communication or scheduling attempts with the patient. 11. Clinical record review on 6/23/2023, for Patient #4, start of care 6/13/2023, evidenced a referral order from Entity E which indicated the patient was discharged to home effective 6/9/2023, and was to receive home health services to include PT, OT, and speech therapy (ST).		assessment will verify and focus on the individual team members knowledge and skill appropriate to assigned responsibilities, communication skills, and the ability to respond to patient needs within their scope of responsibility. C-650 Physician Summary A summary report will be provided to the physician no less than every sixty (60) days. The summary will provide a written report of the patient's current condition, the treatment/services provided, and the patient's response to the current treatment and/or medications, and pertinent changes in the patient's physical, emotional, or environmental condition since the last report. The physician summary will provide the progress report required by the Medicare Conditions of Participation. The report may be submitted on a summary form or as an addendum to the Physician Plan of Care. July 29, 2023 The Administrator and Clinical Manager reviewed all the	

	Review indicated the initial assessment was completed on 6/13/2023, and failed to evidence the agency completed the initial assessment within 48 hours of the referral. During an interview on 6/27/2023, at 12:22 PM, the Alternate Administrator indicated she was unsure why the agency did not complete the initial assessment within 48 hours of referral and indicated there was no documentation regarding the delay in the initial assessment. 12. During an interview on 6/29/2023, at 2:13 PM, the Clinical Manager indicated the initial assessment was the start of care comprehensive assessment. 13. During an interview on 6/27/2023, at 10:07 AM, the Administrator indicated the agency was not advertising for home health aides because aides contact the agency for work. The Administrator indicated the agency was not making a proactive effort to employ additional home health aides. At 2:42 PM, the		afore-mentioned policies for reeducation and clarity. The agency now has the Administrator and Clinical Manager fully responsible for all day-to-day operations of the Home Health Agency. The Administrator and Clinical Manager performed a total program review and are now compliant with all aspects of the Agency management and operations. The Agency now organizes, manages, and administers its resources to attain and maintain the highest practicable functional capacity; including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. We have in writing our organizational structure, including lines of authority, and services furnished. The administrator now maintains the day-to-day operations of the agency; the clinical manager and administrator now	

	Administrator indicated the agency did not have a contract with another agency for HHA services and indicated it never occurred to him that the agency could contract for HHA services. The Administrator indicated the Intake Coordinator oversaw the referral process and was unable to answer how the Intake Coordinator communicated with the office regarding the referrals. At 2:47 PM, the Administrator indicated the agency should not admit patients for which the agency could not provide services and indicated the agency should not admit patients that need HHA services because the agency could not meet those needs. 14. On 6/23/2023, customers were observed coming to the home health agency's office to check in for a fingerprinting service at 9:13 AM, 9:33 AM, 9:38 AM, and 10:00 AM, and was assisted by the Community Liaison. The customers were brought back into the office and assisted by Person F. Person F was observed present in the office throughout the survey while conversations of agency patients were conducted.		coordinate referrals; the clinical manager following in-serviced by the administrator now assure implementation of plan of care; and assure services are being provided in accordance with current clinical practice. The organizational chart has been revised to clearly show the lines of authority and roles. Initial assessments are now being done within 48 hours. Clinical staff received in-serviced (July 28, 2023) on the importance of documenting communication regarding attempts to schedule the initial assessment with the patient if the patient cannot be seen in 48 hours and to obtain orders from the physician with regards to any occurrence. A tool has been created for logging and following up on referrals with referral sources and assigned services, clinical disciplines, and staff. The agency has signed a contract with another agency for HHA for services it is unable to provide. The agency is now advertising	

