STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K165	A. BUILDING B. WING	08/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISITING ANGELS HOME HEALTHCARE	3197 S US HWY 231, GREENCASTLE, IN, 46135

(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
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey of a Home Health provider. Survey Dates: 08/22/23, 08/23/23, 08/24/23, 08/25/23, 08/28/23, 08/29/23 12 month Unduplicated Census: 0 A fully extended survey was announced on 08/24/23 at 3:45 PM. An immediate jeopardy concerning CoP 484.50 Patient Rights was identified on 05/31/23 when it was determined that the agency had failed to investigate a complaint of a suspected patient injury caused by an untrained home health aide and failed to ensure all patients were protected during the investigation. The Administrator was notified of	G0000		

	the Immediate Jeopardy at CoP 484.50 Patient Rights on 08/25/23 at 12:47 PM. An immediate jeopardy concerning CoP 484.80 Home Health Aide Services was identified and announced on 08/29/23 at 12:47 PM, when it was identified that the agency failed to ensure they employed qualified Home Health Aides. The agency failed to submit an acceptable IJ lift plan for 484.50 Patient Rights and 484.80 Home Health Aide Services prior to survey exit on 08/29/23. Based on the Condition-level deficiencies during the Visiting Angels survey, your home health agency was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 08/29/23**.** Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning August 29, 2023 and continuing through August 28, 2024. QR by Area 3 on 9-01-2023.			

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 a patient's right to a thorough complaint investigation, the right to be free from physical harm and injury while receiving care, the right to receive care based on specific care preferences, and the right to be protected from retaliation and/or harm during investigation of a complaint for 1 of 1 clinical record reviewed for a complaint of physical injury (Patient #2). The cumulative effect of this systemic problem resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.50 Patient Rights.	G0406	**G0406** The Administrator will protect the patient's right toa thorough complaint investigation by holding a meeting that includes theGoverning Body, Administrator, Clinical Manager, and Assistant Director ofNursing within 48 hours of a complaint to discuss details of the complaint andchoose a proper course of action. Once the meeting is completed, theAdministrator will carry out the plan for action. The Administrator will ensure the patient's right tobe free from physical harm by immediately removing any employee from patientcontact of any kind while an investigation is performed for any complaint ofinjury or abuse, or potential for injury or abuse. The Clinical Manager will review the specific carepreferences for each of the agency's patients and will ensure that all homehealth aide care plans are updated with each patient's preferences. These careplans will be updated continuously via	2023-09-29

	Findings include: 1. A review of an undated agency policy titled C-381 "Client/family Complaint/Grievance Policy," indicated " ... Grievances will be addressed by the department director ... and response made to the complainant within seven (7) calendar days of receipt. If the grievance is one that will take longer than seven (7) calendar days to investigate and resolve, the director will contact the complainant within that time frame to let him/her know the grievance ... is being investigated ... All persons with a grievance will receive a written notice of the investigators [sic] review which will include the ... steps taken to investigate the grievance, the result of the process and the date of completion ... " The policy failed to evidence a thorough investigation was required for all complaints, failed to evidence investigation processes or steps used to ensure a thorough investigation process, and failed to evidence the need to protect all patients from retaliation, potential harm,		and will beprovided to each caregiver providing care to the patient prior to the provisionof care to ensure patient care preferences are known and adhered to by theagency's home health aides. The Administrator will ensure the patient's right tobe protected from retaliation or harm during an investigation by removing anycaregiver immediately from all patient contact until an investigation iscompleted after any complaint of harm or potential for harm. Patientconfidentiality will be maintained throughout the investigation. The Administrator and Clinical Manager are responsible for compliance.	

	or injury during ongoing investigations. 2. A review of the agency's complaint log evidenced a complaint by the spouse and representative of Patient #2, dated 06/01/23 at 8:40 AM and signed by the Administrator. The complaint indicated during the home health aide (HHA) visit on 05/31/23 the spouse was in the other room while HHA 1 was transferring Patient #2. The spouse reported hearing the patient cry out in pain around noon, which was not abnormal for the patient during transfers. Later that day, Patient #2 complained of left arm pain. The report also indicated HHA 1 reported trying to lift the patient "the same as every other time and did not notice anything out of the ordinary." HHA 1 said that Patient #2 tends to cry out frequently during transfers "and today was no different." On 6/05/23 at 3:45 PM, the spouse notified the Administrator that the patient's left arm was broken. The complaint failed to evidence the aide disregarded the spouse's instructions not to transfer the patient, the aide pulled on the patient's arm to			

	assist in standing, the aide was aware of the injury at the time it occurred, or the patient had specific care requests posted throughout the house. 3. A review of the agency's incident log evidenced an "Incident Report," dated 06/01/23, which indicated an incident date of 05/31/23 at 12:30 PM. The report indicated the incident was recorded on camera and an injury was sustained to Patient #2's left arm. 4. A review of the clinical record for Patient #2 evidenced a comprehensive assessment with clinical summary, dated 07/19/23, which indicated "Recent fracture to LUE [Left Upper Extremity], no current treatment, allowing to heal as is. LUE contracted." The clinical record failed to evidence additional documentation related to the patient's frozen arm, specific transfer preferences and needs, or the investigation, findings, or resolution of the care which resulted in the patient's fractured left humorous and shoulder ball and joint.			

	5. On 08/23/23 at 9:58 AM, Person G, a representative for the patient's physician, was interviewed via phone. Person G confirmed Patient #2 had x-rays and other imaging of the left arm and the results on 06/05/23 indicated a fractured proximal (located toward the center of the body) left humorous (the arm bone that runs from the shoulder to the elbow). Patient #2 was referred to a bone and joint specialist for further evaluation. 6. On 08/24/23 at 3:06 PM, Person H, a Nurse Practitioner (NP) with Entity F, physician's group specializing in bone and joint treatment, stated HHA 1 attended the patient's appointment and said she admitted pulling on the patient's frozen arm during transfer and heard an audible pop. Person H confirmed a fractured left humorous and multiple fractures to the left shoulder ball and socket. 7. During a home visit on 08/24/23 at 11 AM, the spouse indicated Patient #2 had a frozen left arm and had specific care and transfer needs the spouse needed to teach the			

aide, however HHA 1 wasn't trained, didn't listen to instructions, and insisted on doing things her way. On 05/31/23 the spouse told HHA 1 not to transfer the patient until the spouse returned from the garage because HHA 1 wasn't trained on transferring the patient. The aide ran out to the garage a few minutes later and stated, "I think I just broke your wife's arm." The spouse stated a camera in the patient's room captured HHA 1 pulling on the patient's arm at 3 times while attempting to stand and transfer the patient. The patient was heard crying out each time and during the second attempt the patient yelled, "You bitch! You're hurting me!" On the third attempt an audible pop was heard on the video. When asked what training the spouse provided to the aide, the spouse indicated training the aides in all aspects of the patient's care, including but not limited to transfer, personal care, and feeding because the aides weren't trained and didn't know how to transfer, dress, and bathe the patient without affecting the frozen arm.

8. On 08/23/22 at 2 PM, the

	Administrator was interviewed concerning the injury to Patient #2's arm. The Administrator indicated HHA 1 completed retraining by reading a packet for proper transferring and a packet for incident reporting, then demonstrating proper transfer with the Administrator as a pseudo-patient. The Administrator denied removing the aide from direct patient care during the investigation and denied contacting other patients also seen by HHA 1 to determine if there were unreported care concerns or unreported complaints. The Administrator failed to verify the competency of HHA 1 by observing direct patient care and transfer, or by verifying previous education, experience, training, or credentialing. The agency failed to ensure the patient's person and body were treated with respect by failing to ensure the home health aide provided the patient-specific care needed to safely accommodate the patient during transfer and personal care, which subsequently caused a fractured left humorous and multiple fractures to the left shoulder ball and socket.			

G0428	Property and person treated with respect 484.50(c)(1) Have his or her property and person treated with respect; Based on record review and interview, the agency failed to respect the patient's specific requests and care preferences resulting in a patient injury, for 1 of 1 complaint of injury reviewed. (Patient #2) Findings include: 1. A review of the agency's complaint log evidenced a complaint by the spouse of Patient #2, dated 06/01/23 at 8:40 AM and signed by the Administrator. The complaint indicated during the home health aide (HHA) visit on 05/31/23 the spouse was in the other room while HHA 1 was transferring Patient #2. The spouse reported hearing the patient cry out in pain around noon, which was not abnormal for the patient during transfers. Later that day, Patient #2 complained of left arm pain and continued to complain of pain	G0428	**G0428** The Clinical Manager will review the specific carepreferences for each of the agency's patients and keep a face sheet for eachpatient containing details of their care preferences. These documents will beprovided to each caregiver providing care to the patient prior to provision ofcare to ensure patient care preferences are known and adhered to by theagency's caregivers. Patient-specific transfer and personal care trainingwas provided to the home health aide providing care for the patient thatpreviously suffered a broken arm under the agency's care on 8/28/23 by theAssistant Clinical Manager. All agency home health aides have received skills andeducation competency training at Premier Healthcare Training to ensure propertransfer technique is utilized during each patient transfer to prevent the riskof future patient injury. The Administrator is responsible for compliance.	2023-09-29

	on 06/01/23 so the spouse made an appointment with the patient's physician. The report also indicated HHA 1 came into the office on 06/08/23 to complete an incident report and reported trying to lift the patient on 05/31/23 "the same as every other time and did not notice anything out of the ordinary." HHA 1 said that Patient #2 tends to cry out frequently during transfers "and today was no different." The complaint indicated on 6/05/23 at 3:45 PM, the spouse notified the Administrator and confirmed that the patient's left arm was broken. The complaint failed to evidence the aide disregarded the spouse's instructions not to transfer the patient, the aide pulled on the patient's frozen left arm 3 times to assist in standing, the aide was aware of the injury at the time it occurred, or the patient had specific care requests posted throughout the house. 2. A review of the agency's incident log evidenced an "Incident Report," dated 06/01/23, which indicated the patient suffered an injury to the left arm on 05/31/23 at 12:30 PM. The incident was recorded			

	on camera. 3. A review of the clinical record for Patient #2 evidenced a comprehensive assessment clinical summary, dated 07/19/23, which indicated "Recent fracture to LUE [Left Upper Extremity], no current treatment, allowing to heal as is. LUE contracted." 4. During a home visit on 08/24/23 at 11 AM, the spouse indicated Patient #2 had a frozen left arm and had specific care and transfer needs the spouse needed to teach the aide, however HHA 1 wasn't trained, didn't listen to instructions, and insisted on doing things her way. On 05/31/23 the spouse told HHA 1 not to transfer the patient until the spouse returned from the garage because HHA 1 wasn't trained on transferring the patient. The aide ran out to the garage a few minutes later and stated, "I think I just broke your wife's arm." The spouse stated a camera in the patient's room captured HHA 1 pulling on the patient's arm 3 times while attempting to stand and transfer the patient. The patient was heard crying out each time			

and during the second attempt the patient yelled, "You bitch! You're hurting me!" On the third attempt an audible pop was heard on the video. When asked what training the spouse provided for the aide, the spouse stated training the aide in all aspects of the patient's care, including but not limited to transferring, personal care, toileting, and dressing because the aides aren't trained and don't know how to care for the patient without affecting the frozen arm.

5. On 08/23/23 at 9:58 AM, Person G, representative for Person D (the patient's physician), was interviewed via phone. Person G confirmed Patient #2 had x-rays and other imaging of the left arm and the results on 06/05/23 indicated a fractured proximal (located toward the center of the body) left humorous (the arm bone that runs from the shoulder to the elbow). Patient #2 was referred to Entity F, a medical practice that specialized in bone and joint medicine, for further evaluation.

6.On 08/24/23 at 3:06 PM, Person H, a Nurse Practitioner

	(NP) with Entity F, stated HHA 1 attended the patient's appointment and said she admitted pulling on the patient's arms during transfer and heard an audible pop. Person H confirmed a fractured left humorous and multiple fractures to the left shoulder ball and socket. The agency failed to ensure the patient's person and body were treated with respect by failing to ensure the home health aide provided the patient-specific care needed to safely accommodate the patient during transfer and personal care, which subsequently caused a fractured left humorous and multiple fractures to the left shoulder ball and socket. 410 IAC 17-12-3(b)(4)(8)			
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. Based on record review and interview, the agency failed to ensure patients received the physician ordered frequency and duration of services and the home health aide services	G0436	**G0436** The Clinical Manager will audit all clinical recordsof current patients receiving home health aide services to determine if there are additionaltasks not being performed as ordered by the physician. The Clinical Manager will	2023-09-29

	ordered on the plan of care for 1 of 7 active clinical records reviewed. (Patient #2) Findings include: 1. A review of an undated agency policy titled "C-751 Home Health Aide Care Plan," indicated, but was not limited to, "A complete and appropriate Care Plan ... shall be developed ... All home health aide staff will follow the identified plan." 2. A review of the plan of care for Patient #2, for certification period 07/21/23 – 09/18/23, evidenced a physician ordered frequency and duration for home health aide services of 4 hours/day x 1 day/week x 1 week, 4 hours/day x 5 days/week (weeks 2-9), 4 hours/day x 1 day /week x 1 week (week 10) for home health aide to assist with Activities of Daily Living (ADL), weekly bed/chair bath, transfers, meal prep/feeding, toileting, bathroom cleanup, change bed linens, conversation, dressing, encourage fluids, fall risk, hair care, hygiene assistance, incontinence care, nail care, oral care, positioning. A review of the completed visit		re-educate all agency homehealth aides that they are to arrive on the scheduled day and time of thescheduled visit, follow the home health aide plan of care as ordered by thephysician, stay with the patient for the duration of the visit, and documentthe completion of all tasks as listed on the home health aide plan of care. Any deficiencies in documentation of home health aides'visits will be immediately addressed with the home health aides by the ClinicalManager. The agency Scheduler will audit 100% of home healthaide visit notes weekly on an ongoing basis and will present all home healthaide services and tasks that were not completed to the Clinical Manager via areport at scheduled weekly meetings held between the Administrator, ClinicalManager, Assistant Clinical Manager, and Scheduler. The Governing Body will receivethis report during each weekly Governing Body meeting. The Clinical Manager is responsible for compliance.	

	schedule for 07/21/23 – 08/22/23 indicated Patient #2 received a frequency and duration of 3 hours/day x 1 day/week x 1 week, 3 hours/day x 5 days/week (weeks 2-present). A review of the home health aide visit note dated 07/21/23 indicated the patient received no hygiene assistance, incontinence care positioning or transferring. The visit note failed to indicate meal prep/feeding, toileting, change of linens, dressing, fluids, hair care, nail care, or oral care. The visit note indicated "bed bath refused with all 4 visits" and failed to evidence a chair bath was given in lieu of a bed bath. A review of the home health aide visit note dated 07/24/23 indicated the patient received no incontinence care, positioning, or transferring and had fall risk marked as "no." The visit note failed to indicate meal prep/feeding, toileting, change of linens, dressing, fluids, hair care, nail care, oral care, or weekly bed/chair bath. A review of the home health aide visit note dated 07/25/23			

	indicated the patient received no incontinence care, positioning, or transferring and had fall risk marked as "no." The visit note failed to indicate meal prep/feeding, toileting, change of linens, dressing, fluids, hair care, nail care, oral care, or weekly bed/chair bath. The note indicated "Second day of bed bath and change refusal." A review of the home health aide visit note dated 07/26/23 indicated the patient received no incontinence care, positioning, or transferring and had fall risk marked as "no." The visit note failed to indicate meal prep/feeding, toileting, change of linens, dressing, fluids, hair care, nail care, oral care, or weekly bed/chair bath. The note indicated "[Name of spouse]] once again has refused a bed bath for [Name of Patient #2] because [he/she] is sick. I have yet to do one in the two weeks I've been here. I just want to document." A review of the home health aide visit note dated 08/02/23 indicated the patient received no incontinence care, positioning, or transferring and had fall risk marked as "no." The			

	visit note failed to indicate meal prep/feeding, toileting, change of linens, conversation, fluids, hair care, nail care, oral care, or weekly bed/chair bath. A review of the home health aide visit note dated 08/16/23 indicated the patient received no incontinence care, positioning, or transferring and had fall risk marked as "no." The visit note failed to indicate meal prep/feeding, toileting, fluids, hair care, nail care, oral care, or weekly bed/chair bath. A review of the home health aide visit note dated 08/23/23 indicated the patient received no incontinence care, positioning, or transferring and had fall risk marked as "no." The visit note failed to indicate meal prep/feeding, dressing, fluids, hair care, nail care, oral care and indicated upper body bathing was done. A review of home health aide visit notes for 07/27/23, 07/28/23, 07/31/23, 08/01/23, 08/03/23, 08/04/23, 08/07/23, 08/08/23, 08/09/23, 08/10/23, 08/11/23, 08/14/23, 08/15/23, 08/17/23, 08/18/23, 08/21/23,			

	patient received no hygiene assistance, incontinence care positioning or transferring. The visit note failed to indicate meal prep/feeding, toileting, change of linens, dressing, fluids, hair care, nail care, or oral care. 3. On 08/25/23 at 9:06 AM, HHA 2 indicated the visits for Patient #2 consisted of the same tasks she performed when providing unskilled services, such as cleaning tasks and occasional feeding assistance because the patient's spouse refused to allow any personal care. 4. On 08/24/23 at 3:54 PM, the Administrator indicated there had been problems for a long time with the spouse of Patient #2 because the spouse wanted an aide to come but consistently refused all personal care when the aide arrived. When asked about the agency's process and policy concerning patients and/or caregivers who refused services the Administrator stated, "There's never been a hardline rule for how long we can send out a person to work when the patient refuses care. We send them to do non-skilled care while we try to work out			

	services they will accept." The administrator indicated he was aware the patient had not received personal care for weeks and denied contacting the patient's physician for changes in the plan of care. The Administrator indicated he'd spoken many times with the spouse about frequency, duration, and services ordered but did not document the conversations. The Administrator confirmed the current home health aide had another patient until 10:30 AM and couldn't arrive at this patient's house until 11 AM and could only stay until 2 PM. When asked if the services, frequency, and duration followed physician's orders the Administrator indicated they did not.			
G0480	Treatment or care 484.50(e)(1)(i)(A) (i)(A) Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; and Based on record review and interview, the agency failed to investigate complaints made by the patient or representative for	G0480	**G0480** The Administrator will protect the patient's right toa thorough complaint investigation by holding a meeting that includes theGoverning Body, Administrator, Clinical Manager, and Assistant Clinical Managerwithin 48 hours of a complaint to discuss details of	2023-09-29

	1 of 1 complaint reviewed for suspected injury. (Patient #2) Findings include: 1. A review of undated agency policy C-381 "Client/family Complaint/Grievance Policy," indicated " ... Grievances will be addressed by the department director ... and response made to the complainant within seven (7) calendar days of receipt. If the grievance is one that will take longer than seven (7) calendar days to investigate and resolve, the director will contact the complainant within that time frame to let him/her know the grievance ... is being investigated ... All persons with a grievance will receive a written notice of the investigators [sic] review which will include the ... steps taken to investigate the grievance, the result of the process and the date of completion ... " The policy failed to evidence the requirement to investigate all complaints. 2. A review of the agency's complaint log evidenced a "Report of Concern/Complaint/Grievance," signed by the Administrator.		the complaint and choose aproper course of action. Once the meeting is completed, the Administrator willcarry out the plan for action. The Administrator will keep a Complaint Log withrecords of each complaint and subsequent meeting that includes the GoverningBody, Administrator, Clinical Manager, and Assistant Clinical Manager todetermine a proper course of action to resolve the complaint. All complaints foreach month will then be discussed at monthly QAPI meetings to ensure eachcomplaint is met with a resolution. The Administrator is responsible for compliance.	

	The report indicated the spouse for Patient #2 called and spoke with the Administrator on 06/01/23 at 8:40 AM and stated during a home health aide (HHA) visit on 05/31/23 the spouse was in the other room while HHA 1 was transferring Patient #2. Around noon, the spouse heard the patient cry out in pain, which was not abnormal during transfers. Patient #2 continued to complain of left arm pain and x-rays were obtained. An undated/untimed section titled "Immediate Action/Steps Taken" indicated "Call placed to caregiver [Name of HHA 1] to ask about the incident." The complaint form failed to evidence the Administrator initiated a complaint investigation including, but not limited to, assessing the patient, notifying the clinical manager and physician, completing a timely incident report, timely interview of the home health aide, verification of HHA 1's written and skills competency, and on-site observation of HHA 1 during patient transfer and personal care. 3. A review of the clinical record			

	comprehensive assessment with clinical summary, dated 07/19/23, which indicated "Recent fracture to LUE [Left Upper Extremity], no current treatment, allowing to heal as is. LUE contracted." The clinical record failed to evidence additional documentation related to the patient's fractures or the investigation of the complaint of injury. During a home visit on 08/24/23 at 11 AM, the spouse indicated Patient #2 had a frozen left arm and had specific care and transfer techniques the spouse needed to teach the aide, however HHA 1 wasn't trained, didn't listen to instructions, and insisted on doing everything her way. On 05/31/23 the spouse told HHA 1 not to transfer the patient until the spouse returned from the garage because HHA 1 wasn't trained on transferring the patient correctly due to the frozen shoulder. The spouse indicated the aide ran out to the garage a few minutes later and stated, "I think I just broke your wife's arm." The spouse stated a camera in the patient's room captured HHA 1 pulled on the patient's arm 3 times while			

	attempting to stand and transfer the patient. The patient was heard crying out each time and during the second attempt the patient yelled, "You bitch! You're hurting me!" On the third attempt an audible pop was heard on the video. When asked what training the spouse provided for the aide, the spouse stated they trained the aides in all aspects of the patient's care, including transfer, personal care, and feeding because the aides weren't trained and didn't know how to transfer, dress, and bathe the patient without affecting the frozen arm. 4. On 08/23/23 at 9:58 AM, Person G, representative for the patient's physician, Person D, was interviewed via phone. Person G confirmed Patient #2 had x-rays and other imaging of the left arm and the results on 06/05/23 indicated a fractured proximal (located toward the center of the body) left humorous (the arm bone that runs from the shoulder to the elbow). 5. On 08/24/23 at 3:06 PM, Person H, a Nurse Practitioner (NP) with Entity F, physician's			

	group specializing in bone and joint treatment, stated HHA 1 attended the patient's virtual appointment on 06/01/23 and said HHA 1 admitted pulling on the patient's arms during transfer and heard an audible pop. Person H confirmed the patient experienced a fractured left humorous and multiple fractures to the left shoulder ball and socket. 410 IAC 17-12-3(c)(1)(A)			
G0482	Mistreatment, neglect or abuse 484.50(e)(1)(i)(B) (i)(B) Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA. Based on record review and interview, the agency failed to ensure all complaints of potential mistreatment were investigated, for 1 of 1 complaint of injury reviewed. (Patient #2) Findings include: 1. A review of an undated policy titled “C-381 Client/Family	G0482	**G0482** The Administrator will protect the patient’s right toa thorough complaint investigation by holding a meeting that includes theGoverning Body, Administrator, Clinical Manager, and Assistant Director ofNursing within 48 hours of a complaint to discuss details of the complaint andchoose a proper course of action. Once the meeting is completed, theAdministrator will carry out the plan for action. The Administrator will keep a Complaint Log withrecords of each complaint and subsequent meeting that includes the	2023-09-29

