STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157700	A. BUILDING B. WING	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA MASONIC HOME, INC	690 S STATE STREET, FRANKLIN, IN, 46131

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 for a Home Health Provider and Supplier. / Survey Date: 06/12/2024, 06/13/2024, 06/14/2024, and 06/17/2024 Census: 71 At this Emergency Preparedness survey, Indiana Masonic Home, Inc. was found in compliance at 42 CFR 484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies. / QR completed by Area 3 on 6/25/2024.	E0000		

G0000	INITIAL COMMENTS	G0000		
	This visit was for a Federal Complaint Survey of a Deemed Home Health Provider, conducted by the Indiana Department of Health. Survey Dates: 06-12-2024, 06-13-2024, 06-14-2024, and 06-17-2024 The Survey was Fully Extended on 6-13-2024 at 4:08 PM, announced to the Clinical Director/Alternate Administrator. Complaint: IN00104969 Non-compliant, with related and unrelated deficiencies cited. 12-month unduplicated skilled admissions: 379 Indiana Masonic Home Health was found to be out of compliance with 42 CFR 484.60 Care Planning, Coordination, Quality of Care and 484.70 Infection Prevention, as related to this complaint. Based on the Condition level deficiencies during the 06-17-2024 survey, your Home Health Agency was subject to an extended survey pursuant to			

	Social Security Act on 06-13-2024. 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 June 17, 2024 and continuing through June 16, 2026. QR completed by Area 3 on 6-25-2024.			
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.	G0570	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of	2024-07-12

	Based on record review and interview the agency failed to ensure a patient received services as frequently as ordered in the Plan of Care, (see G0572), the agency failed to ensure their clinicians obtained a physician order prior to performing wound care (see G0580), the agency failed to notify the ordering provider when a lapse in ordered, regularly scheduled wound care occurred, and the agency failed to notify physicians when the agency became aware of possible contamination of wounds had occurred, (see G0590), and the agency failed to ensure patients received a Plan of Care, Medication list, and visit schedule (see G0612). The cumulative effect of these deficient practices resulted in the agency's inability to ensure patients received ordered services for all 6 active patients with NPWT (Negative Pressure Wound Therapy, also known as 'wound vac'), with the potential to impact a total of 23 current patients receiving wound care services from the agency.		theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **Deficiency G0570: Care planning, coordination of services andquality of care** Surveycites the following: failure to obtainorder from physician to provide wound care, failure to notify ordering providerwhen lapse in care occurred, failure to notify physicians when made aware ofpossible contamination, failure to ensure patients receive a Plan of Care,medication list, and visit schedule Failure to obtain order	

	*		from physician toprovide wound care 1 *Correctiveaction*: An in-service will beconducted by the Clinical Director for all clinicians involved in patient careto provide education and reinforcement of regulations regarding scope ofpractice and the requirement for obtaining orders prior to providing care by7/12/24. The in-service willinclude: what a clinician should do if anew wound or problem with the patient is identified during a visit, who shouldbe notified, what should be documented, where documentation should be placed,and time set aside for questions and answers. All clinicians will sign acknowledgements that they understand. 2 *Completion dates:* Emailed communication will be distributedby 7/8/24 with in-person in-service completed by 7/12/24. 3 *Prevention for reoccurrence:* All new clinicians will be educated within-service material and sign an	

			understanding. Clinical Supervisor will review each newwound care order as it is received to ensure that orders are reflected in EMRsystem, the frequencies match the number of visits on the clinician's schedule,and the treatment matches what is reflected in the care plan for 3 months. ClinicalSupervisor will conduct a weekly audit of each wound care patient to ensure themost recent visit note treatment matches the most recent orders received for 3months. If 100% compliance is not met,this will continue for another 3 months until 100% compliance is met. Once 100%compliance is achieved, on-going chart audits will continue on a monthly basisto ensure compliance is continued. If100% compliance is not continued, education will be provided to each clinicianout of compliance and weekly chart audits for that clinician will be conducteduntil 100% compliance is achieved. 4 *Person responsible for implementing andmonitoring:* ClinicalSupervisor. In the absence of theClinical Supervisor, the Clinical Director	

			absence of the Clinical Director, theAdministrator will be responsible. Failureto notify ordering provider when lapse in care occurred 1 *CorrectiveAction:* An in-service will beconducted by the Clinical Director for all clinicians involved in patient careto provide education and reinforcement of policies regarding missed visits by7/12/24. The in-service will include: PCP must be contacted at the time theclinician is notified that the visit will be missed or the patient is notavailable for scheduled visit, the visit should be attempted to be moved toanother day during the same week to provide care according to the plan of care,a communication note should be entered with the date and time that the providerwas notified. A communication noteshould be documented if any follow up instructions are given by the provider. If further instructions are communicated bythe provider, a verbal order will be written and sent to provider	

			forsignature. All clinicians will signacknowledgements that they understand. 2 *Completion dates:* Emailed communication will be distributedby 7/8/24 with in-person in-service completed by 7/12/24 3 *Prevention for reoccurrence:* All new clinicians will be educated within-service material and sign an acknowledgement of understanding. Clinical Director will conduct weekly auditsof missed visits for 3 months to ensure provider is contacted and missed visitis documented. If 100% compliance is notmet, this will continue for another 3 months until 100% compliance is met. Once 100% compliance is achieved, on-goingmissed visit audits will continue on a monthly basis to ensure compliance iscontinued. If 100% compliance is not continued,education will be provided to each clinician out of compliance and weeklymissed visit audits for that clinician will be conducted until 100% complianceis achieved. 4 *Person responsible for*	

			implementing andmonitoring: Clinical Director. In the absence of the Clinical Director, theClinical Supervisor will be responsible. In the absence of the Clinical Supervisor, the Administrator will beresponsible. Failureto notify physicians when made aware of possible contamination 1 *Corrective action:* An in-service will be conducted by theClinician Director for all clinicians involved in patient care to provideeducation and reinforcement of policies regarding communication with providersby 7/12/24. The in-service will include:When the provider should be notified of contamination, where the communicationshould be documented, how the communication should be documented and what stepsshould be taken to ensure that the contamination issue is resolved. 2 *Completion dates:* Emailed communication will be distributedby 7/8/24 with	

			by 7/12/24 3 *Prevention for reoccurrence:* All new clinicians will be educated within-service material and sign an acknowledgement of understanding. A weekly audit of the infection controlbinder will be conducted by the Clinical Supervisor for 3months to ensure thateach infection incident is communicated and documented according to policy. If 100% compliance is not achieved within 3months, then weekly audits will continue for another 3 months until 100%compliance is achieved. Once 100% compliance is achieved, on-goinginfection control binder audits will continue on a monthly basis to ensurecompliance is continued. If 100%compliance is not continued, education will be provided to each clinician outof compliance and weekly infection control binder audits for that clinicianwill be conducted until 100% compliance is achieved. 4 *Personresponsible for implementing and monitoring:* Clinical Supervisor. In the	

			Supervisor,the Clinical Director will be responsible. In the absence of the Clinical Director, the Administrator will beresponsible. Failure to ensure patients receive a Plan ofCare, medication list, and visit schedule 1 *Corrective action:* All current patients will be mailed acurrent Plan of Care including medication list by the Intake Coordinator by7/8/24. After every discipline hasconducted an initial evaluation, a Plan of Care will be generated by theClinical Supervisor (Clinical Director in Clinical Supervisor's absence), whichincludes a medication list. This will bemailed to the patient or POA if applicable by the Intake Coordinator and acommunication note will be created to document the date that it wasmailed. As a part of the visit in thepatient home, clinicians will send a photo of the calendar to the Administratorto verify that it is in use. Audit will continue until each patient oncensus is	

			accounted for. Additionally, anew Plan of care will be mailed to the patient or POA if applicable at everyrecertification or under any circumstances when a Plan of Care is updated bythe Intake Coordinator. If the Plan of Care remains unchanged, but a medicationis changed, added, or discontinued, an updated medication list will be mailedto the patient or POA if applicable by the Intake Coordinator and the date thatit was mailed will be documented in a communication note by the IntakeCoordinator, Clinical Supervisor in the absence of the Intake Coordinator. 2 *Completion dates:* Audit for calendar compliance will be initiatedon 7/12/24 and will be ongoing until all patients on census are accounted for. Every patient on active census will be maileda current Plan of Care by 7/8/24. 3 *Prevention for reoccurrence:* A new process has been implemented effective7/2/24: As each new patient is evaluated by each discipline, the Plan of Carewill be generated by the Clinical Supervisor	

			(Clinical Director in the absenceof the Clinical Supervisor) mailed to the patient or POA if applicable by theIntake Coordinator and the date mailed will be documented in a communicationnote. The intake coordinator will benotified of each recertification or updated Plan of Care generated by theClinical Supervisor and will mail the patient/POA a current Plan of Care. Clinicians will notify the Intake Coordinatorof every medication change the same day as it occurs, and an updated medicationlist will be mailed to the patient/POA and the date mailed will be documentedin a communication note. A visitschedule audit will be conducted on a weekly basis for 3 months by theAdministrator (Clinical Director in the absence of the Administrator) until100% compliance is achieved. Eachclinician will be required to send a photograph of the calendar's placement inthe home (with the patient's permission) to the Administrator for each patientthey are seeing for the week to ensure that it is being utilized. If permission is not granted by the patient,the	

			clinician will inform the Administrator of the location of the calendar inthe patient's home. This will continuefor 3 months until 100% compliance is achieved. Once 100% compliance is achieved, ongoing audits will occur on a monthlybasis by the Administrator. If 100%compliance is not maintained, the clinician out of compliance will receiveeducation and will be audited on a weekly basis for 3 months until 100%compliance is achieved. 4 *Person responsible for implementing andmonitoring:* POC/Medication lists: Intake Coordinator. In the absence of the Intake Coordinator, theClinical Supervisor will be responsible. In the absence of the Clinical Supervisor, the Clinical Director will beresponsible. Schedule Audit: Administrator. In the absence of the Administrator, theClinical Director will be responsible.	
G0572	Plan of care 484.60(a)(1)	G0572	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in	2024-07-12