	During the duration of the survey, a cabinet containing medical records for patients of the home health agency was observed to have unlocked drawers on 6/22/2023, at 4:35 PM; 6/23/2023, at 9:13 AM; 6/26/2023, at 10:47 AM; 6/28/2023, at 11:15 AM; and 6/29/2023, at 11:24 AM. During an observation on 6/30/2023, at 2:31 PM, Person F was observed bringing a person from the lobby back into a room next to the room where the Clinical Manager was discussing clinical information for Patient #5 with the door open. During an interview on 6/22/2023, at 4:35 PM, the Administrator indicated Person F was an employee of Entity G, a fingerprinting company that shares an office with the agency. The Administrator indicated the fax machine for the agency was in the same office space as Person G. The Administrator indicated Person F was on the list of active agency personnel by mistake. When queried how the agency protected patient information		staff, particularly, Registered Nurses, Licensed Practical Nurses, and home health aides. The Agency is now relocated to a separate suite away from the finger printing company, Entity G. Person F and Person G. are now staff members of the agency with full orientation and have signed confidentiality and HIPPA statements. Administrative Assistants 4, 5, and 6 have been terminated from the agency. The agency's primary number 219-844-9640 is now forwarded to the 24hr on call nurse after business hours and on weekends. All Criminal background checks are now included in the Personnel records of all staff. The end of episode/30-day summary documents are now being sent to the physician. The Administrator and the Human Resource Officer and Office Assistant #8 will ensure that all needed information including license verification	

	non-agency personnel working for Entity G in a shared office space, the Administrator stated, "I see your point." During an interview on 7/3/2023, at 4:27 PM, the Administrator indicated it was going to be a challenge on how the agency would protect patient information from people coming into the office for fingerprinting for Entity G. 15. During an interview on 6/26/2023, at 2:29 PM, Administrative Assistant 6 indicated she was not an employee of the agency but did work for the agency as a virtual assistant. Administrative Assistant indicated she had access to the agency's electronic medical record as she reviewed aide and nurse visit notes and indicated she did not have a contract with the agency. Administrative Assistant indicated she lived in Nigeria. 16. During an interview on 6/27/2023, at 8:00 AM, Administrative Assistant 4 indicated he lived in the Philippines and was a nurse but did not have a license in the		and criminal background checks are completed and in the staff personnel records before 1st patient contact. The Administrator is responsible for ensuring that this deficiency does not recur.	

	Assistant 4 indicated he had access to the electronic medical record and was a “freelance” employee but did not have a contract with the agency. Administrative Assistant 4 indicated he was the intake coordinator and reviewed all referrals through the patient portal, reviewed to identify what services were needed and verify payor source, called the physician’s office to get the order, if needed, and called the discipline needed to schedule for the comprehensive assessment. 17. During an interview on 6/26/2023, at 2:46 PM, the Administrator indicated there were no contracts with Administrative Assistants 4, 5, and 6 and indicated they all 3 had access to the agency’s electronic medical record. The Administrator indicated there were no personnel files for Administrative Assistants 4, 5, and 6. 18. A phone call was made to the agency’s primary number 219-844-9640 on 6/26/2023, at 10:38 PM, which went unanswered. A message was left with the reason for the call,			

	contact information, and a request for a return call. No return call was received. During an interview on 6/27/2023, at 8:32 AM, the Clinical Manager indicated she was the nurse on-call on 6/26/2023 and indicated 219-844-9640 was the correct number. The Clinical Manager indicated she did not receive a missed call on 6/26/2023. During an interview on 6/27/2023, at 9:42 AM, the Administrator indicated the Clinical Manager was on-call the evening of 6/26/2023 and indicated the agency's main number should be rolled over to the Clinical Manager's phone after hours. The Administrator indicated he received a missed call on his cell phone from the surveyor on 6/26/2023 at 10:36 PM. The Administrator indicated it was odd that the call did not forward to the Clinical Manager's cell phone. 19. Personnel record review on 6/26/2023, failed to evidence a criminal background check for PT 1, first patient contact date 9/26/2020, PT 2, first patient contact date 2/1/2023, HHA 1			

	first patient contact date 5/11/2022, RN 1, first patient contact date 1/31/2019, RN 3, first patient contact date 6/13/2023, HHA 2, first patient contact date 6/14/2023, and HHA 3, first patient contact date 3/11/2023. Review failed to evidence current licensure/certification for PT 1, the Administrator/PT, first patient contact date 12/2/2001, the Alternate Clinical Manager/RN, first patient contact date 7/30/2004, PT 2, RN 1, and the Clinical Manager/RN, first patient contact date 10/4/2005. Review failed to evidence license verification for OT 2, first patient contact date 6/7/2022. Review failed to evidence personnel files included orientation to the job for PT 1, OT 2, HHA 1, PT 2, HHA 2, HHA 3, and the Clinical Manager. Review failed to evidence personnel files included skill competency evaluation for HHA 1, HHA 2, and HHA 3. Review failed to evidence annual performance evaluations for PT 1, OT 2, the Administrator, the Alternate Clinical Manager, the Clinical Manager, HHA 1, and RN 1.			