	Complaint/Grievance Policy" failed to evidence the patient's right to, or an agency policy or process for investigation of complaints related to possible mistreatment. 2. A review of the agency complaint log evidenced a "Report of Concern/Complaint/Grievance" dated 06/01/23 at 8:40 AM, which indicated a "possible accidental left arm injury" to Patient #2. The patient's spouse called and reported that on 05/31/23 the spouse was in the other room and Home Health Aide (HHA) 1 was transferring Patient #2. The spouse heard the patient cry out in pain around noon, which was not abnormal during transfers. Later in the day, Patient #2 began complaining of pain in the left arm. The complaint report indicated a call was placed to HHA 1 to ask about the incident but failed to evidence a date or time the aide was actually contacted and interviewed concerning the complaint. An undated entry on the complaint report follow-up investigation section indicated HHA 1 reported she lifted the patient "the same as every other time		GoverningBody, Administrator, Clinical Manager, and Assistant Clinical Manager todetermine a proper course of action to resolve the complaint. All complaints foreach month will then be discussed at monthly QAPI meetings to ensure eachcomplaint is met with a resolution. The Administrator is responsible for compliance.	

	and did not notice anything out of the ordinary. She said that [Name of Patient #2] tends to cry out frequently during transfer and today was no different." A review of an incident report, dated 06/01/23, indicated the incident was captured on camera. The complaint report and incident report failed to evidence an investigation occurred immediately following the report of suspected injury to the left arm which included determining if mistreatment occurred, whether deliberate or unintended due to lack of training, such as review of the available video recording, observation of the aide's transfer and care techniques, the aide's competency verification for transferring Patient #2, interview with HHA 1's other patients to assess for unreported care concerns, and comprehensive assessment of Patient #2 at the time the suspected injury was reported. 3. On 08/24/23 at 10:56 PM, the spouse for Patient #2 indicated on 05/31/23 they instructed HHA 1 not to transfer Patient #2 until the spouse returned from			

	was not trained on transferring Patient #2, who had a frozen left arm. Soon after, HHA 1 ran into the garage and indicated, "I think I just broke your wife's arm." The spouse indicated the video showed HHA 1 pulling on the patient's frozen left arm at least 3 separate times while trying to transfer the patient. Patient #2 cried out each time and the third time an audible pop was heard. The spouse indicated offering the video to the Administrator for review, but the Administrator stated it wasn't necessary. 4. On 08/24/23 at 3:06 PM, Person H, a Nurse Practitioner with Entity F, bone and joint specialists, indicated HHA 1 attended the visit for evaluation of the patient's left arm and stated she pulled on the patient's frozen arm while trying to transfer the patient, and heard an audible pop. Person H stated this resulted in Patient #2 experiencing a fractured proximal humorous and multiple fractures in the left shoulder ball and socket. 5. On 08/22/23 at 2:07 PM, the Administrator indicated the patient was not assessed after			

	the report of possible injury because they weren't sure at the time of report if there was actually an injury, as the patient had not seen a physician yet, and they weren't sure if the patient could communicate pain effectively. The Administrator also indicated he tried several times to "get [HHA 1] in here in that time between 06/01/23 and 06/08/23 but [he/she] always had a reason [he/she] couldn't come in or it wouldn't work." When asked why the video was not reviewed, the Administrator indicated he didn't think it was necessary.			
G0484	Document complaint and resolution 484.50(e)(1)(ii) (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the agency failed to ensure all complaints and concerns were documented and evidenced a resolution for 1 of 3 active records (Patient #4) reviewed with a home visit and 1 of 2 inactive records reviewed (Patient #8).	G0484	**G0484** Any concern brought forth to the agency will betreated as a complaint and investigated and documented accordingly. TheClinical Manager and Assistant Clinical Manager have contacted each activeagency patient to inquire about any complaints that have not been reported orthat the patient feels were not properly resolved. All issues have beenresolved and documented. The Administrator will protect	2023-09-29

	Findings Include: 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021 Briggs Healthcare policy titled "Client/Family Complaint/Grievance Policy, Policy #C-381". The policy indicated but was not limited to, " … A complaint is defined as 'any expression of dissatisfaction by a client/family regarding care or services that can be addressed at the time of complaint by staff present' … 2. Client complaints will be documented on a client complaint form and filed with the complaint log in an administrative file. …" 2. On 08-28-2023 at 9:05 AM, the complaint log was reviewed. The complaint log failed to evidence Patient #4 and Patient #8's complaints. 3. During an interview with Patient #4 on 08-24-2023 at 9:25 AM at their residence, when queried regarding whether they had made a complaint with the agency, Patient #4 indicated they made a complaint about a certified		the patient's right toa thorough complaint investigation by holding a meeting that includes theGoverning Body, Administrator, Clinical Manager, and Assistant Director ofNursing within 48 hours of a complaint to discuss details of the complaint andchoose a proper course of action. Once the meeting is completed, theAdministrator will carry out the plan for action. The Administrator will keep a Complaint Log withrecords of each complaint and subsequent meeting that includes the GoverningBody, Administrator, Clinical Manager, and Assistant Clinical Manager todetermine a proper course of action to resolve the complaint. All complaints foreach month will then be discussed at monthly QAPI meetings to ensure eachcomplaint is met with a resolution. The Administrator is responsible for compliance.	

	months ago. Patient #4 indicated the CNA never had a job and would not listen. Patient #4 indicated the agency resolved the issue and removed the CNA from their home. Patient #4 indicated they could not remember the CNA's name. The complaint log failed to evidence the complaint. During an interview with the Administrator on 08-25-2023 at 11:58 AM, when queried regarding Patient #4's complaint, they indicated the patient had never made a complaint with the agency. The Administrator indicated they did not see a "caregiver swap" as a direct complaint. The Administrator indicated the patient's concern with the agency's employee was a concern the patient was voicing against the agency. 4. During an interview with Person U, Patient #8's spouse, on 08-25-2023 at 8:42 AM, they indicated the agency provided "terrible service, terrible communication". Person U indicated they would never know what aide was coming out			

	they were unable to get a caregiver to come out and help Patient #8. Person U indicated the management would not listen and they indicated they (the spouse) were not able to care for Patient #8 on their own. Person U indicated they had made a complaint to the Administrator, management, and the owner regarding Patient #8 not receiving HHA services 3 times a week, but nothing was ever done to correct the concern. During an interview with Person U, Patient #8's spouse, on 08-25-2023 at 8:53 AM, they indicated they "made a complaint with everyone the CEO (sic Chief Executive Officer), Administration, management, and nothing happened." The complaint log failed to evidence the complaint made by Person U, Patient #8's spouse. 410 IAC 17-12-3 (c) (2)			
G0486	Protect patient during investigation 484.50(e)(1)(iii)	G0486	**G0486** The Administrator will ensure the patient's right tobe protected from retaliation or	2023-09-29

	(iii) Take action to prevent further potential violations, including retaliation, while the complaint is being investigated. Based on record review and interview, the agency failed to ensure all patients were protected from potential harm and/or retaliation during investigation of a complaint of suspected injury, for 1 of 1 complaints of suspected injury reviewed. (Patient #2) Findings include: Findings include: 1. A review of undated agency policy C-381 "Client/Family Complaint/Grievance Policy" failed to evidence the policy addressed investigation processes or steps, such as interviewing, observation, confirmation of competency, protection of patients, confidentiality, and the patient's rights during an investigation. 2. A review of the clinical record for Patient #2 evidenced a comprehensive assessment with clinical summary dated 07/19/23, which indicated Patient #2 had a recent fracture of the left upper extremity.		harm during an investigation by removing anycaregiver immediately from all patient contact until an investigation iscompleted after any complaint of harm or potential for harm. Patientconfidentiality will be maintained throughout the investigation. The Administrator will keep a Complaint Log withrecords of each complaint and subsequent meeting that includes the GoverningBody, Administrator, Clinical Manager, and Assistant Clinical Manager todetermine a proper course of action to resolve the complaint. All complaints foreach month will then be discussed at monthly QAPI meetings to ensure eachcomplaint is met with a resolution. The Administrator is responsible for compliance.	

	3. On 08/24/23 at 3:06 PM, Person H, a Nurse Practitioner with Entity F, bone and joint specialists, indicated HHA 1 attended the visit for evaluation of the patient's left arm and stated she pulled on the patient's frozen arm while trying to transfer the patient, and heard an audible pop. Person H stated this resulted in Patient #2 experiencing a fractured proximal humorous and multiple fractures in the left shoulder ball and socket. 4. On 08/23/22 at 2 PM, the Administrator was interviewed concerning the injury to Patient #2's arm. The Administrator indicated HHA 1 completed retraining by reading a packet for proper transferring and a packet for incident reporting, then demonstrating proper transfer with the Administrator as a pseudo-patient. The Administrator denied removing the aide from direct patient care during the investigation and denied contacting other patients also seen by HHA 1 to determine if there were unreported care concerns or unreported complaints. The Administrator failed to verify the competency of HHA 1 by			

	observing direct patient care and transfer, or by verifying previous education, experience, training, or credentialing.			
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on record review and interview, the agency failed to ensure all patients received a patient-specific comprehensive assessment that reflected the patient's current status (G526); included the patient's health, psychosocial, functional, and cognitive status (G528); included the patient's strengths, goals, and care preferences (G530); the patient's continuing need for home care (G532); the patient's medical, nursing, rehabilitation, social, and discharge planning needs (G534); was updated for change	G0510	**G0510** The Clinical Manager will audit 100% of all currentpatients' comprehensive assessments using a comprehensive assessment audit toolthat evaluates all components of the comprehensive assessment with auditresults to be provided to each RN Case Manager along with education to correctany mistakes in documentation. RN Case Managers are to make any needed corrections totheir documentation and re-submit the assessment to the Clinical Manager within48 hours of receipt. Ongoing, 100% of newly completed comprehensive assessmentdocumentation must be turned in to the Clinical Manager prior to placement inthe patient's chart. Any documentation errors found by the Clinical Manager must be fixed by the RN CaseManager and re-submitted to the Clinical	2023-09-29

	updated at least every 60 days (G546) for 7 of 7 active clinical records reviewed. (Patients #1, 2, 3, 4, 5, 6, and 7) The cumulative effect of this systemic problem resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CoP 484.55 Comprehensive Assessment. *		Manager within 48 hours of receipt forfurther review. The Clinical Manager will continue to audit 100% ofcomprehensive assessments until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of comprehensive assessments for another 30 days as long as 100% compliance is met to ensure ongoing compliance. A bindercontaining audit sheets for each assessment will be kept by the Clinical Manager,and this binder will be brought to weekly meetings between the Administrator,Clinical Manager, Assistant Clinical Manager, and Scheduler to discuss anydeficiencies that have been found during the week, and to discuss potentialsolutions to deficiencies found. The Clinical Manager will re-educate RN Case Managerson their assessment and documentation responsibilities. The Clinical Manager will perform unannouncedsupervisory visits	

			performing certification visitsto evaluate their ability to perform a complete patient-specific comprehensiveassessment that includes the patient's current status, the patient's health,psychosocial, functional, and cognitive status, the patient's strengths, goals,and care preferences, the patient's continuing need for home care, thepatient's medical, nursing, rehabilitation, social, and discharge planning needs,update for change in condition, and updated at least every 60 days. An RN Case Manager supervisory visit form will be usedto document the results of these supervisory visits. The Clinical Manager is responsible for compliance.	
G0526	Content of the comprehensive assessment 484.55(c) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information:	G0526	**G0526** The Clinical Manager will audit 100% of all currentpatients' comprehensive assessments using a comprehensive assessment audit toolthat evaluates all components of the comprehensive assessment with audit resultsto be provided to	2023-09-29

	Based on record review and interview, the agency failed to ensure all patients received a comprehensive assessment that reflected the patient's current status at the time of assessment, for 2 of 7 active clinical records reviewed. (Patients #2, 6) Findings include: 1. A review of an undated agency policy titled "C-145 Comprehensive Client Assessment" indicated … a. The comprehensive Assessment must accurately reflect the client's status … 2. A review of the comprehensive assessment for Patient #2, dated 07/19/23, indicated a primary diagnosis of Anoxic Brain Damage (brain injury resulting from a complete lack of oxygen to the brain), cephalic seizures (interruption in electrical activity in the brain), Transient Ischemic Attack (TIA – a mini-stroke with no residual effects), Contractures (shortening and hardening of muscles and tendons, often causing deformity), and Cerebral Vascular Accident (CVA – sudden bleeding in or		each RN Case Manager along with education to correct anymistakes in documentation. RN Case Managers are to make any needed corrections totheir documentation and re-submit the assessment to the Clinical Manager within48 hours of receipt. Ongoing, 100% of newly completed comprehensive assessment documentation must be turned in to the Clinical Manager prior to placement in the patient's chart. Any documentation errors found by the Clinical Manager must be fixed by the RN Case Manager and re-submitted to the Clinical Manager within 48 hours of receipt for further review. The Clinical Manager will continue to audit 100% of comprehensive assessments until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of comprehensive assessments for another 30 days as long as 100% compliance is met to ensure ongoing compliance. A binder containing audit sheets for each assessment will be kept by the	

	blockage of blood flow to the brain; stroke). The assessment failed to evidence the patient's current functional, psychosocial, and cognitive status in relation to a anoxic brain injury and a history of CVA and TIA, such as residual effects, mobility, ability to communicate and understand, emotional appropriateness, and level of independence and failed to reflect the patient's current status related to a history current frequency and risk of TIAs, affected limbs with contractures and their limitations, the frequency and quality of seizures and the last known seizure, the presence of a frozen left arm, current transfer needs, and the current status of the recent fracture, including treatment, therapy, immobilization, and pain. The patient's cardiopulmonary, neuromuscular, gastrointestinal, and integumentary statuses were marked as "same" and failed to evidence the patient's current state of health. 3. A review of the comprehensive assessment for Patient #6, dated 08/02/23, evidenced a primary diagnosis of Paraplegia (paralysis of the		Clinical Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. The Clinical Manager will re-educate RN Case Managersto ensure that comprehensive assessments address the requirement to accuratelyreflect the patient's current status at the time of assessment. The Clinical Manager will perform unannouncedsupervisory visits of the RN Case Managers when performing certification visitsto evaluate their ability to perform a complete patient-specific comprehensiveassessment that includes the patient's current status, the patient's health,psychosocial, functional, and cognitive status, the patient's strengths, goals,and care preferences, the patient's continuing need for home care, thepatient's medical, nursing, rehabilitation, social, and	

	lower extremities) and a secondary diagnosis of Type 2 Diabetes Mellitus (a condition where the pancreas is unable to regulate insulin production for the metabolism of sugars. The assessment failed to evidence a functional assessment related to the patient's paraplegia. A skin assessment indicated "No Problem. C/D/I BLE (Clean/Dry/Intact Bilateral Lower Extremity) wrapped." The assessment failed to evidence a diagnosis related to wounds, the type of wound or the reason for BLE wraps, and the current status of the wound(s). The assessment failed to evidence a functional, psychosocial, or cognitive assessment was completed and failed to evidence the patient's current status related to a diagnosis of paraplegia, such as the ability to transfer independently, risk for pressure sores, mobility, risk for depression, and level of independence. 4. On 08/24/23 at 3:54 PM, the contents of the comprehensive assessments were reviewed with the Administrator. The Administrator indicated they lacked detail for Patients #2 and 6, such as a comprehensive		discharge planning needs,update for change in condition, and updated at least every 60 days. An RN Case Manager supervisory visit form will be usedto document the results of these supervisory visits. The Clinical Manager is responsible for compliance.	

	assessment of body systems, a detailed seizure plan for Patient #2, the functional assessments, and follow-up related to Patient #6's severe pain of 8-9/10. 410 IAC 17-15-1(a)			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure all patients received a comprehensive assessment that accurately reflected their current health status, such as assessment of body systems; psychosocial status, such as support systems, living arrangements, and ability to communicate; functional status, such as level of independence, safety precautions, mobility challenges, and need for modifications; and cognitive status, such as ability to understand, need for education concerning disease process, and risk for depression, for 7 of 7 active patient records reviewed. (Patients: #1, 2, 3, 4, 5, 6, and 7)	G0528	**G0528** The Clinical Manager will audit 100% of all currentpatients' comprehensive assessments using a comprehensive assessment audit toolthat evaluates all components of the comprehensive assessment with auditresults to be provided to each RN Case Manager along with education to correctany mistakes in documentation. RN Case Managers are to make any needed corrections totheir documentation and re-submit the assessment to the Clinical Manager within48 hours of receipt. Ongoing, 100% of newly completed comprehensive assessment documentation must be turned in to the Clinical Manager prior to placement in the patient's chart. Any documentation errors found by the Clinical Manager must be	2023-09-29

	Findings Include: A1. review of an undated agency policy titled "C-145 Comprehensive Client Assessment" indicated ... a. The comprehensive Assessment must accurately reflect the client's status, and must include at a minimum ... the client's current health, psychosocial, functional, and cognitive status. This includes an evaluation of mental health and functional capacity ... Cognitive assessment refers to the degree of client's ability to understand, remember and participate ... b. Assess the functional status and their ability to function independently in the home ... 4. ... Functional status is assessed ... using the OASIS (Outcome and Assessment Information Set) data elements with agency specific assessment criteria. When the client is not required to have OASIS data collected the functional status ... will be assessed using this tool or a related tool ... " 2. A review of the		fixed by the RN Case Manager and re-submitted to the Clinical Manager within 48 hours of receipt for further review. The Clinical Manager will continue to audit 100% of comprehensive assessments until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of comprehensive assessments for another 30 days as long as 100% compliance is met to ensure ongoing compliance. A binder containing audit sheets for each assessment will be kept by the Clinical Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. The Clinical Manager will re-educate RN Case Managersto ensure that comprehensive assessments address the requirement to assess anddocument the patient's current health, psychosocial, functional, and	

	Patient #2, dated 07/19/23, indicated a primary diagnosis of anoxic brain damage (brain injury resulting from a complete lack of oxygen to the brain), cephalic seizures (interruption in electrical activity in the brain), transient ischemic attack (TIA – a mini-stroke with no residual effects), contractures (shortening and hardening of muscles and tendons, often causing deformity), cerebral vascular accident (CVA – sudden bleeding in or blockage of blood flow to the brain; stroke). The functional limitations included incontinence and endurance and failed to include contracture, speech, or the frozen left arm. A summary of care indicated the patient required the assistance of a Home Health Aide (HHA) for Activities of Daily Living (ADL), transfers, bathing, hygiene, toileting, meals, and safety. The assessment failed to evidence an OASIS functional assessment or alternate tool, per agency policy, including but not limited to evaluation of the musculoskeletal system, mobility and performance, safety, and transfer methods and failed to evidence the patient's psychosocial and		cognitivestatus. The Clinical Manager will perform unannouncedsupervisory visits of the RN Case Managers when performing certification visitsto evaluate their ability to perform a complete patient-specific comprehensiveassessment that includes the patient's current status, the patient's health,psychosocial, functional, and cognitive status, the patient's strengths, goals,and care preferences, the patient's continuing need for home care, thepatient's medical, nursing, rehabilitation, social, and discharge planning needs,update for change in condition, and updated at least every 60 days. An RN Case Manager supervisory visit form will be usedto document the results of these supervisory visits. The Clinical Manager is responsible for compliance.	

	cognitive statuses were assessed. The patient's cardiopulmonary, neuromuscular, gastrointestinal, and integumentary systems were marked "same" of "NA" (not applicable) and failed to evidence the patient's current health status such as quality of breathing, perfusion, skin integrity, and wound status. 3. A review of the comprehensive assessment for Patient #6, dated 08/02/23, indicated a primary diagnosis of paraplegia and a secondary diagnosis of type 2 diabetes mellitus. Functional limitations included paralysis, endurance, and ambulation. The assessment failed to evidence an OASIS functional assessment or alternate tool, per agency policy, including but not limited to evaluation of the musculoskeletal system, mobility and performance, safety, and transfer methods and failed to evidence the patient's psychosocial and cognitive statuses were assessed. The patient's cardiopulmonary, neuromuscular, gastrointestinal, and integumentary systems were marked "same" or "NA"			

	and failed to evidence the patient's current health status such as quality of breathing, perfusion, skin integrity, and seizure activity. 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021, Visiting Angels Home Health Agency policy titled "Comprehensive Patient Assessment". The policy indicated but was not limited to, " ... 5. The Comprehensive Assessment includes an assessment and documentation ... List of Current diagnoses and symptom control ... height and weight are recorded ... assessment of the patient's pain level, location, what makes it better, worse, frequency of pain, activities affected ... endocrine system ... cardiopulmonary assessment ... Assessment of the integumentary system ... identification of any wounds, including the assessment and staffing of the identified wounds ... diabetic foot exam ... assessment of the patient's overall nutritional status ... assessment of urinary elimination ... assessment of bowel sounds, frequency, and consistency of bowel movements ... urinary status,			

	ability to urinate, frequency … neuro status … psychosocial status …" 2. On 08-22-2023 at 11:05 AM, Patient #1's clinical record was reviewed. The clinical record evidenced a document titled "Recertification/Follow-up Assessment" with a date of 07-03-2023 and timed for 2:00 PM. The document evidenced under a section titled "Frequency of Pain Interfering", the Alternate Director of Nursing (ADON) indicated the patient had pain interfering with activity and movement. The remaining questions regarding pain where left blank. The document failed to indicate how the patient's pain affected different activities and how pain was relieved. The section titled "Systems Review" evidenced the patient was "not weighed". The ADON failed to follow the policy and include the patient's weight. The section titled "Neuro" indicated the patient had a neurological disorder called Multiple Sclerosis (a disorder where the immune system attacks the brain and spinal cord causing communication problems from the brain to the rest of the			

	body). The "Neuro" section indicated but was not limited to, " … How does the patient's condition affect functional ability and/or safety? …" The ADON indicated, "monoplegia LLE (sic paralysis of the left lower extremity). The document failed to indicate how the neurological disorder affected the patient's safety and their functional ability. The section titled "Risk Factors/Hospital Admission/Emergency Room" was left blank, when they noted on page 4, the patient was at risk for hospitalization due to multiple emergency room visits in the past 6 months and the patient had 5 or more medications they were taking. The comprehensive assessment failed to provide a current, accurate view of Patient #1's current health status. 3. On 08-23-2023 at 1:13 PM, Patient #3's clinical record was reviewed. The clinical record evidenced a plan of care (POC) with a start of care date of 01-29-2021 and a certification period of 07-18-2023 to 09-15-2023. The plan of care indicated the patient had the			

	Pulmonary Disease (COPD, a disease causing difficulty breathing and narrowing of the airway) and Diabetes Mellitus Type 2 (a disease were the body is unable to regulate the sugar levels in the body). The POC evidenced the patient also had oxygen for their COPD. The POC evidenced the patient had allergies to Amoxicillin, Celebrex, Levaquin, and Morphine. Patient #3's clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 07-14-2023 at 8:00 AM. The section titled "Gastrointestinal" indicated the patient required a regular diet, which was not appropriate for a patient with a diagnosis of Diabetes. The section titled "Medication" indicated there were changes noted, and the question "instructed on" was left blank. The section titled "Skin/Wound/Ostomy" indicated there were no problems, the comments section indicated "reddened buttocks". The section titled "Allergies" had the box "None known" marked. The section failed to indicate all the allergies Patient #3 had. The			

	comprehensive assessment failed to evidence a Diabetic foot exam was conducted. The comprehensive assessment failed to provide a current, accurate view of Patient #3's current health status. The clinical record evidenced a document titled "Recertification/Follow-up Assessment" with a date of 08-02-2023 and timed for 7:00 AM. The document contained a section titled "Advance Directives", the ADON marked "Education needed", no teaching or instructions were provided to the patient regarding Advance Directives. The section titled "Skin Condition/Wounds" indicated but was not limited to, " ... Skin ... Left great toe surgical ..." The document failed to provide additional information about Patient #3's surgical wound on their left great toe. The section titled "Cardiopulmonary" failed to indicate how much oxygen the patient was on, and/or when they need oxygen. The section titled "Nutritional Status" indicated the patient was on a regular diet, which was not appropriate for a patient			

	with a Diabetes diagnosis. The section titled "Elimination" failed to indicate the patient's bowel frequency as necessary according to the agency's policy. The section titled "DME (sic Durable Medical Equipment) Supplies" failed to include the patient's brief pads for urinary incontinence. The comprehensive assessment failed to indicate a diabetic foot exam was conducted for the patient. The comprehensive assessment failed to provide a current, accurate view of Patient #3's current health status. During an interview with the ADON on 08-23-2023 at 2:43 PM, when queried regarding if diabetic foot assessments were conducted during the comprehensive assessments, they indicated they did not do diabetic foot assessments and document on the comprehensive assessments. 4. On 08-24-2023 at 12:36 PM, Patient #4's clinical record was reviewed. The clinical record evidenced a document "Recertification Comprehensive Assessment" dated 06-19-2023			

	at 10:00 AM. The section titled "Assessment and Observation signs/symptoms" failed to indicate which quadrants the bowel sounds were active. The section titled "Skin/Wound/Ostomy" indicated the patient had a right heel wound with wound care performed weekly. The document failed to evidence what type of wound the patient had, if a dressing covered the wound or if it was open to air, what the wound looked like, and who managed the wound for the patient. Patient #4's clinical record evidenced a document "Recertification Comprehensive Assessment" dated 08-18-2023 at 9:00 AM. The section titled "Medication" indicated there was a medication change, but no evidence the patient was instructed on expiration dates and drug to drug interactions for the medication change. The section titled "Skin/Wound/Ostomy" indicated the patient had a right heel ulcer, and received weekly wound care from Entity T, a wound center. The section failed to indicate if the patient			

	wound was open to air. The comprehensive assessment failed to provide a current, accurate view of Patient #4's current health status. 5. On 08-25-2023 at 9:30 AM, Patient #5's clinical record was reviewed. The clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 06-08-2023 at 12:00 PM. The section titled "Assessment and Observation signs/symptoms" indicated Patient #5 had no pain, but indicated in the comments, the document evidenced the patient had pain in their neck at times. The comprehensive assessment failed to indicate what caused the pain, how the pain was relieved, and the intensity of the pain when it occurred. The section titled "Genitourinary" indicated the patient had incontinence and the foley catheter was replaced by the physician. The comprehensive assessment failed to indicate the type of catheter, when it was placed, who replaced the catheter, and the color and consistency of the urine.			

