STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157569	A. BUILDING B. WING	08/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENHABIT HOME HEALTH	752 E US HWY 30, SCHERERVILLE, IN, 46375

(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: 8/9/2023 – 8/11/2023 Census: 80 At this Emergency Preparedness survey, Enhabit Home Health and Hospice was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000	Agency Administrator acknowledges receipt of the Statement of Deficiencies (CMS form 2567) on August 23,2023.	

E0004	Develop EP Plan, Review and Update Annually 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop 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: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	E0004	CFR(s): 484.102(a) Develop E Update Annually (a) Emergency Plan: The facili emergency preparedness plan updated at least every 2 years. This standard is not met as evi interview the agency failed to d emergency preparedness prog Agency Administrator acknowle Action: Agency Administrator will deve to include communication plan emergency, information to be s during transfer in an emergenc will provide education to 100% and field clinicians on emergen by 9/22/2023. Agency Administrator contacte Coordinator and is scheduled t the District 1 Healthcare Coaliti quarterly thereafter to obtain lo information which will be distrib emergency preparedness plans as pending emergency is identi Monitoring: Agency Administrator will revie annually and ensure 100% of a field clinicians receive annual t preparedness plan to include lo information released by the Dis documentation of training to be	2023-09-22

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Based on record review and interview, the agency failed to develop a comprehensive emergency preparedness program individualized to the agency.

The findings include:

Record review on 8/10/2023, of the agency's emergency preparedness binder evidenced information and resources for multiple different states where agencies are a part of Entity A corporation. Record review failed to evidence a communication plan to include a method for sharing clinical information with other healthcare providers. Record review failed to evidence a plan for occupancy needs with other healthcare providers. Record review failed to evidence a plan to use volunteers or other emergency staffing.

During an interview on 8/11/2023, from 9:35 AM – 10:27 AM, the Administrator indicated the agency did not use volunteers. The Administrator could not identify a communication plan for sharing clinical information or a plan for occupancy needs with other healthcare providers.

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 health agency failed to ensure all patients had an individualized emergency preparedness plan in the home for 4 of 4 home visits conducted (Patient #1, 2, 5, 6). The findings include: 1. During an observation of care at the home of Patient #5, on 8/10/2023, at 2:26 PM, the agency's patient folder was observed. Review of the packet failed to evidence an individualized emergency plan. Clinical record review on 8/10/2023, failed to evidence an individualized	E0017	CFR(s)484.102(b)(1)HHA Comprehensive Assessment in Disaster Policies and Procedures : The HHa must develop and implement emergency preparedness policies and procedure based on emergency plan set fort in paragraph (a) risk assessment at paragraph (a)(1) and communication plan set forth in paragraph (c) Policies and procedures must be reviewed and updated at least every 2 years This standard is not met as evidence by : Based on observation , record review and interview , the home health agency failed to ensure all patients had an individualized emergency preparedness plan in the home for 4 of 4 home visits. Administrator acknowledges rceipt of this deficiency. Action: Agency Administrator will develop and implement and individualized emergency preparedness form with contact information for local emergency services, physician, pharmacy and medical suppliers to be completed at the time of admission, reviewed with the patient and maintained in the patient home folder. Agency Administrator will provide education to 100% of all active patients by 9/20/2023 in order to ensure 100% compliance is achieved and on 100% of admissions at SOC thereafter. Clinicians will upload copy of the Patient Individualized Emergency Preparedness plan to the EMR which will be utilized as par of the communication plan to be utilized with other community providers in the even of emergency requiring transfer of patient to other provider. Monitoring : Once 100% compliance is achieved , Agency Administrator or designee will conduct 8 on site home visits per quarter to ensure 100% compliance is	2023-09-22

	emergency plan. During an interview on 8/10/2023, at 4:01 PM, the Clinical Manager indicated there was not an individualized emergency plan for the patient. 2. During an observation of care at the home of Patient #6, on 8/11/2023, at 9:00 AM, the agency's patient folder was observed. Review of the packet failed to evidence an individualized emergency plan. Clinical record review on 8/10/2023, failed to evidence an individualized emergency plan. *. An observation of a home visit was conducted on 8/10/2023, from 10:35 AM – 11:10 AM, for Patient #1 with RN 2. During the home visit, the patient's admission folder was reviewed for the required individualized emergency preparedness plan. Review of the home folder failed to evidence individualized emergency preparedness information to include an evacuation location, pharmacy and physician contact information, and medical equipment needed daily. Observation failed to evidence an emergency preparedness plan was maintained in the patient's home. On 8/11/2023, at 5:33 PM, the		maintained for a period of 1 year ., Results of home -visits to be communicated with the governing Body and the QAPI team for review and recommendation . If compliance is not maintained additional education and /or employee disciplinary action will be implemented	

patient lived with the relative named as the emergency evacuation address, contact information for the patient's physician, pharmacy, the local police and fire departments, and any medical equipment the patient would need in an emergency.

*. An observation was conducted on 8/10/2023, from 12:57 PM – 1:57 PM, for Patient #2, with PT 1. During the home visit, the patient's admission folder was reviewed for required information and failed to evidence individualized emergency preparedness information to include an evacuation location, pharmacy information, and medical equipment needed daily. Observation failed to evidence an emergency preparedness plan was maintained in the patient's home.

During an interview on 8/10/2023, at 1:45 PM, PT 1 indicated Emergency Preparedness is reviewed with the patient verbally and all individualized information would be documented in the system.

*. During an interview on 8/11/2023, at 9:55 AM, the Administrator indicated the individualized emergency preparedness plan was created at the start of care included in the admission packet and the patient's triage code was documented in the electronic

	health record.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State re-licensure survey of a home health provider. Survey Date: August 9-11, 2023 Unduplicated Skilled Admissions for the last 12 Months: 328 Facility ID: 004608 Survey was fully extended on 8/10/2023. During this Federal Recertification Survey, Enhabit Home Health was found to be out of compliance with Conditions of Participation 42 CFR §484.50 Patient Rights; and 42 CFR §484.105 Organization and Administration of Services. Based on the Condition-level deficiencies during the 8/11/2023 survey, Enhabit Home Health 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	G0000	Agency Administrator acknowledges receipt of the Statement of Deficiencies (CMS form 2567) on August 23,2023.	

	agency is precluded from operating or being the site of a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning 8/11/2023 and continuing through 8/10/2025. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Quality Review Completed 08/22/2023, Area 1			
G0406	Patient rights 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. Based on record review and interview, the agency failed to protect and promote the exercise of patient rights as follows: the agency failed to provide patients with the name and contact information of the administrator in order to receive complaints (see tag G0414); the agency failed to ensure the patients participated in, were informed about, and consented to care in	G0406	CFR:(s): 484.50 Patient Rights G: 0406 The patient and representative, have the right to be informed of the patient rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. This condition is not met as evidenced by: Based on record review and interview, the agency failed to protect and promote the exercise of patient rights as follows: the agency failed to provide patients with the name and contact information of the administrator in order to receive	2023-09-22

	advance of services and treatments with respect to the disciplines that will furnish the care (see tag G0434); the agency failed to ensure the patient had the right to a confidential record (see tag G0438); and the agency failed to ensure the patients were discharged when goals and measurable outcomes were achieved (see tag G0458). 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 484.50 Patient Rights.		complaints; the agency failed to ensure the patients participated in were informed about, and consented to care in advance of services and treatments with respect to the disciplines that will furnish the care; the agency failed to ensure the patient had the right to a confidential record and the agency failed to ensure the patients were discharged when goals and measurable outcomes were achieved. Administrator acknowledges receipt of this condition level deficiency. Action: Agency Administrator to provide education to 100% of administrative and field clinicians on agency policy S03 Patient Rights with focus on provision of contact information for the Agency Administrator in order for patient to file complaint. Patient notification of services to be provided prior to initiation of services, confidentiality of clinical records and agency policy S12 Transfer/Discharge by 9/22/2023. Agency Administrator will ensure 100% of all active patients receive contact information for the Administrator in order to file a complaint by 9/22/2023. Agency Administrator will obtain contract for corporate staff who perform record reviews by 9/22/2023. Agency Administrator will review and instruct Medical Record	

			Specialist on requirement to validate patient information is correct prior to uploading to file by 9/22/2023. Agency Administrator will provide education to 100% of licensed field clinicians on requirement to document all disciplines to be provided to the patient on the client service agreement at admission and as additional disciplines are ordered a home health agency change of care notice will be completed with the patient prior to initiation of care and uploaded to the EMR record. Education to be completed by 9/22/2023. Monitoring: To ensure 100% compliance is maintained, Agency Administrator will perform 8 onsite visits and 8 record reviews per quarter for a period of 1 year to ensure patients received contact information for the Administrator, that home health agency change of care notice is uploaded to the EMR record and that discharge information submitted to provider includes notification of falls within 30 days prior to discharge. Agency Administrator to report results quarterly to the Governing Body and the QAPI team for review and recommendations. If compliance is not maintained additional education and/or employee disciplinary counseling will be implemented.	

G0414	HHA administrator contact information 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. Based on observation, record review, and interview, the agency failed to provide the patients the name and contact information of the administrator in order to receive complaints in 2 of 4 home visits. (Patients #5, 6) The findings include: 1. Review of the agency's admission packet/folder on 8/9/2023, failed to evidence the name of the administrator. 2. During an observation of care at the home of Patient #5 on 8/10/2023, at 2:26 PM, the agency folder was observed but the medication list and name of the administrator were not observed in the patient's home. 3. During an observation of care at the home of Patient #6 on 8/11/2023, at 8:57 AM, the agency folder was	G0414	CFR(s): 484.50(a)(1)ii) HHA Administrator Contact Information Contact information for the HHA Administrator including name, business address and business phone number in order to receive complaints. THis element is not met as evidenced by: Based on observation, record review and interview the agency failed to provide the patients the name and contact information of the administrator in order to receive complaints in 2 of 4 home visits. Agency Administrator acknowledges receipt of this deficiency. Action: Agency Administrator will provide will conducted a mandatory meeting with all RN/PT/OT/ST staff who perform SOC visits and instructed on requirement to provide patient the name and contact information of the Administrator when completing the admission. Education completed on 8/24/2023. Agency Administrator or designee will perform in-home visits for 100% of all active patient by 9/1/2023 to ensure all patients have	2023-09-22

	observed but the medication list and name of the administrator were not observed in the patient's home. 4. During an interview on 8/11/2023, at 4:35 PM, the Administrator indicated the name of the administrator was included on the medication list that was printed and taken to the patient's home.		the name, business address and phone number for the Administrator. Agency Administrator will maintain a list of current patient with completion date of date information was received by the patient to ensure 100% compliance. Agency Administrator will complete education with Medical Record Specialist on requirement to include Administrator contact information in the SOC packets and review pending packets for compliance by 8/25/23. Monitoring: Agency Administrator or designee will audit 100% of SOCs for a period of 90 days to ensure compliance is maintained. Once compliance is achieved, Agency Administrator or designee will perform 20 on-site reviews quarterly for 1 year to ensure compliance is maintained. Agency Administrator to present results of audits quarterly to the QAPI team for review and recommendation. If compliance is not maintained, additional education and/or employee disciplinary counseling will be implemented.	
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	G0434	CFR(s): 484.50(c)(4)(i, ii, iv, v, vi, vii, vii) Participate in Care Participate in, be informed about, and consent or refuse care in	2023-09-22

	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 patients participated in, were informed about, and consented to care in advance of services and treatments with respect to the disciplines that will furnish the care in 7 of 7 active clinical records reviewed (Patient #1, 2, 3, 4, 5, 6, 7). The findings include: 1. Clinical record review on 8/9/2023, for Patient #5, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 8/3/2023-10/1/2023, which indicated the patient was to receive physical therapy (PT) and occupational therapy (OT). Review of an agency document titled "Service Agreement" signed and dated by the patient on 8/3/2023, failed to indicate the disciplines that were to furnish care.		advance of and during treatment where appropriate, with respect to: completion of assessments; care to be furnished; establishing and revising the plan of care; disciplines that will furnish the care; frequency of visits; expected outcomes; any factors that could impact treatment and effectiveness and any changes in care to be furnished. This element is not met as evidenced by: based on record review and interview the agency failed to ensure the patients participated in, were informed about and consented to care in advance of services and treatments with respect to all disciplines that will furnish care in 7 of 7 records reviewed. Action : Agency Administrator provided education to 100%SOC clinicians on Agency Policy S03 Patient Rights: focus on section 2.1.7 requirement to inform patient in advance of care to be provided by disciplines, frequency of visits during the admission visit, and documentation required on the patient Consent for Services Agreement. Administrator completed education on 8/24/2023. Agency Administrator or designee will audit 100% of initial Client Service Agreements for a period of 30 days for compliance with documentation of disciplines to be provided, frequency of visits to ensure 100% compliance is achieved. Agency Administrator or designee will audit 100% of patients who receive orders for additional disciplines following admission for a period of 30 days for compliance with documentation in the record identifying patient was informed and agreed to additional services prior to services being provided to ensure 100% compliance is achieved.	