	During an interview on 6/26/2023, at 9:38 AM, the Administrator indicated Administrative Staff 8 was in charge of license verification. The Administrator indicated the agency had a checklist at time of hire for the personnel record and which he was supposed to review to ensure it was complete. During an interview on 6/26/2023, at 9:48 AM, Administrative Staff 8 indicated he/she probably did not check licenses as often as he/she should. During an interview on 6/27/2023, at 9:23 AM, the Administrator indicated the background checks were conducted by Administrative Staff 7 and were in an electronic communication portal but not included in the personnel records. 20. Clinical record review on 6/22/2023, for Patient #3, start of care 4/19/2022, failed to evidence a summary of care had been sent to the physician since the start of care. During an interview on			

	Administrator indicated the summary of care was not included in the plan of care which was faxed to the physician. The Alternate Administrator indicated the end of episode/30 day summary documents were completed but not sent to the physician. *. Clinical record review on 6/26/2023, for Patient #8, start of care 2/1/2023, evidenced a document titled "Referral Form" from Person B (patient's referring physician) on 1/25/2023, which indicated the patient had frequent urinary tract infections and seizures and stated, "Order for PT and OT." Record review failed to evidence OT services were initiated for the patient. Record review failed to evidence the initial assessment occurred within 48 hours of the referral. *. Clinical record review on 6/26/2023, for Patient #9, pertinent diagnoses included but were not limited to right side hemiplegia (paralysis to one side) and dysphagia (difficulty swallowing), evidenced an order written on prescription paper by Person C			

	that indicated an order for HHA, ST, OT, and PT on 4/24/2023. Record review of the start of care assessment from 5/19/2023, evidenced the need for HHA, ST, OT, and PT services. Record review failed to evidence the agency provided ST services. Review evidenced HHA, PT and OT services ceased without an explanation. Record review failed to evidence the initial assessment occurred within 48 hours of the referral.			
G0964	Coordinate referrals; 484.105(c)(3) Coordinating referrals, Based on record review and interview, the agency failed to ensure the clinical manager provided oversight of the coordination of referrals in 6 of 9 clinical records reviewed resulting in a patient hospitalization. (Patient #1, #2, #4, #6, #8, #9) The findings include: 1. Review of an agency policy revised 6/28/2022, titled "Clinical Manager" stated, "…	G0964	The Director of Nursing and Administrator reviewed the following policies for reeducation and clarification of procedures. Clinical Manager B-105 Agency will appoint one or more qualified individuals for the position of clinical manager. This position provides clinical oversight over all patient care services and team members. The position must have at least one of the following qualifications: licensed physician, registered nurse-including a nurse practitioner or other advance	2023-07-27

	The oversight provided by the clinical manager(s) includes: Making patient and personnel assignments ... Coordinating referrals ...." 2. Review of an agency policy revised 6/28/2022, titled "Patient Admission Process" stated, "... If the agency cannot fulfill the required health care need, a referral will be made to other appropriate community resources ...." 3. Review of an agency policy revised 1/21/2021, titled "Patient Referral and Acceptance" stated, "... Only qualified staff may take referral information ... Persons rejected will be noted along with the reason for rejection...." 4. Clinical record review on 6/23/2023, for Patient #1, start of care 6/1/2023, evidenced a referral order for home health from Entity D which indicated the agency was to provide skilled nursing, physical therapy (PT), and occupational therapy (OT). Review evidenced an agency document titled "Home Health Certification and Plan of Care"		practice nurse, physical therapist, speech language pathologist, occupational therapist, social worker, or audiologist Patient Admission Process C-140 Services will not be initiated until an initial assessment has been completed and identified patient needs can be met by the agency. The agency determines that patient needs can be met by the agency. Patient Referral and Acceptance C-139 The Agency shall have procedures for the receipt, processing, and evaluation of persons referred for service. July 27, 2023 The agency now assures the clinical manager provides oversight of the coordination of referrals. The Clinical Manager and Administrator reviewed all active patients' clinical records and found that 9 out 35 patients did not get adequate	