	Patient #5's clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 08-07-2023 at 12:00 PM. The section titled "Genitourinary" indicated the patient had a catheter, but failed to indicate the type of catheter, who managed it, when it was last changed, and the color and consistency of the urine. The comprehensive assessment failed to provide a current, accurate view of Patient #5's current health status. 6. On 08-25-2023 at 2:55 PM, Patient #7's clinical record was reviewed. The clinical record evidenced a document titled "Comprehensive Adult Assessment" dated 07-05-2023 at 2:00 PM. The document contained a section titled "Prognosis", and the document failed to indicate the patient's prognosis. The section titled "Cardiopulmonary" failed to indicate the patient's height and weight, identify if the patient's respirations were regular or irregular, indicate what the patient used for oxygen, if needed at night, and failed to indicate if the patient's capillary			

	refill was less than or greater than 3 seconds. The section titled “Elimination” evidenced the patient had an ileostomy/colostomy site (a surgical opening made for the small intestine to protrude out of the abdomen and remove waste from the body) but failed to evidence a description of the site. The section titled “Mental Status” indicated the patient was “comatose”, but the section titled “Activities permitted” indicated the patient was “up as tolerated” and able to transfer from the bed and chair. The section titled “Enteral Feedings – Access Device” failed to indicate where the gastrostomy tube (a surgical opening in the abdomen, where a tube was placed to provide nutrients to the individual) was located and the skin around the site. The section titled “Professional Services” failed to evidence the Director of Nursing (DON) taught the disease process, signs and symptoms of infection, home safety, medication education, and oxygen education. Patient #7’s clinical record evidenced a document titled “Recertification Comprehensive			

	Assessment" dated 07-12-2023 at 9:00 AM. The document evidenced a section titled "Assessment and observation signs/symptoms" failed to evidence the patient's weight. The section titled "Cardiopulmonary" failed to indicate the patient used oxygen as needed at night as evidenced by the comprehensive assessment dated 07-05-2023 and as evidenced in the section titled "Summary Checklist", DME (sic durable medical equipment) indicated the patient had and oxygen concentrator. The section titled "Enteral Feedings – Access Device" failed to indicate the amount of feeding the patient was to receive through the gastrostomy tube, the rate, the flush amount, and rate, and who managed the gastrostomy tube. The clinical record evidenced a document titled "Comprehensive Adult Assessment" dated 08-15-2023 at 8:00 AM. The document evidenced a section titled "Pertinent Background Information", which failed to indicate why the patient went to			

	baclofen pump replacement (a device bringing medication for spasticity directly to the spinal cord) and was hospitalized from 08-04-2023 to 08-14-2023. The section titled "Skin Condition/Wounds" indicated the patient had an incision on their left lower abdomen to replace the baclofen pump, if failed to indicate if the incision was open to air, had a dressing, and a description of the incision. The section titled "Cardiopulmonary" failed to evidence a height and weight for the patient, failed to indicate the device used to deliver the oxygen to the patient, and failed to indicate whether the patient's capillary refill was less than or greater than 3 seconds. The section titled "Mental Status" indicated the patient was comatose, but the section titled "Activities Permitted" indicated the patient could be up as tolerated and could transfer from the bed and chair. The section titled "Enteral Feedings – Access Device" failed to indicate when the caregivers were to initiate a water flush and the rate to flush the water. The section titled "Professional Services" failed to evidence the Director of Nursing (DON)			

	taught the disease process, signs and symptoms of infection, home safety, medication education, and oxygen education. The comprehensive assessment failed to provide a current, accurate view of Patient #7's current health status. 7. During an interview with the Alternate Director of Nursing (ADON) on 08-23-2023 at 11:35 AM, they indicated the comprehensive assessment was to be patient-specific, complete, and accurate to the patient. 8. During an interview with the DON on 08-25-2023 at 11:58 AM, they indicated the comprehensive assessment should include who managed the wound, foley catheter, and gastrostomy tube and indicate if there was a dressing, date of when it was last changed or verified, and/or open to air.			
G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress	G0530	**G0530** The Clinical Manager will audit 100% of all currentpatients' comprehensive assessments using a comprehensive assessment audit toolthat	2023-09-29

	toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on observation, record review and interview, the agency failed to ensure all patient's received a comprehensive assessment that reflected their current strengths, patient-specific and measurable goals, and care preferences, for 6 of 7 active clinical records reviewed. (Patients #2, 3, 4, 5, 6, 7) Findings include: A review of an undated agency policy titled "C-145 Comprehensive Client Assessment" indicated ... a. The comprehensive Assessment must accurately reflect the client's status, and must include at a minimum ... c. The client's strengths, goals, and care preferences ... During a home visit on 08/24/23 at 10:56 AM, hand-written care lists were observed in clear view posted on the kitchen cabinets, which indicated numbered points for care preferences, including but not limited to assist with drinks and finger foods, never cut the patient's hair, check under breasts for redness and apply		evaluates all components of the comprehensive assessment with auditresults to be provided to each RN Case Manager along with education to correctany mistakes in documentation. RN Case Managers are to make any needed corrections totheir documentation and re-submit the assessment to the Clinical Manager within48 hours of receipt. Ongoing, 100% of newly completed comprehensive assessment documentation must be turned in to the Clinical Manager prior to placement in the patient's chart. Any documentation errors found by the Clinical Manager must be fixed by the RN Case Manager and re-submitted to the Clinical Manager within 48 hours of receipt for further review. The Clinical Manager will continue to audit 100% of comprehensive assessments until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of comprehensive assessments for another 30 days as long as 100% compliance is met to ensure	

	right boot when standing, braces on both legs daily, never leave on the toile for >15 minutes, and seat patient at the table with DVD player in the kitchen. The patient's spouse stated there were care lists throughout the house, including the bedroom and bathroom and stated no one had ever asked about specific care preferences, including the specific way the patient must be transferred due to a frozen left arm. A review of the comprehensive assessment for Patient #2, dated 07/19/23, evidenced a section titled "Rehabilitation Potential/Goals." A selected goal under the aide category indicated "Assumes responsibility for personal care needs by: (date)." The date was blank. The comprehensive assessment failed to evidence patient-specific, measurable, and pertinent goals or patient strengths and failed to evidence any care preferences, including the ones posted in the patient's home. 2. A review of the comprehensive assessment for Patient #3, dated 08/02/23,		ongoing compliance. A binder containing audit sheets for each assessment will be kept by the Clinical Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. The Clinical Manager will re-educate RN Case Managersto ensure that comprehensive assessments address the requirement to ensure acomplete and accurate assessment of the patient's strengths, goals, and carepreferences. The Clinical Manager will perform unannouncedsupervisory visits of the RN Case Managers when performing certification visitsto evaluate their ability to perform a complete patient-specific comprehensiveassessment that includes the patient's current status, the patient's health,psychosocial, functional, and cognitive status, the patient's strengths, goals,and	

	evidenced a section titled "Rehabilitation Potential/Goals." A selected goal under the aide category indicated “Assumes responsibility for personal care needs by: 60 days. (date).” The comprehensive assessment failed to evidence patient-specific, measurable, and pertinent goals or patient strengths. Based on observation, record review and interview, the agency failed to ensure all patient’s received a comprehensive assessment that		care preferences, the patient’s continuing need for home care, thepatient’s medical, nursing, rehabilitation, social, and discharge planning needs,update for change in condition, and updated at least every 60 days. An RN Case Manager supervisory visit form will be usedto document the results of these supervisory visits. The Clinical Manager is responsible for compliance.	

patient-specific and measurable goals, and care preferences, for 2 of 7 active clinical records reviewed. (Patients #2, 6)

Findings include:

A review of an undated agency policy titled "C-145 Comprehensive Client Assessment" indicated ... a. The comprehensive Assessment must accurately reflect the client's status, and must include at a minimum ... c. The client's strengths, goals, and care preferences ...

During a home visit on 08/24/23 at 10:56 AM, hand-written care lists were observed in clear view posted on the kitchen cabinets, which indicated numbered points for care preferences, including but not limited to assist with drinks and finger foods, never cut the patient's hair, check under breasts for redness and apply triple antibiotic ointment, apply right boot when standing, braces on both legs daily, never leave on the toile for >15 minutes, and seat patient at the table with DVD player in the kitchen. The patient's spouse stated there were care lists

	throughout the house, including the bedroom and bathroom and stated no one had ever asked about specific care preferences, including the specific way the patient must be transferred due to a frozen left arm. A review of the comprehensive assessment for Patient #2, dated 07/19/23, evidenced a section titled "Rehabilitation Potential/Goals." A selected goal under the aide category indicated "Assumes responsibility for personal care needs by: (date)." The date was blank. The comprehensive assessment failed to evidence patient-specific, measurable, and pertinent goals or patient strengths and failed to evidence any care preferences, including the ones posted in the patient's home.			

	1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021, Visiting Angels Home Health Agency policy titled "Comprehensive Patient Assessment". The policy indicated but was not limited to, " ... 5. The Comprehensive Assessment includes an assessment and documentation ... Assessment of the patient's care preferences and their personal goals ... the patient's 'strengths/limitations' ..." 2. On 08-23-2023 at 1:13 PM, Patient #3's clinical record was reviewed. Patient #3's clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 07-14-2023 at 8:00 AM. The comprehensive assessment failed to identify the patient's strengths, goals, and care preferences and their progress toward their goals. 3. On 08-24-2023 at 12:36 PM, Patient #4's clinical record was reviewed. The clinical record evidenced a document "Recertification Comprehensive Assessment" dated 06-19-2023 at 10:00 AM and another comprehensive assessment dated 08-18-2023 at 9:00 AM.			

	The comprehensive assessments failed to identify the patient's strengths, goals, care preferences, and their progress toward their goals. 4. On 08-25-2023 at 9:30 AM, Patient #5's clinical record was reviewed. The clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 06-08-2023 at 12:00 PM and another dated 08-07-2023 at 12:00 PM. The comprehensive assessments failed to identify the patient's strengths, goals, care preferences, and their progress toward their goals. 5. On 08-25-2023 at 2:55 PM, Patient #7's clinical record was reviewed. The clinical record evidenced documents titled "Comprehensive Adult Assessment" dated 07-05-2023 at 2:00 PM and 08-15-2023 at 8:00 AM. The clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 07-12-2023 at 9:00 AM. The comprehensive assessments failed to identify the patient's strengths, goals, care preferences, and their progress toward their goals.			

	6. During an interview with the Director of Nursing (DON) and Alternate Director of Nursing (ADON) on 08-23-2023 at 11:35 AM, the DON indicated the assessment was to include patient-specific and patient-identified goals. The ADON indicated the comprehensive assessment was to be patient-specific, complete, and accurate to the patient.			
G0534	Patient's needs 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview the agency failed to indicate the patient's medical, nursing, rehabilitative, and discharge planning needs for 6 of 7 active records reviewed. (Patient# 2, 3, 4, 5, 6, and 7) Findings Include: 1. A review of the clinical record for Patient #2 evidenced a comprehensive assessment dated 07/19/23 and indicated a primary diagnosis of anoxic brain injury (brain injury caused by a complete lack of oxygen to	G0534	**G0534** The Clinical Manager will audit 100% of all currentpatients' comprehensive assessments using a comprehensive assessment audit toolthat evaluates all components of the comprehensive assessment with auditresults to be provided to each RN Case Manager along with education to correctany mistakes in documentation. RN Case Managers are to make any needed corrections totheir documentation and re-submit the assessment to the Clinical Manager within48 hours of receipt. Ongoing, 100% of newly completed comprehensive	2023-09-29

	the brain) and secondary diagnoses of cephalic seizures (a burst of uncontrolled electrical activity that causes temporary abnormalities in motor skills, sensation, awareness, and emotion), transient ischemic accident (TIA - a temporary period of symptoms similar to a stroke but which are brief and have no lasting effects), contractures (shortening or hardening of the muscles and/or tendons causing deformity), and cerebrovascular accident (CVA - stroke; sudden bleeding in or blockage of blood flow to the brain) The comprehensive assessment clinical summary indicated "Recent fracture to LUE [Left Upper Extremity], no current treatment, allowing to heal as is. LUE contracted." The assessment indicated rehab potential was fair but failed to evidence the patient's rehabilitative needs, treatments, or goals including, but not limited to, use of leg braces and a left boot, functional status, need for physical therapy related to contractures and the previous CVA and anoxic brain injury, difficult transfers, frozen left extremity, and any treatment or immobilization		assessment documentation must be turned in to the Clinical Manager prior to placement in the patient's chart. Any documentation errors found by the Clinical Manager must be fixed by the RN Case Manager and re-submitted to the Clinical Manager within 48 hours of receipt for further review. The Clinical Manager will continue to audit 100% of comprehensive assessments until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of comprehensive assessments for another 30 days as long as 100% compliance is met to ensure ongoing compliance. A binder containing audit sheets for each assessment will be kept by the Clinical Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. The Clinical Manager will re-educate RN Case	

	requirements of the recently fractured LUE. The comprehensive assessment failed to indicate the frequency, severity, or type of seizures experienced by the patient and whether there were nursing needs related to the management and mitigation of seizures. During a home visit on 08/24/23 at 10:56 AM, the patient's spouse indicated signs posted in the kitchen which listed patient-specific care requests, including use of a left boot and leg braces when the patient was up and weightbearing to pivot. 2. A review of the comprehensive assessment for Patient #6, dated 08/02/23, evidenced a primary diagnosis of paraplegia and secondary diagnosis of type 2 diabetes mellitus. The pain assessment indicated chronic pain in the bilateral lower extremities and back at 8-9/10 and failed to evidence the patient's medical needs were assessed in relation to managing and mitigating severe pain. The assessment indicated the patient's rehab		Managersto ensure that comprehensive assessments address the requirement to ensure acomplete and accurate assessment of the patient's medical, nursing,rehabilitative, social, and discharge planning needs. The Clinical Manager will perform unannouncedsupervisory visits of the RN Case Managers when performing certification visitsto evaluate their ability to perform a complete patient-specific comprehensiveassessment that includes the patient's current status, the patient's health,psychosocial, functional, and cognitive status, the patient's strengths, goals,and care preferences, the patient's continuing need for home care, thepatient's medical, nursing, rehabilitation, social, and discharge planning needs,update for change in condition, and updated at least every 60 days. An RN Case Manager supervisory visit form will be usedto document the results of these supervisory visits. The Clinical Manager is	

	evidence the patient's rehabilitative needs, treatments, or goals related to functional status, mobility, or need for physical or occupational therapy related to paraplegia, A skin assessment evidenced "No Problem" and a comment section indicated "C/D/I BLE [Clean/Dry/Intact Bilateral Lower Extremity] wrapped." The assessment failed to evidence if both extremities were wrapped, the reason for and the type of wrap, and the patient's nursing needs related to the leg wraps or unknown wound. 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021, Visiting Angels Home Health Agency policy titled “Comprehensive Patient Assessment”. The policy indicated but was not limited to, “ … 5. The Comprehensive Assessment includes an assessment and documentation … Document the patient’s rehabilitation potential, Discharge planning is initiated, goals are identified, and/or continuing care needs are recognized …” 2. On 08-23-2023 at 1:13 PM, Patient #3’s clinical record was		responsible for compliance.	

	reviewed. Patient #3's clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 07-14-2023 at 8:00 AM. The section titled "Rehabilitation Potential / Goals" had the Aide box marked indicating, "Assumes responsibility for personal care needs by 60 days". The comprehensive failed to identify the patient's potential to reach the identified goal. The comprehensive assessment failed to indicate the patient's social planning needs. Patient #3's clinical record evidenced a document titled "Recertification/Follow-up Assessment" with a date of 08-02-2023 and timed for 7:00 AM. The section titled "Rehabilitation Potential / Goals" had the Aide box marked indicating, "Assumes responsibility for personal care needs by 60 days". The comprehensive failed to identify the patient's potential to reach the identified goal. The comprehensive assessment failed to indicate the patient's social planning needs. 3. On 08-24-2023 at 12:36 PM,			

	Patient #4's clinical record was reviewed. The clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 06-19-2023 at 10:00 AM. The section titled "Rehabilitation Potential / Goals" had the Aide box marked indicating, "Assumes responsibility for personal care needs by (sic blank)". The comprehensive failed to identify the patient's potential to reach the identified goal. The comprehensive assessment failed to indicate the patient's social planning needs. Patient #4's clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 08-18-2023 at 9:00 AM. The section titled "Rehabilitation Potential / Goals" had the Aide box marked indicating, "Assumes responsibility for personal care needs by 60 days". The comprehensive failed to identify the patient's potential to reach the identified goal. The comprehensive assessment failed to indicate the patient's social planning needs. 4. On 08-25-2023 at 9:30 AM, Patient #5's clinical record was			

	reviewed. The clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 06-08-2023 at 12:00 PM. The section titled "Rehabilitation Potential / Goals" had the Aide box marked indicating, "Assumes responsibility for personal care needs by (sic blank)". The comprehensive failed to identify the patient's potential to reach the identified goal. The comprehensive assessment failed to indicate the patient's social planning needs. Patient #5's clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 08-07-2023 at 12:00 PM. The section titled "Rehabilitation Potential / Goals" had the Aide box marked indicating, "Assumes responsibility for personal care needs by 60 days". The comprehensive failed to identify the patient's potential to reach the identified goal. The comprehensive assessment failed to indicate the patient's social planning needs. 5. On 08-25-2023 at 2:55 PM, Patient #7's clinical record was reviewed. The clinical record			

	evidenced a document titled "Comprehensive Adult Assessment" dated 07-05-2023 at 2:00 PM. The section titled "Rehabilitation Potential / Goals" had the Aide box marked indicating, "Assumes responsibility for personal care needs by 07-16-2023". The comprehensive failed to identify the patient's potential to reach the identified goal. The comprehensive assessment failed to indicate the patient's social planning needs. The clinical record evidenced documents titled "Recertification Comprehensive Assessment" 07-12-2023 at 9:00 AM. The section titled "Rehabilitation Potential / Goals" had the Aide box marked indicating, "Assumes responsibility for personal care needs by 09-14-2023". The comprehensive failed to identify the patient's potential to reach the identified goal. The comprehensive assessment failed to indicate the patient's social planning needs. The clinical record evidenced documents titled "Comprehensive Adult			

	AM. The section titled "Rehabilitation Potential / Goals" had the Aide box marked indicating, "Assumes responsibility for personal care needs by 09-14-2023". The comprehensive failed to identify the patient's potential to reach the identified goal. The comprehensive assessment failed to indicate the patient's social planning needs. 6. During an interview with the Director of Nursing (DON) and Alternate Director of Nursing (ADON) on 08-23-2023 at 11:35 AM, the DON indicated the assessment was to indicate the needs of the patient. The ADON indicated the comprehensive assessment was to be patient-specific, complete, and accurate to the patient according to the agency policy.			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and	G0538	**G0538** The Clinical Manager will audit 100% of all currentpatients' comprehensive assessments using a comprehensive assessment audit toolthat evaluates all components of the comprehensive assessment with auditresults to be provided to	2023-09-29

	interview, the agency failed to ensure the comprehensive assessment included the patient's primary caregiver or a potential temporary caregiver and their availability for 5 of 7 active clinical records reviewed. (Patients: #1, 3, 4, 5, and 7) Findings Include: 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021, Visiting Angels Home Health Agency policy titled "Comprehensive Patient Assessment". The policy indicated but was not limited to, " … 5. The Comprehensive Assessment includes an assessment and documentation … access to a temporary caregiver and availability of caregiver is assessed and documented … any available "primary caregiver" is identified and a list of the hours and days the caregiver is available …" 2. On 08-22-2023 at 11:05 AM, Patient #1's clinical record was reviewed. The clinical record evidenced a document titled "Recertification/Follow-up Assessment" with a date of 07-03-2023 and timed for 2:00 PM. The comprehensive		each RN Case Manager along with education to correctany mistakes in documentation. RN Case Managers are to make any needed corrections totheir documentation and re-submit the assessment to the Clinical Manager within48 hours of receipt. Ongoing, 100% of newly completed comprehensive assessment documentation must be turned in to the Clinical Manager prior to placement in the patient's chart. Any documentation errors found by the Clinical Manager must be fixed by the RN Case Manager and re-submitted to the Clinical Manager within 48 hours of receipt for further review. The Clinical Manager will continue to audit 100% of comprehensive assessments until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of comprehensive assessments for another 30 days as long as 100% compliance is met to ensure ongoing compliance. A binder containing audit sheets for each assessment will be kept by the	

	assessment evidenced the following diagnoses Multiple Sclerosis (damage to the spinal cord causing numbness, speech and muscle impairment, fatigue, and blurred vision), Monoplegia of the lower limb (paralysis of the lower limb), and Hypertension (high blood pressure). The document failed to include the outside providers, Person B, a case worker for a social services agency, Entity A, and Person L and Person M, case workers with Entity K, who help provide the patient with community resources. During an interview with Person B, a case worker for Entity A, a social services agency, on 08-24-2023 at 12:45 PM, they indicated they coordinate with service providers and had monthly visits to check-in with Patient #1 and provided guidance to the caregiver.		Clinical Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. The Clinical Manager will re-educate RN Case Managersto ensure that comprehensive assessments identify the patient's primarycaregiver and documents their ability to provide care, their ability, and theirschedule. The Clinical Manager will perform unannouncedsupervisory visits of the RN Case Managers when performing certification visitsto evaluate their ability to perform a complete patient-specific comprehensiveassessment that includes the patient's current status, the patient's health,psychosocial, functional, and cognitive status, the patient's strengths, goals,and care preferences, the patient's continuing need for home care,	

	During an interview with Person L, a case manager at Entity K, indicated they have never been contacted by the home health agency and indicated they provided nursing advice, and provide Patient #1 and their caregivers resources they would need. 3. On 08-23-2023 at 1:13 PM, Patient #3's clinical record was reviewed. Patient #3's clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 07-14-2023 at 8:00 AM. The comprehensive assessment evidenced the diagnoses Chronic Obstructive Pulmonary Disease (COPD, disease causing airflow to be blocked and difficulty breathing), Fibromyalgia (generalized pain, stiffness, and fatigue in the body), and Diabetes Mellitus Type 2 (a disease were the body was unable to regulate the sugar levels in the body). The comprehensive assessment failed to indicate a primary or temporary caregiver and their availability to provide care for the patient. The comprehensive assessment failed to include the other providers providing care in the home Entity O, for wound		rehabilitation, social, and discharge planning needs,update for change in condition, and updated at least every 60 days. An RN Case Manager supervisory visit form will be usedto document the results of these supervisory visits. The Clinical Manager is responsible for compliance.	

	care, and Person P, a podiatrist. The clinical record evidenced a document titled "Recertification/Follow-up Assessment" with a date of 08-02-2023 and timed for 7:00 AM. The section titled "Living Arrangements/Caregiver Information" indicated the patient lived in an apartment alone and "NA (sic not applicable)". The section titled "Emergency Preparedness Plan" indicated Patient #3's child, Person FF, would provide evacuation assistance. The comprehensive assessment failed to indicate whether Person FF was a potential temporary caregiver. The comprehensive assessment failed to include the other providers providing care in the home Entity O, for wound care, and Person P, a podiatrist. Attempted to call Person P, Patient #3's podiatrist, a voicemail was left requesting a return call. The call was never returned for the remainder of the survey. During an interview with Person R, a nurse from Entity O, on 08-24-2023 at 12:10 PM, they			

	indicated they care for Patient #3's wound on their toe. They indicated started care with Patient #3 on 08-01-2023, after the patient was hospitalized for osteomyelitis, an infection in the bone, with a left great toe amputation. 4. On 08-24-2023 at 12:36 PM, Patient #4's clinical record was reviewed. The clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 06-19-2023 at 10:00 AM and another one dated 08-18-2023 at 9:00 AM. The comprehensive assessment evidenced diagnoses, COPD, Right Foot Drop (difficulty in lifting the front part of the foot), Arthritis (stiffness of the joints), Fibromyalgia (generalized pain, stiffness, and fatigue in the body), and Bradycardia (a low heart rate). The comprehensive assessment failed to include whether the patient had a primary caregiver or a temporary caregiver and their schedule and availability. The comprehensive assessments failed to include the other providers Entity A, a social work service, and Entity T, a wound center, providing care			

	for Patient #4. Attempted to contact Person S, a case worker at Entity A for Patient #4, on 08-25-2023 at 8:35 AM. A voicemail was left, but the call was never returned. Attempted to contact Entity T, the wound center for Patient #4, on 08-25-2023 at 8:39 AM. A voicemail was left, but the call was never returned. 5. On 08-25-2023 at 9:30 AM, Patient #5's clinical record was reviewed. The clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 06-08-2023 at 12:00 PM and another dated 08-07-2023 at 12:00 PM. The comprehensive assessment evidenced a primary diagnosis of Quadriplegia (paralysis in all 4 limbs). The comprehensive assessment failed to include whether the patient had a primary caregiver or a temporary caregiver and their schedule and availability. The comprehensive assessment failed to include the other provider, Entity X, a urology physician office, Patient #5 received care.			