	2. Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/27/2023-9/24/2023, which indicated the patient was to receive skilled nursing, PT, and OT services. Review of an agency document titled "Service Agreement" signed and dated by the patient on 7/27/2023, failed to indicate the disciplines that were to furnish care. 3. Clinical record review on 8/10/2023, for Patient #7, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/26/2023-8/24/2023, which indicated the agency was to provide skilled nursing, physical therapy (PT), and occupational therapy (OT). Review of an agency document titled "Service Agreement" dated 12/28/2022 and documented as verbally consented to by the patient, failed to indicate the disciplines that were to furnish care.		Monitoring: Once 100% compliance is achieved, Agency Administrator or designee will audit 20 records quarterly for a period of 1 year to ensure compliance is maintained. Agency Administrator will submit results of audits quarterly to the Governing Body for review and further recommendations. Agency Administrator will also review audit findings quarterly with the QAPI team for review and recommendations. If compliance is not maintained, additional education will be provided and/or employee disciplinary action will be implemented.	

	*. Clinical record review on 8/10/2023, for Patient #1, start of care 7/21/2023, evidenced an agency document titled "Service Agreement" signed by RN 3, indicated the discipline providing services was skilled nursing which would come once a week for 9 weeks. Record review evidenced skilled nursing, physical therapy and occupational therapy services began on 7/21/2023. Review failed to evidence therapy services were reviewed with the patient on the service agreement document. Record review failed to evidence the patient was made aware of changes to the disciplines from the service agreement. *. Clinical record review on 8/11/2023 for Patient #2, start of care 7/18/2023, evidenced an agency document titled "Service Agreement" signed by RN 3, indicated the discipline providing services was skilled nursing once a week for 2 weeks. Record review evidenced PT services were ordered at the start of care. Review failed to evidence therapy services were reviewed with the patient on the service agreement document. Record review failed to evidence the patient was made aware of changes to the disciplines from the service agreement.			

*. Clinical record review on 8/11/2023, for Patient #3, start of care 7/11/2023, evidenced an agency document titled "Service Agreement" signed by RN 3, stated the frequency for the discipline providing services was twice a week. Review failed to evidence therapy services were reviewed with the patient on the service agreement document. This document failed to evidence the discipline and duration of the services provided.

Record review evidenced SN, PT, and OT services were ordered on 7/11/2023. Record review failed to evidence the patient was made aware of the services provided by the agency.

*. Clinical record review on 8/10/2023, for Patient #4, start of care 3/16/2023, evidenced an agency document titled "Service Agreement" signed by PT 2, indicated frequencies for the discipline providing services twice a week for 3 weeks, once a week for 5 weeks and OT to evaluate. This document failed to evidence which discipline would come twice a week for 3 weeks and once a week for 5 weeks.

Record review evidenced the patient received skilled nursing services to provide catheter assistance. Record review failed to evidence the patient

	provided at the start of care. Record review failed to evidence the patient was made aware of changes to the disciplines from the service agreement. *. During an interview on 8/11/2023, at 4:48 PM, the Administrator indicated the agency's interpretation of their document would only have frequencies for the clinician filling out the form.			
G0438	Have a confidential clinical record 484.50(c)(6) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164. Based on record review and interview, the agency failed to ensure the patient had the right to a confidential record in 7 of 7 active clinical records reviewed. (Patients #1, 2, 3, 4, 5, 6, 7) The findings include: 1. Clinical record review on 8/9/2023, for Patient #5, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 8/3/2023-170/1/2023, which indicated Corporate Staff 3's electronic signature.	G0438	CFR(s): 484.50(c)(6) Confidential Clinical Record Must have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance 45 CFR parts 160 and 164. This element is not met as evidenced by: Based on record review and interview the agency failed to ensure the patient had the right to a confidential record in 7 of 7 records reviewed. Administrator acknowledges receipt of this deficiency. Action: Agency Administrator will review process for uploading data into the EMR with the Medical Record Specialist and requirement to validate patient information is entered	2023-09-22

	Review evidenced a document from Entity 2 for Patient #11 scanned into the clinical record of Patient #5. During an interview on 8/10/2023, at 3:57 PM, the Clinical Manager indicated the document was filed in error into the wrong patient's record. 2. Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/27/2023-9/24/2023, which indicated Corporate Staff 3's electronic signature. 3. Clinical record review on 8/10/2023, for Patient #7, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/26/2023-8/24/2023, which indicated Corporate Staff 3's electronic signature. 4. During an interview on 8/10/2023, at 3:39 PM, the Administrator indicated Corporate Staff 3 had access to the agency's plans of care and did quality review for the agency. The Administrator indicated Corporate Staff 3 was not a direct or contracted employee of the agency and was an employee of Entity A. *. Clinical record review on 8/10/2023,		into the correct clinical record by 9/22/2023. Monitoring: Once education is completed, Agency Administrator will audit 8 clinical records quarterly to ensure 100% compliance with attachment of patient information in the EMR quarterly for a period of 1 year. Results of audits to be submitted to the Governing Body and the QAPI team for review and recommendation. If compliance is not achieved, additional education will be provided and/or employee disciplinary counseling will be implemented. Action: Agency Administrator will obtained contract for "corporate staff" identified as "Corporate Staff #2 and 3 who conducting quality of care audits and quality of care packet review audits by 9/11//2023. Agency Administrator will complete written authorization for use of contract and maintain in branch files for review. Monitoring:	

	for Patient #1, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/21/2023 – 9/18/2023, which indicated Corporate Staff 3's electronic signature. *. Clinical record review on 8/11/2023 for Patient #2, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/18/2023 – 9/15/2023, which indicated Corporate Staff 3's electronic signature. *. Clinical record review on 8/11/2023, for Patient #3, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/11/2023 – 9/8/2023, which indicated Corporate Staff 3's electronic signature. During an interview on 8/11/2023, at 4:53 PM, Administrator on speakerphone with Corporate Staff 2 who indicated they were in Patient #3's clinical record. *. Clinical record review on 8/10/2023, for Patient #4, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/14/2023 – 9/11/2023, which indicated Corporate Staff 3's electronic signature.		Agency Administrator will ensure any new corporate staff requested to provide services under contract have a written request for assistance maintained in the branch files and will review quarterly for compliance. Agency Administrator will report contracts being utilized quarterly to the Governing Body.	

G0458	Outcomes/goals have been achieved 484.50(d)(3) The transfer or discharge is appropriate because the physician or allowed practitioner, who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved, and the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services; Based on record review and interview, the agency failed to ensure the patients were discharged when goals and measurable outcomes were achieved in 1 of 1 closed record reviewed due to goals met. (Patient #9) The findings include: Clinical record review on 8/11/2023, for Patient #9, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/28/2023-7//26/2023, which indicated the patient was to receive physical and occupational therapy. Review indicated the patient's goals included, but were not limited to, would remain safe in his/her environment. Review indicated the patient would be discharged when the goals were met or skilled services were no longer needed. Review evidenced an agency document titled "Discharge Summary" dated 7/24/2023, which indicated the	G0458	CFR(s): 484.50(d)(3) Outcomes/goals have been achieved. The transfer or discharge is appropriate because the physician or allowed practitioner, who is responsible for the home health plan of care and the HHA agree that the measureable outcomes and goals set for in the plan of care in accordance with 484.60(a)(2)(xiv) have been achieved and the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the patient no longer needs the HHA services. This element is not met as evidenced by: Based on record review and interview the agency failed to ensure goals were achieved in 1 of 1 clinical records reviewed. Administrator acknowledges receipt of this deficiency. Action: Agency Administrator will provide education to 100% of RN/ PT/OT/ST field clinicians on agency policy S12 Transfer/ Discharge and requirement to address all unmet goals with patient, physician or practitioner responsible with the plan of care prior to discharge from services. Agency Administrator or designee will notify physician or allowed practitioner at the time any identified fall/QI	2023-09-22

	patient was discharged due to goals met. Review of an agency document titled "Visit Note Report" completed by the physical therapist (PT) and dated 7/24/2023, indicated the patient was discharged due to the patient progressed to meet intervention goals. Review indicated the patient's goals for tub/shower transfer, toilet transfer, and level surface gait with walker were not met. Review on 8/9/2023 of an agency document titled "QI [quality improvement] Event Report" evidenced the patient had 5 falls on 4/1/2023, 4/6/2023 x 2, 5/15/2023, and 6/8/2023. During an interview on 8/11/2023, at 1:43 PM, the patient's caregiver indicated the patient still needed physical therapy and the patient had fallen 2 times in the last few days. During an interview on 8/11/2023, at 2:43 PM, the Clinical Manager indicated if the patient's goals were not met, the patient should not have been discharged.		Report at the time they occur and/or are identified and maintain documentation of the notification and/or new orders received from the physician/allowed practitioner in the QI Event report and EMR record. Education to be completed by 9/6/2023. Once education is completed, Agency Administrator or designee will monitor 100% of patients discharged with goals met for a period of 30 days to ensure all goals were either updated based on coordination with the patient and the physician/allowed practitioner prior to discharge and that goals have been addressed/updated/met as indicated and that no additional services are required prior to discharge to ensure 100% compliance Monitoring: Once 100% compliance is achieved, Agency Administrator or designee will audit 8 clinical records of patients discharged with goals met to ensure documentation supports goals met and that no further services were necessary for a period of 1 year. Agency Administrator to report results of audits quarter to the Governing Body and QAPI team for review and recommendation.	

			If compliance is not maintained, additional education and/or employee disciplinary counseling will be implemented.	
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 side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the agency failed to ensure the comprehensive assessment included a review of the patient's medications to identify any potential adverse effects and drug reactions in 3 of 5 clinical records reviewed with only 1 certification period. (Patient #1, 5, 6) The findings include: 1. Clinical record review on 8/9/2023, for Patient #5, evidenced an agency document titled "Skilled Note Report" identified as the start of care comprehensive assessment completed by Physical Therapist (PT) 1 and dated 8/3/2023, which indicated the patient's	G0536	CFR(s) 484.55(c)(5) Review of current medications A review of all medications the patient is currently using in order to identify any potential adverse reactions, including ineffective drug therapy , significant side effect, significant drug interaction, duplicate drug therapy and non -compliance with drug therapy. This element is not met as evidenced by: Based on record review and interview, the agency failed to ensure the comprehensive assessment included a review of the patient medication to identify any potential adverse effects and drug reactions in 3 of 5 clinical records reviewed. Administrator acknowledges receipt of this deficiency. Action: Agency Administrator or designee will perform 100% review of active patient medications utilizing second electronic site to assess for potential medication interactions and notify physician/allowed practitioner of potential moderate/severe interactions to ensure 100% compliance with review of potential interactions/notification to the	2023-09-22

	limited to, aspirin (a medication used to treat pain, fever, and/or to prevent blood clots), nebivolol (a medication used to treat high blood pressure), diclofenac (a medication used to treat pain and/or inflammation), omeprazole (a medication used to treat reflux), ferrous sulfate (an iron supplement), and Lasix (a medication used to treat fluid retention). Review of medication interactions on Medscape.com on 8/10/2023, indicated moderate medication interactions between aspirin and nebivolol causing a decrease in the effects of nebivolol; omeprazole and ferrous sulfate by causing an increase in stomach acid which can lead to a decrease in the effect of ferrous sulfate; and aspirin and diclofenac causing an increase in risk of bleeding. Record review failed to evidence the potential interactions between aspirin and nebivolol; omeprazole and ferrous sulfate; and aspirin and diclofenac. During an interview on 8/10/2023, at 4:16 PM, the Clinical Manager indicated the electronic medical record program alerted the agency to 3 of the potential interactions but not to moderate interactions between aspirin and nebivolol; omeprazole and ferrous sulfate; and aspirin and diclofenac. The Clinical Manager indicated she would contact the IT department for		physician/allowed practitioner is achieved. Documentation of notification to the physician/allowed practitioner and/or changes in orders will be maintained in the EMR. Agency Administrator will identify any issues with current drug database and provide additional education if user error is identified to 100% of all licensed field clinicians. Monitoring: Once 100% compliance with notification to the physician for all current patients is achieved and Administrator validates current drug database is providing notification of potential medication interactions. Agency Administrator will perform duplicate medication reviews on 100% of new admissions utilizing agency drug database and external drug data base for 30 days to ensure current drug database is working appropriately. Once 100% compliance is achieved with new admission, Agency Administrator will then complete 8 audits per quarter for a period of 1 year to ensure 100% compliance is maintained. Agency Administrator to report results of audits quarterly to the Governing Body and the QAPI team for	

	the electronic medical record to inquire on why not all the potential interactions were alerted. 2. Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled "Skilled Note Report" identified as the start of care comprehensive assessment completed by the Alternate Clinical Manager/registered nurse (RN) and dated 7/27/2023, which indicated the patient's medications included, but were not limited to, doxycycline (antibiotic) and amoxicillin-potassium clavulanate (antibiotic). Review of medication interactions on Medscape.com on 8/10/2023, indicated a serious medication interaction between doxycycline and amoxicillin-potassium clavulanate which can cause a decreased therapeutic effect of the amoxicillin. Record review failed to evidence the potential serious interaction between doxycycline and amoxicillin-potassium clavulanate. During an interview on 8/10/2023, at 4:25 PM, the Clinical Manager indicated there were no medication interactions noted for the patient. 3. During an interview at the entrance		review and recommendation. If compliance is not maintained additional education and/or employee disciplinary counseling will be implemented.	