	6/1/2023-7/30/2023, which indicated orders for skilled nursing, PT, and OT services. Review indicated PT completed the comprehensive assessment on 6/7/2023 and OT competed an assessment on 6/8/2023, which failed to be within 5 days of the start of care. During an interview on 6/27/2023, at 10:30 AM, the Clinical Manager indicated the Intake Coordinator must have scheduled the PT and OT for the comprehensive assessments because she was unsure why there was a delay. The Clinical Manager indicated there was no documentation of the communication between the Intake Coordinator and the PT and OT. 5. Clinical record review on 6/23/2023, for Patient #2, start of care 5/15/2023, evidenced a referral order for home health from Entity A which indicated the agency was to provide skilled nursing, PT, and HHA services. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period		oversight of the coordination of their referrals. This deficiency has now been corrected with the agency providing the services through contractors or referring them to other agencies. The Administrator in-serviced the Clinical Manager on the importance of providing oversight of the coordination of referrals. The Administrator and Clinical Manager will review all referrals to ensure that the needed oversight of the coordination of referrals is done. This includes assignment to the various disciplines with adequate follow up to ensure that the patient is assessed, and care is continued. A referral log tool has been developed for this purpose. The Administrator is responsible for ensuring that this situation does not recur.	

	5/15/2023-7/13/2023, which indicated orders for skilled nursing and PT services 2 times a week for 4 weeks. Review of agency documents titled "Physician Order" indicated the patient fell and was on the floor for several hours on document dated 5/22/2023. Review of document dated 5/23/2023, indicated the patient called the agency to report she fell onto the floor and indicated the agency contacted the physician who requested the patient go to the hospital for evaluation. Review of documents obtained from Entity 1 (hospital) on 6/28/2023 indicated the patient was admitted to the hospital from 5/23/2023 to 6/2/2023 and evidenced the assessment from the emergency room on 5/23/2023 included 3 open areas to the patient's coccyx (lower back above the buttocks) and complaints of pain "everywhere". Review failed to evidence the agency provided PT services for an evaluation prior to the patient's 2 falls and subsequent			

admission to the agency. Review failed to evidence the clinical manager coordinated care with the PT regarding the need for the PT evaluation.

During an interview on 6/27/2023, at 11:44 AM, the Clinical Manager indicated the PT said he would complete his comprehensive assessment on 5/17/2023 and indicated the PT had difficulty reaching the patient to schedule the assessment. The Clinical Manager indicated there was no documented communication with the PT regarding attempts to schedule the assessment.

During an interview on 6/27/2023, at 9:38 PM, PT 1 indicated he did not attempt to provide a visit to the patient before the patient's hospitalization because he was not aware of the PT referral until the patient was in the hospital. PT 1 indicated he did the PT comprehensive assessment when the patient returned home from the hospital on 6/7/2023.

6. Clinical record review on 6/23/2023, for Patient #4, start of care 6/13/2023, evidenced a

	referral order from Entity E which indicated the patient was discharged to home effective 6/9/2023, and was to receive home health services to include PT, OT, and speech therapy (ST). Review indicated the PT comprehensive assessment was completed on 6/20/2023 and the OT comprehensive assessment was completed on 6/21/2023, which failed to evidence the therapy comprehensive assessments were completed within 5 days of the start of care. During an interview on 6/27/2023, at 12:22 PM, the Clinical Manager indicated she was unsure why PT and OT did not complete the comprehensive assessments within 5 days of the start of care and indicated there was no documented communication regarding the PT and OT assessments. 7. During an interview on 6/26/2023, at 2:34 PM, PT 2 indicated he received his assignments from the Intake Coordinator. 8. During an interview on			

	indicated he was contacted by Intake Coordinator for new referrals needing a PT comprehensive assessment. 9. During an interview on 6/27/2023, at 2:47 PM, the Clinical Manager indicated she has directed the Intake Coordinator to contact the physicians for amended orders if the referral order was for a service that the agency cannot provide. At 3:13 PM, the Clinical Manager indicated the Intake Coordinator contacted the therapists for the assignment and scheduling of the therapists for the comprehensive assessments after referral. The Clinical Manager indicated she was not always aware of the delay in the comprehensive assessments and indicated the therapists tell her they are going to see the patients and indicated she does not always follow up. *. Clinical record review on 6/23/2023, for Patient #6, start of care 5/24/2023, pertinent diagnosis of recent bilateral below the knee amputations, evidenced a document from Entity A (patient's referring facility) which indicated the			

patient was referred to the agency for skilled nursing and physical therapy services on 4/7/2023.