	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 a patient received services as ordered in the Plan of Care for 1 of 6 patients with a wound vac (device used to aide in the healing of a progressive wound). (Patient #1) Findings include: 1. Review of an undated agency document titled 'PLAN OF CARE C-580' stated, "... 2. The plan of Care shall be completed in full to include: ... c. Type, frequency, and duration of all visits/services ... l. ... treatments, and procedures ... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ..." 2. Review of an undated agency		response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **Deficiency G0572: Plan of Care**	

	document titled 'SKILLED PROFESSIONAL SERVICES C-200' stated, "... 1. Skilled professionals must assume the responsibility for, but not be restricted to the following: ... c. Providing services that are ordered by the physician as indicated in the plan of care ... g. Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care ..." 3. Review of the clinical record for Patient #1 evidenced a start of care date of 11-30-2023 for the certification period of 01-23-2024 to 03-28-2024, contained diagnoses which included but were not limited to: Multiple Sclerosis (a potentially disabling disease of the brain and spinal cord (central nervous system) where the immune system attacks the protective sheath (myelin) that covers nerve fibers and causes communication problems between your brain and the rest of your body), Paraplegia, complete (a total loss of function, including the ability to feel sensation and move, the body also can't control		Survey cites the following: Agency failed to ensure a patient receivedservices as ordered in the Plan of Care for wound vac patient that had twomissed visits. 1 *Correctiveaction:* An in-service will beconducted by the Clinical Director for all clinicians involved in patient careto provide education and reinforcement of policies regarding missed visits by7/12/24. The in-service willinclude: PCP must be contacted at thetime the clinician is notified that the visit will be missed or the patient isnot available for scheduled visit, the visit should be attempted to be moved toanother day to provide care according to the plan of care, a communication noteshould be entered with the date and time that the provider was notified.Consequences of missed visits with wound vac patients will also be discussedwith time left for questions and answers. A verbal order wil be generated if any follow-up instructions are givenby the provider and sent	

	automatic functions that rely on your spinal cord for relaying signals, such as controlling your bladder and bowels), suprapubic catheter (tube which drains urine from the bladder, inserted into the bladder through a small hole in the lower abdomen), and cognitive impairment (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The record indicated the patient was dependent on others for transferring and mobility (the ability to change and control body position). The record evidenced a total of six (6) wounds were being treated. Two (2) of the wounds, the coccyx (tailbone) and left ischium (one of the three bones that make up the pelvis) required the use of specialized equipment. The record contained orders for NPWT (Negative Pressure Wound Therapy also known as 'wound vac': a broad term describing a unique system that aids wound healing through the application of vacuum pressure to reduce inflammatory drainage and promote the growth of healthy tissue) dressing changes 3 times		for sigature. All clinicians will sign acknowledgements that they understand. 2 *Completion dates:* Emailed communication will be distributedby 7/8/24 with in-person in-service completed by 7/12/24 3 *Prevention for reoccurrence:* All new clinicians will be educated bythe Clinical Director (Clinical Supervisor in the Clinical Director's absence)with in-service material and sign an acknowledgement of understanding. Clinical Director will conduct weekly auditsof missed visits for 3 months to ensure provider is contacted and missed visitis documented. If 100% compliance is notmet, this will continue for another 3 months until compliance is met. Once 100%compliance is achieved, ongoing audits will occur on a monthly basis by theClinical Director. If 100% compliance isnot maintained, the clinician out of compliance will receive education and willbe audited on a weekly basis for 3 months until 100% compliance isachieved. 4 *Person responsible for*	

	each week to the coccyx and left ischium wounds. Home Health Skilled Nursing was ordered twice weekly for wound care and wound vac dressing changes, on Mondays and Fridays, and PRN (as needed). Patient #1 would visit Entity G, the ordering provider's wound clinic, for wound vac changes and other wound care every Wednesday. The record evidenced a Missed Skilled Nursing visit for wound care on Friday, 02-16-2024, and again on Monday, 02-19-2024. Communication notes from the record failed to evidence the agency contacted Entity G on Friday, 02-16-2024 regarding the missed Skilled Nursing visit for wound care. 4. Review of a document dated 02-21-2024, from Entity D, a Local Law Enforcement agency, titled 'Investigation Narrative' indicated on 02-21-2024 Entity G, the ordering provider office and wound clinic, had initiated a request for law enforcement to perform a welfare check on Patient #1 and the spouse related to concerns for health and safety. The report indicated after opening an unlocked back		*implementing andmonitoring:* Clinical Director. In the absence of the Clinical Director, theClinical Supervisor will be responsible. In the absence of the Clinical Supervisor, the Administrator will be responsible.	

	spouse had expired, and then found the patient, "... it was evident that [Patient #1] had been laying in bed for quite some time, as [Patient #1] had been laying in what appeared to be [their] own urine and feces, which appeared to saturate [their] side of the bed ...". The report further indicated an ambulance was dispatched to the home and the patient was transported to the hospital. 5. Review of a document dated 02-21-2024, from Entity F, an Acute Care Hospital, titled 'Emergency Documentation' indicated, "... [Patient #1] transported from home after unfortunately being found in bed, unaware that [spouse] had died, likely at least several days ago. Patient is entirely reliant on [spouse] to care for [patient] at home. I am concerned about prolonged time down in bed. Differential diagnosis includes acute kidney injury, rhabdomyolysis, dehydration, electrolyte derangement, urinary tract infection related to contaminated suprapubic catheter, many others." 'Discharge Summary' indicated, "... [Patient #1] was admitted for UTI and infection of chronic			

	wounds ... Patient presented to [Entity F] following PCP [Entity G] calling a well check as the patient had been a no show for appointment today. Home Healthcare provider was also unable to gain access to patient's home at which time [Entity D] was called. [Entity D] broke into the home and found patient soiled and unkempt for unknown time frame. Patient's [spouse] was then discovered dead ... for an estimated seven days time. [Spouse] was patient's primary care provider performing all patient's ADLs and was responsible for all positioning in mobility. Patient is unable to report the last time [they] saw [spouse] ... Admitted per above. Patient previously following with [Entity G] for chronic osteo to the sacrum, gluteal pressure ulcer and left heel ulcer. Wounds found to be infected and did grow streptococcus agalactiae and enterococcus faecalis. [Patient #1] did receive 5 days of IV Rocephin and plan to continue Azithromycin for 5 additional days at time of discharge. Urine culture also growing Proteus mirabilis treated with 5 days of Ceftriaxone. Also initiated on			

	Citalopram for history of anxiety, depression in the setting of dementia, MS and recent death of [spouse]. Discharge to [Entity L, a skilled nursing facility] for skilled nursing care for complex wound management ...” 6. On 06-12-2-024 at 11:59 AM Nurse Practitioner (NP) H with Entity G, a wound clinic, indicated had cared for Patient #1 for years and indicated Patient #1 was last seen in their office on Wednesday, 02-14-2024 accompanied by the patient’s spouse who was also the primary caregiver. Indicated their office did not receive a call from the home health agency on Friday, 02-16-2024 when RN 1 did not see the patient for wound care, but first learned of missed visits when they received a call on Monday, 02-19-2024 from the home health agency who then reported the patient could not be contacted for a second time. 7. On 06-12-2024 at 6:02 PM, in a telephone interview, when queried as to what actions would be taken if a wound patient were unable to be			

	(RN) 1 indicated would contact the agency office, contact the doctor, and would keep the patient on their schedule and adjust their day to accommodate the patient as needed. Indicated further they often worked holidays 'because wound vacs can't be moved'. When queried as to what would occur if a wound vac patient could not be reached after multiple attempts, RN 1 indicated 'never had that happen' but if it did, they would call the office or for a 'well visit' especially if it was an outlier or out of the normal for the patient. When asked to define a 'well visit', indicated this meant calling the police. Indicated had called for 'well visits' in the past for other patients, and would 'stay until they (police) get there, to find out what happens' (to the patient). When queried as to the events surrounding Patient #1, indicated it was not uncommon for Patient #1's spouse to cancel nursing visits and perform the wound care themselves, often telling staff 'I got it, don't worry about it'. When queried as to what happened when Patient #1 could not be reached for their			

	wound care visit on 02-16-2024, RN 1 indicated could not recall dates, but recalled the last time he/she went back to the home, no one answered so they told the Director of Nursing to call 'well check' and indicated 'that's when they found what they found'. 8. On 06-13-2024 at 9:13 AM, in a follow-up telephone interview, when queried as to how often a wound vac dressing ought to be changed, RN 1 indicated 'for Monday, Wednesday, and Friday usually' and indicated the consequences of overdue wound vac changes were infection or sepsis. Indicated that the Friday, 02-16-2024 visit for Patient #1 was missed as the patient could not be reached by phone or by knocking on the door. When queried as to why a 'well check' was not requested, indicated would not call for a well check on every missed visit, and reiterated that it was not abnormal for the spouse to remove the wound vac and apply a wet-to-dry dressing instead. Indicated there was no need for a well check because the spouse knew how to care for the wound.			

	9. On 06-13-2024 at 9:23 AM, when queried as to Patient #1's missed visits for care and what had transpired afterward, the Clinical Director indicated that she and RN 1 had spoken at length, but there was no documentation of that conversation nor of what was discussed. Indicated RN 1 did not call the doctor because they were not prompted to call the doctor by the agency's Electronic Medical Record (EMR) system, but then indicated RN 1 'still' should have called the doctor the same day. 10. On 6-13-2024 at 1:08 PM, in an in-person interview, RN 1 was asked to clarify what was meant by 'I would have never gone in the back' as stated in the previous interview. RN 1 indicated 'I am not creeping around houses' 'for my safety'. Then indicated on Friday, 02-16-2024, had gone to Patient's #1 home and called from the home while on-site, and could hear the phone ringing inside, believed the patient answered the phone and thought the patient and spouse could both be heard			

	sound was muffled, and they did not answer/address the nurse. RN 1 attempted to call back a few times, but 'kept getting busy signals' and suspected the patient and spouse had not properly hung up/disconnected their cordless phone handset. RN 1 indicated had returned to the home the following Monday, 02-19-2024, but this time could hear the phone just continuing to ring from the outside. When queried as to a back-up plan when the patient could not be reached the first time, the Clinical Director indicated there was not a plan, and a follow-up nursing visit was not attempted over that weekend, nor had a follow-up nursing visit been considered. When queried as to whether there was concern in light of the fact the caregiver, who was normally communicative (by the agency's account and by the account of Entity G), could not be readily reached, should have alerted the agency and prompted further action or follow-up on the agency's part, RN 1 and the Clinical Director indicated affirmatively this should have alerted the agency. RN 1 then indicated, 'I wouldn't have			

	changed anything' they had done.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview the agency failed to ensure their clinicians obtained a physician order prior to performing wound care in 1 of 6 active record reviews. (Patient #3) Findings include: 1. A review of an undated policy titled 'PLAN OF CARE C-580' revealed, "... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ...". 2. A review of an undated policy titled 'PHYSICIAN ORDERS C-635' revealed, "... All medications and treatments, ... must be ordered by the physician ...". 3. A review of the clinical	G0580	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan	2024-07-12

	record for Patient #3 revealed a document titled "Home Health Care Certification and Plan of Care for the certification periods of 04/11/2024 through 06/09/2024 signed by the Director of Nursing on 04/16/2024. Patient #3 diagnoses included but were not limited to Pressure ulcer of other site Stage 2 (partial thickness loss of dermis [middle layer of skin] presenting as a shallow open area with a red or pink wound bed, without slough or bruising] and Abrasion of lower back and pelvis. For the certification period of 04/16/2024 through 06/09/2024 Patient #3 was to receive skilled nursing visits 1 time a week to assess pain, assess pressure ulcer status. Further review of the clinical record evidenced a skilled nursing visit conducted on 06/04/2024, from 12:28 PM to 1:03 PM signed by LPN 2, the narrative note evidenced, "SN performed wound care per MD order without complication ... Pt indicates discomfort at right pannus. Upon SN visual assessment pt has stage 2 skin breakdown of area approximation 10 x 8.5x 0.1 ...		ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **G0580: Only as ordered by a physician** Survey cites the following: Agency failed to ensure their cliniciansobtained a physician order prior to performing wound care	