	the Clinical Manager indicated the electronic medical record program automatically reviews the medications for potential interactions when the medications are entered into the electronic medical record. *. Clinical record review on 8/10/2023, for Patient #1, evidenced an agency document indicated to be the start of care comprehensive assessment completed by RN 3 on 7/21/2023. This document indicated a medication reconciliation was performed at the start of care for 13 medications and reported no medication interactions. Record review of an internet resource (www.medscape.com) to check medication interactions for the patient's 13 medications evidenced 26 medication interactions, which included 2 serious interactions between Aspirin (over the counter non-steroidal anti-inflammatory drug and anti-platelet/blood thinner) and Ibuprofen (over the counter non-steroidal anti-inflammatory drug), a serious interaction between Carbamazepine (anticonvulsant) and Simvastatin (medication used to treat high cholesterol), and a serious interaction between Carbamazepine and Losartan (used to treat high blood pressure). Record review failed to evidence any interactions were			

	reconciliation. During an interview on 8/10/2023, at 4:18 PM, the Administrator did not identify medication interactions notifications in the coordination notes. *. During an interview on 8/10/2023, at 4:16 PM, the Administrator indicated any medication interactions were sent to their computer to approve via the coordination notes in the patient's electronic health record.			
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 transfer/discharge summary contained all necessary medical information pertaining to the patient's current treatment to the receiving facility in 2 of 2 clinical records reviewed with falls. (Patients #8, 9) The findings include:	G0564	CFR(s): 484.58(b)(1) 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. This standard is not met as evidence by: based on record review and interview, the agency failed to ensure the transfer/discharge summary contained all the necessary medical information pertaining to the patient's current treatment to the receiving facility in 2 of 2 clinical	2023-09-22

	1. Review on 8/9/2023 of an agency document titled "QI [quality improvement] Event Report" evidenced Patient #8 had 3 falls on 1/29/2023, 2/2/2023, and 2/13/2023 and evidenced Patient #9 had 5 falls on 4/1/2023, 4/6/2023, x 2, 5/15/2023, and 6/8/2023. 2. Clinical record review on 8/11/2023, for Patient #8 evidenced an agency document titled "Discharge Summary" dated 3/7/2023, which failed to evidence the patient's 3 falls. 3. Clinical record review on 8/11/2023, for Patient #9 evidenced an agency document titled "Discharge Summary" dated 7/26/2023, which failed to include the patient's falls. 4. During an interview on 8/11/2023, at 2:21 PM, the Clinical Manager indicated the falls were not included in the discharge summary.		records review with falls. Administrator acknowledges receipt of this deficiency. Action: Agency Administrator will instruct Medical Record Specialist (MRS) to include QI even reports related to falls which occurred within 30 days of planned discharge as an attachment to the discharge summary submitted to the allowed practitioner and document submission of the report in the clinical record. Once education is completed, Agency Administrator will audit 100% of discharged records with QI Event/fall occurring within 30 days prior to discharge for inclusion of the QI event report to be included with discharge information submitted to receiving provider for a period of 30 days to ensure 100% compliance is achieved. Monitoring: Once 100% compliance is achieved, Agency Administrator will audit 8 discharged records per quarter for a period of 1 year to ensure compliance is maintained. Agency Administrator will report results of audits quarterly to the Governing Body and the QAPI team for review and	

			recommendations. If compliance is not maintained additional education and/or employee disciplinary counseling will be implemented.	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review and interview, the agency failed to provide services as directed by the plan of care in 4 of 7 active clinical records reviewed. (Patients #1, 3, 5, 6) The findings include: 1. Clinical record review on 8/9/2023, for Patient #5, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 8/3/2023-10/1/2023, which indicated the patient's primary diagnosis was heart failure and indicated the physical therapist (PT) was to provide education related to heart failure.	G0572	CFR(s): 484.60(a)(1) Plan of Care 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/her state license, certification or registration If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. This standard is not met as evidenced by: Based on observation, record review and interview, the agency failed to provide services as directed by the plan of care in 4 of 7 active clinical records. Agency Administrator acknowledges receipt of this deficiency. Action:	2023-09-22

	Review of an agency document titled "Visit Note Report" completed by the PT and dated 8/8/2023, indicated the patient had swelling of both lower extremities. Review failed to evidence the PT educated the patient on interventions for the lower extremity swelling related to the heart failure. During an interview on 8/10/2023, at 3:50 PM, the Clinical Manager indicated the PT should have educated the patient on interventions to include elevating the legs and compliance with medication to reduce swelling. 2. Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/27/2023-9/24/2023, which indicated the patient's diagnoses included, but were not limited to, cardiomyopathy (a disease affecting the heart muscle making it more difficult to pump blood around the body) and hypertension (high blood pressure). Review indicated the skilled nurse was to assess co-morbidities including hypertension and other conditions that presented themselves during the course of the episode and intervene to minimize complications. Review indicated the skilled nurse was to change the wound vac (a medical		Agency Administrator will instruct all licensed field clinicians on agency policies S06 Role of Physician with attention to section 3.5.2 requirement to notify physician for any modifications to the plan of care, to complete care as ordered by the physician; and on agency policy S01 Scope of Services with attention to performance of complete assessment, care initiated per orders only and requirements to complete education and interventions per the plan of care and S07 Medications with requirement to review medications with each visit and ensure Patient Instruction Report is in the home and medications are current per physician orders. Agency Administrator will provide additional education to 100% of licensed RN/LPN staff and Patient Services Coordinator (PSC) on agency policy S22 Wound Ulcer Management with requirement to perform weekly wound measurements. Once education is completed, Agency Administrator will perform on-site visit with 100% of licensed field clinicians to validate accurate assessment, education/interventions are performed and that accurate medication list (Patient Instruction Report) and medication review is completed and compliant with the plan of care to ensure 100% compliance. Onsite visits to be completed by 9/20/2023.	

	wound) every Monday and Thursday. Review indicated the PT was to educate the patient on impaired nutritional risk. Review of an agency document titled "Visit Note Report" 8/2/2023, and completed by the skilled nurse, indicated the wound vac dressing was changed on a Wednesday. Review failed to evidence an order prior to the date of the dressing change on 8/2/2023 for the dressing change to be completed on a Wednesday and not on Thursday per the plan of care. Review of an agency document titled "Visit Note Report" completed by the physical therapist assistant (PTA) and dated 8/8/2023, failed to evidence the PTA educated the patient on the impaired nutritional risk per the plan of care. During an interview on 8/10/2023, at 4:42 PM, the Clinical Manager indicated the original order was for wound vac dressing changes to be completed on Mondays and Thursdays and indicated there was an order obtained on 8/9/2023 for dressing changes 3 times a week but not for the dressing that was changed on 8/2/2023. At 4:54 PM, the Clinical Manager indicated she did not see any documentation the PTA educated the patient on the impaired nutritional risk.		Once education is completed, agency PSC will audit 100% of patient receiving wound care for completion of wound measurements weekly and wound care completed as ordered in the plan of care for a period of 30 days until 100% compliance is achieved and report results to Agency Administrator weekly. Monitoring: Once initial education and validation on-sites have been completed. Agency Administrator will conduct 4 on-site visits with field clinicians quarterly for a period of 1 year to ensure 100% compliance is maintained with provision services interventions, instruction completed as ordered on the plan of care. On-site will be to validate appropriate completion of medication reviews and updated Patient Instruction within the patient residence. Agency Administrator will report results of wound measurement audits and on-sites quarterly to the Governing Body and the QAPI team for review and recommendations. If compliance is not maintained, additional education and/or employee disciplinary counseling will be implemented.	

	Review of agency documents titled "Visit Note Report" indicated the patient had 1+ pitting edema (excess fluid of the body causes swelling, and leaving indentation when pressure applied from a grade 1-4 with 1 being the least and 4 being the worst) to both lower extremities on 7/27/2023 as completed by the Alternate Clinical Manager/registered nurse (RN). Document dated 7/28/2023, indicated the patient had 2+ pitting edema to the right lower extremity and document dated 7/31/2023, indicated the patient had 2+ pitting edema to both lower extremities. Review of document completed on 7/29/2023 by the Atlernate Clinical Manager failed to evidence the patient's lower extremities were assessed for swelling. Review failed to evidence the RN intervened on the increasing edema as directed in the plan of care. During an interview on 8/10/2023 at 1:21 PM, the Alternate Clinical Manager indicated he/she believed the patient was not taking her medications properly which may have attributed to the patient's edema and did not assess the patient's lower extremity edema on 7/29/2023, because he/she was more focused on the patient's wound. During an observation at the patient's home on 8/11/2023, at 9:00 AM, with RN 1 and the Alternate Clinical			

	Manager, the patient's lower legs were observed to be red, swollen, and with tight and shiny skin. RN 1 and the Alternate Clinical Manager failed to be observed to have assessed the patient's vital signs to include blood pressure and failed to be observed listening to the patient's chest for heart and lung sounds. During an interview on 8/10/2023, at 4:35 PM, the Clinical Manager indicated the RN should have educated the patient on elevating the lower extremities, compliance with medications, and monitoring fluid intake. During an interview on 8/11/2023, at 1:58 PM, the Alternate Clinical Manager indicated they had never seen the patient's legs that red before and wondered if it was cellulitis (an infection of the skin). The Alternate Clinical Manager indicated the vital signs should be obtained and the heart and lung sounds should be assessed at every visit. *. Clinical record review on 8/10/2023, for Patient #1, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/21/2023 – 9/18/2023. An area subtitled "Orders of Discipline and Treatments" stated "…			

	profile and reconcile medications as needed. Skilled nurse may instruct and reinforce medication teaching related to use of medications to treat disease processes. Skilled nurse may fill medi-planner per current medication orders/ profile Q week ….” Record review of the medication profile retrieved on 8/9/2023, indicated the patient was prescribed 13 different medications. An observation of a home visit was conducted on 8/2/2023, from 10:35 AM – 11:10 AM, for Patient #1 with RN 2. At 10:43 AM, the patient’s caregiver indicated to RN 2 there was not a medication list in the home. The caregiver indicated they fill the patient’s medi-planner for the morning medications and the patient was independent with their nighttime medications. The caregiver led RN 2 to the bedroom and indicated that was where the patient’s medications were kept on a bedside table. 12 bottled were observed on the table but not picked up to check the labels by RN 2. Observation failed to evidence a medication review was performed as ordered on the plan of care. During an interview on 8/11/2023, at 5:33 PM, when queried how the skilled nurse would observe issues with			

labels were not compared to a medication list, Administrator stated, "I see what you're saying" and indicated the patient received skilled nursing for medication management.

*. Clinical record review on 8/10/2023, for Patient #3, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/11/2023 – 9/8/2023. An area subtitled "Orders of Discipline and Treatments" ordered the skilled nurse to observe and assess skin integrity and to perform wound care treatments.

Record review of skilled nurse visit documents from 7/31/2023 and 8/4/2023, failed to evidence complete assessments of all patient wounds to include measurements. Review failed to evidence wound measurements were documented for the patient from 7/24/2023 – 8/10/2023 (17 days).

During an interview on 8/11/2023, at 5:19 PM, the Administrator indicated the electronic health record system was not carrying over the documentation of measurements.

*. During an interview on 8/11/2023, at 4:51 PM, the Administrator indicated the skilled nurse should measure wounds weekly.