Record review of the start of care assessment conducted on 5/24/2023, evidenced the skilled nurse indicated the patient would benefit from occupational therapy services. Record review failed to evidence OT evaluation and subsequent visits as ordered.

Record review evidenced the patient received a physical therapy evaluation on 5/26/2023, which established subsequent visits would be twice a week for 4 weeks. Record review failed to evidence the patient received subsequent visits from a physical therapist.

Record review failed to evidence the Clinical Manager coordinated with the occupational therapist and physical therapist to ensure the patient received services requested by the physician.

During an interview on 6/29/2023, at 12:58 PM, the Clinical Manager indicated that

	unable to reach the patient by phone, which was not documented in the clinical record. During an interview on 6/29/2023, at 1:03 PM, the Clinical Manager indicated the patient decided not to receive physical therapy due to a more complicated wound therapy, which was not documented in the clinical record. *. Clinical record review on 6/26/2023, for Patient #8, start of care 2/1/2023, pertinent diagnosis of seizure disorder, evidenced a document titled "Referral Form" signed by Person B (patient's referring physician), on 1/25/2023, which requested physical therapy and occupational therapy services for the patient.			

	Record review failed to evidence the patient received an evaluation from an occupational therapist. Record review failed to evidence the Clinical Manager coordinated with the occupational therapist to ensure the patient received services requested by the physician. During an interview on 6/28/2023, at 1:56 PM, Patient #8 indicated they did not refuse occupational therapy services or was offered additional therapy services other than physical therapy. During an interview on 6/28/2023, at 2:13 PM, when queried if the patient would be appropriate for occupational therapy based on their assessment, PT stated “yes” and indicated that should be in process. *. Clinical record review on 6/26/2023, for Patient #9, start of care 5/19/2023, pertinent diagnoses included but were not limited to paralysis of the right side and dysphagia (difficulty swallowing),			

	Person C (Patients referring physician) on 4/24/2023, for skilled nursing, home health aide (HHA), speech therapy (ST) and physical therapy. Record review of the start of care assessment conducted on 5/19/2023, evidenced the skilled nurse indicated the patient would benefit from occupational therapy services. Record review evidenced an occupational therapy evaluation was conducted on 6/12/2023, and failed to evidence subsequent visits as ordered. Record review evidenced a single HHA visit was conducted on 6/14/2023. Record review failed to evidence notification to Person C, the agency was not providing the requested services to the patient. Record review failed to evidence the Clinical Manager coordinated with the occupational therapist and speech therapist to ensure the patient received services requested by the physician. During an interview on 6/29/2023, at 1:34 PM, the Clinical Manager indicated there			

	OT services at the start of care and was waiting for authorization from the insurance company. The Clinical Manager indicated the physician was not made aware of the failure to provide ordered OT services. During an interview on 6/29/2023, at 1:43 PM, the Clinical Manager indicated the speech therapist should have been notified to start services with the patient and the physician was not notified for the failure to provide requested ST services. *. During an interview on 6/28/2023, at 2:15 PM, when queried how they are notified of referrals, the Physical Therapist (PT) indicated the Clinical Manager, Intake Coordinator, or Office Manager will notify them via text message or phone call. PT indicated if there were issues with authorization from the patient's insurance company, the agency should notify the patient and rest of care team.			
G0968	Assure implementation of plan of care	G0968	The Clinical Manager and	2023-07-28

	484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. Based on record review and interview, the clinical manager failed to assure the development and implementation of the plan of care based on the patient's orders and assessed needs in 4 of 9 clinical records reviewed. (Patients #1, #2, #4, #8) The findings include: 1. Review of an agency policy revised 6/28/2022, titled "Clinical Manager" stated, "... The oversight provided by the clinical manager(s) includes: ... Assuring the development, implementation, and updates to the individualized plans of care...." 2. Clinical record review on 6/23/2023, for Patient #1, start of care 6/1/2023, evidenced a referral order for home health from Entity D which indicated the agency was to provide skilled nursing, physical therapy (PT), occupational therapy (OT), and home health aide (HHA)		Administrator reviewed the following policy for reeducation and clarification of procedures. Clinical Manager B-105 Agency will appoint one or more qualified individuals for the position of clinical manager. This position provides clinical oversight over all patient care services and team members. The position must have at least one of the following qualifications: licensed physician, registered nurse-including a nurse practitioner or other advance practice nurse, physical therapist, speechlanguage pathologist, occupational therapist, social worker, or audiologist Emphasis on 4. The oversight provided by the clinical manager(s) includes: a. Making patient and personnel assignments. b. Coordinating patient care. c. Coordinating referrals. d. Assuring the patient needs are continually assessed. e. Assuring the development, implementation, and updates to the individualized plans of care	