	SN to call MD and request order for tx. SN cleansed area with saline, pat dry, applied saline moistened Puracol sheet and bordered gauze dressing to area ... ". A review of the clinical record of Patient #3 evidenced a document titled "PATIENT CARE ORDER" dated 06/05/2024 signed by LPN 2 evidenced, "Cleanse wound with normal saline, pat dry, apply Puracol to the wound bed, cover with border foam gauze. Effective 06/05/2024, Twice weekly, - read back and confirmed; start date 06/05/2024". The agency failed to ensure staff obtained physician orders before the treatment of a wound on 06/04/2024. 4. On 06/14/2024 at 2:45 PM, LPN 2 stated, "If a Patient has a new wound, I can look at it but I can't treat it and must notify the physician". When queried if they would notify anyone else, LPN 2 indicated they would notify the office. On 06/14/2024 at 8:25 AM, the Director of Nursing indicated when a new wound is identified		1 *Correctiveaction*: An in-service will beconducted by the Clinical Director for all clinicians involved in patient careto provide education and reinforcement of regulations regarding scope ofpractice and the requirement for obtaining orders prior to providing care by7/12/24. The in-service willinclude: what a clinician should do if anew wound or problem with the patient is identified during a visit, who shouldbe notified, what should be documented, where documentation should be placed,and time set aside for questions and answers. All clinicians will sign acknowledgements that they understand. 2 *Completion dates:* Emailed communication will be distributedby 7/8/24 with in-person in-service completed by 7/12/24. 3 *Prevention for reoccurrence:* All new clinicians will be educated within-service material and sign an acknowledgement of understanding. Clinical Supervisor will review each newwound care order as it is	

	should not treat it, maybe cover it, report it to the physician preferably while onsite with the Patient, and obtain physician orders.		received to ensure that orders are reflected in EMRsystem for 3 months. Clinical Supervisorwill conduct a weekly audit of each wound care patient to ensure the mostrecent visit note treatment matches the most recent orders received for 3months. If 100% compliance is not met,this will continue for another 3 months until 100% compliance is met. Once 100%compliance is achieved, ongoing audits will occur on a monthly basis by the ClinicalSupervisor. If 100% compliance is notmaintained, the clinician out of compliance will receive education and will beaudited on a weekly basis for 3 months until 100% compliance is achieved. 4 *Person responsible for implementing andmonitoring:* ClinicalSupervisor. In the absence of theClinical Supervisor, the Clinical Director will be responsible. In the absence of the Clinical Director, theAdministrator will be responsible.	
G0590	Promptly alert relevant physician of changes	G0590	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of	2024-07-12

	484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview the agency failed to notify the ordering provider when a lapse in ordered, regularly scheduled wound care occurred and the agency failed to notify physicians when the agency became aware of possible contamination of wounds had occurred, in 1 of 10 clinical records reviewed (Patient #1) and 2 of 3 home visits observed (Patients #4 and #8) Findings include: 1. Review of an undated agency document titled 'PLAN OF CARE C-580' stated, "... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ..." 2. Review of an undated agency document titled 'CLINICAL DOCUMENTATION C-680' stated, "... 6. Services not		Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance."	

	missed visit will be documented and reported to the physician ..." 3. Review of the clinical record for Patient #1 indicated the patient was dependent on others for transferring and mobility (the ability to change and control body position). The record evidenced a total of six (6) wounds were being treated by the home health agency. Two (2) of the wounds, the coccyx (tailbone) and left ischium (one of the three bones that make up the pelvis) required the use of specialized equipment. The record contained orders for NPWT (Negative Pressure Wound Therapy also known as 'wound vac': a broad term describing a unique system that aids wound healing through the application of vacuum pressure to reduce inflammatory drainage and promote the growth of healthy tissue) dressing changes 3 times each week to the coccyx and left ischium wounds. Home Health Skilled Nursing was ordered twice weekly for the wound care and wound vac dressing changes, on Mondays and Fridays, and PRN (as needed). Patient #1 would then		**G0590: Promptly alert relevant physician of changes** Surveycites: Agency failed to notify orderingprovider when a lapse in ordered wound care occurred, and agency failed tonotify physicians when agency became aware of possible contamination of wounds. 1 *Correctiveaction:* An in-service will be conducted by theClinical Director for all clinicians involved in patient care to provideeducation and reinforcement of policies regarding missed visits by7/12/24. The in-service willinclude: PCP must be contacted at thetime the clinician is notified that the visit will be missed or the patient isnot available for scheduled visit, the visit should be attempted to be moved toanother day to provide care according to the plan of care, a communication noteshould be entered with the date and time that the provider was notified. Additionally, the in-service willinclude: When the provider should benotified of	

	visit Entity G, the ordering Provider's wound clinic, for wound vac changes and other wound care every Wednesday. The record evidenced a Missed Skilled Nursing visit note for wound care on Friday, 02-16-2024, and again on Monday, 02-19-2024. Communication notes from the record failed to evidence the agency contacted Entity G on Friday, 02-16-2024 regarding the first missed Skilled Nursing visit for wound care. 4. On 06-12-2-024 at 11:59 AM, Nurse Practitioner (NP) H with Entity G, a wound clinic, indicated had cared for Patient #1 for years and indicated Patient #1 was last seen in their office on Wednesday, 02-14-2024 accompanied by the patient's spouse who was also the primary caregiver. Indicated their office did not receive a call from the home health agency on Friday, 02-16-2024 when RN 1 did not see the patient for wound care, but first learned of missed visits when they received a call on Monday, 02-19-2024 from the home health agency who then reported the patient could not be contacted for a second time.		contamination, where the communication should be documented, whatsteps should be taken to ensure that the contamination issue is resolved. 2 *Completion dates:* Emailed communication will be distributedby 7/8/24 with in-person in-service completed by 7/12/24. 3 *Prevention for reoccurrence:* All new clinicians will be educated within-service material and sign an acknowledgement of understanding. Clinical Director will conduct weekly auditsof missed visits for 3 months to ensure provider is contacted and missed visitis documented. If 100% compliance is notmet, this will continue for another 3 months until 100% compliance is met. Additionally, a weekly audit of the infectioncontrol binder will be conducted by the Clinical Supervisor for 3 months toensure that each infection incident is communicated and documented according topolicy. Once 100% compliance isachieved, ongoing audits will occur on a monthly basis by the Clinical Directorfor missed visits and the Clinical Supervisor for	

	Indicated it was abnormal for the spouse not to call, as he/she was very communicative with the wound care clinic. Indicated the wound clinic themselves attempted to reach Patient #1 on Tuesday, 02-20-2024 and followed up with other providers as well, without success. On Wednesday, 02-21-2024 when Patient #1 did not show up for their weekly appointment, Entity G indicated other providers were again contacted to determine the patient's whereabouts, and it was at that time the police were dispatched to perform a welfare check at the patient's home. NP H indicated was worried about the patient, the wound vac still being in place, and expressed concern for possible infection or sepsis. Indicated had learned of the spouse's demise and that the patient had been transported to a local hospital for care and had since been transferred to a Skilled Nursing Facility. On 06-12-2024 at 6:02 PM, in a telephone interview, when queried as to what actions would be taken if a wound patient were unable to be		Infection Controlbinder. If 100% compliance is notmaintained, the clinician out of compliance will receive education and will beaudited on a weekly basis for 3 months until 100% compliance is achieved. 4 *Person responsible for implementing andmaintaining:* The ClinicalDirector will be responsible for the missed visits audit. The Clinical Supervisor will be responsiblein the absence of the Clinical Director. The Clinical Supervisor will be responsible for the audit of theinfection control binder. The ClinicalDirector will be responsible in the absence of the Clinical Supervisor.	

	(RN) 1 indicated would contact the agency office, contact the doctor, and would keep the patient on their schedule and adjust their day to accommodate the patient as needed. Indicated further they often worked holidays 'because wound vacs can't be moved'. When queried as to what would occur if a wound vac patient could not be reached after multiple attempts, RN 1 indicated 'never had that happen' but if it did, they would call the office or for a 'well visit' especially if it was an outlier or out of the normal for the patient. When asked to define a 'well visit', indicated this meant calling the police. Indicated had called for 'well visits' in the past for other patients, and would 'stay until they (police) get there, to find out what happens' (to the patient). When queried as to the events surrounding Patient #1, indicated it was not uncommon for Patient #1's spouse to cancel nursing visits and perform the wound care themselves, often telling staff 'I got it, don't worry about it'. When queried as to what happened when Patient #1 could not be reached for their			

	wound care visit on 02-16-2024, RN 1 indicated could not recall dates, but recalled the last time he/she went back to the home, no one answered so they told the Director of Nursing to call 'well check' and indicated 'that's when they found what they found'. On 06-13-2024 at 9:13 AM, in a follow-up telephone interview, when queried as to how often a wound vac dressing ought to be changed, RN 1 indicated 'for Monday, Wednesday, and Friday usually' and indicated the consequences of overdue wound vac changes were infection or sepsis. Indicated that the Friday, 02-16-2024 visit for Patient #1 was missed as the patient could not be reached by phone or by knocking on the door. When queried as to why a 'well check' was not requested, indicated would not call for a well check on every missed visit, and reiterated that it was not abnormal for the spouse to remove the wound vac and apply a wet-to-dry dressing instead. Indicated there was no need for a well check because the spouse knew how to care for the wound.			