G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the agency failed to ensure all orders were incorporated into the plan of care for 1 of 1 active clinical record reviewed where an additional wound developed (Patient #3). The findings include: Clinical record review on 8/11/2023, for Patient #3, start of care 7/11/2023, evidenced a physician's order from 7/10/2023, for skilled nursing services to provide wound care to the patient's bilateral heels and coccyx. Record review of an agency document titled "Home Health Certification and Plan of Care" evidenced wound care treatment orders for the right and left heels. Review of the plan of care failed to evidence all wound care orders were incorporated into the plan of care. During an interview on 8/11/2023, at 5:00 PM, Administrator was heard on speakerphone with Corporate Staff 2, who indicated wound care for the coccyx wound should be on the plan of care.	G0576	CFR(s): 484.60()(3) All orders recorded in plan of care All patient care orders, including verbal orders, must be recorded in the plan of care. This element is not met as evidenced by: based on record review and interview the agency failed to ensure all orders were incorporated in the plan of care for 1 of 1 active clinical record reviewed where additional wound developed. Administrator acknowledges receipt of this deficiency. Action: Agency Administrator provided education on agency policy S06 Physician Role with attention to requirement for order for all care provided to be in the plan of care to 100% of all licensed field clinicians on 8/29/2023 Agency Administrator or designee will audit 100% of all wound patients to ensure orders for treatments/interventions to address wound care are contained in the clinical record by 9/22/2023 to ensure 100% compliance with orders for	2023-09-22

			wound care to be provided is achieved. Monitoring: Once compliance is achieved, Agency Administrator or designee will audit 8 wound records quarterly for a period of 1 year to ensure compliance with orders for wound care provided by agency staff are identified and ordered in the plan of care. Agency Administrator will report results of audits to the Governing Body and the QAPI team for review and recommendation. If compliance is not maintained, additional education and/or employee disciplinary counseling will be implemented.	
G0586	Review and revision of the plan of care 484.60(c) Standard: Review and revision of the plan of care. Based on record review and interview, the agency failed to revise the plan of care in 4 of 5 clinical records reviewed who recieved skilled nursing, physical therapy, and occupational therapy. (Patients #3, 4, 6, 7) The findings include:	G0586	CFR(s): 484.60(c) Review and revision of the plan of care This standard is not met as evidenced by: based on review and interview the agency failed to revise the plan of care in 4 of 5 clinical records reviewed who received skilled nursing, physical therapy and occupational therapy. Administrator acknowledges receipt of this deficiency. Action:	2023-09-22

	1. Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 7/27/2023-9/24/2023, which indicated the skilled nurse was to change the wound vac (a medical device used to suction drainage from a wound) every Monday and Thursday. Review of an agency document titled “Physician Order” dated 8/9/2023, indicated the wound vac dressing was to be changed 3 times per week. Review failed to evidence the agency revised the plan of care to reflect the change in wound vac dressing change frequency. During an interview on 8/10/2023, at 4:50 PM, the Clinical Manager indicated the plan of care should have been updated with a new order but it was not. 2. Clinical record review on 8/10/2023, for Patient #7, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 6/26/2023-8/24/2023, which indicated the agency was to provide skilled nursing services 2 times a week for 8 weeks and then 1 time a week for 1 week. Review of agency documents titled		Agency Administrator will provide additional education to 100% of all licensed administrative and field clinicians on need to include "update to the plan care" on 100% of all verbal orders which modify the initial plan of care and requirement to review all orders including most recent verbal orders prior to providing care to ensure staff identify most recent updates to the plan of care by 9/8/2023. Per CMS guidance in QSO 18-25-HHA "all orders, including verbal orders are part of the plan of care... It is not necessary for the physician to sign an updated plan of care until the patient is recertified to continue care and the plan of care is updated reflect current ongoing orders, including verbal orders." Once education is completed, Agency Administrator or designee will audit 100% of all verbal orders for identification of the verbal orders as an "update to the plan of care" for a period of 30 days to ensure staff are easily able to identify the verbal orders as an updated to the plan of care and 100% compliance is achieved. Monitoring: Agency Administrator or designee will audit 8 clinical records	

	"Physician Order" indicated the patient was to take sulfamethoxazole-trimethoprim (an antibiotic) for a wound infection for 10 days on document dated 6/26/2023. Review of document dated 7/7/2023, indicated the agency was to increase the skilled nursing visits to 3 times a week per document dated 7/7/2023. Review failed to evidence the agency revised the plan of care to reflect the change in skilled nurse frequency and the new antibiotic. During an interview on 8/11/2023, at 3:11 PM, the Clinical Manager indicated the plan of care was not revised. *. Clinical record review on 8/11/2023, for Patient #3, start of care 7/11/2023, evidenced a physicians order from 7/21/2023, for wound care to the right ankle performed 3 times a week. Record review of an agency document titled "Home Health Certification and Plan of Care" evidenced wound care orders for the right and left heels. Record review failed to evidence the plan of care was revised to include the current treatment orders for all wounds. During an interview on 8/11/2023, at 5:22 PM, the Administrator indicated the wound care order for the right		quarterly for a period of 1 year to ensure additional orders include" update to the plan of care" prior to final approval of the orders and submission to the physician for signature to ensure 100% compliance is maintained. If compliance is not maintained, additional education and/or employee disciplinary action will be implemented.	

	care. *. Clinical record review on 8/10/2023, for Patient #4, start of care 3/16/2023, evidenced a physicians order from 7/25/2023, that ordered the patient to take Levaquin (antibiotic), miconazole (antifungal), and changed skilled nurse frequencies to once a week. Record review failed to evidence the plan of care was revised to include current discipline frequencies and treatment orders. During an interview on 8/11/2023, at 5:32 PM, the Administrator indicated the orders from 7/25/2023 were not revised into the plan of care.			
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.	G0590	CFR(s): 486.60(c)(1) Promptly alert the physician of relevant changes The HHA must promptly alert the relevant physician/allowed practitioners on any changes in the patient condition or needs that suggest that outcomes are not being achieved,	2023-09-22

Based on record review and interview, the agency failed to ensure the physician was notified of a change in the patient's condition in 2 of 4 clinical records reviewed with wounds. (Patients #6, 7)

The findings include:

1. Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/27/2023-9/24/2023, which indicated the patient's diagnoses included, but were not limited to, cardiomyopathy (a disease affecting the heart muscle making it more difficult to pump blood around the body) and hypertension (high blood pressure).

Review of agency documents titled "Visit Note Report" indicated the patient had 1+ pitting edema (excess fluid of the body causes swelling, and leaving indentation when pressure applied from a grade 1-4 with 1 being the least and 4 being the worst) to both lower extremities on 7/27/2023, as completed by the Alternate Clinical Manager/registered nurse (RN). Document dated 7/28/2023, indicated the patient had 2+ pitting edema to the right lower extremity and document dated 7/31/2023, indicated the patient had 2+ pitting edema to

and/or that the plan of care should be altered.

Based on record review and interview, the agency failed to

ensure the physician was notified of a change in the patient's

condition in 2 of 4 clinical records reviewed with wounds.

Agency Administrator acknowledges receipt of this deficiency.

Action:

Agency Administrator provided education to 100% of all

licensed field/administrative clinicians on agency policy

S06 Physician's Role with attention to section 3.5.1

requirement to notify physician for changes in patient condition

which suggest a need to modify the plan of care and agency

policy S05 Coordination of services with requirements in

section 3.1.2 promptly alerting physician to changes which

suggest a need to modify the plan of care and 3.1.4 staff to

initiate revisions and requirement for coordination of care

with primary disciplines involved in providing patient care.

Once education is completed, Agency Administrator will

instruct clinicians to enter a physician notification coordination

note for visits findings which identified changes in status which

require or potentially require updated to the plan of care

	both lower extremities. Review of failed to evidence the agency notified the physician of the increase in edema. During an interview on 8/10/2023, at 4:42 PM, the Clinical Manager indicated the physician should have been notified of the increase in edema and did not see any documentation the physician was notified. 2. Clinical record review on 8/10/2023, for Patient #7, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/26/2023-8/24/2023, indicated Person C was the practitioner responsible for the plan of care. Review of agency documents titled "Visit Note Report" dated 6/30/2023 and 8/9/2023, indicated the wound to the left heel was debrided by Person D. Review failed to evidence the agency notified Person C of the wound debridement to the left foot. During an interview on 8/11/2023, at 3:17 PM, the Clinical Manager indicated she did not see any documentation which indicated Person C was notified of the wound debridement. Review of an agency document titled "Visit Note Report" dated 8/2/2023, indicated the wound to the left heel		to include coordination completed with other primary disciplines providing care to patient. Agency Administrator will review coordination notes daily to ensure notification/coordination with physician and primary disciplines involved in care completed until 100% compliance is achieved. Monitoring: Once 100% compliance is achieved, Agency Administrator or designee will complete 8 quality of care audits quarterly for a period of 1 year to ensure 100% compliance is maintained and notification to physician of actual/potential changes to the plan of care and coordination of care with primary disciplines involved in care is maintained. Agency Administrator will report results of audits quarterly to the QAPI team for review and recommendations. If compliance is not maintained additional education and/or employee disciplinary action will be implemented.	

	had soft black necrotic tissue noted, which was a change from previous notes of white tissue. Review failed to evidence the practitioner responsible for the plan of care and Person D, physician providing wound care, were notified of the change in wound status. During an interview on 8/11/2023, at 3:29 PM, the Clinical Manager indicated the clinician should have notified the physician of the black necrotic tissue and did not see documentation that the physician was notified.			
G0606	Integrate all services 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 record review and interview, the agency failed to coordinate care in 5 of 10 clinical records reviewed. (Patient #5, 6, 7, 8, 9) The findings include: 1. Review of an undated agency policy on 8/11/2023, titled "Coordination of Services" stated, "... Staff implement actions which reflect coordination,	G0606	CFR:(s): 484.60(d)(3) Integrate all services 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. This element is not met as evidenced by: based on record review and interview, the agency failed to coordinate care in 5 of 10 clinical records reviewed.	2023-09-22

	including … Contact with … community agencies, non-agency providers ….” 2. During an observation of care at the residence of Patient #5 at an assisted living facility on 8/10/2023, at 2:45 PM, a document from the assisted living facility titled “Physician’s Orders” was reviewed which indicated the patient’s diet was regular with no added salt. Clinical record review on 8/9/2023, for Patient #5, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 8/3/2023-10/1/2023, which indicated the patient’s diet was heart healthy, low sodium, low cholesterol, low fat, high protein, high calorie diet. During an interview on 8/10/2023, at 3:55 PM, the Clinical Manager indicated clinicians should coordinate care with the assisted living facilities and should notify the physician to clarify any discrepancies. 3. Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 7/27/2023-9/24/2023, which indicated the patient’s diagnoses included, but were not limited to, cardiomyopathy (a disease affecting the heart muscle making it more difficult to pump blood		Agency Administrator acknowledges receipt of this deficiency. Action: Agency Administrator to provide additional education to 100% of all licensed field and administrative staff members on agency policy S05 Coordination of care with requirements in for coordination of care in sections 3.1.2 promptly notifying the physician to changes which suggest need to modify the POC; 3.1.4 initiate revisions to the plan of care; 3.3.11 coordination of care with interdisciplinary communication, reporting education and supervision; 3.3.1.3 notification to physician regarding change in patient condition or needs; 3.3.1.4 coordination with vendors, suppliers, community agencies/non-agency providers and 4.2.2 notification to the physician, patient/family and other staff on significant events or revision to the plan of care and/or revisions to the discharge plan by 9/8/2023. Agency Administrator or designee to review 100% of all plans of care for patients residing in facilities to evaluate orders for diet requirements per plan of care and facility identified diet by and coordinate dietary requirements with physician and	

	around the body) and hypertension (high blood pressure). Review of agency documents titled "Visit Note Report" indicated the patient had 1+ pitting edema (excess fluid of the body causes swelling, and leaving indentation when pressure applied from a grade 1-4 with 1 being the least and 4 being the worst) to both lower extremities on 7/27/2023 as completed by the Alternate Clinical Manager/registered nurse (RN). Document dated 7/28/2023, and completed by the Alternate Clinical Manager, indicated the patient had 2+ pitting edema to the right lower extremity. Document dated 7/29/2023 and completed by the Alternate Clinical Manager failed to evidence an assessment of the lower extremity edema. Review of document completed by Licensed Practical Nurse (LPN) 1 and dated 7/31/2023, evidenced the patient had 2+ pitting edema to both lower extremities. Review failed to evidence any coordination between the Alternate Clinical Manager and LPN 1 regarding the patient's increased edema and need to notify the physician of the change in status. During an interview on 8/10/2023, at 1:21 PM, the Alternate Clinical Manager indicated she did not call the physician to inform the physician of		facility to resolve discrepancies and ensure dietary requirements are consistent between the facility and the plan of care by 9/8/2023. Once education is completed, Agency Administrator will instruct clinicians to enter a physician notification coordination note for visits findings which identified changes in status which require or potentially require update to the plan of care to include coordination completed with other primary disciplines providing care to patient. Agency Administrator will review coordination notes daily to ensure notification/coordination with physician and primary disciplines and other providers involved in care has occurred until 100% compliance is achieved. Monitoring: Once 100% compliance is achieved, Agency Administrator or designee will audit 8 clinical records per quarter for coordination of care between physician/patient/caregiver, interdisciplinary team, vendors, suppliers, community agency and non-agency vendors on changes with might require a change to the plan of care/needs, significant events or and changes to discharge plans to ensure 100% compliance is maintained.	

	the patient's increased edema because she wanted to see how the patient was doing on Monday, 7/31/2023. When queried if she communicated the patient's change in status regarding the increased edema and need to inform the physician if the edema was not improved on 7/31/2023, the Alternate Clinical Manager indicated she believed she informed LPN 1 to make sure the patient was taking all of her medications. During an interview on 8/10/2023, at 1:32 PM, LPN 1 indicated the Alternate Clinical Manager informed her that the patient had a history of lymphedema (build up of fluid in the soft tissue) but did not provide any further direction. 4. Clinical record review on 8/10/2023, for Patient #7, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 6/26/2023-8/24/2023, which indicated the agency was to provide skilled nursing, physical therapy (PT), and occupational therapy (OT). Review of agency documents titled "Visit Note Report" completed by the licensed practical nurse (LPN) and dated 6/30/2023 and 8/9/2023, indicated the wound was debrided by		Agency Administrator will report results of audits quarterly to the Governing Body and the QAPI team for a period of 1 year to ensure 100% compliance is maintained. If compliance is not maintained, additional education and/or employee disciplinary counseling will be implemented.	