	services. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/1/2023-7/30/2023, which failed to evidence HHA services were included in the plan of care and provided. During an interview on 6/26/2023, at 4:17 PM, Patient #1 indicated the agency knew she needed assistance in the morning to get out of bed. Patient #1 indicated she was unaware the agency did not have any aides at time of admission to the agency and requested the agency find her another agency that had HHA services. During an interview on 6/27/2023, at 10:02 AM, the Clinical Manager indicated the agency did not provide HHA services to the patient due to staffing issues. 3. Clinical record review on 6/23/2023, for Patient #2, start of care 5/15/2023, evidenced a referral order for home health from Entity A which indicated the agency was to provide		July 28, 2023 The agency now assures the development and implementation of the plan of care based on the patient's orders and assessed needs. The Clinical Manager and Administrator reviewed all active patients' clinical records and found that 12 out 35 patient's plans of care were not developed and implemented based on the patient's orders and assessed needs. The Administrator and Clinical Manager in-serviced the clinical staff on the importance of developing and implementing the patient's plan of care based on the patient's orders and assessed needs. The Clinical Manager and the quality assurance team will review all intake and admission documentation to ensure that the patient's plans of care were developed and implemented based on the patient's orders and assessed needs. The Clinical Manager is responsible for ensuring that this situation does not recur.	

	services. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/15/2023-7/13/2023, which failed to evidence HHA services were included in the plan of care and provided. During an interview on 6/28/2023, at 1:07 PM, the Clinical Manager indicated the agency did not have a HHA to provide the patient. 4. Clinical record review on 6/23/2023, for Patient #4, start of care 6/13/2023, evidenced an agency document titled "Physician Order" dated 6/14/2023, which indicated the agency was to provide HHA services 2 times a week for 8 weeks. Review failed to evidence home health aide services were included in the plan of care and failed to evidence the agency provided HHA services.			

During an interview on 6/27/2023, at 12:18 PM, the Clinical Manager indicated the agency did not provide HHA services because the agency did not have a HHA available.

*. Clinical record review on 6/26/2023, for Patient #8, start of care 2/1/2023, evidenced a document titled “Referral Form” from Person B (patient’s referring physician) on 1/25/2023, which indicated the patient had frequent urinary tract infections and seizures and stated, “Order for PT and OT.”

Record review of an agency document titled "Home Health Certification and Plan of Care" for certification period 2/1/2023 - 4/1/2023, failed to evidence OT services incorporated into the plan of care or provided.

During an interview on 6/28/2023, at 1:56 PM, Patient #8 indicated they were not offered OT services through the agency.

During an interview on 6/28/2023, at 2:13 PM, PT 1 was queried if the patient would be

	based on their assessment and stated “Yes, it would be helpful.”			
G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on record review and interview, the agency failed to ensure current clinical practice was maintained in accordance with professional standards of practice in 1 of 1 clinical record reviewed with urine collection. (Patient #5) The findings include: Review of an agency policy revised 6/28/2022, titled “Admission Policy” stated, “… Services and care must conform to current standards of practice for the respective disciplines ….” Review on 7/17/2023 of a National Institute of Health website article, https://www.ncbi.nlm.nih.gov/books/NBK557685/ titled "Urinalysis [a laboratory test for urine]" dated 5/1/2023, stated "... urine should be ideally examined within the first hour	G0984	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. Admission Policy C-120 Patients are accepted for treatment in the home based on reasonable criteria and under the expectation that the patient’s medical, nursing, and social needs can be met adequately by Agency in the patient’s place of residence. Emphasis on SS 12 12. Services and care must conform to current standards of practice for the respective disciplines and should be reasonable and necessary to the treatment of a medical or psychiatric order. July 28, 2023 The agency now ensures current clinical practice is maintained in accordance with professional standards of practice. The Clinical Manager and the	2023-07-28