	6. On 08-25-2023 at 2:55 PM, Patient #7's clinical record was reviewed. The clinical record evidenced documents titled "Comprehensive Adult Assessment" dated 07-05-2023 at 2:00 PM and 08-15-2023 at 8:00 AM. The comprehensive assessment the patient had diagnoses TBI (Traumatic Brain injury, trauma caused damage to the brain), seizures (uncontrolled electrical activity causes abnormal movement in the body), and Oglivies Syndrome (a distended abdomen when the individual does not have a mechanical obstruction in the abdomen). The comprehensive assessment failed to include the caregivers, Person Z and Person DD, Patient #7's parents, availability to care for the patient. The clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 07-12-2023 at 9:00 AM. The comprehensive assessment failed to indicate who Patient #7's primary caregivers were and their availability and willingness to assist in care. 7. During an interview with the			

	(ADON) on 08-23-2023 at 11:35 AM, the ADON indicated the comprehensive assessment was to be patient-specific, complete, and accurate to the patient according to the agency policy.			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on record review and interview, the agency failed to ensure patients received an updated comprehensive assessment when a change in condition was identified, for 1 of 7 active patient records reviewed. (Patient #2) Findings include: 1. A review of an undated agency policy titled "C-145 Comprehensive Client Assessment" indicated, but was not limited to, "The assessment identifies facilitating factors and	G0544	**G0544** The Clinical Manager willaudit 100% of all current patients' comprehensive assessments using acomprehensive assessment audit tool that evaluates all components of thecomprehensive assessment with audit results to be provided to each RN CaseManager along with education to correct any mistakes in documentation. RNCase Managers are to make any needed corrections to their documentation andre-submit the assessment to the Clinical Manager within 48 hours of receipt. Ongoing, 100% of newly completed comprehensive assessment documentation must be turned in to the Clinical Manager prior to placement in the patient's chart. Any documentation errors found by the Clinical Manager must be fixed by the RN Case Manager and re-submitted to the Clinical Manager within 48 hours of receipt for further review. The Clinical Manager will	2023-09-29

	reaching his or her goals including presenting problems. The depth and frequency of ongoing assessments will depend on client needs, goals and the care treatment and services provided, but will be done at least once in every sixty (60) day period ... 12. Reassessments are conducted based on client needs, physician orders, professional judgement and/or OASIS or other regulatory requirement ... "The policy failed to indicate the requirement to reassess patients for a change in condition. 2. A review of the agency's complaint log evidenced a complaint report dated 06/01/23 which indicated the spouse for Patient #2 called in and informed the Administrator that they called the patient's physician because the patient suffered a left arm injury on 05/31/23 and was still complaining of pain. The agency failed to complete a comprehensive assessment on Patient #2 after notification of a change in condition due to a possible injury. 3. On 08/22/23 at 2:07 PM, the		continue to audit 100% of comprehensive assessments until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of comprehensive assessments for another 30 days as long as 100% compliance is met to ensure ongoing compliance. A binder containing audit sheets for each assessment will be kept by the Clinical Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. TheClinical Manager will re-educate RN Case Managers to ensure that comprehensiveassessments are updated and revised as frequently as the patient's conditionwarrants due to a major decline or improvement in health status. TheClinical Manager will perform unannounced supervisory visits of the RN CaseManagers when	

	Administrator indicated a nurse didn't assess Patient #2 "because at the time we didn't know if there was actually an injury." The Administrator indicated they should have seen the patient immediately for an assessment but didn't know if the patient could accurately communicate pain. The agency failed to complete a comprehensive assessment for a patient with a significant change in condition. 4. On 08/22/23 at 9:36 AM, during the entrance conference, the Clinical Manager was asked how the agency determined if a patient had a major decline or improvement in health status. The Clinical Manager indicated determination was made based on assessments, which occurred every 60 days. If they go to the hospital, they receive an assessment visit upon return home unless there was no notice of changes from the hospital, in which case the assessment was made with the next supervisory visit. 410 IAC 17-14-1(a)(1)(B)		performing certification visits to evaluate their ability toperform a complete patient-specific comprehensive assessment that includes thepatient's current status, the patient's health, psychosocial, functional, andcognitive status, the patient's strengths, goals, and care preferences, thepatient's continuing need for home care, the patient's medical, nursing,rehabilitation, social, and discharge planning needs, update for change incondition, and updated at least every 60 days. AnRN Case Manager supervisory visit form will be used to document the results ofthese supervisory visits. The Clinical Manager is responsible for compliance.	

G0546	Last 5 days of every 60 days unless: 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. Based on record review and interview, the agency failed to ensure all patients received a comprehensive assessment at least every 60 days, for 1 of 7 active patient records reviewed. (Patient #6) Findings include: 1. A review of an undated agency policy titled "C-145 Comprehensive Client Assessment" indicated, but was not limited to, "The assessment identifies facilitating factors and possible barriers to client reaching his or her goals including presenting problems. The depth and frequency of ongoing assessments will depend on client needs, goals and the care treatment and	G0546	**G0546** The Clinical Manager will audit 100% of all currentpatients' comprehensive assessments using a comprehensive assessment audit toolthat evaluates all components of the comprehensive assessment with auditresults to be provided to each RN Case Manager along with education to correctany mistakes in documentation. RN Case Managers are to make any needed corrections totheir documentation and re-submit the assessment to the Clinical Manager within48 hours of receipt. Ongoing, 100% of newly completed comprehensive assessment documentation must be turned in to the Clinical Manager prior to placement in the patient's chart. Any documentation errors found by the Clinical Manager must be fixed by the RN Case Manager and re-submitted to the Clinical Manager within 48 hours of receipt for further review. The Clinical Manager will	2023-09-29

	services provided, but will be done at least once in every sixty (60) day period ... " 2. A review of the clinical record for Patient #6 evidenced a "Recertification Comprehensive Assessment," dated 04/03/23 for the recertification period of 04/05/23 - 06/03/23; a "Comprehensive Adult Assessment," dated 05/24/23 which indicated it was completed because the patient was hospitalized on 05/22/23 - 05/23/23; and a comprehensive assessment dated 08/02/23 for certification period 08/03/23 - 10/01/23. The record failed to evidence a recertification comprehensive assessment was completed between day 56 - 60 for the certification period of 06/04/23 - 08/02/23. On 08/24/23 at 2:25 PM, the Alternate Clinical Manager and the Administrator indicated a comprehensive assessment for Patient #6 was due between 05/30/23 and 06/03/23 but was not done. 3. On 08/22/23 at 9:36 AM, during the entrance conference, the Clinical Manager was asked		continue to audit 100% of comprehensive assessments until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of comprehensive assessments for another 30 days as long as 100% compliance is met to ensure ongoing compliance. A binder containing audit sheets for each assessment will be kept by the Clinical Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. The Clinical Manager willre-educate RN Case Managers to ensure that comprehensive assessments are madewithin the last 5 days of every 60-day recertification period. The Clinical Manager will perform unannouncedsupervisory visits of the RN Case Managers when performing certification visitsto evaluate their ability to perform a complete patient-specific comprehensiveassessment that includes the patient's current status, the patient's	

	patient had a major decline or improvement in health status. The Clinical Manager indicated determination was made based on assessments, which occurred every 60 days. 410 IAC 17-14-1(a)(1)(B)		health,psychosocial, functional, and cognitive status, the patient's strengths, goals,and care preferences, the patient's continuing need for home care, thepatient's medical, nursing, rehabilitation, social, and discharge planning needs,update for change in condition, and updated at least every 60 days. An RN Case Manager supervisory visit form will be usedto document the results of these supervisory visits. The Clinical Manager is responsible for compliance.	
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 a current medication profile and goals were sent to	G0564	**G0564** The Clinical Manager will audit 100% of all transfer and discharge documentation until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of transfer and discharge paperwork for the another 30 days as long as 100% compliance is met to ensure ongoing compliance. A binder containing audit sheets for each transfer and discharge will be kept by the Clinical	2023-09-29

	the physician for 2 of 2 inactive clinical records reviewed. (Patients: #8 and 9) Findings Include: 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021 Briggs Healthcare policy titled, "Discharge Summary, Policy No. C-820". The policy indicated but was not limited to, " ... Special Instructions ... 3. The physician will be involved in the discharge plan and specific ongoing care needs will be identified and addressed as part of the plan ... Discharge Criteria ... 5. Agency staff will document the following ... b. Client status (clinical, mental, psychosocial, cognitive, and functional) at the start of care ... e. A description of the client's clinical, mental, psychosocial, cognitive, and functional status at the end of care. f. The client's most recent drug profile ..." 2. On 08-24-2023 at 3:25 PM, Patient #8's inactive clinical record was reviewed. The clinical record evidenced a document titled "Summary (Non-OASIS)". The document indicated it was a discharge		Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler throughout this audit process to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. The Clinical Manager will ensure as part of the auditthat all medical information pertaining to the patient's current course ofillness and treatment, medication profile, post-discharge goals of care, andtreatment preferences are sent to the receiving facility or practitioner upontransfer or discharge. The Clinical Manager will re-educate RN Case Managersto ensure that current medication profiles and goals are sent to the physicianupon any transfer of care or discharge. The Clinical Manager is responsible for compliance.	

	summary because the patient/family requested for Patient #8 to be discharged from the agency. The subsection titled "Condition at Discharge" indicated "same". The document failed to provide a description of the patient at discharge or their condition at their most current assessment. The document failed to include the medications the patient was taking at the time of discharge. The document evidenced instructions were not provided to the patient and caregiver, but the document indicated the patient and caregiver understood the instructions provided. The clinical record failed to evidence instructions were provided to the patient and caregiver. The document failed to identify the patient's treatment preferences and goals of care after discharge. The document indicated the patient's spouse, Person U, was transferring services to another agency. The document failed to indicate under the reason for discharge, the patient was transferred to another agency. The clinical record failed to evidence the home health agency contacted and sent a discharge summary, medication			

	profile, and order to the patient's new home health provider. 3. On 08-24-2023 at 3:40 PM, Patient #9's inactive clinical record was reviewed. The clinical record evidenced a document titled "Summary (Non-OASIS)". The document indicated it was a discharge summary because the patient and/or family requested. The subsection titled "Condition at Discharge" indicated "no change". The document failed to indicate the patient's condition at discharge or their condition at their most current assessment. The document failed to include the medications the patient was taking at the time of discharge. The document failed to identify the patient's treatment preferences and goals of care after discharge. 4. During an interview with the Alternate Director of Nursing (ADON) on 08-28-2023 at 3:10 PM, the ADON indicated they would send to the physician the discharge summary according to the policy and order only, if the patient was discharged to home. They indicated if the			

	patient were to transfer to another home health agency, they would send the discharge summary, order, and medication profile to the other home health agency.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the agency failed to ensure they met the needs of 7 of 7 active (Patients: #1, 2, 3, 4, 5, 6, and 7) clinical records reviewed by failing to provide all services written in the plan of care (G572), failing to provide	G0570	**G0570** The Clinical Manager will audit 100% of current patient clinicalrecords to identify all patients that have not been provided all of theservices written in the plan of care, do not have patient-specificinterventions, education, and measurable outcomes and goals, safety measures,supplies and equipment needed, discharge planning and nutritional requirements,and other providers involved in the plan of care, do not have all orders in theplan of care, have not been provided care, services, and treatments as orderedby a physician, have not received verbal orders to provide services, do nothave a plan of care that has been reviewed and revised by the physician atleast every 60 days, do not have a plan of care that contains all	2023-09-29

	education, and measurable outcomes and goals, safety measures, supplies and equipment needed, discharge planning and nutritional requirements, and other providers involved in the patient's care (G574), failed to include all orders in the plan of care (G576), failed to provide care as ordered by a physician's orders (G578), failed to provide services and treatments only as ordered by a physician (G580), failed to receive verbal orders to provide services (G584), failed to ensure a plan of care was reviewed and revised by the ordering physician every 60 days, or as the patient's condition warrants (G588), failed to ensure the plan of care contained all necessary information from the updated comprehensive assessment and their progress toward their identified goals (G592), failed to ensure the physician and patient were involved in the discharge planning process (G598), failed to ensure they coordinated care with patients, family members/caregivers, patient representatives, and other providers (G608), failed to ensure the patient and their caregiver received ongoing		necessaryinformation from their updated comprehensive assessment and progress towardidentified goals, do not ensure the physician and patient were involved in thedischarge planning process, do not ensure care was coordinated with patients,family members, patients representatives and other providers, do not ensure thepatient and their caregiver received ongoing education and training regardingcare and services provided by the agency, and do not provide all pertinentinformation and instructions related to the patient's care and treatment. Any patients identified during the audit as havingclinical records not containing the required information will be immediatelymodified and corrected with physician orders for correction to be acquired asneeded. The Clinical Manager will provide re-education to RNCase Managers regarding all aspects of care planning, coordination of services,and quality of care to ensure that ongoing actions and documentation areaccurate	

	education and training regarding the care and services provided by the agency (G610), and failed to provide all pertinent information and instructions related to the patient's care and treatment (G620). The cumulative effects of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Conditions of Participation of 42 CFR 484.60, Care Planning, Coordination of Care, and Quality of Care. Findings Include: * 410 IAC 17-13-1(a)		and appropriate. The Clinical Manager will oversee employee schedulesto ensure that all the agency's patients' needs are met on a continuous basis. The Clinical Manager will continue to audit 100% of patient clinical records until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of patient clinical records for another 30 days as long as 100% compliance is met to ensure ongoing compliance. A binder containing audit sheets for each assessment will be kept by the Clinical Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. The Clinical Manager will arrange to receive anddocument daily updates from RN Case Managers that include any patient or	

			important to ensure that all patients receive the care thatthey need. The daily report is to contain any scheduling issues, non-complianceconcerns, changes in condition, infections, newly prescribed antibiotics,falls, health and safety concerns, complaints, hospitalizations, and visits tothe emergency room. The Clinical Manager is responsible for compliance.	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure patients received all services as outlined in a plan of care that included	G0572	**G0572** The Clinical Manager will audit 100% of current clinicalrecords to identify all patients who do not have an individualized care planthat includes patient-specific and measurable goals along with visitfrequencies specific to their needs. The Clinical Manager will provide training to RN CaseManagers to re-educate them to ensure that all care plans are individualizedwith visit frequencies specific to the patients' needs and to includepatient-specific	2023-09-29

	patient-specific, measurable, and pertinent goals for 5 of 7 active clinical records (Active Patients: #2, 4, 5, 6, and 7) and 1 of 2 closed clinical records (Patient: #8) reviewed. Findings Include: 1. A review of the comprehensive assessment for Patient #2 indicated a primary diagnosis of anoxic brain damage (brain injury resulting from a complete lack of oxygen to the brain), cephalic seizures (interruption in electrical activity in the brain), transient ischemic attack (TIA – a mini-stroke with no residual effects), contractures (shortening and hardening of muscles and tendons, often causing deformity), cerebral vascular accident (CVA – sudden bleeding in or blockage of blood flow to the brain; stroke). The assessment further indicated the patient was a fall risk, was incontinent, had a recent fracture, and utilized a wheelchair. Review of the patient's home health aide visit notes for 07/19/23 - 08/22/23 indicated the patient and/or spouse continued to refuse bathing, personal care, assist		measurable goals. The Clinical Manager will continue to audit 100% of plans of care until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of plans of care for another 30 days as long as 100% compliance continues to be met to ensure that patients receive all services on the plan ofcare and that the plan of care contains patient-specific measurable goals. Abinder containing each audit will be kept by the Clinical Manager, and thisbinder will be brought to weekly meetings between the Administrator, Clinical Manager,Assistant Clinical Manager, and Scheduler for 60 days to discuss any deficiencies that havebeen found during the week, and to discuss potential solutions to deficienciesfound. The Clinical Manager is responsible for compliance.	

	with feeding, dressing, oral care, and assist with toileting. A review of the plan of care for Patient #2, for certification period 07/21/23 - 09/18/23, indicated the patient received home health aide services 4 hours/ day x 5 days/week for personal care including, but not limited to weekly bed/chair bath, transfers, meal prep/feeding, and dressing and evidenced a goal of "Patient to maintain good hygiene with no impaired skin AEB [As Evidenced By] complying with bathing schedule and incontinence care as needed. The plan of care failed to evidence patient-specific, individualized, and measurable goals pertinent to the patient's diagnoses, mobility and personal care needs as determined by comprehensive assessment, and reason for home health services. A review of the comprehensive assessment for Patient #6 indicated a primary diagnosis of paraplegia and a secondary diagnosis of type 2 diabetes mellitus. The patient used a slide board, experienced chronic pain at 8-9/10, utilized leg			

wraps, was a fall risk, and denied monitoring blood sugars.

A review of the plan of care, for certification period 08/03/23 - 10/01 23 evidenced a goal of "Patient to elevate BLEs (Bilateral Lower Extremities) 2x/day to decrease edema x 60 days." The plan of care failed to evidence patient-specific, individualized, and measurable goals pertinent to the patient's mobility, fall risk status, severe chronic pain, application of leg wraps, and diabetic non-compliance.

1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021 Briggs Healthcare policy titled, “Home Health Aide Services, Policy No. C-220”. The policy indicated but was not limited to, “ … 3. The Aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising Nurse … “

2. On 08-24-2023 at 12:36 PM, Patient #4’s clinical record was reviewed. The clinical record

	start of care date of 10-24-2022 and a certification period of 06-21-2023 to 08-19-2023. The plan of care evidenced Patient #4 was to receive Home Health Aide (HHA) services 2.5 hours a day, 3 days a week for the first week and 2.5 hours a day, 4 days a week for the remainder of the certification period. The clinical record evidenced document titled "Physician Notification" dated 6-30-2023 and 07-14-2023. The notification dated 6-30-2023 evidenced Patient #4 had missed home visits on 06-26-2023 and 06-30-2023 because the caregiver called in. The notification dated 07-14-2023 evidenced Patient #4 had missed home visits on 07-13-2023 and 07-14-2023 because the caregiver called in. The agency failed to ensure the patient received all the services, days, and hours as ordered in the plan of care.			

	During an interview with Patient #4 on 08-24-2023 at 9:25 AM, the patient indicated the agency did not contact them if HHA 12 was unavailable and were "not good about getting me a new one if (sic HHA 12) misses". 3. On 08-24-2023 at 3:25 PM, Patient #8's discharge record was reviewed. The clinical record evidenced a plan of care with a start of care date of 05-02-2022 and a certification period of 12-28-2022 to 02-25-2023. The plan of care evidenced Patient #8 was to receive Home Health Aide (HHA) services 1 hour a day, 2 times a week for the first week and 1 hour a day, 3 times a week for the remainder of the certification period. The discharge clinical record of Patient #8 evidenced documents titled "Physician Notification". The "Physician Notification" note dated 12-9-2022 indicated on 12-07-2022 and 12-09-2022 the patient had missed HHA visits because the caregiver called in. The "Physician Notification" note dated 12-23-2022 indicated on 12-19-2022 and 12-23-2022 the patient had			

	missed HHA visits because the caregiver called in. The "Physician Notification" note dated 01-27-2023 indicated on 01-25-2023 the patient had missed a missed visit because the caregiver called in. The "Physician Notification" note dated 02-03-2023 indicated on 01-30-2023 and 02-03-2023 the patient had missed HHA visits because the caregiver called in.			