LPN notified the RN, PT, and OT of the wound debridement to the left foot.

During an interview on 8/11/2023, at 3:17 PM, the Clinical Manager indicated she did not see any documentation indicating the RN, PT, and OT were notified of the wound debridement.

5. Clinical record review on 8/11/2023, for Patient #8, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/31/2023-3/31/2023, which indicated the agency provided PT, OT, and speech therapy (ST) services.

Review of an agency document titled "Client Occurrence Report" completed by the ST and dated 2/10/2023, evidenced the ST was informed by the caregiver the patient fell resulting in treatment at the emergency room to rule out a concussion. Review failed to evidence the ST coordinated care with the PT and OT regarding the patient's fall.

During an interview on 8/11/2023, at 2:21 PM, the Clinical Manager indicated there was no documentation the PT and OT were notified of the patient's fall.

6. Clinical record review on 8/11/2023,

	document titled "Home Health Certification and Plan of Care" for certification period 5/28/2023-7/26/2023, which indicated the agency provided PT and OT services. Review of an agency document titled "Client Occurrence Report" completed by the physical therapy assistant (PTA) and dated 6/8/2023, indicated the patient fell resulting in an abrasion to the right elbow. Review failed to evidence the PTA coordinated care with the PT and the OT regarding the patient's fall. During an interview on 8/11/2023, at 2:43 PM, the Clinical Manager indicated there was no documentation the PTA coordinated care with the other disciplines regarding the fall.			
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, record review, and interview, the agency failed to ensure the patient was provided with a written visit schedule including the frequency of visits by agency personnel in 4 of 4 home visits. (Patients #1, 2, 5, 6)	G0614	CFR(s): 484.60(e)(1) Visit schedule Visit schedule, including frequency of visits by the HHA personnel and personnel acting on behalf of the HHA. This element is not met as evidenced by: based on observation, record review, and interview, the agency failed to ensure the patient was provided with a written visit schedule including the frequency of visits by agency personnel in 4 of 4 home visits.	2023-09-22

The findings include:

1. During an observation of care at the home of Patient #5 on 8/10/2023, at 2:26 PM, the agency folder was observed but the written visit schedule failed to include the visits to be provided by the occupational therapists.

2. During an observation of care at the home of Patient #6 on 8/11/2023, at 8:57 AM, the agency folder was observed but the written visit schedule was not observed in the patient's home.

3. During an interview on 8/11/2023, at 4:35 PM, the Clinical Manager indicated the calendar in the planner inside of the agency packet should be completed and left in the patient's home to inform the patient of their visit schedule.

*. An observation of a home visit was conducted on 8/2/2023, from 10:35 AM – 11:10 AM, for Patient #1 with RN 2. During the home visit, the patient's admission folder was reviewed for required information and failed to evidence a written visit schedule for all disciplines. A calendar planner was provided to the patient in the admission folder but remained blank. Observation failed evidence a visit

Agency Administrator acknowledges receipt of this deficiency.

Action:

Agency Administrator provided education on 8/29/2023 to

100% of all licensed field and administrative clinicians on

agency policy S03 Patient Rights with focus on 2.1.7 right to

be informed in advance of care to be provided to include

disciplines who will provide care, frequency of proposed visits

and any changes in care before changes made and

requirement for written instructions to be in the patient home,

requirement for clinician to review and update the PIR if indicated

with each subsequent visits. Updates to PIR to be documented in the

clinical record to ensure patient made aware of changes prior

to implementing changes. Agency will utilize the home health

agency change of care notice to identify changes to services

and upload into the EMR.

Agency will utilize patient calendar to provide written schedule

to patient at the SOC and update as revisions to the plan of

care are received. Agency will also utilize the Patient Instruction

Report (PIR). Once the POC has been approved, the agency

	schedule for nursing and therapy services was maintained in the patient's home. On 8/11/2023, at 5:33 PM, the Administrator was informed the calendar planner was completed in the patients home. *. An observation of a home visit was conducted on 8/2/2023, from 12:57 PM – 1:57 PM, for Patient #2, with PT 1. At 1:10 PM, the patient's admission folder was reviewed for required information and failed to evidence a written visit schedule for all disciplines. A calendar planner was provided to the patient in the admission folder but remained blank. Observation failed evidence a visit schedule for nursing and therapy services was maintained in the patient's home.		will ensure the PIR (Patient Instruction Report) is delivered to home which identifies disciplines with frequency and duration, current medications, services to be provided by discipline, and requirement for clinician to review and update if needed at subsequent visits. Once education is completed, Clinician will review PIR/schedule with patient/caregiver to include services to be provided by agency. Clinicians will upload copy of delivered PIR to patient file. Agency Administrator to validate/document delivery of PIR reports to all active patients by 9/22/2023 to ensure 100% compliance is achieved. Agency Administrator will complete onsite home visits with 100% of all licensed clinicians and validate that Patient Instruction Report (PIR) is in patient home and updated by 9/20/2023 to achieve 100% compliance. Monitoring: Agency Administrator or designee will perform 8 on-sites per quarter for a period of 1 year to ensure compliance with patient calendar (PIR) is in home and identifies care to be performed for all disciplines to include frequency and duration	

			of services to be provided to ensure compliance is maintained. Agency Administrator will report results of audits to the Governing Body and the QAPI for review and recommendations. If compliance is not maintained, additional education and/or employee disciplinary action will be implemented.	
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, record review, and interview, the agency failed to ensure the patient was provided with written medication instructions and schedule in 4 of 4 home visits. (Patients #1, 2, 5, 6) The findings include: 1. During an observation of care at the home of Patient #5 on 8/10/2023, at 2:26 PM, the agency folder was observed but the written medication instructions and schedule failed to be	G0616	CFR(s): 485.60(e)(2) Patient medication schedule/instruction Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. This element is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the patient was provided with written medication instructions and schedule in 4 of 4 patients. Administrator acknowledges receipt of this deficiency. Agency Administrator will provide education to 100% of licensed administrative and field clinicians on agency policies S02 Admission Process and Patient Assessment with focus	2023-09-22

	observed in the patient's home. 2. During an observation of care at the home of Patient #6 on 8/11/2023, at 8:57 AM, the agency folder was observed but the written medication instructions and schedule was not observed in the patient's home. 3. During an interview on 8/11/2023, at 4:35 PM, the Clinical Manager indicated the medication list should be included in the agency folder in the patient's home. 4. An observation of a home visit was conducted on 8/2/2023, from 10:35 AM – 11:10 AM, for Patient #1 with RN 2. During the home visit, the patient's admission folder was reviewed and failed to evidence a medication list with instructions. At 10:43 AM, the patient's caregiver indicated to RN 2 there was not a medication list in the home. Observation failed evidence a medication list was maintained in the patient's home. On 8/11/2023, at 5:33 PM, the Administrator was informed the medication list with instructions was not located in the home.		on section 4.3 admitting professional completes documentation for medication profile; 4.6.1.13 resource booklet (home folder) includes medication profile to be printed and place in folder following review of evaluation packet and agency policy S07 Medications with focus on sections 3.2.1 staff will assess medications with each visit, 3.2.2 staff documents all medication patient maybe taking on the medication profile and 3.2.3 staff promptly report any problems to the physician. Education to be completed by 9/1/2023. Once education is completed, Clinician will review PIR/schedule with patient/caregiver to include services to be provided by agency. Clinicians will upload copy of delivered PIR to patient file. Agency Administrator will validate delivery and review of PIR all active patients by 9/22/2023 to ensure 100% compliance is achieved. Agency Administrator will perform onsite home visit with 100% of licensed field clinicians to validate skills in review of medications and verify that PIR medications is in the patient home and updated as indicated to ensure 100% compliance. Monitoring:	

	5. An observation of a home visit was conducted on 8/2/2023, from 12:57 PM – 1:57 PM, for Patient #2, with PT 1. During the home visit, the patient's admission folder was reviewed and failed to evidence a medication list with instructions. Observation failed evidence a medication list was maintained in the patient's home.		Once 100% compliance with PIR in the patient's home is achieved, Agency Administrator will perform 8 onsite visits per quarter for a period of 1 year to ensure compliance with PIR (medication profile) is maintained. Agency Administrator will report results of audits quarterly to the Governing Body and the QAPI team for a period of 1 year to ensure compliance is maintained. If compliance is not maintained additional education will be provided and/or employee disciplinary counseling will be implemented.	
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, record review, and interview, the agency failed to ensure the patient was provided with written instruction related to the care and treatments to be provided by the agency in 4 of 4 home visits. (Patient #1, 2, 5, 6) The findings include:	G0618	CFR(s): 484.60(e)(3) Treatments and therapy services. Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA including therapy services. This element is not met as evidenced by: based on observation, record review and interview the agency failed to ensure the patient was provided with written instruction related to the care and treatments to be provided by the agency in 4 of 4 home visits. Administrator acknowledges receipt of this deficiency. Action: Agency Administrator provided education on 8/29/2023 to 100% of all licensed field and administrative clinicians on	2023-09-22

	1. During an observation of care at the home of Patient #5 on 8/10/2023, at 2:26 PM, the agency folder was observed but the written instruction related to the care and treatments to be provided by the agency was not observed in the patient's home. 2. During an observation of care at the home of Patient #6 on 8/11/2023, at 8:57 AM, the agency folder was observed but the written instruction related to the care and treatments to be provided by the agency was not observed in the patient's home. 3. During an interview on 8/11/2023, at 4:35 PM, the Clinical Manager indicated the plan of care should be printed and provided to the patient once the plan of care was locked. 4. An observation of a home visit was conducted on 8/2/2023, from 10:35 AM – 11:10 AM, for Patient #1 with RN 2. During the home visit, the patient's admission folder was reviewed for required information and failed to evidence a treatment plan for all disciplines. Observation failed evidence a plan of treatment for skilled nursing and therapy services were maintained in the patient's home.		agency policy S03 Patient Rights with focus on 2.1.7 right to be informed in advance of care to be provided to include disciplines who will provide care, frequency of proposed visits and any changes in care before changes made and requirement for written instructions to be in the patient home, requirement for clinician to review and update the PIR if indicated with each subsequent visits. Updates to PIR to be documented in the clinician record utilizing the home health agency change form to ensure patient made aware of changes prior to implementing changes. Once education is completed, Clinician will review PIR/schedule with patient/caregiver to include services to be provided by agency. Clinicians will upload copy of delivered PIR to patient file. Agency Administrator will validate delivery and review of PIR all active patients by 9/20/2023 to ensure 100% compliance is achieved. active patients by 9/20/2023 to ensure 100% compliance is achieved. Agency Administrator will complete onsite home visits with 100% of all licensed clinicians and validate that Patient Instruction Report (PIR) is in patient home and updated	

	On 8/11/2023, at 5:33 PM, the Administrator was informed of the missing treatment plan in the patient's home. 5. An observation was conducted on 8/2/2023, from 12:57 PM – 1:57 PM, for Patient #2, with PT 1. During the home visit, the patient's admission folder was reviewed for required information and failed to evidence a treatment plan for all disciplines. Observation failed evidence a plan of treatment for skilled nursing and therapy services were maintained in the patient's home.		by 9/20/2023 to achieve 100% compliance.	
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. Based on observation, record review and interview, the agency failed to provide the patient and caregiver in writing with the name and contact information of the clinical manager in 4 of 4 home visits conducted. (Patients #1, 2, 5, 6) The findings include: 1. During an observation of care at the home of Patient #5 on 8/10/2023, at	G0622	CFR(s): 484.60(e)(5) Name/contact information for clinical manager Name and contact information of the HHA clinical manager. This element is not met as evidenced by: based on observation, record review and interview, the agency failed to provide the patient/caregiver in writing with the name and contact information of the clinical manager in 4 of 4 home visits conducted. Administrator acknowledges receipt of this deficiency.	2023-09-22