	On 06-13-2024 at 9:23 AM, when queried as to Patient #1's missed visits for care and what had transpired afterward, the Clinical Director indicated that she and RN 1 had spoken at length, but there was no documentation of that conversation nor of what was discussed. Indicated RN 1 did not call the doctor because they were not prompted to call the doctor by the agency's Electronic Medical Record (EMR) system, but then indicated RN 1 'still' should have called the doctor the same day. On 6-13-2024 at 1:08 PM, in an in-person interview, RN 1 was asked to clarify what was meant by 'I would have never gone in the back' as stated in the previous interview. RN 1 indicated 'I am not creeping around houses' 'for my safety'. Then indicated on Friday, 02-16-2024, had gone to Patient's #1 home and called from the home while on-site, and could hear the phone ringing inside, believed the patient answered the phone and thought the patient and spouse could both be heard			

	sound was muffled, and they did not answer/address the nurse. RN 1 attempted to call back a few times, but 'kept getting busy signals' and suspected the patient and spouse had not properly hung up/disconnected their cordless phone handset. RN 1 indicated had returned to the home the following Monday, 02-19-2024, but this time could hear the phone just continuing to ring from the outside. When queried as to a back-up plan when the patient could not be reached the first time, the Clinical Director indicated there was not a plan, and a follow-up nursing visit was not attempted over that weekend, nor had a follow-up nursing visit been considered. When queried as to whether there was concern in light of the fact the caregiver, who was normally communicative (by the agency's account and by the account of Entity G), could not be readily reached, should have alerted the agency and prompted further action or follow-up on the agency's part, RN 1 and the Clinical Director indicated affirmatively this should have alerted the agency. RN 1 then indicated, 'I wouldn't have			

changed anything' they had done.

On 06-14-2024 at 2:22 PM, LPN 1 was interviewed after a home visit for a wound vac dressing change with Patient #8. When queried as to how often wound vacs needed to be changed indicated according to doctors orders but that this was usually ordered as three times per week, Mondays, Wednesdays, and Fridays. When queried as to why it was important the wound vac dressing changes were performed timely indicated there would be risk for the good tissue to grow into the black foam, infection, or the machine could malfunction. And when queried as to what actions would be taken if a wound vac patient could not be reached for a regularly scheduled skilled nursing visit, LPN 1 indicated would look in the system for other contacts, call the office, call the physician, look for a vehicle at the home, ask for a welfare check to be done, and seek guidance from their supervisor.

6. On 06-14-2024 at 4:57 PM, the Clinical Director and the Alternate Clinical Director were

	informed of infection prevention breaches that occurred during the home observations for Patient #4 and Patient #8, related to poor aseptic technique during wound vac dressing changes. The Clinical Director indicated understanding that there were now two potentially contaminated wounds in the field and then indicated to the Alternate Clinical Director they 'needed to get those changed'.			

	On 06-17-2024 at 11:30 AM, the Administrator, Clinical Director, and Alternate Clinical Director were queried as to actions taken and outcome for Patients #4 and #8 after being notified of breaches in infection prevention during the wound care provided three days prior. The Clinical Director indicated that the patient's physicians had not been notified, the patients had not been seen, and could not answer if either patient was currently receiving antibiotic therapy. The Clinical Director indicated the patients' physicians should have been contacted on Friday, but indicated both patients were scheduled for nursing visits today.			
G0612	Written instructions to patient include: 484.60(e) Standard: Written information to the patient. The HHA must provide the patient and caregiver with a copy of written instructions outlining: Based on record review and interview, the agency failed to ensure patients received a Plan of Care, a Medication list, and a schedule in 2 of 3 home visits	G0612	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be	2024-07-12

	conducted. (Patients #4 and #6) Findings include: 1. On 06/17/2024 at 11:48 AM, the Clinical Director indicated there was no agency policy to provide their Patients with a copy of their Plan of Care, a medication list, and a schedule. 2. On 06/14/2024 at 12:30 PM, during a home visit at Patient #4"s home, when queried regarding their agency folder, Person I, a family member to Patient #4 indicated they had been given one but they didn't remember where they put it. When queried if they had been given or received a mailing of a schedule of visits, a medication list, and a plan of care, both Patient #4 and Person I indicated they had never received anything in the mail or from a nurse regarding a schedule, a medication list, or a plan of care.		construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **G0612: Written instructions to patient** Surveycites: Agency failed to ensure patientsreceived a Plan of Care, a medication list, and a schedule. 1 *Correctiveaction:* After every discipline hasconducted an initial evaluation, a Plan of Care will be generated by	

	3. On 06/17/2024 at 9:44 AM, the Administrator indicated all Patient's should have an updated Plan of Care, a medication list, and a schedule in their home folders, and they should be updated every 60 days. 4. On 06/17/2024 at 9:30 AM, during a home visit for Patient #6, the home folder failed to evidence a Plan of Care, a completed visit schedule, or a medication list. 5. On 06/17/2024 at 10:30 AM, when queried as to whether they were aware or played a role in patient's receiving their Plans of Care/485, visit schedule/calendar, or a medication list, or if they were ever instructed by the office to bring such documents out to the patients home, RN 1 indicated was not a part of this and was not aware of this practice. 6. On 06/17/2024 at 11:31 AM, Registered Nurse (RN) 1 indicated had been wrong about their earlier recollection regarding Plans of Care, visit		theClinical Supervisor (Clinical Director in Clinical Supervisor's absence), whichincludes a medication list. This will bemailed to the patient or POA if applicable effective 7/2/24. As a part of the visit in the patient home,clinicians will send a photo of the calendar to the Administrator to verifythat it is in use. Audit will continueuntil each patient on census is accounted for. Additionally, a new Plan of care will bemailed to the patient or POA if applicable by the Intake Coordinator at everyrecertification or under any circumstances when a Plan of Care is updated. Ifthe Plan of Care remains unchanged, but a medication is changed, added, ordiscontinued, an updated medication list will be mailed to the patient or POAif applicable. 2 *Completion dates:* Audit for calendar compliance will initiatedby 7/12/24 and will continue until all patients are accounted for. Every active patient on census will be maileda current Plan of Care by the Intake Coordinator by 7/8/24. 3 *Prevention for reoccurrence:*	

	medication lists being provided for patients, and indicated they had in fact been educated upon hire regarding the patients needing to receive the aforementioned items, but had subsequently forgotten. 7. On 06/17/2024 at 12:19 PM, during a telephone interview, Patient #6 indicated they had not ever been provided with a Plan of Care or '485' document, a calendar or visit schedule, nor had they been provided with a list of their medications from the agency. Reiterated they had their own list of medications, but this was not from the agency.		A new process has been implemented effective7/2/24: As each new patient is evaluated by each discipline, the Plan of Carewill be mailed to the patient or POA if applicable by the Intake Coordinatorwith the date mailed documented in a communication note. The intake coordinator will be notified ofeach recertification or updated Plan of Care generated by the ClinicalSupervisor and will mail the patient/POA a current Plan of Care. Clinicians will notify the Intake Coordinatorof every medication change the same day as it occurs, and an updated medicationlist will be mailed to the patient/POA by the Intake Coordinator with the datemailed documented in a communication note. A visit schedule audit will be conducted on a weekly basis for 3 monthsby the Administrator until 100% compliance is achieved. Each clinician will be required to send aphotograph of the calendar's placement in the home (with the patient'spermission) to the Administrator for each patient they are seeing for the weekto ensure that it is being utilized. Ifpermission is not granted by	

			the patient, the clinician will inform theAdministrator of the location of the calendar in the patient's home. If 100%compliance is not achieved, the audit will continue for an additional 3months. Once 100% compliance isachieved, ongoing audits will occur on a monthly basis by the Administrator. If 100% compliance is not maintained, theclinician out of compliance will receive education and will be audited on aweekly basis for 3 months until 100% compliance is achieved. 4 *Person responsible for implementing andmonitoring:* POC/Medication lists: Intake Coordinator. In the absence of the Intake Coordinator, theClinical Supervisor will be responsible. In the absence of the Clinical Supervisor, the Clinical Director will beresponsible. Schedule Audit: Administrator. In the absence of the Administrator, theClinical Director will be responsible.	
G0654	Track adverse patient events 484.65(c)(2)	G0654	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in	2024-07-12

	Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview the agency failed to ensure their Quality Assessment Performance Improvement program included tracking adverse events, analyzing their cause, and implementing preventive actions. Findings include: 2. Review of an undated agency document titled 'SAFETY MANAGEMENT PROGRAM B-315' stated, "... 10. Documentation of incidents, including follow-up documentation with trends and patterns will be incorporated into the the agency performance improvement plan ..." 3. Review of agency records evidenced a Fall Log, Complaint/Incident Log, and rehospitalization log containing entries of events. The rehospitalization log contained an entry regarding Patient #1, dated 02-19-2024, which stated, "... Reason for Admission ... Husband (sole caregiver) passed at home ..." and failed to detail information on the patient,		response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **G0654 Track adverse patient events**	

	hospitalization, or their admitting diagnosis. 4. Review of the agency's QAPI Binder failed to evidence the agency had Performance Improvement Plans (PIPs) in place, indicated action was taken on areas of concern but failed to evidence details of the actions/strategies referred to, and failed to evidence measurable progress toward established goals. The program failed to evidence the incident regarding Patient #1 had been addressed. 5. Review of the clinical record for Patient #1 indicated the patient was dependent on others for transferring and mobility (the ability to change and control body position). The record evidenced a total of six (6) wounds were being treated by the home health agency. Two (2) of the wounds, the coccyx (tailbone) and left ischium (one of the three bones that make up the pelvis) required the use of specialized equipment. The record contained orders for NPWT (Negative Pressure Wound Therapy also known as 'wound vac': a broad term describing a		Survey cites: Agency failed to ensure their Quality Assessment Performance Improvementprogram included tracking adverse events, analyzing their cause, andimplementing preventative actions 1 *CorrectiveAction:* Agency will implementmonthly QAPI meetings for the next 6 months to monitor the following: Infection control, Adverse event monitoring,Survey results and implementation of new processes. Additionally, Performance Improvement Planswill be implemented for each topic. ThePIP will include the following: Identifying the problem, establishing measurable goals to improve theissue, delegating specific team members with tasks to track progress,evaluating progress on a monthly basis for 6 months, and documentation. Additionally, an audit will be conducted ofthe Complaint Log, Fall Log, Infection Log and Hospitalization log on a weeklybasis for 3 months by the Clinical Supervisor to ensure that propercommunication and documentation takes place.	