	During an interview with Person U, Patient #8's spouse, on 08-25-2023 at 8:42 AM, they indicated the agency provided "terrible service, terrible communication". Person U indicated they never knew what aide was coming out and would not let them know if they were unable to get a caregiver to come out and help Patient #8. Person U indicated the management would not listen and they indicated they (the spouse) were not able to care for Patient #8 on their own. Person U indicated they had made a complaint to the Administrator, management, and the owner regarding Patient #8 not receiving HHA services 3 times a week, but nothing was ever done to correct the concern. 4. On 08-25-2023 at 9:30 AM, Patient #5's active clinical record was reviewed. The clinical record evidenced plans of care with a start of care date of 10-12-2022 and a certification period from 06-09-2023 to 08-07-2023. The plan of care indicated the patient was to receive HHA services 8 hours a day, 1 day a week for the first week, 8.5			

	hours a day, 4 days a week and 8 hours a day 1 day a week for weeks 2-9 of the certification period, and 8.5 hours a day, 1 day a week for the last week of the certification period. The aide was to assist the patient with activities of daily living (ADLs), bathing, hygiene, dressing, transfers, toileting, positioning, fall risk/safety, companionship, and light housekeeping. The clinical record evidenced aide visit notes from HHA 13. On the visit note dated 06-13-2023, the note evidenced HHA 13 worked from 7:19 AM to 11:12 AM and 9:34 PM to 12:00 AM. The document failed to evidence Patient #5 received all hours according to the plan of care. On the visit note dated 06-14-2023, the note evidenced HHA 13 worked from 8:08 AM to 3:49 PM and 10:05 PM to 11:53 PM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 06-15-2023, the note evidenced HHA 13 worked from 8:13 AM to 4:45 PM to 11:11 PM to 1:38 AM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note			

	dated 06-16-2023, the note evidence HHA 13 worked from 8:30 AM to 10:30 AM and 9:00 PM to 11:30 PM. The document failed to evidence the patient received all hours according to the plan of care. On the visit note dated 06-17-2023, the note evidenced HHA 13 worked from 7:00 AM to 10:30 AM. The document failed to evidence the plan of care was followed by the patient receiving an additional day of services. On the visit note dated 06-19-2023, the note evidenced HHA 13 worked from 7:58 AM to 3:30 PM and 10:00 PM to 11:30 PM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 06-20-2023, the note evidenced HHA 13 worked from 8:03 AM to 1:30 PM and 10:03 PM to 11:30 PM. The document failed to evidence the patient received all hours according to the plan of care. On the visit note dated 06-21-2023, the note evidenced HHA 13 worked from 8:23 AM to 3:00 PM and 10:00 PM to 11:30 PM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 06-22-2023, the note evidenced			

	HHA 13 worked from 8:30 AM to 4:30 PM and 9:30 PM to 12:30 AM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 06-27-2023, the note evidenced HHA 13 worked from 8:15 AM to 3:30 PM and 10:00 PM to 12:00 AM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 06-28-2023, the note evidenced HHA 13 worked from 8:50 AM to 2:22 PM and 10:06 PM to 11:39 PM. The document failed to evidence the patient received all hours according to the plan of care. On the visit note dated 06-29-2023, the note evidenced HHA 13 worked from 8:17 AM to 12:00 PM and 7:30 PM to 12:30 AM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 07-06-2023, the note evidenced HHA 13 worked from 8:10 AM to 3:22 PM and 9:00 PM to 11:30 PM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 07-06-2023, the note evidenced HHA 13 worked from			

	6:00 PM to 11:00 PM. The document failed to evidence the patient received all hours according to the plan of care. On the visit note dated 07-10-2023, the note evidenced HHA 13 worked from 7:36 AM to 3:30 PM and 10:15 PM to 11:30 PM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 07-11-2023, the note evidenced HHA 13 worked from 8:35 AM to 4:26 PM and 10:10 PM to 11:40 PM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 07-17-2023, the note evidenced HHA 13 worked from 7:31 AM to 1:29 PM and 10:15 PM to 11:59 PM. The document failed to evidence the patient received all hours according to the plan of care. On the visit note dated 07-20-2023, the note evidenced HHA 13 worked from 7:57 AM to 11:45 AM and 8:02 PM to 11:45 PM. The document failed to evidence the patient received all hours according to the plan of care. On the visit note dated 07-21-2023, the note evidenced HHA 13 worked from 8:48 AM to 4:21 PM and 9:23 PM to			

	10:53 PM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 07-24-2023, the note evidenced HHA 13 worked from 8:30 AM to 4:00 PM and 10:04 PM to 11:30 PM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 07-25-2023, the note evidenced HHA 13 worked from 8:18 AM to 3:24 PM and 10:00 PM to 11:29 PM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 07-26-2023, the note evidenced HHA 13 worked from 8:15 AM to 1:20 PM and 10:08 PM to 11:45 PM. The document failed to evidence the patient received all hours according to the plan of care. On the visit note dated 07-28-2023, the note evidenced HHA 13 worked from 8:04 AM to 5:30 PM and 10:03 PM to 11:30 PM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 07-31-2023, the note evidenced HHA 13 worked from 8:06 AM to 4:30 PM and 9:53 PM to 12:00 AM. The document			

	evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 08-01-2023, the noted evidenced HHA 13 worked from 8:03 AM to 2:00 PM and 10:07 PM to 11:30 PM. The document failed to evidence the patient received all hours according to the plan of care. On the visit note dated 08-02-2023, the note evidenced HHA 13 worked from 7:47 AM to 11:45 AM and 10:12 PM to 11:45 PM. The document failed to evidence the patient received all hours according to the plan of care. On the visit note dated 08-04-2023, the note evidenced HHA 13 worked from 8:56 AM to 12:32 PM and 9:00 PM to 3:00 AM. The document evidenced the patient received more hours than ordered on the plan of care. On the visit note dated 08-07-2023, the note evidenced HHA 13 worked form 7:17 AM to 2:41 PM and 9:15 PM to 11:00 PM. The document evidenced the patient received more hours than ordered on the plan of care. Attempted to call Patient #5 on 08-25-2023 at 2:08 PM, a voicemail was left requesting a			

returned.

5. On 08-25-2023 at 2:55 PM, Patient #7's active clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 03-24-2022 and a certification period from 07-17-2023 to 09-14-2023. The plan of care evidenced Patient #7 was to receive HHA services 8 hours a day, 5 days a week for the first 8 weeks of the certification period and 8 hours a day, 4 days a week for the last week of the certification period. A review of the clinical record evidenced the agency sent a discharge notice to Patient #7 and their family. During a review of the HHA visit notes, they evidenced the patient had not received HHA services since 08-18-2023. A visit note dated 08-22-2023 evidenced HHA 11 clocked in and clocked out, but no services were provided to the patient.

On 08-28-2023 at 9:30 AM, attempted to call Patient #7's family member, Person Z, a voicemail was left requesting a return call. Person Z never returned the call.

	During an interview with the Director of Nursing (DON) on 08-28-2023 at 10:43 AM, they indicated HHA 11 had put their notice in, and Patient #7 had not been staffed since the aide had put in their notice. The DON indicated Patient #7's family refused another HHA than the normal aide. The record failed to evidence Patient #7, and their family, refused services from another HHA. 6. During an interview with the Administrator on 08-28-2023 at 11:58 AM, they indicated if an on-call HHA was not available, they cancel the visit if they are unable to staff it and notify the physician of the missed visit. 7. During an interview with the Administrator on 08-28-2023 at 12:18 PM, they indicated the plan of care was to be followed. 8. On 08-28-2023 at 1:08 PM, an attempt to call HHA 11 was made. A voicemail was left requesting a return call. The call was not returned by HHA 11.			
G0574	Plan of care must include the following	G0574	**G0574** The Clinical Manger will audit	2023-09-29

	484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review and interview, the agency failed to implement its policy requiring the plan of care to be individualized to include all pertinent diagnoses, all		100% of active patientclinical records to analyze the plan of care for correct content including allpertinent diagnoses, mental, psychosocial, and cognitive status, types ofservices, supplies, and equipment required, the frequency and duration ofvisits to be made, prognosis, rehabilitation potential, functional limitations,activities permitted, nutritional requirements, all medications, treatments,and safety measures to protect against injury, a description of the patient'srisk for emergency department visits and hospital readmissions, necessaryinterventions to address the underlying risk factors, patient and caregivereducation and training to facilitate timely discharge, patient-specificinterventions and education, measurable outcomes and goals identified by theHHA and patient, information related to advanced directives, and any additionalitems the HHA or physician may choose to include. Any identified items orinformation missing will be corrected with physician verbal orders. The Clinical Manager will	

	supplies and equipment necessary to meet the patient's needs, mental status, nutritional requirements, type, frequency, and duration of all services the patient was receiving, all safety measures, services being provided by outside agencies and facilities, all necessary interventions, specific education and training, measurable outcomes and goals, discharge planning needs for 5 of 7 active clinical records reviewed. (Patients: #1, 3, 4, 5, and 7) Findings Include: 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021, Briggs Healthcare policy titled, "Plan of Care, Policy No. C580". The policy indicated but was not limited to, " ... 2. The Plan of Care shall be completed in full to include:. a. all pertinent diagnoses ... c. type, frequency, and duration of all visits/services ... h. Rehabilitation potential ... k. specific dietary or nutritional requirements or restrictions ... l. medications ... m. Medical supplies and equipment required, n. Any safety		continue to audit 100% ofplans of care until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of plans of care for another 30 days as long as 100% compliance continues to be met to ensure ongoing compliance. Findings of incorrect or missinginformation will be given to the RN Case Managers for corrections that arerequired to be turned back into the Clinical Manager after revision within 48hours. A binder containing each audit will be kept by theClinical Manager, and this binder will be brought to weekly meetings betweenthe Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler for 60 days to discuss any deficiencies that have been found during the week, and todiscuss potential solutions to deficiencies found. RN Case Managers will receive education and trainingon all parameters of the plan of care from the Clinical Manager along withreview of correct examples. The Clinical Manager is	

	injury, o. Instructions to client/caregiver … p. Treatment goals … r. Discharge plans … t. other appropriate items …" 2. On 08-22-2023 11:05 AM, Patient #1's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 09-13-2021 and a certification period of 07-05-2023 to 09-02-2023. The plan of care (POC) evidenced the following diagnoses Multiple Sclerosis (damage to the spinal cord causing numbness, speech and muscle impairment, fatigue, and blurred vision), Monoplegia of the lower limb (paralysis of the lower limb), and Hypertension (high blood pressure). The POC indicated the patient was to receive Skilled Nursing (SN) services 2 hours every 60 days for recertification assessments and as needed for injury, complaint, or supervisory visit. The POC failed to indicate the patient was to have their medication setup every 2 weeks by the Registered Nurse. The POC failed to indicate the patient's rehabilitation potential. The POC evidenced a section titled "Goals/Rehabilitation		responsible for compliance.	

	Potential/Discharge Plans", the section indicated, "Patient to maintain good skin integrity r/t (sic related to) decreased mobility and incontinence AEB (sic as evidenced by) no alterations in skin during certification period. ..." The plan of care failed to include treatment goals and discharge plans. The POC failed to include the other agencies and facilities involved in Patient #1's care. The clinical record for Patient #1 evidenced a document titled "Recertification of care – Physician Verbal Orders". The document indicated the patient was to receive SN 1 hour every two week for medication setup, assessment, and supervisory visit. The order failed to be listed on Patient #1's plan of care. During an interview with Person B, a case worker for Entity A, a social services agency, on 08-24-2023 at 12:45 PM, they indicated they coordinate with service providers and had monthly visits to check-in with Patient #1 and provided guidance to the caregiver. During an interview with Person			

	L, a case manager at Entity K, indicated they had never been contacted by the home health agency and indicated they provided nursing advice, and provided Patient #1 and their caregivers community resources to improve the patient's quality of care. 3. On 08-23-2023 at 1:13 PM, Patient #3's clinical record was reviewed. The POC evidenced a start of care date of 01-29-2021 and a certification period from 07-18-2023 to 09-15-2023. The POC indicated the patient had the following diagnoses Chronic Obstructive Pulmonary Disease (COPD, a disease causing difficulty breathing and narrowing of the airway) and Diabetes Mellitus Type 2 (a disease were the body is unable to regulate the sugar levels in the body). The POC failed to identify the patient's rehabilitation potential. The POC evidenced a section titled "DME (sic Durable medical equipment) and Supplies", the section listed, "O2 (sic oxygen), nebulizer, commode, wheelchair, gloves, walker, insulin pump. The POC failed to include the equipment used to bring the oxygen to the patient			

	for a diagnosis of COPD, failed to include a glucometer and chemstrips for a diagnosis of Diabetes Mellitus Type 2. The POC indicated the patient had bowel/bladder incontinence limitations, the DME failed to evidence incontinence supplies for the patient. The POC evidenced a section titled "Goals/Rehabilitation Potential/Discharge Plans", the section indicated, "PT (sic Patient) will maintain adequate nutrition for this recertification period AED (sic as evidenced by) eating 3 meals a day. Patient education provided on importance of adequate nutrition. ..." The POC failed to include patient-specific education, instruction, and treatment goals. The POC failed to provide blood sugar parameters for their diagnosis of Diabetes Mellitus Type 2. 4. On 08-24-2023 at 9:25 AM, a home observation was conducted at Patient #4's residence. Upon entry into the patient's residence the patient indicated they had an ulcer on their right heel for a year, the patient had a sock on the right foot. It was observed the patient			

	home. On 08-24-2023 at 11:25 AM, Patient #4's record was reviewed. The clinical record evidenced plans of care with a start of care date of 10-24-2022 and a certification period from 06-21-2023 to 08-19-2023 and a certification period from 08-20-2023 to 10-18-2023. The POC evidenced the following diagnoses, COPD, Right foot drop (difficulty in lifting the front part of the foot), Arthritis (stiffness of the joints), Fibromyalgia (generalized pain, stiffness, and fatigue in the body), and Bradycardia (low heart rate). The POC failed to evidence the patient's right heel ulcer on the list of the patient's diagnoses. The POC failed to identify the patient's rehabilitation potential. The plans of care evidenced a section titled "DME and Supplies", the section listed the patient had bilateral lower extremity braces, a walker, and a shower seat. The POC failed to include the electric wheelchair found in the patient's home during the home observation. The POC failed to indicate when the as needed medication Albuterol would be used. The			

	POC evidenced a section titled "Goals/Rehabilitation Potential/Discharge Plans", the section indicated, "Patient to maintain adequate hygiene aeb showering 3x weekly. Educated patient on when to call SN (Skilled Nurse), MD (Medical Doctor) or 911. Educated to utilize adaptive equipment for safe mobility and transfers." The POC failed to include patient-specific education, instruction, treatment goals, and discharge plans. The POC failed to include all other providers involved in Patient #4's care. The other providers included Entity A, a social work service, and Entity T, a wound center, providing care for Patient #4. Patient #4's clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 06-19-2023 at 10:00 AM. The section titled "Skin/Wound/Ostomy" indicated the patient had a right heel wound with wound care performed weekly. A document titled "Recertification Comprehensive Assessment" dated 08-18-2023 at 9:00 AM, included a section titled			

	indicated the patient had a right heel ulcer, and received weekly wound care from Entity T, a wound center. Attempted to contact Person S, a case worker at Entity A for Patient #4, on 08-25-2023 at 8:35 AM. A voicemail was left, but the call was never returned. Attempted to contact Entity T, the wound center for Patient #4, on 08-25-2023 at 8:39 AM. A voicemail was left, but the call was never returned. 5. On 08-25-2023 at 9:30 AM, Patient #5's clinical record was reviewed. The clinical record evidenced a POC with a start of care date of 10-12-2022 and a certification period from 06-09-2023 to 08-07-2023 and a POC with a certification period from 08-08-2023 to 10-06-2023. The POC evidenced a primary diagnosis of Quadriplegia (paralysis in all 4 limbs). The POC failed to identify the patient's rehabilitation potential. The POC evidenced a section titled "DME and Supplies", the section listed the patient had a wrist brace, abdominal binder,			

	shower chair, gloves, and a hospital bed. The POC indicated the patient had bowel/bladder incontinence limitations and failed to include the necessary supplies, briefs, in the DME. The POC evidenced a section titled "Goals/Rehabilitation Potential/Discharge Plans", the section indicated, "Patient to have no new skin breakdown due to pressure injuries x 60 days. ..." The POC failed to include patient-specific education and treatment goals. The POC failed to include all other providers involved in Patient #5's care. The other provider included Entity X, a urology physician office, where Patient #5 received care. 6. On 08-25-2023 at 2:55 PM, Patient #7's clinical record was reviewed. The clinical record evidenced a POC with a start of care date of 03-24-2023 and a certification period from 05-18-2023 to 07-16-2023 and a POC with a certification period from 07-17-2023 to 09-14-2023. The comprehensive assessment the patient had diagnoses TBI (Traumatic Brain injury, trauma caused damage to the brain), seizures (uncontrolled electrical activity			

	causes abnormal movement in the body), and Oglivies Syndrome (a distended abdomen when the individual does not have a mechanical obstruction in the abdomen). The POC contained a section titled "Nutritional Req. (sic Requirements), the section indicated, "Two cal 2.0 via (sic through) g-tube (gastrostomy tube, a surgical opening in the abdomen, where a tube was placed to provide nutrients to the individual). The POC failed to evidence the amount, rate, duration, and frequency of the feedings. The POC failed to evidence a water flush amount, rate, duration, and frequency for before and after the feedings. The POC indicated the patient had oxygen on their DME and supplies list but failed to indicate oxygen as a safety measure. The section titled "DME and Supplies" failed to list seizure pads for the patient's hospital bed to protect the patient during a seizure episode. The POC evidenced a section titled "Goals/Rehabilitation Potential/Discharge Plans", the section indicated, "PT (sic Patient) to maintain skin integrity aeb no skin breakdown			

	r/t incontinence of bowel and bladder within this certification period. ..." The POC failed to include patient-specific education, interventions, and treatment goals. 7. During an interview with the Director of Nursing (DON) on 08-23-2023 at 11:35 AM, when queried regarding the elements to be included on the POC, they indicated they would include the patient's diagnoses, medications, services provided, 60-day recertification dates, allergies, DME, facility information, patient information, goals, discharge planning, prognosis. The DON indicated the goals and discharge planning were to be patient-specific and patient-identified goals.			

	8. During an interview with the DON on 08-28-2023 at 10:50 AM, they indicated the POC should be patient specific and include all pertinent information pertaining to the patient's care. The DON indicated the nutritional needs and safety measures were to be patient-specific, and all pertinent information should be included. 410 IAC 17-13-1(a)(1)(D)(ii, iii, v, viii, x, xi, and xiii)			
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 physician orders, including verbal orders, were listed on the plan of care for 1 of 3 active clinical records reviewed with a home visit. (Patients: #1) Findings Include: 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021, Briggs	G0576	**G0576** The Clinical Manager will audit 100% of active patientclinical records to analyze the plan of care for correct content and inclusionof all physician orders, including verbal orders. Any identified items or information missing will becorrected with physician verbal orders. The Clinical Manager will continue to audit 100% ofplans of care until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of plans of care for another 30	2023-09-29

	Healthcare policy titled, "Plan of Care, Policy No. C580". The policy indicated but was not limited to, " ... 2. The Plan of Care shall be completed in full to include:. ... c. type, frequency, and duration of all visits/services ... t. other appropriate items ..." 2. On 08-22-2023 11:05 AM, Patient #1's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 09-13-2021 and a certification period of 07-05-2023 to 09-02-2023. The plan of care indicated the patient was to receive Skilled Nursing (SN) services 2 hours every 60 days for recertification assessments and as needed for injury, complaint, or supervisory visit. The plan of care failed to indicate the patient was to have their medication setup every 2 weeks by the Registered Nurse. The clinical record for Patient #1 evidenced a document titled "Recertification of care – Physician Verbal Orders". The document indicated the patient was to receive SN 1 hour every two week for medication setup, assessment, and supervisory visit. The order failed to be		days as long as 100% compliance continues to be met to ensure ongoing compliance with all orders being recorded onthe plan of care. A binder containing each audit will be kept by theClinical Manager, and this binder will be brought to weekly meetings betweenthe Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler for 60 days to discuss any deficiencies that have been found during the week, and todiscuss potential solutions to deficiencies found. The Clinical Manager is responsible for compliance.	

	listed on Patient #1's plan of care.			
G0584	Verbal orders 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. Based on record review and interview, the agency failed to ensure orders were obtained in advance of providing care and failed to ensure verbal/phone orders were obtained by a Registered Nurse, then documented, read back, and verified at the time of receipt and in advance of providing care for 3 of 7 active clinical records reviewed. (Patients: #1, 2, and 6)	G0584	**G0584** The Clinical Manager will audit 100% of active patientclinical records to identify any additional potentially missing verbal orders. The Clinical Manager will re-educate RN Case Manageron the proper procedure for obtaining verbal orders prior to provision of careincluding that verbal orders must be obtained by an RN, documented, read back,and verified at the time of receipt. The Clinical Manager will continue to audit 100% of patientclinical records until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of patient clinical records for another 30 days as long as 100% compliance continues to be met to ensure compliance. A binder containing eachaudit will be kept by the Clinical Manager, and this binder will be brought toweekly meetings between the	2023-09-29

	Findings Include: 1. A review of the comprehensive assessment for Patient #2, dated 07/19/23, evidenced care coordination with the physician was marked but failed to evidence the 07/19/23 comprehensive assessment findings were reviewed with the physician and verbal orders for continued services were received, documented, read back and verified, and sent for signature. A review of a "Recertification of Care/Physician Verbal Orders" document indicated the patient's physician was notified of the assessment findings on 07/19/23 at 10 AM. The record failed to evidence additional documentation that the orders were discussed with the physician or representative, rather than created and faxed to the physician for review, then documented, read back, and verified including but not limited to the patient's nutrition, durable medical equipment, care of a fractured extremity, patient-specific and measurable goals, functional limitations, and seizure precautions.		Administrator, Clinical Manager, Assistant ClinicalManager, and Scheduler for 60 days to discuss any deficiencies that have been found duringthe week, and to discuss potential solutions to deficiencies found. RN Case Managers will turn in verbal orders receivedfrom the physician to the agency Clinical Manager for verification that theyare correct and complete prior to the carrying out of the verbal order. The Clinical Manager is responsible for compliance.	

	2. A review of the comprehensive assessment for Patient #6, dated 08/02/23, evidenced care coordination with the physician was marked but failed to evidence the date and time that the orders were discussed with the physician or representative, rather than created and faxed to the physician for review, then documented, read back, and verified including but not limited to the patient's nutrition, durable medical equipment, patient-specific and measurable goals, functional limitations, and chronic pain. 3. On 08/24/23 at 2:15 PM, the Clinical Manager indicated after a comprehensive assessment was completed, and the orders needed to continue services were placed by nursing onto a plan of care then faxed to the physician for review and signature. The Clinical Manager indicated the physician's receipt of the plan of care of the "Recertification of Care/Physician Verbal Orders" form was considered review of orders. When asked if the comprehensive assessment findings were reviewed verbally			

	the Clinical Manager indicated yes. When asked if a nurse was allowed to give or write orders not received verbally from a physician the Clinical Manager indicated no. When asked if the nurse wrote orders, rather than obtaining them verbally from the physician, then provided care based on those orders in advance of physician review and signature, the Clinical Manager indicated yes.			