	2:26 PM, the agency folder was observed but the name and contact information of the clinical manager and the medication list were not observed in the patient's home. 2. During an observation of care at the home of Patient #6 on 8/11/2023, at 8:57 AM, the agency folder was observed but the name and contact information of the clinical manager and the medication list were not observed in the patient's home. 3. During an interview on 8/11/2023, at 4:35 PM, the Clinical Manager indicated the name of the clinical manager should be included on the patient's medication list in the home. 4. An observation of a home visit was conducted on 8/2/2023, from 10:35 AM – 11:10 AM, for Patient #1 with RN 2. During the home visit, the patient's admission folder was reviewed for required information and failed to evidence the name of the Clinical Manager. Observation failed evidence contact information for the Clinical Manager was maintained in the patient's home. On 8/11/2023, at 5:33 PM, the Administrator was informed the patient's folder did not have a sticker with contact information. 5. An observation was conducted on		Action: Agency Administrator will provide will conducted a mandatory meeting with all RN/PT/OT/ST staff who perform SOC visits and instructed on requirement to provide patient the name and contact information of the Administrator when completing the admission. Education completed on 8/24/2023. Once education is completed, clinician will deliver contact information for all active patients by 9/20/2023 to ensure 100% compliance is achieved. Clinician to enter a coordination note that information has been provided to the patient in the EMR. Agency Administrator printed list of active patients effective 8/24/2023 and will validate receipt of information by audit of coordination reports to ensure information shared with 100% of active patient to ensure 100% compliance. Agency Administrator or designee will audit 100% of new SOCs for a period of 30 days to ensure compliance with inclusion of Administrator contact information is achieved. Monitoring: Once 100% compliance is achieved for current patients,	

	8/2/2023, from 12:57 PM – 1:57 PM, for Patient #2, with PT 1. During the home visit, the patient's admission folder was reviewed for required information and failed to evidence the name of the Clinical Manager. Observation failed evidence contact information for the Clinical Manager was maintained in the patient's home.		Agency Administrator or designee will perform 8 on-site reviews quarterly for 1 year to ensure compliance is maintained. Agency Administrator to present results of audits quarterly to the Governing Body and QAPI team for review and recommendation. If compliance is not maintained, additional education and/or employee disciplinary counseling will be implemented.	
G0644	Program data 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and interview, the agency failed to ensure the quality assessment performance improvement (QAPI) program collected quality indicator data to monitor the effectiveness and	G0644	CFR(s): 484.65(b)(1)(2)(3) Program data 1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable and other relevant data, in the design of the program. 2) the HHA must use the data collected to (i) monitor the effectiveness and safety of services and quality of care, and (ii) identify opportunities for improvement (3) frequency and detail of the data collection must be approved by the HHA Governing Body. This standard is not met as evidenced by: Based on record review and interview, the agency failed to ensure the quality assessment performance improvement (QAPI) program collected quality indicator data to monitor the	2023-09-22

	quality of care related to wounds for 4 of the active 6 clinical records with skilled nursing services. (Patients #2, 3, 6, 7) The findings include: 1. Clinical record review on 8/11/2023, for Patient #2 indicated the agency provided skilled nursing services for the surgical wound treatment to the left thigh. 2. Clinical record review on 8/11/2023, for Patient #3 indicated the agency provided skilled nursing services for the pressure ulcer (wounds caused by pressure applied to the skin) treatment to the left heel, right ankle, and coccyx (lower back above the buttocks). 3. Clinical record review on 8/10/2023, for Patient #6 indicated the agency provided skilled nursing services for the surgical wound treatment to the left breast. 4. Clinical record review on 8/10/2023, for Patient #7 indicated the agency provided skilled nursing services for the diabetic ulcer (a wound caused by diabetes, a disease affecting the blood sugar) treatment to the left heel. 5. Review of the QAPI program on 8/11/2023, failed to evidence data collected on the wounds and review failed to evidence the governing body		effectiveness and quality of care related to wounds for 4 of the 6 active clinical records with skilled nursing services. Administrator acknowledges receipt of this deficiency. Action: Agency Administrator will conduct QAPI meeting quarterly and as indicated to review agency data to include evaluation and trending of QI occurrences related to patients who received wound care. Agency Administrator will schedule and complete an interim period review of QI events related to patients receiving wound care by 9/20/2023. Data will be trended to determine if problem/high risk area identified and if area for performance improvement is identified, Administrator will implement a performance improvement plan (PIP). Agency Administrator will submit QAPI data to include trends with QI events and status of QAPI work plan quarterly to the Governing Body for approval and of frequency and detail of the program's data collection. Monitoring: Agency Administrator will submit QAPI information to	

	approved the frequency and detail of the program's data collection. 6. During an interview on 8/11/2023, at 3:38 PM, the Clinical Manager indicated patients with wounds were considered high risk and the agency did not collect data on the wounds.		Governing Body quarterly for review, recommendations, approval of frequency and detail of the program's data collection. Exchange of data for QAPI program will be on-going. Agency Administrator will ensure that any guidance given by the Governing Body in relation to the QAPI program will be implemented upon receipt.	
G0646	Program activities 484.65(c) Standard: Program activities. The HHA's performance improvement activities must-- Based on record review and interview, the agency failed to ensure the performance improvement activities focused on high risk areas as evidenced in 4 of the active 6 clinical records with skilled nursing services. (Patients #2, 3, 6, 7) The findings include: 1. Clinical record review on 8/11/2023, for Patient #2 indicated the agency provided skilled nursing services for the surgical wound treatment to the left thigh. 2. Clinical record review on 8/11/2023, for Patient #3 indicated the agency	G0646	CFR:(s): 484.65(c) Program Activities Standard: Program Activities This standard is not met as evidenced by: based on record review and interview, the agency failed to ensure the performance improvement activities focused on high risk areas as evidenced in 4 of the active 6 clinical records with skilled nursing services. Agency Administrator acknowledges receipt of this deficiency. Action: Agency Administrator will conduct QAPI meeting quarterly and review agency data to include evaluation and trending	2023-09-22

	provided skilled nursing services for the pressure ulcer (wounds caused by pressure applied to the skin) treatment to the left heel, right ankle, right ankle, and coccyx (lower back above the buttocks). 3. Clinical record review on 8/10/2023, for Patient #6 indicated the agency provided skilled nursing services for the surgical wound treatment to the left breast. 4. Clinical record review on 8/10/2023, for Patient #7 indicated the agency provided skilled nursing services for the diabetic ulcer (a wound caused by diabetes, a disease affecting the blood sugar) treatment to the left heel. 5. Review of the QAPI program on 8/11/2023, failed to evidence performance improvement activities for the agency's wound-related care. 6. During an interview on 8/11/2023, at 3:38 PM, the Clinical Manager indicated patients with wounds were considered high risk and there was nothing about wounds in the quality assessment and performance improvement (QAPI) plan.		of QI occurrences related to patients who received wound care. Data will be trended to determine if problem area exist and if area for performance improvement is identified, Administrator will implement a performance improvement plan (PIP). Agency Administrator will schedule and complete an interim period review of QI events related to patients receiving wound care by 9/20/2023. Data will be trended to determine if problem/high risk area identified and if area for performance improvement is identified, Administrator will implement a performance improvement plan (PIP). Agency Administrator will submit QAPI data to include trends with QI events and status of QAPI work plan quarterly to the Governing Body for approval and of frequency and detail of the program's data collection. Monitoring: Agency Administrator will submit QAPI information o include trending for all QI events for high risk problem prone areas to Governing Body quarterly for review, recommendations, approval of frequency and detail of the program's data collection. Exchange of data for QAPI program will be on-going.	

			Agency Administrator will ensure that any guidance given by the Governing Body in relation to the QAPI program will be implemented upon receipt.	
G0652	Activities lead to an immediate correction 484.65(c)(1)(iii) (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview, the agency failed to ensure quality assessment performance improvement (QAPI) activities led to an immediate correction of the patient falls. The findings include: Review on 8/9/2023, of an agency document titled "QI [quality improvement] Event Report" indicated of the 75 incidents from 1/1/2023 to 8/9/2023, 67 were patient falls. Review of the QAPI program on 8/11/2023, indicated there was a trend up in patient falls with 24 falls reported for quarter 2 of 2023 compared to 17 falls reported in quarter 1 of 2023.	G0652	CFR(s): 484.65(c)(1)(iii) Activities lead to immediate correction. Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. This element is not met as evidenced by: base on record review and interview the agency failed to ensure quality assessment performance improvement (QAPI) activities led to an immediate correction of the patient falls. Administrator acknowledges receipt of this deficiency. Action: Agency Administrator will conduct quarterly QAPI team meeting with focus on review and trending of QI events with attention to increase in patient falls. Falls to be trended to determine common factors involved in falls. Agency Administrator will then implement a performance improvement	2023-09-22

	Review failed to evidence performance improvement actions to address and correct the patient falls. During an interview on 8/11/2023, at 3:38 PM, the Clinical Manager indicated all the QAPI program indicated was a trend up in falls but no specific plan to address the patient falls.		plan (PIP) to address interventions to be implemented to reduce risk of falls for patient population served by 9/22/2023. Agency Administrator will schedule and complete an interim period review of QI events related to patients for patients with falls by 9/20/2023. Data will be trended to determine if problem/high risk area identified and if area for performance improvement is identified, Administrator will implement a performance improvement plan (PIP). Agency Administrator will submit QAPI work plan to Governing Body for approval. Monitoring: Agency Administrator will continue to conduct QAPI team reviews quarterly to include review and trending of all QI events with QAPI work plan to the Governing Body for approval of data collection and work plan. Ongoing action item to be completed quarterly.	
G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview, the	G0654	CFR(S): 484.65(c)(2) Track adverse patient events Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. This standard is not met as evidenced by: based on record review and interview, the agency failed to analyze the	2023-09-22

agency failed to analyze the cause and implement preventive actions related to infections.

The findings include:

Review of an undated agency document titled "Quality Indicator Analysis" on 8/11/2023, identified as the data for Quarter 1, 2023, indicated the agency did not meet the target goal for infections in 6 of the past 12 months and had an increase from 4 infections in March 2023 to 10 infections in April 2023. Review indicated 5 infections were related to skin/wound and 6 infections were related urinary tract infections. Review failed to evidence an analysis of the cause of infections and implementation of preventive actions related to infections. Review of the undated agency document titled "Quality Indicator Analysis" identified as the data for Quarter 2, 2023, the agency did not meet the target goal for infections for 2 of the 3 months for the quarter. Review failed to evidence an analysis of the types and cause of infections and implementation of preventive actions.

During an interview on 8/11/2023, at 3:38 PM, the Clinical Manager indicated the agency did not meet the average for infections and did not

cause

and implement preventive actions related to infections.

Action:

Administrator will conduct QAPI team meeting and review

trending and analyze of all QI events for trends/common

causes and implement preventive actions and interventions

performance improvement plan (PIP) if data analysis

identifies area for improvement related to patients with

wound infections by 9/22/2023.

Agency Administrator will schedule and complete an interim

period review of QI events related to patients for patients with

infections by 9/20/2023. Data will be trended to determine

if problem/high risk area identified and if area for

performance improvement is identified, Administrator will

implement a performance improvement plan (PIP).

Agency Administrator will submit data on QAPI work plan and

analysis of QI events to the Governing Body for review and

approval of the data collection and work plan.

Monitoring:

Agency Administrator will continue to conduct QAPI team

	collect data on the type of infections.		reviews quarterly to include review and trending of all QI events with QAPI work plan to the Governing Body for approval of data collection and work plan. Ongoing action item to be completed quarterly.	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the skilled professional failed to prepare clinical documentation accurately in 3 of 7 active clinical records reviewed. (Patients #4, 5, 6) The findings include: 1. Clinical record review on 8/9/2023, for Patient #5, evidenced an agency document titled "Skilled Note Report" identified as the start of care comprehensive assessment completed by Physical Therapist (PT) 1 and dated 8/3/2023, which indicated the patient's medications included, but were not limited to, aspirin (a medication used to treat pain, fever, and/or to prevent blood clots), nebivolol (a medication used to treat high blood pressure),	G0716	FR(s): 484:75(b)(6) Preparing clinical notes This element is not met as evidenced by: based on record review and interview, the skilled professional failed to prepare clinical documentation accurately in 3 of 7 active clinical records reviewed. Administrator acknowledges receipt of this deficiency. Agency Administrator or designee will perform 100% review of active patient medications utilizing second electronic site to assess for potential medication interactions and notify physician/allowed practitioner of potential moderate/severe interactions to ensure 100% compliance with review of potential interactions/notification to the physician/allowed practitioner is achieved. Documentation of notification to the physician/allowed practitioner and/or changes in orders will be maintained in the EMR.	2023-09-22

	pain and/or inflammation), omeprazole (a medication used to treat reflux), ferrous sulfate (an iron supplement), and Lasix (a medication used to treat fluid retention). Review indicated the PT checked no issues were identified during the medication review. Review of agency documents titled "Client Coordination Note Report" dated 8/3/2023 and completed by PT 1 indicated moderate medication interactions between diclofenac and nebivolol; diclofenac and Lasix; and aspirin and Lasix. Review of medication interactions on Medscape.com on 8/10/2023, indicated moderate medication interactions between aspirin and nebivolol causing a decrease in the effects of nebivolol; omeprazole and ferrous sulfate by causing an increase in stomach acid which can lead to a decrease in the effect of ferrous sulfate; and aspirin and diclofenac causing an increase in risk of bleeding. Record review failed to evidence the potential interactions between aspirin and nebivolol; omeprazole and ferrous sulfate; and aspirin and diclofenac. During an interview on 8/10/2023, at 4:16 PM, the Clinical Manager indicated the PT should have checked on the comprehensive assessment that medication interactions were identified		Documentation of notification to the physician/allowed practitioner and/or changes in orders will be maintained in the EMR. Agency Administrator will identify any issues with current drug database and provide additional education if user error is identified to 100% of all licensed field clinicians. Agency Administrator will work with IT to identify any issues with current drug database and provide additional education if user error is identified to 100% of all licensed field clinicians. Monitoring: Once 100% compliance with notification to the physician for all current patients is achieved and Administrator validates current drug database is providing notification of potential medication interactions. Agency Administrator will perform duplicate medication reviews on 100% of new admissions utilizing agency drug database and external drug data base for 30 days to ensure current drug database is working appropriately. Once 100% compliance is achieved with new admission, Agency Administrator will then complete 8 audits per	

	and indicated the document was inaccurate. 2. Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled "Skilled Note Report" identified as the start of care comprehensive assessment completed by the Alternate Clinical Manager/registered nurse (RN) and dated 7/27/2023, which indicated the patient's medications included, but were not limited to, doxycycline (antibiotic) and amoxicillin-potassium clavulanate (antibiotic). Review indicated the RN checked no issues were identified during the medication review. Review of medication interactions on Medscape.com on 8/10/2023, indicated a serious medication interaction between doxycycline and amoxicillin-potassium clavulanate which can cause a decreased therapeutic effect of the amoxicillin. Record review failed to evidence the potential serious interaction between doxycycline and amoxicillin-potassium clavulanate. During an interview on 8/10/2023, at 4:25 PM, the Clinical Manager indicated there were no medication interactions noted for the patient.		quarter for a period of 1 year to ensure 100% compliance is maintained. Agency Administrator to report results of audits quarterly to the Governing Body and the QAPI team for review and recommendation. If compliance is not maintained additional education and/or employee disciplinary counseling will be implemented.	