	unique system that aids wound healing through the application of vacuum pressure to reduce inflammatory drainage and promote the growth of healthy tissue) dressing changes 3 times each week to the coccyx and left ischium wounds. Home Health Skilled Nursing was ordered twice weekly for the wound care and wound vac dressing changes, on Mondays and Fridays, and PRN (as needed). Patient #1 visited Entity G, the ordering Provider's wound clinic, for wound vac changes and other wound care every Wednesday. The record evidenced a Missed Skilled Nursing visit note for wound care on Friday, 02-16-2024, and again on Monday, 02-19-2024. Communication notes from the record failed to evidence the agency contacted Entity G on Friday, 02-16-2024 regarding the first missed Skilled Nursing visit for wound care. The record evidenced a well check was requested for Patient #1 on Wednesday, 02-21-2024 when Entity G, reported the patient was a no-show for their weekly visit. 6. Review of a third-party		2 *Completion Dates:* The first monthly QAPI meeting will beheld by 7/12/24, with monthly meetings held for the next 6 months. If after 6 months, goals identified in thePIP are not achieved, the agency will continue to meet on a monthly basis foranother 6 months to monitor and adjust goals as needed to achieve desiredoutcomes. If desired outcomes areachieved after the first six months, QAPI meetings will be held quarterly on anon-going basis. The weekly log auditswill start on 7/12/24 and continue ongoing to maintain 100% compliance. 3 *Prevention for reoccurrence:* Dates for QAPI meetings for the next 6 monthswill be set at the QAPI meeting scheduled for 7/12/24. The Administrator, Clinical Director,Clinical Supervisor, and Intake Specialist will be present for the meeting andattendance will be documented. Allsubsequent meetings will be added to the calendar of each attendee to ensurethe appropriate amount of time is blocked for QAPI meetings. If 100% compliance is not achieved within 3months, the weekly audit will take place	

	acute care hospital, indicated the patient was found by Entity D, local law enforcement, during the welfare check and had been left in their bed, unattended for 3-7 days. The patient's spouse (who was the primary caregiver) was found deceased in the home. The patient was transported to Entity F and admitted with a urinary tract infection and infection of the wounds. 7. On 06-13-2024 at 9:23 AM, when queried as to whether the incident regarding Patient #1's two (2) missed skilled nursing visits and subsequent hospitalization would be found in QAPI, the Clinical Director indicated this incident was not in QAPI, as it was not a 'complaint', but was instead likely under 'rehospitalizations'.		for an additional 3 months until 100%compliance is achieved. Once 100% compliance is achieved, ongoing log auditswill occur on a monthly basis by the Clinical Supervisor. If 100% compliance is not maintained, theclinician out of compliance will receive education and will be audited on aweekly basis for 3 months until 100% compliance is achieved. 4 *Person responsible for implementing andmonitoring:* QAPI/PIP Meetings: TheAdministrator. In the absence of theAdministrator, the Clinical Director will be responsible. Log Audits: The Clinical Supervisor. In theabsence of the Clinical Supervisor, the Clinical Director will beresponsible.	
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct	G0658	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of	2024-07-12

	improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview the agency failed to ensure their Quality Assessment Performance Improvement (QAPI) program evidenced at least one Performance Improvement Project (PIP) being conducted. Finding include: 1. Review of an undated agency document titled 'Quality Assessment and Performance Improvement (QAPI) B-260' stated,"... PERFORMANCE IMPROVEMENT PROJECTS 1. Beginning July 13, 2018, agencies must conduct performance improvement projects a. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the agency services and operations b. The agency must document the		Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **G0658: Performance Improvement Projects** Survey cites that agency failed to ensure theirQAPI program evidenced at least one PIP being conducted.	

	improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects ..." 2. On 06-13-2024, a review of agency records evidenced a Fall Log, Rehospitalization Log, and Complaint/Incident Log. The QAPI Binder failed to evidence Performance Improvement Plans (PIPs) were in place, made reference to actions taken/strategies utilized, but failed to evidence details, information or documentation on follow-up or measurable progress toward established goals. 3. On 06-13-2024 at 4:08 PM, the Clinical Director/Alternate Administrator indicated would get in touch with the Administrator to inquire if there was documentation anywhere else regarding any agency PIP(s). On 06-14-2024 at 10:05 AM, the Clinical Director indicated had conferred with the Administrator who indicated regarding any QAPI documentation or Performance Improvement Plans, everything		1 *CorrectiveAction:* Agency will implementmonthly QAPI meetings for the next 6 months to monitor the following: Infection control, Adverse event monitoring,Survey results and implementation of new processes. Additionally, Performance Improvement Planswill be implemented for each topic. ThePIP will include the following: Identifying the problem, establishing measurable goals to improve theissue, delegating specific team members with tasks to track progress,evaluating progress on a monthly basis for 6 months, and documentation. 2 *Completion Dates:* The first monthly QAPI meeting will beheld by 7/12/24, with monthly meetings held for the next 6 months. If after 6 months, goals identified in thePIP are not achieved, the agency will continue to meet on a monthly basis foranother 6 months to monitor and adjust goals as needed to achieve desiredoutcomes. If desired outcomes areachieved after the first six months, QAPI meetings will be held quarterly on anon-going basis.	

	would be in the binder and there was not anything more.		3 *Prevention for reoccurrence:* Dates for QAPI meetings for the next 6 monthswill be set at the QAPI meeting scheduled for 7/12/24. The Administrator, Clinical Director,Clinical Supervisor, and Intake Coordinator will be present for the meeting andattendance will be documented. Allsubsequent meetings will be added to the calendar of each attendee by theAdministrator to ensure 100% compliance for QAPI meetings. 4 *Person responsible for implementing andmonitoring:* QAPI/PIP Meetings: TheAdministrator. In the absence of theAdministrator, the Clinical Director will be responsible.	
G0680	Infection prevention and control 484.70 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 record review and interview the agency failed to	G0680	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an	2024-07-12

	ensure field staff followed appropriate infection control practices per agency policy while providing wound care to patients, and the agency failed to take action when the agency became aware patients' wounds had been potentially contaminated (see G0682). The cumulative effect of these deficient practices resulted in the agency's inability to ensure patients received appropriate services which has the potential to affect all 6 current patients with NPWT (Negative Pressure Wound Therapy, also known as 'wound vac'), with the potential to impact a total of 23 current patients receiving wound care services from the agency. *		admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **G0680: Infection prevention and control** Survey cites: Agency failed to ensure field staff followed appropriate infectioncontrol practices per agency policy. 1 *Correctiveaction:* All nurses were brought infor a mandatory in-service on 6/17/24 after	

			learning of infection control issueduring site visits during survey to discuss wound vac policy, and to be checkedoff on bag technique and hand hygiene prior to seeing another patient in thefield by the Clinical Director. AllClinical field staff will be checked off for a second time for compliance bythe Clinical Director (Clinical Supervisor in the absence of the ClinicalDirector) with hand washing and bag technique to ensure 100% compliance by7/8/24. Additionally, the ClinicalDirector will conduct Supervisory visits for nursing staff once weekly for 3months to ensure that 100% compliance is achieved during visits in the home forbag technique and hand washing as well as maintaining clean/dirty barriersthroughout the care of the patient. Eachnurse (current and new hires during orientation) will be required to watch aneducational video on the following topics: Wound measurement, nutrition and wound healing, Braden Scale andpressure injury staging, dressing selection, and pressure injuryprevention. Acknowledgement that thesevideos were viewed will be	

			obtained in writing . An in-service will be conducted by theClinical Director and a third party wound vac provider to train current fieldstaff on wound vac application and troubleshooting. A pre-test and a post-test will beadministered to test knowledge and there will be an opportunity for returndemonstration for each field nurse. Time will be allotted for questions andanswers to ensure understanding and a signed acknowledgment will be obtainedfor each field clinician involved in wound care. 2 *Completion Dates:* The hand hygiene and bag techniquecheck-offs will be completed by 7/8/24. The weekly supervisory visits will initiated by 6/18/24. The in-service and acknowledgement of woundeducation videos watched will be completed by 7/12/24. 3 *Prevention for reoccurrence:* It will be required that each new fieldstaff member watch a bag technique video and be checked off on bag techniqueand hand hygiene	

			prior to providing patient care. All new LPNs and RNs will shadow an RN casemanager that has been checked off by the Clinical Supervisor (Clinical Directorin absence of Clinical Supervisor) for a wound vac visit duringorientation. After shadowing for avisit, the new LPN or RN will be accompanied by the Clinical Supervisor(Clinical Director in absence of Clinical Supervisor) for a minimum of twowound vac visits prior to completing a wound vac visit independently. The Clinical Supervisor will check the nurseoff for 100% compliance in infection control and wound vac application duringthe visit. If 100% compliance is notachieved, the Clinical Supervisor will continue to supervise wound vac visitsuntil 100% compliance is achieved for at least two consecutive visits prior toallowing LPN or RN to provide treatment independently. Once 100% compliance is achieved, ongoingsupervisory visits will occur on a monthly basis by the Clinical Supervisor(Clinical Director in absence of Clinical Supervisor). If 100% compliance is not maintained,	

			theclinician out of compliance will receive education and will be supervised onall wound vac visits until 100% compliance is achieved for at least twoconsecutive visits. 4 *Person responsible for implementing andmonitoring:* ClinicalSupervisor. In the absence of theClinical Supervisor, the Clinical Director will be responsible.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure field staff followed appropriate infection control practices per agency policy while providing patient care in 3 of 3 home visits conducted, and the agency failed to take action when made aware wounds were potentially contaminated (Registered Nurse (RN) 1,	G0682	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue	2024-07-12

	and 2, and Clinical Director) Findings include: 1. A review of an undated policy titled, 'INFECTION PREVENTION/CONTROL B-403' revealed, "... STANDARD PRECAUTIONS - TIER ON ... 2. Hands are washed ... immediately after gloves are removed, between client contacts, and when indicated to prevent transfer of microorganisms ...". 2. A review of an undated policy titled, 'HANDWASHING/HAND HYGIENE D-330' revealed, "... SPECIAL INSTRUCTIONS ... 3. Indications for hand washing and hand antisepsis: ... d. Between tasks on the same client. e. Before touching a wound. f. After removing gloves. g. After touching objects that are potentially contaminated. ...". 3. On 06/14/2024 at 1:18 PM		at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **G0682: Infection Prevention** Surveycites: Agency failed to ensure fieldstaff followed appropriate infection control practices while providing patientcare. 1 *Correctiveaction:* All Clinical field staffwill be checked off for compliance by the Clinical Director (ClinicalSupervisor in the absence of the Clinical Director) with hand washing and bagtechnique to ensure 100% compliance. Adaily infection control reminder will be emailed by the Clinical Supervisor toall field staff.	