	1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021, Briggs Healthcare policy titled, "Physician Orders, Policy No. C635". The policy indicated but was not limited to, " ... 1. When the nurse ... receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly ... The order must include the date, specific order, be signed with the full name and titled of the person receiving the order and be sent to the physician for signature ..." 2. On 08-22-2023 at 11:05 AM, Patient #1's clinical record was reviewed. The clinical record evidenced a document titled "Recertification of Care – Physician Verbal Orders" dated 07-03-2023 at 2:00 PM by the Alternate Director of Nursing (ADON) and signed by Person J, Patient #1's physician, on 07-05-2023. During an interview with Person N, a registered nurse from Entity I, Patient #1's physician's			

	office on 08-23-2023 at 3:33 PM, they indicated the home health agency only notified Patient #1's physician, Person J, through fax for verbal orders. 3. On 08-25-2023 at 2:55 PM, Patient #7's active clinical record was reviewed. The clinical record evidenced a document titled "Resumption of Care, Physician Orders" dated by the Director of Nursing (DON) on 08-14-2023 at 2:00 PM. During an interview with Person 29, a nurse from Entity 27, Patient #7's physician's office, on 08-28-2023 at 11:13 AM. Person 29 indicated the home health agency communicated with Person 28, Patient #7's physician, through fax. The last communication they received from the home health agency was the resumption of care starting 08-14-2023.			
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	G0590	**G0590** The Clinical Manager will audit 100% of active patientclinical records to identify any patients who might have experienced a changein condition that was not	2023-09-29

	achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to notify the physician of a patient's change in condition, for 1 of 7 active patient records reviewed. (Patient #2) Findings include: A review of the agency's complaint log evidenced a complaint dated 05/31/23, which indicated Patient #2's spouse called and stated the patient was complaining of pain after the aide injured the patient's left frozen arm by pulling on it during a transfer on 05/31/23. The log failed to evidence the patient's physician was contacted to notify the physician of a potential injury and change in condition. Further review of the clinical record failed to evidence documentation that the agency communicated with the patient's primary care physician or the bone and joint specialist. On 08/22/23 at 2:07 PM, the Administrator indicated the physician was not contacted		reported to their physician. If any instances ofunreported changes are found, they will be reported to the patient's physicianimmediately. The Clinical Manager will re-educate all RN CaseManagers on the importance and requirement to contact the physician of anypatient who experiences a change in condition immediately to determine if theplan of care should be altered. The Clinical Manager will continue to audit 100% of patient clinical records until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of patient clinical records for another 30 days as long as 100% compliance continues to be met to ensure compliance. A binder containing each audit will be kept by the Clinical Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler for 60 days to discuss any deficiencies that have been found during the week, and to	

	was actually an injury, and the patient hadn't seen the physician yet. 410 IAC 17-13-1(a)(2)		discuss potential solutions to deficiencies found. RN Case Managers will be instructed to inform theAdministrator and Clinical Manager of any patient changes in condition viagroup message at the time the change is noticed or reported. The Clinical Manager is responsible for compliance.	
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on record review and interview, the agency failed to ensure all patients received a revised plan of care that reflected current information from an updated comprehensive assessment, including but not limited to the patient's progress toward previous goals, changes since the previous care plan, updated medications, and all orders, for	G0592	**G0592** The Clinical Manager will audit 100% of active patientclinical records to identify any further patients who might be missing anupdated comprehensive assessment for their last two certification periods. The Clinical Manager will continue to audit 100% of patient clinical records until 100% documentation compliance is met for 30 days. Then the Clinical Manager will audit 50% of patient clinical records for another 30 days as long as 100% compliance continues to be met to ensure compliance. A binder containing each audit will be kept by the Clinical Manager, and this	2023-09-29

	1 of 7 active patient records reviewed. (Patient #6) Findings include: A review of the clinical record for Patient #6 evidenced a comprehensive assessment titled "Recertification Comprehensive Assessment," dated 04/03/23, for the recertification period of 04/05/23 - 06/03/23 and a plan of care for the certification period of 04/05/23 - 06/03/23. The record review evidenced a second comprehensive assessment titled "Comprehensive Adult Assessment," dated 05/24/23, indicated the patient was hospitalized from 05/22/23 - 05/23/23 and was resuming services. The record review evidenced a third comprehensive assessment titled "Recertification Comprehensive Assessment," dated 08/02/23 for the recertification period of 08/03/23 - 10/01/23 and a plan of care for the certification period of 08/03/23 - 10/01/23. The record failed to evidence an updated or revised plan of care for the certification period of		binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler for 60 days to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. The Clinical Manager will re-educate all RN CaseManagers on the requirement to perform a comprehensive assessment for eachpatient for every certification period. The Clinical Manager will schedule the comprehensiveassessment visits according to each patient's 60-day recertification dates foreach RN Case Manager monthly. RN Case Managers will turn in their comprehensiveassessment visit documentation to the Clinical Manager within 48 hours ofcompletion. The Clinical Manager is responsible for compliance.	

	06/04/23 - 08/02/23. On 08/29/23 at 1:52 PM, the Administrator indicated there was no comprehensive assessment completed at the time the patient's recertification was due for the certification period starting 06/04/23, which resulted in a missed plan of care for the same certification period and Patient #6 received services from 06/04/23 - 08/02/23 without orders or a physician ordered plan of care.			
G0598	Discharge plans communication 484.60(c)(3)(ii) (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). Based on record review and interview, the agency failed to ensure the physician was notified of a change in the patient's condition requiring a discharge and transfer to another agency for 1 of 7 active clinical records reviewed.	G0598	**G0598** The Clinical Manager will audit 100% of active patientclinical records to identify any patients that have undergone a recent changein condition that has not been reported to the physician. Any findings ofunreported changes in condition will be met with immediate contact with thepatient's physician's office by the agency Clinical Manager to report thechange. The Clinical Manager will continue to audit 100% of patient clinical records until 100% documentation compliance is met for 30 days.	2023-09-29

	(Patient #7) Findings Include: 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021 Briggs Healthcare policy titled "Client Discharge Process, Policy # C-500". The policy indicated but was not limited to, " ... 3. The physician will be involved in the discharge plan ... 6. The Registered Nurse shall ensure ... appropriate referrals are made to agencies/institutions to meet continuing client needs ... 8. ... a. Evidence that the decision was not made unilaterally. The client, family, and physician participated in the decision to discharge client from the agency. ... d. Documentation of all communication with the client ..." 2. On 08-25-2023 at 2:55 PM, Patient #7's active clinical record was reviewed. The clinical record evidenced a discharge notification letter sent to the patient and their family on 08-18-2023. The clinical record failed to evidence coordination notes to the physician regarding the need to discharge the patient. The		Then the Clinical Manager will audit 50% of patient clinical records for another 30 days as long as 100% compliance continues to be met to ensure compliance. A binder containing each audit will be kept by the Clinical Manager, and this binder will be brought to weekly meetings between the Administrator, Clinical Manager, Assistant Clinical Manager, and Scheduler for 60 days to discuss any deficiencies that have been found during the week, and to discuss potential solutions to deficiencies found. A meeting will be held by the Governing Body, ClinicalManager, and Administrator to discuss any patient the agency feels should bedischarged to a higher level of care due to a change in condition. As part ofthat discussion, contact information for agencies in the area surrounding thepatient's residence will be compiled with contact made to the agencies on thepatient's behalf if or when the patient chooses an agency they would like tohave their services transferred to. The Clinical Manager is	

	clinical record failed to evidence coordination notes to the patient assisting them in finding a new home health agency to transfer to after discharge. The clinical record failed to evidence coordination notes to other potential agencies the patient would go to after discharge. The clinical record evidenced a document titled "Coordination of care with other providers" for Patient #7. The document indicated but was not limited to, " ... Provider: (sic Person BB), Date of Contact: 08-15-2023 ... Contact Person: (sic Person CC, a medical assistant at Person BB's physician's office) ... Concerns/Goals/ Barriers to achievement of goals: resumption findings, acuity level, possible other providers ..." During an interview with the Director of Nursing (DON) on 08-28-2023 at 10:26 AM, they indicated they contacted Patient #7's physician's, Person BB, office, Entity AA, regarding the need to discharge the patient for nursing services. The DON indicated they contacted the other agencies they recommended the Patient #7's		responsible for compliance.	

	family to determine if they offered Skilled Nursing (SN) services. The DON indicated there were no other communication notes documented. During an interview with Person CC, a medical assistant at Patient #7's physician's, Person BB, office, Entity AA, on 08-28-2023 at 11:13 AM, Person CC indicated the home health agency would typically communicate only through fax. They indicated the agency faxed them a resumption of care on 08-15-2023. Person CC indicated there were no notes or communication from the agency regarding them discharging or planning to discharge Patient #7. Person CC indicated Person DD, Patient #7's family member, called Entity AA on 08-15-2023 at 10:01 AM, and indicated they required a referral for a home health agency because they were losing their aide on Friday, 08-18-2023 and the patient required more assistance. Person CC indicated the only recent communication from the home health agency was regarding the resumption of care order. Person EE, an office			

	assistant from Entity AA, sent a document titled "All Conversations: Patient Outreach" and confirmed the conversation from Patient #7's family member, Person DD and the Medical Assistant, Person CC.			
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the agency failed to coordinate care with all individuals and other agencies and facilities involved in the patient's care for 6 of 7 clinical records reviewed. (Patients: #1, 2, 3, 4, 5, and 6) Findings Include: 1. A review of the agency's complaint log evidenced a complaint, dated 06/01/23, which indicated the spouse of Patient #2 notified the Administrator of a suspected injury to the patient's left arm which occurred on 05/31/23	G0608	**G0608** The Clinical Manager andAssistant Clinical Manager will build a patient roster complete with eachpatient's individuals, other agencies, and facilities involved in their care. Theseindividuals, other agencies, and facilities will be contacted when a patienthas a change in condition, when appropriate or applicable to the patient's careor needs, or at least every 60 days to coordinate care. Documentationof each contact made with each individual, other agency, or facility will bekept in the patient's file on the agency's coordination of care template. TheClinical Manager will audit 100% of each patient's clinical documentation as itis handed in by the RN Case Managers until 100% documentation	2023-09-29

	because of the HHA pulling on the patient's frozen arm. the complaint indicated on 06/05/23 that the patient's spouse notified the Administrator that the patient's left arm was fractured. The complaint failed to evidence the agency contacted the patient's physician to coordinate care concerning the suspected injury. 2. A review of the comprehensive assessment for Patient #2, dated 07/19/23, evidenced a box checked for care coordination with the physician. The assessment failed to evidence which physician was contacted and what care was discussed, including but not limited to the current assessment findings, the recent left arm fracture, functional limitations, progress toward previous goals, and the patient's and representative's non-compliance with personal care. On 08/23/23 at 2 PM, the patient's spouse indicated the patient was seen virtually by Person E, a nurse practitioner, and received x-rays on 06/01/23. The patient was then		Then the Clinical Manager will audit 50% of clinical documentation handed in by RN Case Managers for another 30 days as long as 100% compliance continues to be met. And as part of the audit, the Clinical Manager will ensurethat each individual, other agencies, and facilities involved with the patient’scare are contacted at least every 60 days to coordinate care. A bindercontaining each audit will be kept by the Clinical Manager, and this binderwill be brought to weekly meetings between the Administrator, Clinical Manager,Assistant Clinical Manager, and Scheduler for 60 days to discuss any deficiencies that havebeen found during the week, and to discuss potential solutions to deficienciesfound. The Clinical Manager is responsible for compliance.	

	practitioner with Entity F, a bone and joint specialist, who determined the patient had a left humorous fracture and multiple fractures in the left shoulder ball and joint. The record failed to evidence care coordination concerning the fractured extremity with the physician, specialist, Clinical Manager, Alternate Clinical Manager, or Administrator. 3. A review of the comprehensive assessment for Patient #6, dated 08/02/23, evidenced a box was checked for coordination of care with the physician. The comprehensive assessment failed to evidence what care was coordinated, who was involved, the date and time of the care coordination and whether the assessment findings were reviewed. A review of a document titled "Coordination of Care with Other Providers," dated 08/03/23, evidenced a provider name of Person GG, the patient's physician, and the physician representative, Person HH. Concerns/goals/Barriers to achievement was answered as "Recert/POC			

	(Recertification/Plan of Care)" The remainder of the form was blank. The record failed to evidence care coordination occurred with the patient's care team, including the physician, the Administrator, the Clinical Manager, the Alternate Clinical Manager, and the home health aides assigned to the patient's case. 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021 Briggs Healthcare policy titled, "Coordination of Client Services, Policy No. C360". The policy indicated but was not limited to, " ... 4. Agency will communicate with ALL physicians who are writing orders regarding the plan of care ... 5. Coordination of care will include dealing with multiple programs for the complex clients ... 6. Clients, their representatives, and other caregivers will be included in the coordination activities and will receive direct communication related to planning and change in the plan ... 11. Coordination will include providers of care who are not part of the agency ..." 2. On 08-22-2023 at 11:05 AM,			

	Patient #1's clinical record was reviewed. The clinical record evidenced documents titled "Coordination of Care with Other Providers". The document failed to indicate the home health coordinated care with Entity A, a social services agency, and Entity K, an agency who provided the patient with community resources. During an interview with Person B, a case worker for Entity A, a social services agency, on 08-23-2023 at 12:45 PM, they indicated they coordinate with service providers and had monthly visits to check-in with Patient #1 and provided guidance to the caregiver. They indicated Patient #1 received services from Entity K, an agency who provided patients with community resources. During an interview with Person L, a case manager at Entity K, on 08-23-2023 at 2:07 PM, indicated they have never been contacted by the home health agency and indicated they provided nursing advice, and provide Patient #1 and their caregivers resources they would need.			

During an interview with Person N, a registered nurse from Entity I, Patient #1's physician's office on 08-23-2023 at 3:33 PM, they indicated the home health agency only notified Patient #1's physician, Person J, through fax for verbal orders.

3. On 08-23-2023 at 1:13 PM, Patient #3's clinical record was reviewed. Patient #3's clinical record evidenced documents titled "Coordination of Care with Other Providers". The documents failed to evidence Person P, a Patient #3's podiatrist, was contacted to coordinate with for the patient.

During an interview with HHA 15 on 08-24-2023 at 8:59 AM, they indicated Patient #3 went to Person P, a podiatrist, once a week for the patient's left great toe amputation.

Attempted to call Person P, Patient #3's podiatrist, on 08-24-2023 at 9:15 AM, a voicemail was left requesting a return call. The call was never returned for the remainder of the survey.

4. On 08-24-2023 at 12:36 PM, Patient #4's clinical record was reviewed. The clinical record

	evidenced documents titled "Case Conference/Coordination of Care". The documents failed to evidence care was coordinated with Person S, Patient #4's case worker from social work service agency, Entity A. Attempted to contact Person S, a case worker at Entity A for Patient #4, on 08-25-2023 at 8:35 AM. A voicemail was left, but the call was never returned. 5. On 08-25-2023 at 9:30 AM, Patient #5's clinical record was reviewed. The clinical record evidenced a document titled "Recertification Comprehensive Assessment" dated 06-08-2023 at 12:00 PM and another dated 08-07-2023 at 12:00 PM. The comprehensive assessment failed to include whether the patient had a primary caregiver or a temporary caregiver and their schedule and availability. The clinical record of Patient #5 failed to evidence Coordination of care notes with the patient, caregiver, and Entity X, a urology physician office, Patient #5 received care. 7. On 08-25-2023 at 2:55 PM,			

	record was reviewed. The clinical record evidenced a discharge notification letter sent to the patient and their family on 08-18-2023. The clinical record failed to evidence coordination notes to the physician regarding the need to discharge the patient. The clinical record failed to evidence coordination notes to the patient assisting them in finding a new home health agency to transfer to after discharge. The clinical record failed to evidence coordination notes to other potential agencies the patient would go to after discharge. The clinical record evidenced a document titled "Coordination of care with other providers" for Patient #7. The document indicated but was not limited to, " ... Provider: (sic Person 28), Date of Contact: 08-15-2023 ... Contact Person: (sic Person 29, a medical assistant at Person 28's physician's office) ... Concerns/Goals/ Barriers to achievement of goals: resumption findings, acuity level, possible other providers ..." During an interview with the Director of Nursing (DON) on			

	08-28-2023 at 10:26 AM, they indicated they contacted Patient #7's physician's, Person 28, office, Entity 27, regarding the need to discharge the patient for nursing services. The DON indicated they contacted the other agencies they recommended the Patient #7's family to determine if they offered Skilled Nursing (SN) services. The DON indicated there were no other communication notes documented. During an interview with Person 29, a medical assistant at Patient #7's physician's, Person 28, office, Entity 27, on 08-28-2023 at 11:13 AM, Person 29 indicated the home health agency would typically communicate only through fax. They indicated the agency faxed them a resumption of care on 08-15-2023. Person 29 indicated there were no notes or communication from the agency regarding them discharging or planning to discharge Patient #7. Person 29 indicated Person 30, Patient #7's family member, called Entity 27 on 08-15-2023 at 10:01 AM, and indicated they required a referral for a home			

	health agency because they were losing their aide on Friday, 08-18-2023 and the patient required more assistance. Person 29 indicated the only recent communication from the home health agency was regarding the resumption of care order. Person 31, an office assistant from Entity 27, sent a document titled "All Conversations: Patient Outreach" and confirmed the conversation from Patient #7's family member, Person 30 and the Medical Assistant, Person 29. 8. During an interview the Administrator and Director of Nursing (DON) on 08-29-2023 at 8:55 AM, the Administrator indicated they had discussed improving on documentation of coordination of care with all providers and individuals involved in the plan of care for the patients. The DON indicated the communication to physician offices and all outside providers was not all included in the clinical records.			
G0640	Quality assessment/performance improvement	G0640	**G0640** The Governing Body has	2023-09-29

	484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the Governing Body failed to develop, implement, evaluate, and maintain an ongoing, agency-wide QAPI program that measured, analyzed, and tracked measurable and data-driven quality indicators, including adverse events, for health, safety, agency operations, and quality of care (G642); failed to use quality indicator data to monitor the effectiveness and safety of care and services and identified opportunities for improvement (G644); failed to focus on high risk, high volume, or problem-prone areas, such as hospitalizations, infections, adverse events, and home health aide services (G648); Considered		recognized that the currentQAPI program does not encompass all required elements including infections,hospitalizations, complaints, and adverse events. The Governing Body alsorecognizes that a plan to attempt to identify and decrease the occurrence ofinfections, hospitalizations, complaints, and adverse events should be part ofthe overall QAPI plan and QAPI meetings should discuss these issues todetermine actions that could be taken to improve quality of care. In addition to the current Visit Notes QAPI projectthe agency is conducting, a QAPI project that addresses complaints and adverseevents will be implemented due to the severity of the adverse event thatoccurred at the agency in May of 2023. All complaints will result in a meetingbetween the Governing Body, Administrator, Clinical Manager, and AssistantClinical Manager within 48 hours of the complaints to ensure the plan forresolution of the complaint is appropriate and approved by each member of management.	

	problems in those areas (G650); failed to immediately correct any identified problem(s) that threatened the health and safety of patients (G652); initiated performance improvement plans which tracked and analyzed adverse events and implemented corrective or preventative actions G654); measured and tracked the success of performance improvement in the identified areas to ensure that improvements were sustained (G656); conducted performance improvement projects (PIP) that reflected the scope and complexity of the needs of the agency's patient needs and previously identified regulatory performance needs, and documented the PIPs undertaken and the measurable progress achieved (G658); failed to ensure the QAPI program established clear expectations for patient safety and assessed for and addressed any findings of fraud or waste (G660) for 1 of 1 Governing Body of a Home Health Agency. The cumulative effects of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.65, Quality Assessment and Performance Improvement. 1. On 08-29-2023 at 8:10 AM,		All infections and hospitalizations will be discussedduring monthly QAPI meetings to determine if management finds that anyinfections or hospitalizations might be correlated in any way and have thepossibility of being prevented due to action that the agency could take toprotect patients or employees. The Administrator will keep tracking records ofinfections, complaints, hospitalizations, and falls to aid in determining anypossible reasons for further analyzation or performance improvement plansregarding these events. 100% of infections, hospitalizations, complaints,falls, and adverse events will be monitored on an ongoing basis by the agencyAdministrator. The Governing Body and Administrator are responsiblefor ongoing compliance.	

	the Administrator provided a February 22, 2021 Briggs Healthcare policy titled, Quality Assessment and Performance Improvement (QAPI), Policy No. C260". The policy indicated but was not limited to, " ... To use performance improvement activities to track adverse client events, analyze their causes and implement preventive actions ... 1. The program will be capable of showing measurable improvement in indicators that will improve health outcomes, client safety, and quality of care. 2. The agency will ... analyze ... indicators that include client adverse events, and other relevant data to assess processes of care, services, and operations ... Standard Program Activities ... 1. The agency's performance improvement activities will focus on high risk, high volume, or problem prone areas ..." 2. On 08-24-2023 at 11:35 AM, QAPI and the binders associated with QAPI were reviewed with the Administrator. The binder titled "QAPI Meeting" evidenced documents titled "Monthly QAPI Meeting". The documents dated 06-06-2023, 07-03-2023,			

	and 08-01-2023 evidenced the issue with visit notes not being turned in on time and the efforts made to decrease the number of visit notes not being turned in on time. 3. On 08-29-2023 at 8:55 AM, QAPI was reviewed with the Administrator. The Administrator provided a binder titled "Monthly QAPI meetings. The binder contained documents titled "Monthly QAPI Meeting". The document dated 01-03-2023 evidenced the agency had 4 hospital visits, 1 complaint, and 3 coronavirus 19 infections. The document dated 02-07-2023 evidenced the agency had 1 fall with no injury and 4 hospital visits for seizure, bradycardia, dyspnea, and unstable vital signs. The document dated 03-07-2023 evidenced the agency had 1 resolved complaint, 3 hospital visits, 2 coronavirus infections. The document dated 04-04-2023 evidenced the agency had 1 fall, 1 hospital visit, and 1 infection. The document dated 05-02-2023 evidenced the agency had 2 hospital visits for bowel obstruction and facial burn and 1 coronavirus infection. The			

	document dated 06-06-2023 evidenced the agency had 1 fall and 3 hospitalizations. The document dated 07-03-2023 evidenced the agency had 1 complaint and 3 hospital visits. The document dated 08-01-2023 evidenced the agency had 2 hospital visits. The documents failed to evidence the identified hospitalizations, cancellations, call-ins, and infections were discussed and action taken to prevent them in the future. The QAPI program failed to evidence the agency analyzed all adverse events and identified issues affecting the quality of care, patient safety, and efforts to improve health outcomes. 4. On 08-29-2023 at 12:30 PM, a review of the binder titled "Home Visit/Attendance QAPI" evidenced documents titled "Weekly Scheduling/Attendance Meeting". The document dated 01-06-2023 evidenced the agency had a total of 22 missed visits because of 4 cancelations and 18 caregiver call-ins. The document dated 01-13-2023 evidenced the agency had a total of 24 missed visits because			

	of 1 hospitalization, 8 cancellations, and 15 caregiver call-ins. The document dated 01-20-2023 evidenced the agency had a total of 13 missed visits because of 2 cancellations and 11 caregiver call-ins. The document dated 01-27-2023 evidenced the agency had a total of 30 missed visits because of 5 cancellations and 25 caregiver call-ins. The document dated 02-03-2023 evidenced the agency had a total of 23 missed visits because of 4 hospitalizations, 4 cancellations, and 15 caregiver call-ins. The document dated 02-10-2023 evidenced the agency had a total of 17 missed visits because of 1 hospitalization, 2 cancellations, 12 caregiver call-ins, and 2 coronavirus 19 infections. The document dated 02-17-2023 evidenced the agency had a total of 35 missed visits because of 5 hospitalizations, 11 cancellations, and 19 caregiver call-ins. The document dated 02-24-2023 evidenced the agency had a total of 30 missed visits because of 2 hospitalizations, 6 cancellations, and 22 caregiver call-ins. The document dated 03-03-2023 evidenced the agency had a			

	total of 30 missed visits because of 4 hospitalizations, 7 cancellations, and 19 caregiver call-ins. The document dated 03-10-2023 evidenced the agency had a total of 43 missed visits because of 9 hospitalizations, 11 cancellations, 19 caregiver call-ins, and 4 coronavirus 19 infections. The document dated 03-17-2023 evidenced the agency had a total of 15 missed visits because of 6 cancellations and 9 caregiver call-ins. The document dated 03-24-2023 evidenced the agency had a total of 10 missed visits because of 1 cancellation and 9 caregiver call-ins. The document dated 03-31-2023 evidenced the agency had a total of 15 missed visits because of 1 hospitalization, 2 cancellations, and 12 caregiver call-ins. The document dated 04-07-2023 evidenced the agency had a total of 23 missed visits because of 6 cancellations and 17 caregiver call-ins. The document dated 04-14-2023 evidenced the agency had a total of 16 missed visits because of 6 cancellations and 10 caregiver call-ins. The document dated 04-21-2023 evidenced the agency had a total of 20 missed			

	visits because of 3 hospitalizations, 7 cancellations, and 10 caregiver call-ins. The document dated 04-28-2023 evidenced the agency had a total of 23 missed visits because of 6 hospitalizations, 10 cancellations, and 7 caregiver call-ins. The document dated 05-05-2023 evidenced the agency had a total of 20 missed visits because of 2 hospitalizations, 12 cancellations, and 6 caregiver call-ins. The document dated 05-12-2023 evidenced the agency had a total of 20 missed visits because of 5 hospitalizations, 2 cancellations, and 10 caregiver call-ins. The documents failed to evidence the identified hospitalizations, cancellations, call-ins, and infections were discussed and action taken to prevent them in the future. The QAPI program failed to evidence the agency analyzed all adverse events and identified issues affecting the quality of care, patient safety, and efforts to improve health outcomes. The agency failed to ensure adverse events were analyzed			

	and actions taken to prevent further actions. 5. During an interview with the Administrator on 08-24-2023 at 11:35 AM, when queried regarding whether complaints were incorporated into the QAPI program, the Administrator indicated complaints were not directly incorporated into the program. The Administrator indicated the performance improvement program focused on reviewing visit notes and identifying missing notes. They indicated they were assessing to determine what tasks the aide performed, what tasks the patients were accepting, and whether they were needing to modify the aide plan of care. The QAPI documents failed to evidence they discussed the tasks performed by the aides, what tasks the patients were denying, and any modification needed to the care plans. The QAPI program failed to evidence discussions and meetings evidencing how the aide visit notes affected the quality of patient care. 5. During an interview with the			