	after the collection due to the instability of some urinary components ... If not possible, the sample should be refrigerated at 4 degrees C [Celsius] for up to 24 hours, which will slow down the decomposition process. Any specimen older than 24 hours cannot be used for urinalysis...." Clinical record review on 6/26/2023, for Patient #5, evidenced an agency document titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" completed by LPN 1 and dated 6/23/2023, which indicated the nurse obtained a urine sample per physician order for a urine analysis and culture. Review indicated the nurse visit was from 7:00 AM to 9:00 AM and failed to evidence the time the nurse obtained the urine sample. Review failed to evidence the nurse dropped the urine specimen off at the lab. Review of an agency document titled "Skilled Nurse Visit" completed by RN 2 and dated 6/24/2023, indicated the nurse visit was from 7:30 AM to 9:30 AM. Review indicated the patient had abdominal pain and		quality assurance team reviewed all active patients' clinical records and found that 2 out 35 patient's care did not follow and maintain current clinical practice in accordance with professional standards of practice. The clinical manager in-serviced the clinical staff on the importance of following and maintaining current clinical practice in accordance with professional standards of practice. The Clinical Manager and the quality assurance team will review all clinical records daily to ensure that current clinical practice is maintained in accordance with professional standards of practice. The Clinical Manager is responsible for ensuring that this situation does not recur.	

	symptoms of a urinary tract infection. Review indicated RN 2 delivered the urine specimen to the hospital lab and failed to document what time the specimen was delivered. During an interview on 6/29/2023, at 4:15 PM, LPN 1indicated she did not want to drive to the lab in Hobart because it was too far and indicated RN 2 agreed to deliver it to the lab the next day. LPN 1 indicated she left the urine specimen in the patient's refrigerator and did not verify the temperature of the refrigerator was within acceptable temperature range for specimen storage. During an interview on 6/29/2023, at 4:15 PM, the Clinical Manager indicated the specimen should be delivered to the lab on the same day the specimen was obtained. During an interview on 7/3/2023, at 3:45 PM, the Clinical Manager indicated RN 2 indicated he/she took the urine to the lab after her visit with the patient on 6/24/2023.			

G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the home health agency failed to ensure all electronic entries were authenticated to include the name and date of the clinician responsible for 3 of 3 clinical records reviewed with home health aide (HHA) services. (Patient #1, #5, #9) The findings include: 1. Clinical record review on 6/23/2023, for Patient #1, evidenced an agency document titled "HHA Visit" completed by the HHA and dated 6/9/2023, which indicated a heart rate of 100/60. During an interview on 6/27/2023, at 9:44 AM, the Clinical Manager indicated that was a documentation error. 2. Clinical record review on 6/29/2023, for Patient #5,	G1024	The Director of Nursing and Administrator reviewed the following policy for reeducation and clarification of procedures. C-872 Electronic Signature An electronic signature will authenticate certain clinical record documents generated in the computerized medical record system. The documents affected by this policy include visit notes, charting sessions, verbal orders, and summaries July 28, 2023 The agency now ensures all electronic entries are authenticated to include the name and date of the clinician responsible. The Clinical Manager and the quality assurance team reviewed all active patients' clinical records and found that 6 out 35 patient's electronic entries were not authenticated to include the name and date of the clinician responsible. The clinical Manager and the quality assurance team will monitor and review all electronic entries including visit notes, and are authenticated to	2023-07-28

	titled "HHA Visit" for the evening shift dated 6/26/2023, and assigned to the HHA and failed to evidence the document was completed. During an interview on 6/29/2023, at 4:20 PM, the Clinical Manager indicated the aide did complete the visit on 6/26/2023 for the evening shift and indicated the HHA should have completed the document by now. 1. Record review of an agency policy titled "Electronic Signature" revised 1/21/2021, stated "Policy ... An electronic signature will authenticate certain clinical record documents generated in the computerized medical record system. The documents affected by this policy include visit notes ...." *. Clinical record review on 6/26/2023, for Patient #9, start of care 5/19/2023, evidenced an agency document titled "HHA [home health aide] Visit" conducted on 6/14/2023. This document failed to evidence a signature and date from the clinician. Record review failed to evidence clinician		include the name and date of the clinician responsible. The Clinical Manager is responsible for ensuring that this situation does not recur.	

	authentications for all clinical documents.			

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
ABEL DAFIAGHOR	ADMINISTRATOR	8/14/2023 6:41:34 PM