	LPN 2 for Patient #4's wound care, LPN 2 created a barrier for their nursing bag, performed hand hygiene, reached into the nursing bag for supplies, put normal saline syringes on the barrier and put gauze pads and scissors on top of their laptop, which was not observed to be clean. LPN 2 placed alcohol pads on the table. LPN 2 cleaned the pulse oximeter (an electronic device that measures the saturation of oxygen carried in your red blood cells and checks your pulse rate) with an alcohol pad, placed it on Patient #4's finger, used a gloved hand reached into their nursing bag to retrieve their thermometer, took Patient #4 temperature, and placed the thermometer on top of alcohol pads that were on the table. LPN 2 moved the barrier that contained the normal saline syringes along with the gauze and scissors to the floor by the recliner, placed a box of gloves on the floor next to the barrier, and placed a barrier under Patient #4 right heel. Without a change of gloves and hand hygiene performed, LPN #2 used normal saline syringes to clean the wound on the right heal, dried it with the gauze, and applied the		Additionally, the Clinical Director will conduct Supervisoryvisits for nursing staff once weekly for 3 months to ensure that 100%compliance is achieved during visits in the home for bag technique and handwashing as well as maintaining clean/dirty barriers throughout the care of thepatient. Each nurse (current and newhires during orientation) will be required to watch an educational video on thefollowing topics: Wound measurement,nutrition and wound healing, Braden Scale and pressure injury staging, dressingselection, and pressure injury prevention. Acknowledgement that these videos were viewed by the clinician will beobtained in writing. An in-service will be conducted by theClinical Director and a third party wound vac provider to train current fieldstaff on wound vac application and troubleshooting. A pre-test and a post-test will beadministered to test knowledge and there will be an opportunity for returndemonstration for each field nurse. Time will be allotted for questions and answers to ensure	

	Quticell (used on superficial exuding wounds such as first- and second-degree burns, cuts and abrasions, lacerations, radiation injuries, and donor and recipient skin graft sites), and covered with roll gauze, and then ace wrapped the right heel. While wound care was performed, 2 normal saline syringes had fallen off the barrier onto the floor. At 1:46 PM, LPN 2 removed their gloves did not perform hand hygiene, picked up the 2 normal saline syringes, the package of gauze, and the box of gloves off the floor and placed them into their nursing bag, gathered the barriers off the floor, threw them in the trash, went to the kitchen sink, and washed their hands appropriately, and turned the water off with their bare hands. Patient #4 proceeded to their bedroom for the wound treatment to their left buttock and indicated they would say when they were ready. At 1:53 PM, LPN 2 asked if Patient #4 was ready, and they indicated they were. LPN 2 created a barrier on Patient #4's bed, hand hygiene performed, and reached into their bag for scissors, alcohol pads, and a marker. LPN 2 reached into a		understandingand a signed acknowledgment will be obtained for each field clinician involvedin wound care. 2 *Completion Dates:* The hand hygiene and bag techniquecheck-offs will be completed by 7/8/24. The weekly supervisory visits will initiated by 6/18/24. The in-service and acknowledgement of wound educationvideos watched will be completed by 7/12/24. 3 *Prevention for reoccurrence:* It will be required that each new fieldstaff member watch a bag technique video and be checked off on bag techniqueand hand hygiene prior to providing patient care. All new LPNs and RNs will shadow an RN casemanager that has been checked off by the Clinical Supervisor (Clinical Directorin absence of Clinical Supervisor) for a wound vac visit duringorientation. After shadowing for avisit, the new LPN or RN will be accompanied by the Clinical Supervisor(Clinical Director in absence of Clinical Supervisor) for a minimum of twowound vac visits prior to completing a	

	box by Patient #4's bed to retrieve the Negative pressure wound therapy kit (NPWT) (Negative Pressure Wound Therapy also known as 'wound vac': a broad term describing a unique system that aids the optimization of wound healing through the application of vacuum pressure to reduce inflammatory drainage and promote the growth of healthy tissue), and without hand hygiene, reached into their nursing bag for the box of gloves and placed them on the foot of Patient #4's bed, performed hand hygiene, donned gloves, placed a barrier under Patient #4's buttock, then touched the clean barrier, and reached into their nursing bag for more barriers. LPN 2 cleaned their scissors with an alcohol pad, turned the NPWT pump off, doffed their gloves, without hand hygiene donned a pair of gloves, and opened gauze dressings and syringes. At 2:03 PM LPN 2 unhooked the tubing from the dressing, with the end that was attached to the machine lying on Patient #4's bed, LPN 2 removed the dressing. Once removed, LPN 2 doffed their gloves, without hand hygiene, reached into		wound vac visit independently. The Clinical Supervisor will check the nurseoff for 100% compliance in infection control and wound vac application duringthe visit. If 100% compliance is notachieved, the Clinical Supervisor will continue to supervise wound vac visitsuntil 100% compliance is achieved for at least two consecutive visits prior toallowing LPN or RN to provide treatment independently. Once 100% compliance is achieved, ongoingsupervisory visits will occur on a monthly basis by the Clinical Supervisor(Clinical Director in absence of Clinical Supervisor). If 100% compliance is not maintained, theclinician out of compliance will receive education and will be supervised onall wound vac visits until 100% compliance is achieved for at least twoconsecutive visits. 4 *Person responsible for implementing andmonitoring:* ClinicalSupervisor. In the absence of theClinical Supervisor, the Clinical Director will be responsible.	

	their nursing bag, retrieved packaged Q-tips, then performed hand hygiene, and donned gloves. Using a Q-tip and a measuring device to obtain measurements of the wound, doffed their gloves, without hand hygiene, picked up the marker, and marked on the measuring tape the measurements of the wound. LPN #2 without hand hygiene, donned gloves, used normal saline syringes began to cleanse the wound, used gauze to dry the wound, doffed their gloves, and performed hand hygiene. LPN 2 donned gloves, using skin prep around the wound, then doffed their gloves without hand hygiene. While performing that task, a packaged normal saline syringe and 3 skin prep packages slid off the barrier onto the bed. Without hand hygiene, LPN 2 donned a pair of gloves, opened the NPWT kit, cut strips to prepare for placement around the wound, then placed them around the peri-wound.. LPN 2 began cutting a long strip (approximately 12 inches) of the black sponge that was to be placed in the wound bed. As LPN 2 had attempted to place the sponge into the wound bed			

	with their gloved finger, some of the sponge came out, and they pushed it back into the wound, and continued to pack the wound with their finger until it appeared to be full, then proceeded to dress the wound, reapplied the NPWT to the dressing, and turned the pump on. 4. On 06/14/2024 at 2:45 when queried if it was normal to use their finger to try to pack the wound with the sponge, LPN 2 indicated they felt they couldn't stop the dressing change at that point to retrieve a Q-tip from their nursing bag. When queried about hand hygiene, LPN 2 indicated they thought they performed hand hygiene when they should have. When queried if they were to put unused items that had fallen off the barriers or items that had been placed on the floor or the patient's bed back into their nursing bag, they indicated it was fine. When queried LPN 2 if the inside of the nursing bag was clean, they indicated it was, this writer queried after placing the normal saline syringes, gauze pads, and the box of gloves that had been on the floor and the patient's bed, was			

	their nursing bag still clean, LPN 2 indicated it probably was not. On 06/14/2024 at 3:59 PM the Clinical Director indicated they expect clinicians to perform hand hygiene every time gloves are removed, a sterile Q-tip should be used to push the black sponge into the wound, and anytime disposable items fall off the barrier the items should be discarded, not placed back into the nursing bag. 5. On 06/14/2024 at 1:00 PM during a home visit with Licensed Practical Nurse (LPN) 1 for Patient #8's wound care, the LPN was observed performing a wound vac dressing change to the patient's right heel. Patient #8 was positioned in their recliner with their legs propped up on the chair's footrest and LPN 1 placed their scissors, a small pair of pink bandage scissors, a larger pair of pink bandage scissors, and a few packets of Skin-Prep Protective Wipes (pre-packaged moistened wipes that when applied to the skin forms a barrier between the skin and adhesives to help preserve skin integrity and prevent insult or injury during removal of tapes			

	and films) directly on the surface of the footrest, between the patient's legs, without a barrier. Later in the visit the nurse, with gloved hands, picked up the larger pair of pink scissors and used them to cut a piece of black foam wound dressing that was then placed directly against the wound bed. Later in the visit LPN 1 took the patient's vital signs, utilizing the following vital sign equipment: a stethoscope, pulse oximeter (an electronic device that measures the saturation of oxygen carried in your red blood cells and checks your pulse rate), thermometer, and blood pressure cuff, which had all been sitting on the bare surface of a coffee table nearby. The table was visibly dusty and there was not a barrier in place. After vital signs were taken, all items were then sanitized with a disposable sanitizing wipe and put directly back into the nursing bag. At the end of the visit, the nurse pulled a disposable barrier out from underneath their nursing bag which had been placed on the floor, the nursing bag then sat in direct contact with the surface of the bare floor. LPN 1 was queried as to whether they			

	had sanitized the surface of the footrest before placing items there, LPN 1 indicated they had not sanitized the surface and indicated understanding they had likely contaminated the wound using scissors that had contact with a potentially contaminated surface, and then had cut into the black foam wound dressing which was then placed directly on the surface of the wound, thereby potentially contaminating the wound. LPN 1 indicated should have used a barrier from the start for the vital sign equipment and indicated realized their mistake when pulling the disposable barrier out from underneath the nursing bag, and should have done that differently. 6. On 6-17-2024 at 9:30 AM during a home visit with Registered Nurse (RN) 1 for Patient #6's wound care, the RN was observed performing a wound vac dressing change to the lower abdomen. The patient was reclined in bed and the old dressing was removed. The nurse doffed their gloves, performed hand hygiene and donned new gloves, cleansed the wound with wound cleanser			

	noted to be wearing a dark, thin, string-like bracelet on the right hand, the loose end of the bracelet hanging down approximately 1.0 - 1.5 inches off the wrist, this not covered by the glove worn. The loose end of the bracelet made contact with the bare wound bed, and gloves were doffed. When it was noted the bracelet had made contact with the wound bed, the nurse promptly removed the bracelet. When queried, the nurse indicated understanding they had inadvertently but likely contaminated the wound. Returning to the wound the nurse performed hand hygiene, donned new gloves, cleansed the wound again, and completed the wound vac dressing change. 7. On 06-14-2024 at 4:57 PM, the Clinical Director and the Alternate Clinical Director were informed of infection prevention breaches that occurred during the home observations for Patient #4 and Patient #8 on 06-14-2024, related to poor aseptic technique during wound vac dressing changes. The Clinical Director indicated			

	understanding that there were now two potentially contaminated wounds in the field and indicated to the Alternate Clinical Director they 'needed to get those changed'. On 06-17-2024 at 11:30 AM, the Administrator, Clinical Director, and Alternate Clinical Director were queried as to actions taken and outcome for Patients #4 and #8 after being notified of breaches in infection prevention during the wound care provided three days prior. The Clinical Director indicated that the patient's physicians had not been notified, the patients had not been seen, and could not answer if either patient was currently receiving antibiotic therapy. The Clinical Director indicated the patients' physicians should have been contacted on Friday, but indicated both patients were scheduled for nursing visits today.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes;	G0716	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is	2024-07-12