	3. Clinical record review on 8/10/2023, for Patient #4, start of care 3/16/2023, evidenced an initial comprehensive assessment which indicated the agency planned to discharge the patient to an assisted living facility. Review failed to evidence the patient lived in a facility. During an interview on 8/11/2023, at 5:26 PM, the Administrator indicated the patient lived in a house, not an assisted living facility and stated, "I have to read into this."			
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 governing body failed to assume full legal authority and responsibility for the agency's overall management and	G0940	CFR(s): 484.105 Organization and administration of services 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 the administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and	2023-09-22

	administrator failed to report to the governing body (see tag G0946); the governing body failed to authorize in writing the a pre-designated person in the administrator's absence (see tag G0954); failed to ensure the clinical manager provided oversight of the patient assignments (see tag G0960); and failed to ensure all services provided under arrangement provided by other entities had a written agreement (see tag G0978). 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. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the agency failed to ensure the organizational structure was set forth in writing to include the lines of authority and services furnished and failed to ensure all services not furnished directly were monitored and controlled. The findings include: 1. Review of an untitled agency		controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority and services furnished. This condition is not met as evidenced by: 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 governing body failed to assume full legal authority and responsibility for the agency's overall management and operation (see tag G0942); the administrator failed to report to the governing body (See tag G0946); the governing body failed to authorize in writing a pre-designated person in the administrator's absence (see tag G0954); failed to ensure administrator provided oversight of patient assignments (see tag G0960); and failed to ensure all services provided under arrangement provided by other entities had a written agreement (see tag G0978). 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 COP 42CFR 484.105 Organization and Administration of Services. a deficient practice citation was also evidenced at this	

document dated 4/3/2023, and identified as the organizational chart, indicated field staff provided care to the patients and failed to evidence the types of services furnished to the patients and lines of authority for the field staff.

During an interview at the entrance conference on 8/9/2023, at 10:06 AM, the Administrator indicated the agency provided skilled nursing services from registered nurses and licensed practical nurses; therapy services from physical therapists, physical therapy assistants, occupational therapists, occupational therapy assistants, and speech therapists; and social work services.

2. Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled "Skilled Note Report" identified as the start of care comprehensive assessment completed by the Alternate Clinical Manager/registered nurse (RN) and dated 7/27/2023, which indicated Corporate Staff 3 made edits to the note in collaboration with the Alternate Clinical Manager.

During an interview on 8/10/2023, at 3:39 PM, the Administrator indicated Corporate Staff 3 had access to the agency's plans of care and did quality review for the agency. The Administrator indicated Corporate

standard as follows:

Based on record review and interview, the agency failed to ensure

the organizational structure was set forth in writing to include the

lines of authority and services furnished and failed to ensure all

services not furnished directly were monitored and controlled.

Administrator acknowledges receipt of this deficiency.

Action:

Agency Administrator ensured organizational chart was updated

to reflect types of services furnished to the patients and the

lines of authority for the field staff by 9/11/2023.

Agency Administrator will submit written request for contract to

obtained written agreement for utilization of corporate staff

identified as corporate employee #3 and #2in the statement of

deficiencies to perform quality clinical audits for care to be

performed by agency staff and for quality review of plans of care

by 9/11/2023.

Quality Clinical Audits:

Information obtained on quality clinical audits regarding plan of

	Staff 3 was not a direct or contracted employee of the agency and was an employee of Entity A. Review of an agency document dated 7/20/2023, titled "Quality Assessment [and Performance Improvement (QAPI) Meeting Agenda and Governing Body Report" indicated Corporate Staff 2 was included in the QAPI meeting. During an interview on 8/11/2023, at 3:38 PM, the Administrator indicated Corporate Staff 2 was not a direct or contracted employee but was an employee of Entity A. The Administrator indicated Corporate Staff 2 assisted in QAPI by gathering and reviewing data. Review failed to evidence the agency defined the roles and responsibilities of Entity A to include how the services provided by Entity A would be monitored and controlled. During an interview at the entrance conference on 8/9/2023, at 10:06 AM, the Administrator indicated the agency did not have a contract with Entity A and indicated the agency was owned by Entity A. The Administrator indicated Entity A was involved in the quality assessment performance improvement (QAPI) program, policy development, and quality review of the clinical records and plans of care.		care performed by individuals with written contract will be submitted to the Administrator for review and inclusion in quality assurance and improvement plan (QAPI) and agency performance improvement plans (PIPs) as the Administrator deems appropriate. Quality Review Plans of Care; Information obtain on quality review of the plans of care which suggested edits will not be completed until review of proposed edits is completed by the admitting clinician and the admitting clinician approves the edits. Quality Packet Review will enter a coordination note at the time review is completed and approved to include employee who performed the evaluation and approval by clinician of recommended edits. Monitoring: Agency Administrator will ensure written request for use of contract and contract is maintained in the branch files. Agency Administrator will review written agreements quarterly for a period of 1 year to ensure written agreements are maintained and that individuals performing quality clinical audits and quality packet review audits continue to perform within	

	During an interview on 8/9/2023, at 2:20 PM, Corporate Staff 1 indicated there was not a contract or agreement between Entity A and the agency. Corporate Staff 1 indicated the agency was under the umbrella of Entity A and was subject to the corporation's policies and procedures and not agency specific policies as per the purchase agreement.		parameters as identified in the written agreement. Agency Administrator will report to Governing Body on status of written agreements as changes are indicated to ensure 100% compliance is maintained. , .	
G0942	Governing body 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on observation, record review and interview, the governing body failed to assume full legal authority and responsibility for the agency's overall management and operation and failed to ensure the accuracy of public information per agency policy. The findings include:	G0942	CFR(s): 484.105(a) Governing Body Standard: Governing Body A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. This standard is not met as evidenced by: based on observation record review, and interview the governing body failed to assume full legal authority and responsibility for the agency's overall management and operation and failed to ensure the accuracy of	2023-09-22

	1. Review of an undated agency policy on 8/11/2023, titled "Governing Body" stated, "... The Governing Body prepares to ... Direct to prepare and oversee an overall budget that includes an annual operating budget ... The Governing Body ensures that the Agency ... Disperses accurate information in publications and advertisements available to the public...." 2. During an interview at the entrance coferenced on 8/9/2023, at 10:06 AM, the Administrator indicated the agency was not a part of corporate and became independent in July 2022. Review on 8/9/2023 of an agency document titled "First Amendment to Amended and Restated Limited Liability Company Agreement of [Entity E]" dated 10/1/2021, and identified as the agency's bylaws, indicated the document was signed solely by Corporate Staff 4 from Entity F. Review of an agency document on 8/9/2023, titled "Governing Body" and dated 2023, failed to list Corporate Staff 4 as a governing body member.		public information per agency policy. Administrator acknowledges receipt of this deficiency. Action: Agency Administrator will initiate contact with contractor to remove hospice information from door signage by 9/1/2023. Agency Administrator will contact provider regarding marketing collateral and need to remove hospice information from marketing material and business cards. Agency will utilize skilled nurse to provide aide services as ordered by the physician. Monitoring: Agency Administrator will coordinate weekly with providers to ensure completion of update to signage and marketing materials to ensure compliance with accurate information available to the public by 9/22/2023.	

During an interview on 8/10/2023, at 9:37 AM, with Administrative Staff 4 (governing body member), Administrative Staff 4 indicated Corporate Staff 4 was on the board of directors for Entity F.

3. During an observation upon entrance to the agency on 8/9/2023, at 9:39 AM, a sign on the building and the lettering on the front door indicated Enhabit Home Health and Hospice.

During an entrance conference on 8/9/2023, at 10:06 AM, the Administrator distributed business cards with her contact information that indicated Enhabit Home Health and Hospice.

During an interview at the entrance conference on 8/9/2023, at 10:06 AM, the Administrator indicated the agency did not provide hospice services and indicated the signage on the front of the door and on the building and the name on her business card was the company's logo. The Administrator indicated the agency did not provide home health aide services.

Review of the agency admission packet on 8/9/2023, indicated the agency provided home health aide services.

A banner in the lobby of the agency

	which indicated the agency provided home health aide services. Review of a survey document titled "CMS 1572" completed by the Administrator and dated 8/9/2023, failed to evidence the agency provided home health aide services. During an interview on 8/9/2023, at 1:43 PM, the Administrator indicated the sign in the lobby may have come from the corporate office. The Administrator indicated the agency had not provided home health aide services in awhile and did not have any active home health aides employed directly or via contract. 4. During an interview during a review of the agency's budget for 2023 on 8/9/2023, at 2:20 PM, the Administrator indicated she was unsure how much monthly was budgeted on staffing costs total. The Administrator indicated the budget was generated by the finance department at the corporate office and she was just expected to follow it.			
G0946	Administrator appointed by governing body	G0946	CFR(s): 484.105(b)(1)(i) Administrator appointed by the	2023-08-28

	484.105(b)(1)(i) (i) Be appointed by and report to the governing body; Based on record review and interview, the administrator failed to report to the governing body. The findings include: Review of an untitled agency document dated 4/3/2023, and identified as the organizational chart, indicated the Administrator reported to Corporate Staff 1. Review of an agency document on 8/9/2023, titled "Governing Body" and dated 2023, failed to list Corporate Staff 1 as a governing body member. During an interview on 8/9/2023, at 2:20 PM, Corporate Staff 1 indicated she was the administrator's direct supervisor. During an interview on 8/9/2023, at 3:11 PM, the Administrator indicated she reported to Corporate Staff 1 and was unsure per CMS regulations who the administrator was to report to.		Governing Body. (i) Be appointed by and report to the governing body. This element is not met as evidenced by: based on record review and interview, the administrator failed to report to the Governing body. Administrator acknowledges receipt of deficiency. Organization structure was reviewed by Governing Body and changes to structure were implemented to ensure Administrator reports directly to a member of the Governing Body. Update to organization chart completed on 8/28/2023 and maintained in agency records and available for review.	
G0954	Ensures qualified pre-designated person 484.105(b)(2)	G0954	CFR(s): 484.105(b)(2) Ensures qualified pre-designated person When the administrator is not available, a qualified,	2023-08-30

When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section.

Based on record review and interview, the governing body and administrator failed to authorize in writing a pre-designated person in the absence of the administrator.

The findings include:

Review of an agency document dated 10/20/2022, titled "Delegation of Authority" failed to evidence the governing body authorized the Alternate Administrator to assume the responsibilities of the administrator in the administrator's absence.

During an interview on 8/9/2023, at 1:55 PM, the Administrator indicated there was no other documentation for the appointment of the Alternate Administrator and indicated the Alternate Administrator was authorized by the Administrator.

pre-designated person, who is authorized in writing by the

administrator and the governing body, assumes the same

responsibilities and obligations as the administrator. The

pre-designated person may be the clinical manager as described

in paragraph (c) of this section.

This element is not met as evidenced by: based on record

review and interview, the governing body and administrator

failed to authorize in writing a pre-designated person in the

absence of the administrator.

Administrator acknowledges receipt of deficiency.

Action:

Agency Administrator authorized alternate and obtained written

authorization from the Governing Body on 8/29/2023.

Signature page for authorization will be maintained for review

within the agency.