	8:55 AM, the Administrator indicated the QAPI program was focusing on visit notes being turned in in a timely manner. The Administrator indicated the Owner, Director of Nursing (DON), and Alternate Director of Nursing (ADON), and the Administrator had meetings daily to discuss concerns and issues. The Administrator indicated they focused on the most severe issues. When queried regarding the number of hospitalizations recorded each month, the Administrator indicated they had not noticed any patterns or view it as an issue. They indicated many of the hospitalizations were because of Patient #7. They evidenced they had an issue with Coronavirus 19 infections in their patient and employee population but did not analyze the data and determine an action to take to prevent the spread of Coronavirus 19.			
G0680	Infection prevention and control 484.70	G0680	**G0680** The agency will implementan agency-wide infection control program that follows its policy "InfectionPrevention/Control." Theagency will utilize a Weekly	2023-09-29

	Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. Based on observation, record review, and interview the agency failed to maintain an infection control program with a goal of prevention, control of infections and communicable diseases. The agency failed to ensure proper hand hygiene and infection control (G 682). The agency failed to prevent, control, and investigate infections for their patients (G 684). The cumulative effects of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for all patients and staff under the Condition of Participation of 42 CFR 484.70, Infection Control. Findings Include: *		Update Report provided by the RN Case Managers tothe Clinical Manager for reporting of all potential and actual infections dailythat includes reporting of changes in condition, patients placed onantibiotics, patients with signs, symptoms, or infection with Covid 19, andpatients that have been seen in the emergency department or admitted to thehospital in the last 24 hours. Whena patient is identified with an actual or potential infection, the agencyAdministrator will keep tracking records of all agency infections in anInfection Control Tracking binder for use in identifying trends, remediationeducation of staff if appropriate, and for identifying the types of infectionsthat agency patients are experiencing so that management can implementeducation and interventions to decrease the incidence of infections. Allinfections will be discussed during monthly QAPI meetings to determine ifmanagement finds that any infections might be correlated and have	

			thepossibility of being prevented due to action the agency could take to protectpatients or employees. The Clinical Manager willre-educate RN Case Managers on proper bag technique with emphasis on performinghand hygiene prior to entering and re-entering the bag for instruments orsupplies. Allcurrent agency home health aides will receive formal competency training onhand hygiene and infection control at Premier Health Training Services as partof the home health aide competency training required to provide home healthcare. A record of this training will be placed in each home health aide's file. Aspart of the new-hire process for home health aides, the agency will requiredocumentation of infection control competency training completion as part ofthe aide's overall skills and education competency training which will bemaintained in each home health aide's file. Agency RN Case Managers will focus on witnessing homehealth aides perform proper hand hygiene and utilization of standardprecautions when performing home health aide supervisory visits to ensure thathome health aides are following the procedures they have been trained toperform.	

			The Administrator is responsible for compliance.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation and interview, the agency failed to ensure infection control practices were followed according to the agency's policy in 2 of 3 home visits for hand hygiene and gloving. (Patients: #1 and 4) Findings Include: 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021 Briggs Healthcare policy titled, "Competency Evaluation – Supply Bag Technique, Policy No. D-160". The policy indicated but was not limited to, " … Hands washed before entering bag … Hands washed prior to re-entry after possible contamination …" 2. On 08-29-2023 at 8:10 AM,	G0682	**G0682** The Clinical Manager will re-educate RN Case Managerson proper bag technique with emphasis on performing hand hygiene prior toentering and re-entering the bag for instruments or supplies. Agency home health aides will receive formalcompetency training on hand hygiene and infection control at Premier HealthTraining Services as part of the home health aide competency training requiredto provide home health care. A record of this training will be placed in eachhome health aide's file. As part of the new-hire process for home health aides,the agency will require documentation of infection control competency trainingcompletion as part of the aide's overall skills and education competencytraining which will be maintained in each home health aide's file. Agency RN Case Managers will	2023-09-29

	the Administrator provided a February 22, 2021 Briggs Healthcare policy titled, "Handwashing/Hand Hygiene", Policy No. D-330". The policy indicated but was not limited to, " ... 3. Indications for handwashing and hand antisepsis ... d. between tasks on the same client ... f. after removing gloves ... o. Decontaminate hands before having direct contact with clients ... p. Decontaminate hands after contact with client's intact skin ..." 3. On 08-22-2023 at 1:02 PM, during a home visit with Patient #1, the Alternate Director of Nursing (ADON) was observed performing a medication set-up and assessment for the patient. The ADON failed to complete hand hygiene before reaching into the bag after handling dusty medication containers without gloves. The ADON failed to perform hand hygiene prior to entering the bag to retrieve a stethoscope. Failed to perform hand hygiene prior to re-entering the bag to retrieve a blood pressure cuff. Failed to perform hand hygiene prior to reaching into the bag to retrieve		focus on witnessing homehealth aides perform proper hand hygiene and utilization of standardprecautions when performing home health aide supervisory visits to ensure thathome health aides are following the procedures they have been trained toperform. The Clinical Manager is responsible for compliance.	

	temporal thermometer probe. The ADON failed to perform hand hygiene prior to entering the bag to grab a wipe to clean equipment. During an interview with the ADON on 08-22-2023 at 1:30 PM, they indicated they were to perform hand hygiene before and after care, before entering the bag, when hands were soiled, before donning gloves, and after doffing gloves. 4. On 08-24-2023 at 9:25 AM, during a home visit with Patient #4, Home Health Aide (HHA) 12 was observed providing personal care for the patient. HHA 12 was observed assisting the patient in washing their back, bottom, and the back of the patient's legs with gloves. HHA 12 doffed the used gloves and failed to perform hand hygiene. HHA 12 proceeded to provide the patient with their clean towel, wiped the patient's back with the towel, helped transfer the patient to a chair out of the shower, then removed the bag protecting the patient's foot dressing from the water, and then washed their hands.			

	During an interview with HHA 12 during the home observation on 08-24-2023 at 9:55 AM, they indicated they were to wash their hands before putting gloves on and taking gloves off, and anytime they touch something new.			
G0684	Infection control 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview, the agency failed to track, trend and investigate infectious and communicable diseases for 40 of 40 active patients.	G0684	**G0684** The agency will implement an agency-wide infectioncontrol program that follows its policy "Infection Prevention/Control." The agency will utilize a Weekly Update Report built from daily notification of any patient infections providedby the RN Case Managers to the Clinical Manager for reporting of all potentialand actual infections daily that includes reporting of changes in condition,patients placed on antibiotics, patients with signs, symptoms, or infectionwith Covid 19, and patients that have been seen in the emergency department oradmitted to the hospital in the last 24 hours. When a patient is identified with an actual orpotential infection, the agency	2023-09-29

	Findings Include: 1. On 08-29-2023 at 8:10 AM, the Administrator provided a February 22, 2021 Briggs Healthcare policy titled, "Infection Control Surveillance, Policy No. B-402". The policy indicated but was not limited to, " ... Total surveillance – all infections identified in clients and employees ... The Agency will implement a process of identifying all infections in the client and/or employee population and evaluate effectiveness of current control measures or identify an action plan to improve incidence of infections ... b. When a pattern or trend in infections is identified, the agency will investigate where clients and/or staff may have acquired the infections and what the source of contamination was ... 6 ... The agency will identify follow-up actions taken as a result of identified infections ..." 2. On 08-29-2023 at 12:30 PM, the binder titled "Infection Control" was reviewed. The binder contained documents titled "Infection Control Tracking and Reporting Tool". The documents evidenced		Administrator will keep tracking records of allagency infections in an Infection Control Tracking binder for use inidentifying trends, remediation education of staff if appropriate, and foridentifying the types of infections that agency patients are experiencing sothat management can implement education and interventions to decrease theincidence of infections. All infections will be discussed during monthly QAPImeetings to determine if management finds that any infections might becorrelated and have the possibility of being prevented due to action the agencycould take to protect patients or employees. The Administrator is responsible for compliance.	

	infection of Coronavirus (COVID) 19 on the documents dated 09-22-2022, 11-28-2022, 12-05-2022, 12-08-2022, 12-20-2022, 02-03-2023, 02-12-2023, 03-06-2023, and 04-24-2023. The document failed to evidence an investigation or action plan took place to prevent the spread of COVID 19. The document evidenced urinary tract infection for the documents dated 09-21-2022, 10-24-2022, 11-27-2022, and 08-18-2023. The documents failed to indicate the potential cause of the urinary tract infections. The documents failed to evidence an investigation or action plan took place to prevent urinary tract infections in all active patients. The document dated 08-01-2023 indicated Patient #3 had a bone infection, but the document failed to evidence an investigation and action plan was enacted to prevent further harm or infection risks. The document dated 09-30-2022 evidenced an upper respiratory infection, but failed to evidence an investigation and action plan was enacted to prevent further infection risks.			

	3. During an interview with the Administrator on 08-29-2023 at 8:55 AM, when queried regarding the infection tracking, they indicated for the COVID infections, nothing was specifically done to prevent the spread of infections. They indicated they did not have the next steps to prevent the spread of infections.			
G0750	Home health aide services 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Based on record review and interview, the agency failed to ensure home health aide services were provided by qualified individuals who successfully completed an approved training and competency program, including the required minimum number of hours for classroom and practical training, and are in good standing on the state aide registry and failed to maintain documentation of the	G0750	**G0750** All certifications foragency home health aides have been printed from the professional licensingagency website and filed in the home health aides' personnel files. Anyhome health aide that does not have a CNA or HHA certification posted to theprofessional licensing agency website has been removed from patient contact andwill not be eligible to provide patient care for the agency until successfulcompletion of home health specific skills and education competency training. Allcurrent agency home health aides that do not have documentation of home healthspecific competency training and education will be	2023-09-29

	employee's successful completion of certification, testing, competency, and aide registry status for 5 of 5 active home health aide personnel files reviewed (HHA 2, 3, 4, 5, 6) and 1 of 1 former home health aide personnel file reviewed. (HHA 1) The cumulative effect of this systemic problem resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.80 Home Health Aide Services. Findings include: 1. A review of the personnel file for terminated HHA 1, date of hire 02/28/23, evidenced an application, dated 02/28/23, with an incomplete employment history showing as a Certified Nursing Assistant (CNA) and 3 illegible previous places of employment without dates, contact information, or reason for leaving. An interview form dated 02/28/23 indicated HHA 1 had 15 years of experience as a CNA. An undated CNA license		formalskills and education competency training that covers all topics of 484.80(b)(3)at Premier Healthcare Training Services. Theagency will require all newly hired home health aides who cannot providedocumentation showing that they have received home health specific skills andeducation competency training to successfully complete home health skills andeducation competency training that covers all topics of 484.80(b)(3) at PremierHealthcare Training Services before being eligible to provide patient care. Documentationof home health specific skills and education competency training will bemaintained in each employee’s file after completion. Theagency will maintain a description of the skills and education competencytraining program, methods used to verify competency, and qualifications of theprogram’s instructors at the agency. Theagency Administrator is	

	information verification failed to evidence HHA 1's CNA license was verified in advance of providing patient care. The personnel file failed to evidence documentation of successful completion of a home health aide or CNA training program, written test, and skills competency. 2. A review of the personnel file for Home Health Aide (HHA) 2, date of hire 06/07/23, evidenced an interview form dated 05/23/23 which indicated HHA 2 had worked for an unskilled personal services agency for approximately 5 years and took care of a spouse during the spouse's hospice treatment. A review of the "Home Health Aide Applicant Checklist," dated 05/23/23, indicated HHA 2 had no experience in rehabilitation facilities, with quadriplegics (paralysis of all limbs), or seizure disorders. A review of the job description for HHA 2, dated 05/23/23, evidenced a qualified aide must evidence successful completion of a formal certification training program and/or a written skills test and competency evaluation. The personnel file failed to evidence		home health aides have aCNA or HHA certification posted to the professional licensing agency websitealong with documentation of home health specific skills and educationcompetency training prior to the home health aide having any patient contact. The Administrator is responsible for compliance.	

	documentation of successful completion of a home health aide or CNA training program, written test, and skills competency. 3. A review of the personnel file for HHA 3, date of hire 03/06/23, evidenced an application dated 03/06/23. The work history indicated experience at a personal services agency but no dates of employment. An applicant checklist indicated HHA 3 had no experience with hospitals, rehabilitation facilities, hospice care, or post-mortem care, The personnel file failed to evidence verification of license, written or skills competency, or successful completion of an HHA or CNA program. 4. A review of the personnel file for HHA 4, date of hire 06/15/23, evidenced an application dated 06/15/23. The section for work history was blank. HHA 4 indicated their training or experience was "My mom was a CNA. I volunteered where she worked at I took care of my granparents." [sic] The personnel file failed to evidence an aide registry verification or confirmation of written and			

	skills competency and completion of an HHA or CNA program. 5. A review of the personnel file for HHA 5, date of hire 07/20/23, evidenced an incomplete application dated 07/20/24 which indicated a work history of "Burger King, 2016." HHA 5 indicated their training and experience was "I went for a CNA when I was 19 than [sic] I have taken care of relative for 7 years." An agency interview form indicated HHA 5 " ... took care of a relative for 7 years. It persisted of transferring. total care." A home Health Aide Applicant Checklist indicated sections for hospital, rehabilitation facility, and geriatrics were blank and HHA 5 had no experience in hospice care, Alzheimer's/dementia, psychiatric patients, stroke, post-mortem care, Parkinson's, and paraplegia care. The personnel file failed to evidence verification of completion of an HHA or CNA program, written competency, skills competency, and license verification. 6. A review of the personnel file for HHA 6, date of hire 07/31/23, evidenced an			

	application dated 07/31/23 with a with a work history showing a personal services agency from "June to current." The personnel file failed to evidence verification of completion of an HHA or CNA program, written competency, skills competency, and license verification. 7. On 08/28/23 at 2 PM, the Administrator indicated he did not verify employment due to staffing shortages. When asked for the process followed to determine if an individual was qualified to provide aide services, the Administrator indicated the check for a license online. If there is an active license, they hire the individual because the license is proof that they passed their competency. The Administrator indicated they have not verified licenses in many of the personnel files because it takes up to 60 days for the license to show on the registry after the class and testing is passed.			
G0754	A qualified HH aide successfully completed: 484.80(a)(1)(i-iv)	G0754	**G0754** All certifications for agency home health aides havebeen printed from the professional	2023-09-29

	A qualified home health aide is a person who has successfully completed: (i) A training and competency evaluation program as specified in paragraphs (b) and (c) respectively of this section; or (ii) A competency evaluation program that meets the requirements of paragraph (c) of this section; or (iii) A nurse aide training and competency evaluation program approved by the state as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the state nurse aide registry; or (iv) The requirements of a state licensure program that meets the provisions of paragraphs (b) and (c) of this section. Based on record review and interview, the agency failed to ensure all home health aides successfully completed a training and competency program or successfully completed a nurse aide training and competency program and are in good standing on the state aide registry for 1 of 1 terminated home health aide (HHA 1) and 5 of 5 active home health aides. (HHA 2, 3, 4, 5, 6) Findings include: 1. A review of the personnel file for HHA 1, date of hire 02/28/23, evidenced an undated Certified Nursing		licensing agency website and filed in thehome health aides' personnel files. Any home health aide that does not have a CNA or HHAcertification posted to the professional licensing agency website has beenremoved from patient contact and will not be eligible to provide patient carefor the agency until successful completion of home health specific skills andeducation competency training. All current agency home health aides that do not havedocumentation of home health specific competency training and education will berequired to complete formal skills and education competency training thatcovers all topics of 484.80(b)(3) at Premier Healthcare Training Services. The agency will require all newly hired home healthaides who cannot provide documentation showing that they have received homehealth specific skills and education competency training to successfullycomplete home health skills and education	

	verification but failed to evidence the aide was verified in good standing on the nurse aide registry in advance of providing care, and failed to evidence verification of previous home health aide or CNA training, written, and/or skills competency verification. 2. A review of the personnel file for Home Health Aide (HHA) 2, date of hire 06/07/23, failed to evidence documentation of successful completion of a home health aide or CNA training program, written test, or skills competency and failed to evidence the license was verified in good standing on the state aide registry. 3. A review of the personnel file for HHA 3, date of hire 03/06/23, failed to evidence verification of license in good standing on the state aide registry, successful completion of an HHA or CNA program, and/or verification of written and skills competency. 4. A review of the personnel file for HHA 4, date of hire 06/15/23, evidenced an application dated 06/15/23, which indicated HHA 4's		competency training that covers alltopics of 484.80(b)(3) at Premier Healthcare Training Services before beingeligible to provide patient care. Documentation of home health specific skills andeducation competency training will be maintained in each employee's file aftercompletion. The agency will maintain a description of the skillsand education competency training program, methods used to verify competency,and qualifications of the program's instructors at the agency. The agency Administrator is responsible for verifyingthat home health aides have a CNA or HHA certification posted to theprofessional licensing agency website along with documentation of home healthspecific skills and education competency training prior to the home health aidehaving any patient contact. The Administrator is responsible for compliance.	

	training or experience was "My mom was a CNA. I volunteered where she worked at I took care of my granparents." [sic] The personnel file failed to evidence the aide's license was verified in good standing on the state aide registry and failed to evidence verification of written and skills competency and/or completion of an HHA or CNA program. 5. A review of the personnel file for HHA 5, date of hire 07/20/23, evidenced an application dated 07/20/24, which indicated training and experience was "I went for a CNA when I was 19 than [sic] I have taken care of relative for 7 years." The personnel file failed to evidence verification of completion of an HHA or CNA program, written competency, skills competency, and license verification in good standing on the state aide registry.			

	6. A review of the personnel file for HHA 6, date of hire 07/31/23, failed to evidence verification of completion of an HHA or CNA program, written competency, skills competency, and license verification in good standing on the state aide registry. 7. On 08/28/23 at 2 PM, the Administrator indicated an aide applicant was qualified if the applicant had an active CNA license on the state aide registry. Due to the lack of available applicants, if the license was active the applicant was hired because an active license was proof the applicant passed their competency. If an applicant was not a CNA, the agency paid for the applicant to attend a nurse aide training program. After the applicant passed written competency testing, they could work as an HHA while finishing the nurse aide training program and practical competency portion. Once they received their certificate of completion they were qualified to work as an HHA or CNA. The Administrator indicated he thought the certificate of completion was sufficient to ensure the aide was			

	qualified since it can take up to 60 days for the aide's name to show on the registry. The Administrator indicated he would need to contact the training facility to obtain the certificates of completion for aides 1-6. When asked how he confirmed successful completion of a qualified CNA or HHA program without the certificate the Administrator indicated he paid the bill for the applicant's training and assumed that meant they successfully finished.			
G0760	Classroom and supervised practical training 484.80(b)(1) Home health aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing services to an individual under the direct supervision of a registered nurse, or a licensed practical nurse who is under the supervision of a registered nurse. Classroom and supervised practical training must total at least 75 hours. Based on record review and interview, the agency failed to ensure all home health aides received training that included classroom and supervised	G0760	**G0760** All certifications for agency home health aides havebeen printed from the professional licensing agency website and filed in thehome health aides' personnel files. Any home health aide that does not have a CNA or HHAcertification posted to the professional licensing agency website has beenremoved from patient contact and will not be eligible to provide patient carefor the agency until	2023-09-29

	practical training totaling at least 75 hours under the supervision of a registered nurse for 1 of 1 terminated home health aides (HHA 1) and 5 of 5 active home health aides. (HHA 2, 3, 4, 5, 6) Findings include: 1. A review of the personnel file for HHA 1, date of hire 02/28/23, failed to evidence a certificate or comparable document which indicated successful completion of a qualified training program that included classroom and supervised practical training totaling at least 75 hours under the supervision of a registered nurse. 2. A review of the personnel file for Home Health Aide (HHA) 2, date of hire 06/07/23, failed to evidence a certificate or comparable document which indicated successful completion of a qualified training program that included classroom and supervised practical training totaling at least 75 hours under the supervision of a registered nurse.		successful completion of home health specific skills andeducation competency training. All current agency home health aides that do not havedocumentation of home health specific competency training and education will berequired to complete formal skills and education competency training thatcovers all topics of 484.80(b)(3) at Premier Healthcare Training Services. The agency will require all newly hired home healthaides who cannot provide documentation showing that they have received homehealth specific skills and education competency training to successfullycomplete home health skills and education competency training that covers alltopics of 484.80(b)(3) at Premier Healthcare Training Services before beingeligible to provide patient care. Documentation of home health specific skills andeducation competency training will be maintained in each employee’s file aftercompletion. The agency will maintain a	

	3. A review of the personnel file for HHA 3, date of hire 03/06/23, failed to evidence a certificate or comparable document which indicated successful completion of a qualified training program that included classroom and supervised practical training totaling at least 75 hours under the supervision of a registered nurse. 4. A review of the personnel file for HHA 4, date of hire 06/15/23, failed to evidence a certificate or comparable document which indicated successful completion of a qualified training program that included classroom and supervised practical training totaling at least 75 hours under the supervision of a registered nurse. 5. A review of the personnel file for HHA 5, date of hire 07/20/23, failed to evidence a certificate or comparable document which indicated successful completion of a qualified training program that included classroom and supervised practical training totaling at least 75 hours under the supervision of a registered		description of the skillsand education competency training program, methods used to verify competency,and qualifications of the program's instructors at the agency. The agency Administrator is responsible for verifyingthat home health aides have a CNA or HHA certification posted to theprofessional licensing agency website along with documentation of home healthspecific skills and education competency training prior to the home health aidehaving any patient contact. The Administrator is responsible for compliance.	

	nurse. 6. A review of the personnel file for HHA 6, date of hire 07/31/23, failed to evidence a certificate or comparable document which indicated successful completion of a qualified training program that included classroom and supervised practical training totaling at least 75 hours under the supervision of a registered nurse. 7. On 08/28/23 at 2 PM, the Administrator indicated an aide applicant was qualified if the applicant had an active CNA license on the state aide registry. The Administrator indicated he thought the certificate of completion was sufficient to ensure the aide was qualified since it can take up to 60 days for the aide's name to show on the registry. The Administrator indicated he would need to contact the training facility to obtain the certificates of completion for aides 1-6. When asked how he confirmed successful completion of a qualified CNA or HHA program without the certificate the Administrator indicated he paid the bill for the			

	applicant's training and assumed that meant they successfully finished.			
G0764	HH aide training program topics 484.80(b)(3) A home health aide training program must address each of the following subject areas: (i) Communication skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff. (ii) Observation, reporting, and documentation of patient status and the care or service furnished. (iii) Reading and recording temperature, pulse, and respiration. (iv) Basic infection prevention and control procedures. (v) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (vi) Maintenance of a clean, safe, and healthy environment. (vii) Recognizing emergencies and the knowledge of instituting emergency procedures and their application. (viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy, and his or her property. (ix) Appropriate and safe techniques in performing personal hygiene and grooming tasks that include -- (A) Bed bath; (B) Sponge, tub, and shower bath;	G0764	**G0764** All certifications for agency home health aides havebeen printed from the professional licensing agency website and filed in thehome health aides' personnel files. Any home health aide that does not have a CNA or HHAcertification posted to the professional licensing agency website has beenremoved from patient contact and will not be eligible to provide patient carefor the agency until successful completion of home health specific skills andeducation competency training. All current agency home health aides that do not havedocumentation of home health specific competency training and education will berequired to complete formal skills and education competency training thatcovers all topics of 484.80(b)(3) at Premier Healthcare Training	2023-09-29