	Based on record review and interviews, the agency failed to ensure clinicians followed the agency's policy on completion of the documentation of services they provided on the day the service was rendered in 4 of 6 active clinical records reviewed. (Employee: RN 1, RN 2, LPN 1 and LPN 2) Findings include: 1. A review of an undated policy titled, 'CLINICAL DOCUMENTATION C-680' revealed, "... 5. Documentation of services ordered on the plan of care will be completed the day service is rendered ... ". 2. A review of the clinical record for Patient #3 revealed two (2) documents titled "Home Health Care Certification and Plan of Care for the certification periods of 04/11/2024 through 06/09/2024 signed by the Director of Nursing on 04/16/2024 and the 2nd for the certification period of 06/10/2024 through 08/08/2024 signed by the Alternate Director of Nursing on		required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **G0716: Preparing Clinical Notes** Surveycites: Agency failed to ensureclinicians followed	

	06/12/2024. Patient #3 diagnoses included but were not limited to Pressure ulcer of other site Stage 2 (partial thickness loss of dermis [middle layer of skin] presenting as a shallow open area with a red or pink wound bed, without slough or bruising] and Abrasion of lower back and pelvis. For the certification period of 04/16/2024 through 06/09/2024 Patient #3 was to receive skilled nursing visits 1 time a week, physical therapy 1 time a week for 1 week, 2 times a week for 6 weeks, and 1 time a week for 1 week. For the certification period of 06/10/2024 through 08/08/2024 Patient #3 was to receive skilled nursing 2 times a week for 9 weeks, and physical therapy 2 times a week for 8 weeks. Further review of the clinical record for Patient #3 evidenced skilled nursing visits and when the clinicians completed the visit notes: on 04/11/2024 signed by RN 1 on 04/16/2024, on 05/07/2024 signed by RN1 on 05/09/2024, on 05/09/2024 signed by LPN 2 on 05/11/2024, on 05/16/2024 signed by LPN 2 on 05/23/2024, on 05/23/2024		agency's policy on completion of documentation of servicesprovided on the day service was rendered. 1 *Correctiveaction:* An updated Agency policywill be implemented effective 6/18/24 that states that documentation will becompleted within 24-48 hours of services rendered. An in-service to discuss the updated policywith all field staff members will be conducted by the Clinical Director by7/12/24. During in-service, all staffmembers will be educated regarding the expectation for documentation to becompleted within 48 hours of services rendered and will sign acknowledgement ofunderstanding. A daily audit (businessweek days) will be conducted by the Administrator for a period of 3 months toensure 100% compliance. 2 *Completion Dates:* In-service and acknowledgment of newpolicy will be conducted by 7/12/24. Dailyaudits will be conducted effective 7/12/24. 3 *Prevention for reoccurrence:* All new employees will be provided with acopy of the new	

	signed by LPN 2 on 05/28/2024, on 06/4/2024 signed by LPN 2 on 06/06/2024, and on 06/07/2024 signed by RN 1 on 06/11/2024. The Clinical Record failed to evidence the skilled nursing documentation was completed on the day services were rendered. 2. A review of the clinical record for Patient #4 revealed two (2) documents titled "Home Health Care Certification and Plan of Care" for the certification periods of 04/10/2024 through 06/08/2024 signed by the Clinical Director on 04/16/2024 and the 2nd for the certification period of 06/09/2024 through 08/07/2024 signed by the Alternate Clinical Director on 06/11/2024. Patient #4's diagnoses included but were not limited to Cellulitis of the buttock (a deep infection of the skin), Pressure ulcer of left buttock stage 4 (Full-thickness skin loss extends through the fascia[thin casing of connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fiber and muscle in place] with considerable tissue loss),		policy for documentation and sign acknowledgement ofreceipt/understanding of policy. A dailyaudit will be conducted by the Administrator of outstanding visit documentationfor 3 months to achieve 100% compliance. If 100% compliance is not achieved, the audit will continue for anadditional 3 months until 100% compliance is achieved. Once 100% compliance is achieved, theAdministrator will continue to conduct weekly audits of outstanding documentationon-going. Any clinician out ofcompliance will receive education and daily audits until 100% compliance isachieved. 4 *Person responsible for implementing andmonitoring:* Administrator will beresponsible. Clinical Director will beresponsible	

	and Pressure ulcer of Left heel, stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed). Patient #4 was to receive skilled nursing visits for the certification period of 04/10/2024 through 06/08/2024 3 times a week and for the certification period of 06/09/2024 through 08/07/2024 wound care was to be performed 2 times a week. Further review of the clinical record for Patient #4 evidenced the following skilled nursing visits and when the clinicians completed the visit notes were: on 04/10/2024 signed by RN 1 on 04/15/2024, on 04/15/2024 signed by RN 1 on 04/16/2024, on 04/19/2024 signed by LPN 2 on 04/22/2024, on 04/22/2024 signed by LPN 2 on 04/23/2024, on 04/26/2024 signed by LPN 2 on 04/30/2024, on 04/29/2024 signed by LPN 1 on 05/03/2024, on 05/03/2024 signed by LPN 1 on 05/07/2024, 0n 05/06/2024 signed by LPN 1 on 05/11/2024, on 05/08/2024 signed by RN 3 on 05/09/2024, on 05/10/2024 signed by LPN 1 on 05/14/2024, on 05/13/2024 signed by LPN 1 on 05/14/2024, on 05/17/2024 signed by RN 3 on 05/18/2024,			

	on 05/20/2024 signed by LPN 1 on 05/30/2024, on 05/24/2024 signed by LPN 1 on 05/30/2024, on 05/27/2024 signed by LPN 1 on 05/28/2024, on 05/31/2024 signed by LPN 1 on 06/03/2024, on 06/03/2024 signed by LPN 1 on 06/06/2024, on 06/07/2024 signed by RN 3 on 06/11/2024, and on 06/12/2024 signed by RN 3 on 06/13/2024. The Clinical Record failed to evidence the skilled nursing documentation was completed on the day services were rendered.			

	3. A review of the clinical record for Patient #6 revealed a document titled "Home Health Care Certification and Plan of Care" signed by the Alternate Clinical Director and dated 04/25/2024 for the certification period of 04/25/2024 through 06/23/2024. Patient #6's diagnoses included but were not limited to Disruption of external operation (surgical) wound (surgical complication where a surgery wound reopens, either internally or externally). Patient #6 was to receive skilled nursing visits 2 times a week for wound care/dressing change. Further review of the clinical record evidenced the following skilled nursing visits and when the clinician completed the visit notes were: on 04/25/2024 signed by RN 1 on 04/29/2024, on 04/29/2024 signed by RN 1 on 05/01/2024, on 05/06/2024 signed by RN 1 on 05/08/2024, on 05/17/2024 signed by LPN 1 on 05/18/2024, on 05/24/2024 signed by RN 1 on 05/25/2024, on 05/27/2024 signed RN 1, on 05/31/2024 signed by RN 1 on 06/01/2024, on 06/03/2024 signed by RN 1 on 06/05/2024,			

	LPN 2. The Clinical Record failed to evidence the skilled nursing documentation was completed on the day services were rendered. 4. A review of the clinical record for Patient #10 revealed a document titled "Home Health Care Certification and Plan of Care" signed by the Alternate Clinical Director and dated 05/30/2024 for the certification period of 05/27/2024 through 07/25/2024. Patient #10's diagnoses included but were not limited to Encounter for change or removal of surgical wound dressing and Encounter for orthopedic aftercare following surgical amputation. Patient #6 was to receive skilled nursing visits 2 times a week for wound care assessment. Further review of the clinical record evidenced the following skilled nursing visits and when the clinicians completed the visit notes were: on 05/27/2024 signed by RN 1 on 05/28/2024, on 05/29/2024 signed by RN 1 on 06/02/2024, on 06/10/2024 signed by RN 1 on 06/11/2024,			

	and on 06/12/2024 signed by RN 1 on 06/14/2024, The Clinical Record failed to evidence the skilled nursing documentation was completed on the day services were rendered. On 06/14/2024 at 8:39 AM, RN 3 indicated they were to have their documentation completed within 24-48 hours. On 06/14/2024 at 2:45 PM, LPN 2 indicated they were to have their documentation completed within 24-48 hours. On 06/14/2024 at 9:03 AM, RN 1 indicated they were to have their documentation completed within 24-48 hours. On 06/17/2024 at 11:39 AM, the Clinical Director indicated all clinicians should have their documentation completed within 24-48 hours.			
G0984	In accordance with current clinical practice	G0984	"Home Health Services by CompassPark (the "Agency") is	2024-07-12

	484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on record review and interview the agency failed to ensure clinicians followed the agency's policy when performing wound care with the use of negative pressure wound therapy in 1 of 3 home visits. (LPN 2) Findings include: 1. A review of a policy titled 'NEGATIVE PRESSURE WOUND THERAPY POLICY' dated May 17, 2023 revealed, "... 8. General application process: ... e. Select foam type to the size and characteristics of the wound, and place gently into the wound ... ". 2. A review of the clinical record for Patient #4 revealed two (2) documents titled "Home Health Care Certification and Plan of Care" for the certification period 06/09/2024 through 08/07/2024 signed by the Alternate Clinical Director on 06/11/2024. Patient #4's diagnoses included but were		submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **G0984: In accordance**	

	not limited to Cellulitis of the buttock (a deep infection of the skin), Pressure ulcer of left buttock stage 4 (Full-thickness skin loss extends through the fascia[thin casing of connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fiber and muscle in place] with considerable tissue loss), and Pressure ulcer of Left heel, stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed). Patient #4 was to receive skilled nursing wound care visits, "Left buttock cleanse with normal saline, use skin prep for peri-wound, cover with transparent dressing, Negative pressure wound therapy (NPWT) (Negative Pressure Wound Therapy also known as 'wound vac': a broad term describing a unique system that aids the optimization of wound healing through the application of vacuum pressure to reduce inflammatory drainage and promote the growth of healthy tissue), type of dressing, black foam, and NPWT settings continuous 125 mmHg (millimeters of mercury)". On 06/14/2024 at 1:53 PM		**with current clinical practice** Survey cites: Agency failed to ensure clinicians followed the agency's policy whenperforming wound care with the use of negative pressure wound therapy. 1 *Correctiveaction:* An in-service will beconducted by the Clinical Director andthird party wound vac company representative for all nurses in the field by7/12/24. The in-service will includedistribution of wound vac policy, procedure for applying a wound vac, what todo when the wound vac fails, education requirements for caregivers/patients inthe home, troubleshooting, and demonstration of understanding of procedures. Apre-test and a post-test will be administered to test knowledge and there willbe an opportunity for return demonstration for each field nurse. Time will be allotted for questions andanswers to ensure understanding and a signed acknowledgment will be obtainedfor each field clinician involved in wound care. Additionally, all nurses will be	