Monitoring:

Agency Administrator will ensure any future changes to

Administrator/Alternate are reported to the Governing Body and

that the agency receives confirmation of the appointment from

the members of the Governing Body which is maintained

			in the agency files for review.	
G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, Based on record review and interview, the clinical manager failed to provide oversight of patient assignments in 1 of 3 home visits receiving services from a certified occupational therapy assistant (COTA). (Patient # 6) The findings include: Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/27/2023-9/24/2023, which indicated the agency was to provide physical therapy services 2 times a week and occupational therapy services 1 time a week for the week of 8/6/2023. During an interview at the home of Patient #6 on 8/11/2023, at 9:55 AM, Patient #6 indicated he/she did not want 2 therapy visits on the same day as it was too much and made him/her tired. Patient #6 indicated the physical	G0960	CFR(s):484.105(c)(1) Make patient and personnel assignments This element is not met as evidenced by: Based on record review and interview, the clinical manager failed to provide oversight of patient assignment in 1 of 3 home visits receiving services from a certified occupational therapy assistant (COTA). Administrator acknowledges receipt of this deficiency. Action: Agency Administrator will instruct all field clinicians to contact Administrator via phone on the date the visit is to be missed for a period of 30 days and to enter a missed visit coordination note with the missed visit reason on the date the visit was scheduled Education completed 8/29/2023. Once education is completed, agency Patient Services Coordinator will run a missed visit report daily for 30 days and validate that coordination of care note has been entered by clinician to ensure 100% compliance is achieved.	2023-08-30

	that was who contacted the patient first. Review of an agency document on 8/9/2023, titled "Worker Schedule Report" indicated Physical Therapist Assistant (PTA) 3 was scheduled for visits with Patient #6 on 8/8/2023 and 8/11/2023, and indicated COTA 1 was scheduled a visit with Patient #6 on 8/10/2023. Clinical record review on 8/11/2023, failed to evidence a occupational visit had been provided to the patient for the week of 8/6/2023. Review failed to evidence a missed visit note or communication regarding why the occupational therapy visit was not provided as scheduled on 8/10/2023. During an interview on 8/11/2023, at 5:56 PM, COTA 1 indicated Patient #6 had 2 doctor appointments on 8/10/2023 so the patient was rescheduled for 8/11/2023. COTA 1 indicated the patient's caregiver informed COTA 1 that the patient did not want 2 therapy visits in 1 day and already had a scheduled visit with PTA 1. COTA 1 indicated he/she would not be available on 8/12/2023, to conduct the visit and meet the patient's frequency as ordered and would just submit a missed visit note. COTA 1 indicated he/she had not yet		Patient Services Coordinator will report results of review to Clinical Manager for review and for any required action. Monitoring: Once 100% compliance is achieved, Agency Administrator or designee will audit 8 clinical records with missed visits quarterly and review for completion of missed visit coordination note by agent for a period of 1 year to ensure 100% compliance is maintained. f compliance is not maintained additional education and/or disciplinary counseling will be implemented.	

	therapist and the office regarding the patient's missed visit and had not yet documented the missed visit. During an interview on 8/11/2023, at 6:53 PM, the Clinical Manager indicated she had not been informed by COTA 1 of the change in patient's schedule, the missed visit and the inability to meet the patient's ordered frequency.			
G0978	Must have a written agreement 484.105(e)(2)(i-iv) An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid; (iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program. Based on record review and interview, the agency failed to have a written agreement with another organization furnishing services under arrangement to the agency's patients in 1 of 1 agency.	G0978	CFR(s): 484.105(e)(2)(i-iv) Must have a written agreement An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been: denied Medicare or Medicaid enrollment; been excluded or terminated from any federal healthcare program or Medicaid; had its Medicare or Medicaid billing privileges revoked; or been debarred from participation in any government program.	2023-08-30

The findings include:

1. Clinical record review on 8/10/2023, for Patient #5, evidenced an agency document titled “Skilled Note Report” identified as the start of care comprehensive assessment completed by Physical Therapist (PT) 1 and dated 8/3/2023, which indicated Corporate Staff 3 made edits to the note in collaboration with the PT.

2. Clinical record review on 8/10/2023, for Patient #6, evidenced an agency document titled “Skilled Note Report” identified as the start of care comprehensive assessment completed by the Alternate Clinical Manager/registered nurse (RN) and dated 7/27/2023, which indicated Corporate Staff 3 made edits to the note in collaboration with the Alternate Clinical Manager.

3. During an interview on 8/10/2023, at 3:39 PM, the Administrator indicated Corporate Staff 3 had access to the agency’s plans of care and did quality review for the agency. The Administrator indicated Corporate Staff 3 was not a direct or contracted employee of the agency and was an employee of Entity A.

4. Clinical record review on 8/10/2023, for Patient #1, evidenced an agency

This element is not met as evidenced by: based on record review

and interview, the agency failed to have a written agreement with

another organization furnishing services under arrangement

to the agency's patients in 1 of 1 agency.

Administrator acknowledges receipt of this deficiency.

Action:

Agency Administrator obtained written agreement for utilization

of corporate staff identified as corporate employee #3 and #2

in the statement of deficiencies to perform quality clinical audits

for care being performed by agency staff and for quality review

of plans of care on 8/30/23.

Quality Clinical Audits:

Information obtained on quality clinical audits regarding plan of

care performed by agency staff will be submitted to the

Administrator for review and inclusion in quality assurance and

improvement plan (QAPI) and agency performance improvement

plans (PIPs) as the Administrator deems appropriate.

Quality Review Plans of Care;

Information obtain on quality review of the plans of care and

	document titled "Skilled Note Report" identified as the start of care comprehensive assessment completed by the Alternate Clinical Manager/ RN and dated 7/21/2023, which indicated Corporate Staff 3 made edits to the note in collaboration with the Alternate Clinical Manager. 5. Clinical record review on 8/11/2023, for Patient #3, evidenced an agency document titled "Skilled Note Report" identified as the start of care comprehensive assessment completed by the Alternate Clinical Manager/ RN and dated 7/11/2023, which indicated Corporate Staff 3 made edits to the note in collaboration with the Alternate Clinical Manager.		suggested edits will not be completed until review of proposed edits is completed by the admitting clinician and the admitting clinician approves the edits. Quality Packet Review will enter a coordination note at the time review is completed and approved to include employee who performed the evaluation and approval by clinician of recommended edits. Monitoring: Agency Administrator will review written agreements quarterly for a period of 1 year to ensure written agreements are maintained and that individuals performing quality clinical audits and quality packet review audits continue to perform within parameters as identified in the written agreement. Agency Administrator will report to Governing Body on status of written agreements as changes are indicated to ensure 100% compliance is maintained. If compliance with written agreements is not maintained, Agency Administrator will initiate action immediately.	
N0000	Initial Comments	N0000	Agency Administrator acknowledges receipt of Indiana State Department of Health	

	This visit was for a State re-licensure survey of a home health provider. Survey Date: August 9-11, 2023 Unduplicated Skilled Admissions for the last 12 Months: 328		Statement of Deficiencies on August 23, 2023.	
N0490	Q A and performance improvement 410 IAC 17-12-2(k) Rule 12 Sec. 2(k) A home health agency must continue, in good faith, to attempt to provide services during the fifteen (15) day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide the services must be documented. Based on record review and interview, the agency failed to document attempts to provide services 15 days prior to discharge for 1 of 1 clinical record reviewed who was discharged for noncompliance (Patient #10).	N0490	CFR(s): 410 IAC 1701202(k) N0490 Home health agency must continue, in good faith, to attempt to provide services during the 15 day period described in subsection (i) of this rule. If the home health agency cannot provide such services during that period, its continuing attempts to provide services must be documented. This licensure requirement is not met as evidenced by: based on record review and interview, the agency failed to document attempts to provide services 15 days prior to discharge for 1 of 1 clinical records reviewed who was discharged for non-compliance. Administrator acknowledges receipt of this deficiency.	2023-09-22

	The findings include: Clinical record review on 8/11/2023, for Patient #10, evidenced an agency document titled "Home Health Certification and Plan of Care" which ordered physical therapy (PT) services twice a week for 4 weeks and once a week for 5 weeks. Record review during week 3 of services on 4/28/2023, a missed visit was documented which indicated the patient refused a visit. Record review during week 5 of services on 5/12/2023, a missed visit was documented which indicated the patient refused a visit. Record review evidenced the patient was discharged due to noncompliance on 5/12/2023. Record review failed to evidence documented efforts were made to service the patient from 4/28/2023 to 5/12/2023 (14 days).		Action: Agency Administrator will provide education to all licensed administrative and field clinicians on IAC Rule 12 Sec 2(k) and requirement for agency to provide notice of discharge at least 15 days prior to services being stopped. Agency Administrator or designee will audit 100% of discharged records for 30 days to ensure 100% compliance is achieved. Monitoring: Once 100% compliance is achieved, Agency Administrator or designee will 20 discharged records per quarter for a period of 1 year to ensure compliance is maintained. Agency Administrator will report results of audits quarterly to Governing Body and QAPI team for review and recommendation. If compliance is not maintained, additional education and/or employee disciplinary counseling will be implemented	
N0518	Patient Rights 410 IAC 17-12-3(e) Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance,	N0518	CFR(s):410 IAC 17-12-3(e) Patient rights Rule 12 Sec. 3(e) N0518 The home health agency must inform and distribute written information to the patient in advance, concerning its policies on advanced directives, including a description of applicable state law. The	2023-09-22

	concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on record review and interview, the agency failed to ensure the patients were provided in advance of care furnished written information on advance directives, to include a description of the applicable state law. The findings include: Review on 8/9/2023 of the agency admission packet failed to provide written information regarding the applicable state law regarding advance directives. During an interview on 8/9/2023, at 2:17 PM, the Administrator indicated all the information provided to the patient regarding advance directives was inside of the patient admission packet. The Administrator indicated she did not see anything specific to the state law for advance directives.		home health agency may furnish advanced directive information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. This licensure requirement is not met as evidenced by: Based on record review and interview, the agency failed to ensure the patients were provided in advance of care furnished written information on advance directives to include a description of applicable state law. Administrator acknowledges receipt of deficiency. Action: Agency Administrator will provide education to 100% of all licensed RN/PT/ST/OT administrative and field clinicians and to Medical Record Specialist on state requirement to provide state specific information at the time of admission prior to provision of care. Administrator will instruct all SOC clinicians on requirement to document review of advanced directive prior to provision of care in an EMR note at the time of admission. Agency Administrator will review contents of admission prepared admission packets with Medical Record Specialist and ensure all prepared packets contain State specific information on Advanced Directives. Agency Administrator or designee will audit 100% of all SOC coordination notes to ensure 100% compliance is achieved. Monitoring: Once 100% compliance is achieved, Agency Administrator will review 8 SOC coordination notes quarterly for a period of 1 year to ensure compliance is maintained and report results of audits to the Governing Body and QAPI for review and	

			recommendation. If compliance is not maintained, additional education and/or employee disciplinary counseling will be implemented.	
N0529	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the agency failed to send the physician responsible for the plan of care a written summary report at least every 2 months in 2 of 2 clinical records reviewed with more than 1 certification period. (Patients #4, 7) The findings include: Clinical record review on 8/10/2023, for Patient #7, start of care 12/28/2022, failed to evidence a written summary of care was sent to the physician.	N0529	CFR(s): 410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1(2)(2) A written summary report for each patient shall be sent to the: physician, dentist; chiropractor; optometrist or podiatrist at least every 60 days This licensure requirement is not met as evidenced by" based on review and interview, the agency failed to send the physician responsible for the plan of care a written summary report at least every 2 months in 2 of 2 clinical records reviewed with more than 1 certification period. Administrator acknowledges receipt of this deficiency. Action: Agency Administrator will provide education to licensed administrative staff and Medical Record Specialist on state requirement to submit written summary to physician supervising the plan of care at least every 60 days. Medical Record Specialist will submit a 60 day summary report to the supervising physician at the time the recertification plan of care is submitted to the physician for signature and document that the summary has been sent in the EMR. Agency Administrator or designee will audit 100% of coordination notes for patients receiving recertification	2023-09-22

	During an interview on 8/11/2023, at 3:10 PM, the Clinical Manager indicated she did not believe the agency sends anything like a 60 day summary to the physician every 60 days other than the plan of care. 1. Clinical record review on 8/10/2023, for Patient #4, start of care 3/16/2023, of an agency document titled "Home Health Certification and Plan of Care" for certification period 7/14/2023 – 9/11/2023, failed to evidence a 60-day summary included within the document. Record review failed to evidence a summary of the previous episode was sent to the physician.		visits for a period of 60 days to ensure 100% compliance is achieved. Monitoring: Once 100% compliance is achieved, Agency Administrator or designee will audit 10 patients with recertification visits quarterly for a period of 1 year to ensure compliance is maintained. Agency Administrator to report results of audits quarterly to the Governing Body and the QPI team for review and recommendations. If compliance is not maintained, additional education and/or employee disciplinary counseling will be implemented.	

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
Linda Krippel	Director of Operations	8/31/2023 9:46:39 AM