	(C) Hair shampooing in sink, tub, and bed; (D) Nail and skin care; (E) Oral hygiene; (F) Toileting and elimination; (x) Safe transfer techniques and ambulation; (xi) Normal range of motion and positioning; (xii) Adequate nutrition and fluid intake; (xiii) Recognizing and reporting changes in skin condition; and (xiv) Any other task that the HHA may choose to have an aide perform as permitted under state law. (xv) The HHA is responsible for training home health aides, as needed, for skills not covered in the basic checklist, as described in paragraph (b)(3)(ix) of this section. Based on record review and interview, the agency failed to ensure all home health aides completed a training and competency program including, but not limited to communication skills, observation/reporting/documentation, basic elements of body functioning, recognizing and reporting changes in skin integrity, and appropriate and safe techniques for bed/sponge/tub/shower bath and shampoo, nail and skin care, oral hygiene, safe transfer, range of motion, and adequate nutrition and fluid intake for 1 of 1 terminated home health aides (HHA 1) and 5 of 5 active		Services. The agency will require all newly hired home healthaides who cannot provide documentation showing that they have received homehealth specific skills and education competency training to successfullycomplete home health skills and education competency training that covers alltopics of 484.80(b)(3) at Premier Healthcare Training Services before beingeligible to provide patient care. Documentation of home health specific skills andeducation competency training will be maintained in each employee's file aftercompletion. The agency will maintain a description of the skillsand education competency training program, methods used to verify competency,and qualifications of the program's instructors at the agency. The agency Administrator is responsible for verifyingthat home health aides have a CNA or HHA certification posted to theprofessional licensing agency website along with documentation of home healthspecific skills and	

	home health aides. (HHA 2, 3, 4, 5, 6) Findings include: 1. A review of the personnel file for Home Health Aide (HHA) 1, date of hire 02/28/23, failed to evidence documentation of successful completion of a home health aide or CNA training program that included the content specified in 484.80(b)(3). 2. A review of the personnel file for Home Health Aide (HHA) 2, date of hire 06/07/23, failed to evidence documentation of successful completion of a home health aide or CNA training program that included the content specified in 484.80(b)(3). 3. A review of the personnel file for HHA 3, date of hire 03/06/23, failed to evidence documentation of successful completion of a home health aide or CNA training program that included the content specified in 484.80(b)(3). 4. A review of the personnel file for HHA 4, date of hire 06/15/23, failed to evidence documentation of successful		education competency training prior to the home health aidehaving any patient contact. The Administrator is responsible for compliance.	

	completion of a home health aide or CNA training program that included the content specified in 484.80(b)(3). 5. A review of the personnel file for HHA 5, date of hire 07/20/23, failed to evidence documentation of successful completion of a home health aide or CNA training program that included the content specified in 484.80(b)(3). 6. A review of the personnel file for HHA 6, date of hire 07/31/23, failed to evidence documentation of successful completion of a home health aide or CNA training program that included the content specified in 484.80(b)(3). 7. On 08/28/23 at 2 PM, the Administrator indicated Visiting Angels paid for an aide applicant to attend CNA training at Entity II, but he was not familiar with the specific content the program provided.			
G0766	HHA maintains documentation of training 484.80(b)(4)	G0766	**G0766** All certifications for agency home health aides havebeen	2023-09-29

	The HHA must maintain documentation that demonstrates that the requirements of this standard have been met. Based on record review and interview, the agency failed to maintain documentation of aide training for 5 of 5 active home health aides (HHA 2, 3, 4, 5) and 1 of 1 terminated home health aides. (HHA 1) Findings include: 1. A review of the personnel file for Home Health Aide (HHA) 1, date of hire 02/28/23, failed to evidence documentation of the individual's successful completion of a home health aide or CNA training program. 2. A review of the personnel file for Home Health Aide (HHA) 2, date of hire 06/07/23, failed to evidence documentation of the individual's successful completion of a home health aide or CNA training program. 3. A review of the personnel file for HHA 3, date of hire 03/06/23, failed to evidence documentation of the individual's successful		printed from the professional licensing agency website and filed in thehome health aides' personnel files. Any home health aide that does not have a CNA or HHAcertification posted to the professional licensing agency website has beenremoved from patient contact and will not be eligible to provide patient carefor the agency until successful completion of home health specific skills andeducation competency training. All current agency home health aides that do not havedocumentation of home health specific competency training and education will berequired to complete formal skills and education competency training thatcovers all topics of 484.80(b)(3) at Premier Healthcare Training Services. The agency will require all newly hired home healthaides who cannot provide documentation showing that they have received homehealth specific skills and education competency training to successfullycomplete home	

	aide or CNA training program. 4. A review of the personnel file for HHA 4, date of hire 06/15/23, failed to evidence documentation of the individual's successful completion of a home health aide or CNA training program. 5. A review of the personnel file for HHA 5, date of hire 07/20/23, failed to evidence documentation of the individual's successful completion of a home health aide or CNA training program. 6. A review of the personnel file for HHA 6, date of hire 07/31/23, failed to evidence documentation of the individual's successful completion of a home health aide or CNA training program. 7. On 08/28/23 at 2 PM, the Administrator indicated Visiting Angels paid for an applicant to attend CNA training at Entity II and he considered the payment to Entity II as confirmation that the individual successfully completed a CNA training and competency program. When asked if they are only required to pay for the training if the individual passed it, the		health skills and education competency training that covers alltopics of 484.80(b)(3) at Premier Healthcare Training Services before beingeligible to provide patient care. Documentation of home health specific skills andeducation competency training will be maintained in each employee's file aftercompletion. The agency will maintain a description of the skillsand education competency training program, methods used to verify competency,and qualifications of the program's instructors at the agency. The agency Administrator is responsible for verifyingthat home health aides have a CNA or HHA certification posted to theprofessional licensing agency website along with documentation of home healthspecific skills and education competency training prior to the home health aidehaving any patient contact. The Administrator is responsible for compliance.	

	Administrator stated no.			
G0768	Competency evaluation 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. Based on record review and interview, the agency failed to ensure all home health aides successfully completed a competency evaluation	G0768	**G0768** All certifications for agency home health aides havebeen printed from the professional licensing agency website and filed in thehome health aides' personnel files. Any home health aide that does not have a CNA or HHAcertification posted to the professional licensing agency website has beenremoved from patient contact and will not be eligible to provide patient carefor the agency until successful completion of home health specific skills andeducation competency training. All current agency home health aides that do not havedocumentation of home health specific competency training and education will berequired to complete formal skills and education competency training thatcovers all topics of 484.80(b)(3) at Premier Healthcare Training Services. The agency will require all newly	2023-09-29

	program that included the subjects indicated in 484.80(c)(3), in advance of providing care, for 1 of 1 terminated home health aide (HHA 1) and 5 of 5 active home health aides (HHA 2, 3, 4, 5, 6). Findings include: 1. A review of the personnel file for HHA 1, date of hire 02/28/23, failed to evidence verification of skills competency as listed in 484.80(b)(3). 2. A review of the personnel file for Home Health Aide (HHA) 2, date of hire 06/07/23, failed to evidence verification of skills competency as listed in 484.80(b)(3). 3. A review of the personnel file for HHA 3, date of hire 03/06/23, failed to evidence verification of skills competency as listed in 484.80(b)(3). 4. A review of the personnel file for HHA 4, date of hire 06/15/23, failed to evidence verification of skills competency as listed in 484.80(b)(3). 5. A review of the personnel file		hired home healthaides who cannot provide documentation showing that they have received homehealth specific skills and education competency training to successfullycomplete home health skills and education competency training that covers alltopics of 484.80(b)(3) at Premier Healthcare Training Services before beingeligible to provide patient care. Documentation of home health specific skills andeducation competency training will be maintained in each employee's file aftercompletion. The agency will maintain a description of the skillsand education competency training program, methods used to verify competency,and qualifications of the program's instructors at the agency. The agency Administrator is responsible for verifyingthat home health aides have a CNA or HHA certification posted to theprofessional licensing agency website along with documentation of home healthspecific skills and education competency training prior to the home health	

	for HHA 5, date of hire 07/20/23, failed to evidence verification of skills competency as listed in 484.80(b)(3). 6. A review of the personnel file for HHA 6, date of hire 07/31/23, failed to evidence verification of skills competency as listed in 484.80(b)(3). 7. On 08/28/23 at 2 PM, the Administrator indicated an aide applicant was qualified if the applicant had an active CNA license on the state aide registry. Due to the lack of available applicants, if the license was active the applicant was hired because an active license was proof the applicant passed their competency. If an applicant was not a CNA, the agency paid for the applicant to attend a nurse aide training program. After the applicant passed written competency testing, they could work as an HHA while finishing the nurse aide training program and practical competency portion. Once they received their certificate of completion they were qualified to work as an HHA or CNA. The Administrator indicated he thought the certificate of completion was		aidehaving any patient contact. The Administrator is responsible for compliance.	

	sufficient to ensure the aide was qualified since it can take up to 60 days for the aide's name to show on the registry. The Administrator indicated he would need to contact the testing facility to obtain verification of skills competency for HHAs 1 - 6.			
G0772	Documentation of competency evaluation 484.80(c)(5) The HHA must maintain documentation which demonstrates that the requirements of this standard have been met. Based on record review and interview, the agency failed to maintain documentation of competency verification for all aides, including a description of the program, qualification of instructors, method used to determine competency, such as direct care or use of a pseudo-patient, for 1 of 1 terminated aide (HHA 1) and 5 of 5 active aides. (HHA 2, 3, 4, 5, 6) Findings include:	G0772	**G0772** All certifications foragency home health aides have been printed from the professional licensingagency website and filed in the home health aides' personnel files. Anyhome health aide that does not have a CNA or HHA certification posted to theprofessional licensing agency website has been removed from patient contact andwill not be eligible to provide patient care for the agency until successfulcompletion of home health specific skills and education competency training. Allcurrent agency home health aides that do not have documentation of home healthspecific competency training and education will be required to complete formalskills and education competency training that covers	2023-09-29

	1. A review of the personnel file for HHA 1, date of hire 02/28/23, failed to evidence documentation of the aide's competency verification that included a description of the competency program, instructor qualifications, and methods used to verify competency. 2. A review of the personnel file for Home Health Aide (HHA) 2, date of hire 06/07/23, failed to evidence documentation of the aide's competency verification that included a description of the competency program, instructor qualifications, and methods used to verify competency. 3. A review of the personnel file for HHA 3, date of hire 03/06/23, failed to evidence documentation of the aide's competency verification that included a description of the competency program, instructor qualifications, and methods used to verify competency. 4. A review of the personnel file for HHA 4, date of hire 06/15/23, failed to evidence documentation of the aide's		all topics of 484.80(b)(3)at Premier Healthcare Training Services. Theagency will require all newly hired home health aides who cannot providedocumentation showing that they have received home health specific skills andeducation competency training to successfully complete home health skills andeducation competency training that covers all topics of 484.80(b)(3) at PremierHealthcare Training Services before being eligible to provide patient care. Documentation of home health specific skills andeducation competency training will be maintained in each employee’s file aftercompletion. The agency will maintain a description of the skillsand education competency training program, methods used to verify competency,and qualifications of the program’s instructors at the agency. The agency Administrator is responsible for verifyingthat home health aides have a CNA or HHA certification posted to	

	included a description of the competency program, instructor qualifications, and methods used to verify competency. 5. A review of the personnel file for HHA 5, date of hire 07/20/23, failed to evidence documentation of the aide's competency verification that included a description of the competency program, instructor qualifications, and methods used to verify competency. 6. A review of the personnel file for HHA 6, date of hire 07/31/23, failed to evidence documentation of the aide's competency verification that included a description of the competency program, instructor qualifications, and methods used to verify competency. 7. On 08/28/23 at 2 PM, the Administrator indicated an aide applicant was qualified if the applicant had an active CNA license on the state aide registry. The Administrator indicated he thought the certificate of completion was sufficient to ensure the aide was qualified since it can take up to 60 days for the aide's name to		agency website along with documentation of home healthspecific skills and education competency training prior to the home health aidehaving any patient contact. The Administrator is responsible for compliance.	

	Administrator indicated they paid for applicants to attend Entity II for CNA training but he was not familiar with the details of the program offered.			
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 agency failed to ensure the agency policies were reviewed and revised annually (G 948). The agency failed to ensure the agency employed qualified personnel (G 952). The agency failed to coordinate patient care (G 962). The agency failed to	G0940	**G0940** The Administrator willreview all company policies and procedures to ensure they are up to date. Anypolicies or procedures found to be outdated will be discussed with theGoverning Body to determine if changes or revisions need to be implemented. Theagency's policies and procedures will be reviewed yearly by the Administratorand Governing Body to ensure ongoing compliance. The Administrator will sign inthe agency's policies and procedures manual to verify that policies andprocedures have been reviewed and updated as seen fit by the Governing Body. All certifications foragency home health aides have been printed from the professional licensingagency website and filed in the home health aides' personnel files. Anyhome health aide that does not have a CNA or HHA certification posted to the professionallicensing agency website has been removed from patient contact and will not beeligible to provide patient care for the agency until successful completion ofhome health specific skills and education competency training. Allcurrent agency home health	2023-09-29

	continuously assessed (G 966). The agency failed to assure the development, implementation and updates to the plans of care (G 968). These deficiencies had a potential cumulative effect on all 40 patients and 39 active staff. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Conditions of Participation of 42 CFR 484.105, Organization and Administration of Services. Findings Include: * 410 IAC 17-12-1(a)(1)(2)		aides that do not have documentation of home healthspecific competency training and education will be required to complete formalskills and education competency training that covers all topics of 484.80(b)(3)at Premier Healthcare Training Services. Theagency will require all newly hired home health aides who cannot providedocumentation showing that they have received home health specific skills andeducation competency training to successfully complete home health skills andeducation competency training that covers all topics of 484.80(b)(3) at PremierHealthcare Training Services before being eligible to provide patient care. The Clinical Manager and Assistant Clinical Managerwill build a patient roster complete with each patient's individuals, otheragencies, and facilities involved in their care. These individuals, other agencies, and facilities willbe contacted when a patient has a	

			appropriate orapplicable to the patient's care or needs, or at least every 60 days tocoordinate care. Documentation of each contact made with eachindividual, other agency, or facility will be kept in the patient's file on theagency's coordination of care template. The Clinical Manager will audit 100% of all currentpatients' comprehensive assessments using a comprehensive assessment audit toolthat evaluates all components of the comprehensive assessment with auditresults to be provided to each RN Case Manager along with education to correctany mistakes in documentation. RN Case Managers are to make any needed corrections totheir documentation and re-submit the assessment to the Clinical Manager within48 hours of receipt. 100% of newly completed comprehensive assessmentdocumentation must be turned in to the Clinical Manager prior to placement inthe patient's chart. Any documentation errors must be fixed by the RN CaseManager	

			and re-submitted to the Clinical Manager within 48 hours of receipt forfurther review. The Clinical Manager will re-educate RN Case Managersto ensure that comprehensive assessments are updated and revised as frequentlyas the patient's condition warrants due to a major decline or improvement inhealth status. The Clinical Manager will perform unannouncedsupervisory visits of the RN Case Managers when performing certification visitsto evaluate their ability to perform a complete patient-specific comprehensiveassessment that includes the patient's current status, the patient's health,psychosocial, functional, and cognitive status, the patient's strengths, goals,and care preferences, the patient's continuing need for home care, thepatient's medical, nursing, rehabilitation, social, and discharge planning needs,update for change in condition, and updated at least every 60 days. An RN Case Manager	

			supervisory visit form will be usedto document the results of these supervisory visits. The Clinical Manager will re-educate RN Case Managersto ensure that comprehensive assessments are made within the last 5 days ofevery 60-day recertification period to ensure development, implementation, andupdates to the plan of care. The Administrator and Clinical Manager are responsible for compliance.	
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the Administrator failed to ensure the agency's policies and procedures were reviewed and revised at least annually by 1 of 1 Governing Body. Findings Include: 1. On 08-29-2023 at 8:10 AM, the Administrator provided a	G0948	**G0948** The Administrator will review all company policies andprocedures to ensure they are up to date. Any policies or procedures found tobe outdated will be discussed with the Governing Body to determine if changesor revisions need to be implemented. The agency's policies and procedures willbe reviewed at the beginning of each year by the Administrator and GoverningBody and verification of this will be recorded in weekly Governing	2023-09-29

	February 22, 2021 Briggs Healthcare policy titled, "Policy Development, Policy No. B-210". The policy indicated but was not limited to, " ... Selected policies and procedures will be reviewed and revised at least annually by the Governing Body and designees ..." 2. On 08-29-2023 at 8:10 AM, during the review of the policy binder, it evidenced a document titled "Effective Date, Policy No. A-100". The document evidenced the policy manual went into effect on 02-22-2021. The section titled "Annual Review" was blank. The Administrator failed to ensure the policies and procedures were reviewed annually by the Governing Body and Administrator. 3. On 08-29-2023 at 9:30 AM, the Governing Body Meeting Minutes were reviewed with the Administrator. The Governing Body Meeting Minutes failed to evidenced the policies and procedures were reviewed annually. 3. During an interview with the Administrator on 08-29-2023 at 8:55 AM, they indicated the last		Body meetingminutes to ensure ongoing compliance. The Administratorwill sign the agency's policies and procedures manual to verify that policiesand procedures have been reviewed and updated as seen fit by the GoverningBody. The Governing Body and Administrator are responsiblefor ongoing compliance.	

	time the policies and procedures were reviewed would be listed in the policy and procedures binder. The policy and procedures binder failed to evidence the policies and procedures were reviewed annually. 410 IAC 17-12-1(c)(1)			
G0952	Ensure that HHA employs qualified personnel 484.105(b)(1)(iv) (iv) Ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies. Based on record review and interview, the agency failed to ensure that all home health aides were qualified to provide patient care services, including but not limited to verification of previous experience, verification of completion of a qualified home health aide or certified nursing assistant program, verification of references, and verification of successful training and competency testing for 1 of 1 terminated home health aides (HHA 1) and 5 of 5 active home health aides. (HHA 2, 3, 4, 5, 6)	G0952	**G0952** All certifications for agency home health aides havebeen printed from the professional licensing agency website and filed in thehome health aides' personnel files. Any home health aide that does not have a CNA or HHAcertification posted to the professional licensing agency website has beenremoved from patient contact and will not be eligible to provide patient carefor the agency until successful completion of home health specific skills andeducation competency training. All current agency home health aides that do not havedocumentation of home	2023-09-29

	Findings include: 1. A review of the personnel file for terminated HHA 1, date of hire 02/28/23, evidenced an application, dated 02/28/23, with an incomplete employment history showing as a Certified Nursing Assistant (CNA) and 3 illegible previous places of employment without dates, contact information, or reason for leaving. An interview form dated 02/28/23 indicated HHA 1 had 15 years of experience as a CNA. An undated CNA license information verification failed to evidence HHA 1's CNA license was verified in advance of providing patient care. The personnel file failed to evidence documentation of successful completion of a home health aide or CNA training program, written test, and skills competency. 2. A review of the personnel file for Home Health Aide (HHA) 2, date of hire 06/07/23, evidenced an interview form dated 05/23/23 which indicated HHA 2 had worked for an unskilled personal services agency for approximately 5 years and took care of a spouse		training and education will berequired to complete formal skills and education competency training thatcovers all topics of 484.80(b)(3) at Premier Healthcare Training Services. The agency will require all newly hired home healthaides who cannot provide documentation showing that they have received homehealth specific skills and education competency training to successfullycomplete home health skills and education competency training that covers alltopics of 484.80(b)(3) at Premier Healthcare Training Services before beingeligible to provide patient care. All home health aide applicants will be required tofill out their pertinent work history on their application for employment. Acall will be placed, or a verification form will be sent to the two most recentemployers to verify that the home health aide was employed during the datesclaimed in their application, to inquire about the role the applicant heldwhile working for the employer, and to inquire as to whether the home healthaide is eligible for	

	during the spouse's hospice treatment. A review of the "Home Health Aide Applicant Checklist," dated 05/23/23, indicated HHA 2 had no experience in rehabilitation facilities, with quadriplegics (paralysis of all limbs), or seizure disorders. A review of the job description for HHA 2, dated 05/23/23, evidenced a qualified aide must evidence successful completion of a formal certification training program and/or a written skills test and competency evaluation. The personnel file failed to evidence documentation of successful completion of a home health aide or CNA training program, written test, and skills competency and failed to evidence the agency followed its policy for pre-employment reference and employment verification. 3. A review of the personnel file for HHA 3, date of hire 03/06/23, evidenced an application dated 03/06/23. The work history indicated experience at a personal services agency but no dates of employment. An applicant checklist indicated HHA 3 had		rehire at their workplace. All home health aide applicants will be required toprovide at least two references who will be contacted prior to employment toattempt to verify the applicant’s experience, character, and fit for the rolewhich they are applying. The agency Scheduler will turn in documentation to theagency Administrator of contact made with each newly hired home health aide’stwo most recent employers and at least two references prior to the home healthaide having any patient contact. This documentation will be maintained in theemployee’s file. The agency Administrator is responsible for ongoingcompliance.	

rehabilitation facilities, hospice care, or post-mortem care, The personnel file failed to evidence verification of license, written or skills competency, or successful completion of an HHA or CNA program.

4. A review of the personnel file for HHA 4, date of hire 06/15/23, evidenced an application dated 06/15/23. The section for work history was blank. HHA 4 indicated their training or experience was "My mom was a CNA. I volunteered where she worked at I took care of my granparents." [sic] The personnel file failed to evidence an aide registry verification or confirmation of written and skills competency and completion of an HHA or CNA program.

5. A review of the personnel file for HHA 5, date of hire 07/20/23, evidenced an incomplete application dated 07/20/24 which indicated a work history of "Burger King, 2016." HHA 5 indicated their training and experience was "I went for a CNA when I was 19 than [sic] I have taken care of relative for 7 years." An agency

" ... took care of a relative for 7 years. It persisted of transferring. total care." A home Health Aide Applicant Checklist indicated sections for hospital, rehabilitation facility, and geriatrics were blank and HHA 5 had no experience in hospice care, Alzheimer's/dementia, psychiatric patients, stroke, post-mortem care, Parkinson's, and paraplegia care. The personnel file failed to evidence verification of completion of an HHA or CNA program, written competency, skills competency, and license verification.

6. A review of the personnel file for HHA 6, date of hire 07/31/23, evidenced an application dated 07/31/23 with a with a work history showing a personal services agency from "June to current." The personnel file failed to evidence verification of completion of an HHA or CNA program, written competency, skills competency, and license verification.

7. On 08/28/23 at 2 PM, the Administrator indicated he did not verify employment due to staffing shortages. When asked for the process followed to determine if an individual was

	qualified to provide aide services, the Administrator indicated the check for a license online. If there is an active license, they hire the individual because the license is proof that they passed their competency. The Administrator indicated they have not verified licenses in many of the personnel files because it takes up to 60 days for the license to show on the registry after the class and testing is passed.			

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
Shea Brock	Administrator	10/6/2023 8:48:36 AM