	during a home observation with LPN 2 for Patient #4's stage 4 left buttock wound care. LPN 2 created a barrier on Patient #4's bed, hand hygiene performed, and reached into their bag for scissors, alcohol pads, and a marker. LPN 2 reached into a box by Patient #4's bed to retrieve the NPWT kit, without using hand hygiene, reached into their nursing bag for the box of gloves and placed them on the foot of Patient #4's bed, then performed hand hygiene, donned gloves, placed a barrier under Patient #4's buttock, touched the clean barrier before getting back into their nursing bag for more barriers. LPN 2 cleaned their scissors with an alcohol pad, turned the NPWT pump off, doffed their gloves, with no hand hygiene, donned a pair of gloves, and opened gauze dressing packages, and normal saline syringes. At 2:03 PM LPN 2 unhooked the tubing from the dressing, with the end of the tubing attached to the machine lying on Patient #4's bed, LPN 2 removed the dressing. Once removed, LPN 2 doffed their gloves, reached into their nursing bag retrieved packaged Q-tips, performed hand hygiene, and donned		supervisedby the Clinical Supervisor (Clinical Director in absence of ClinicalSupervisor) for a minimum of two wound vac visits to be checked off on woundvac policy compliance starting 7/12/24. If 100% compliance is not demonstrated, supervisory visits will continueuntil at least two consecutive visits occur with 100% compliance. 2 *Completion dates:* Wound vac supervisory visits will beinitiated on 7/12/24 and continue until each nurse has had two supervisoryvisits exhibiting 100% compliance. 3 *Prevention for reoccurrence:* All nurses will be supervised for two woundvac visits to ensure 100% compliance with wound vac application effective7/12/24. If 100% compliance is notachieved, supervisory visits will continue until two consecutive visitsdemonstrate 100% compliance. Once 100% compliance is achieved, ongoingsupervisory visits will occur on a monthly basis by the Clinical Supervisor(Clinical Director in absence of Clinical Supervisor). If 100%	

	gloves. Using a Q-tip and a measuring device to obtain measurements of the wound, doffed their gloves with no hand hygiene, picked up the marker, and marked on the measuring tape the measurements of the wound. LPN #2 donned gloves, using normal saline syringes began washing the wound, using gauze to dry the wound, doffed their gloves, and performed hand hygiene. LPN 2 donned gloves, using skin prep around the wound, then doffed their gloves. LPN 2 donned a pair of gloves without performing hand hygiene, opened the NPWT kit, cut strips of a clear dressing for the drape placement around the wound, and placed them around the peri-wound. LPN 2 began cutting a long strip (approximately 12 inches) of the black sponge. As LPN 2 attempted to place the sponge into the wound bed with their gloved finger, some of the sponge came out, and they pushed it back into the wound with their finger, and continued to pack the wound with the sponge with their finger until it appeared to be full, took the tail of the the black sponge approximately four inches and		compliance is not maintained, theclinician out of compliance will receive education and will be supervised onall wound vac visits until 100% compliance is achieved for at least twoconsecutive visits. 4 *Personresponsible for implementing and monitoring:* Clinical Supervisor. In the absence of the Clinical Supervisor,the Clinical Director will be responsible.	

	ran it up Patient #4's buttock toward their waist, proceeded to cover the wound with a clear dressing, cut a hole in the clear dressing at the end of the sponge, and used the attached tubing adhesive drape sealed the tubing on top of the dressing, and reapplied the NPWT to the dressing and turned the pump on. On 06/17/2024 at 10 AM, a review of the Personnel Record for LPN 2 was conducted, evidenced a hire date of 10/23/2023 and failed to evidence training specific to NPWT. On 06/14/2024 at 2:45 PM, LPN 2 indicated they should have used a Q-Tip to push the sponge into the wound. When queried if they normally cut a long strip of foam, they indicated they do and pack it into the wound. When queried if they had been trained on how to properly use NPWT, they indicated they had not received official training but had job shadowed, and could reach out to the case manager if there were any tasks they were unsure of.			

	On 06/14/2024 at 3:59 PM, the Clinical Director indicated LPN 2 should have not used their finger to put the sponge into the wound, and should have cut the sponge to fit the wound, not packed the wound with the sponge. The Clinical Director indicated that the agency needed to have a Registered Nurse (RN) follow up with the visit. On 06/17/2024 at 9:11 AM, Person K with Entity J indicated they were familiar with Patient #4, indicated the agency hadn't reached out to them since 06/14/2224, and they were not comfortable with giving answers regarding wound care vac dressing changes, they would have their Supervisor return this writer's phone call. On 06/17/2024 at 11:18 AM, this writer requested from the Clinical Director training or in-services for NPWT which LPN 2 had completed. On 06/17/2024 at 11:33 AM, the Clinical Director indicated they had not notified the Physician of the visit nor had an RN follow-up over the weekend. On 06/17/2024 at 3:13 the			

	Clinical Director indicated LPN 2 had not received any training or in-services for NPWT.			
N0000	Initial Comments This visit was for a State Complaint Survey of a Deemed Home Health Provider, conducted by the Indiana Department of Health. Survey Dates: 06-12-2024, 06-13-2024, 06-14-2024, and 06-17-2024 The Survey was Fully Extended on 6-13-2024 at 4:08 PM, announced to the Alternate Administrator. Complaint: IN00104969 Non-compliant, with related and unrelated deficiencies cited. 12-month unduplicated skilled admissions: 379	N0000		

	Indiana Masonic Home Health was found to be out of compliance with 410 IAC 17. QR completed by Area 3 on 6-27-2024.			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview the agency failed to ensure a criminal background check had been completed for a clinician prior to contact with	N0458	Home Health Services by CompassPark (the Agency) is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in	2024-06-18

	agency patients, in 1 of 6 personnel records reviewed. (Registered Nurse (RN) 1) Findings include: 1. Review of an undated agency document titled 'CRIMINAL BACKGROUND CHECKS D-190' stated, "POLICY Home Health Services at Compass Park requires background screenings to be completed on all final candidates for employment ... Employees will not be able to start working with clients until the background check clearance has been received by the agency ... PURPOSE To provide increased safety for clients of the Agency. To reduce risk to the Agency ..." 2. On 6-13-2024 a review of the personnel record for Registered Nurse (RN) 1 evidenced a Start Date of 01-03-2024, a date of First Patient Contact of 01-15-2024, and failed to evidence a criminal background check had been performed. 3. On 6-17-2024 a criminal background check was provided for RN 1, which evidenced had been completed on 03-12-2024. 4. On 06-17-2024 at 1:44 PM,		the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance. Survey cites: Licensure requirement not met as evidenced by agency failing to ensure a criminal background check has been completed for a clinical prior to contact with agency patients. Corrective Action: An audit has been conducted effective 6/18/24 of all employee files to ensure all required documents are present. A new procedure has been implemented regarding the intake process for new home health employees effective 6/18/24. The new procedure implements a two-step verification process to ensure that all employees have a background check, drug screen, and physical completed prior to attending agency orientation and performing patient care. The initial intake process will be conducted by the Human Resources Specialist. Once all the information is	

	when queried as to the criminal background check being performed after RN had already started seeing patients, indicated the Human Resources Department had missed this upon hire but caught this recently when a criminal background check was required for the agency to apply for Medicaid certification. The Administrator further indicated the background should have been checked before the nurse saw patients, and in fact, should have been checked before orientation.		received, the Director of Human Resources will ensure that all steps are completed and copies of each are placed in the employee's HR file. Completion dates: The procedure will be effective 6/18/24 Prevention for Reoccurrence: The new procedure will ensure that a two-step process is implemented to achieve 100% compliance. This process will continue ongoing to ensure 100% compliance is maintained. Person responsible for implementing and maintaining: The Director of Human Resources will be responsible. The CEO will be responsible in the absence of the Human Resources Director.	
N0470	Home health agency administration/management 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws.	N0470	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is	2024-07-12

	Based on observation, record review, and interview, the agency failed to ensure field staff followed appropriate infection control practices per agency policy while providing patient care in 3 of 3 home visits conducted. (Registered Nurse (RN) 1, Licensed Practical Nurse (LPN) 1 and 2) Findings include: 3. On 06/14/2024 at 1:18 PM during a home observation with LPN 2 for Patient #4's wound care, LPN 2 created a barrier for their nursing bag, performed hand hygiene, reached into the nursing bag for supplies, put normal saline syringes on the barrier and put gauze pads and scissors on top of their laptop, which was not observed to be clean. LPN 2 placed alcohol pads on the table. LPN 2 cleaned the pulse oximeter (an electronic device that measures the saturation of oxygen carried in your red blood cells and checks your pulse rate) with an alcohol pad, placed it on Patient #4's finger, used a gloved hand reached into their nursing bag to retrieve their thermometer, took Patient #4 temperature, and placed the thermometer on		not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance."	

	top of alcohol pads that were on the table. LPN 2 moved the barrier that contained the normal saline syringes along with the gauze and scissors to the floor by the recliner, placed a box of gloves on the floor next to the barrier, and placed a barrier under Patient #4 right heel. Without a change of gloves and hand hygiene performed, LPN #2 used normal saline syringes to clean the wound on the right heal, dried it with the gauze, and applied the Quticell (used on superficial exuding wounds such as first- and second-degree burns, cuts and abrasions, lacerations, radiation injuries, and donor and recipient skin graft sites), and covered with roll gauze, and then ace wrapped the right heel. While wound care was performed, 2 normal saline syringes had fallen off the barrier onto the floor. At 1:46 PM, LPN 2 removed their gloves did not perform hand hygiene, picked up the 2 normal saline syringes, the package of gauze, and the box of gloves off the floor and placed them into their nursing bag, gathered the barriers off the floor, threw them in the trash, went to the kitchen sink, and washed their		**N0470: Home health agency administration/management-Policies and proceduresshall be written and implemented for the control of communicable disease incompliance with federal and state laws** Surveycites: Agency failed to ensure fieldstaff followed appropriate infection control practices per agency policy whileproviding patient care. 1 *Correctiveaction:* All Clinical field staffwill be checked off for compliance by the Clinical Director (ClinicalSupervisor in the absence of the Clinical Director) with hand washing and bagtechnique to ensure 100% compliance. Additionally, the Clinical Director will conduct Supervisory visits fornursing staff once weekly for 3 months to ensure that 100% compliance isachieved during visits in the home for bag technique and hand washing as wellas maintaining clean/dirty barriers throughout the care of the patient. Each nurse (current and new hires duringorientation) will be	

	hands appropriately, and turned the water off with their bare hands. Patient #4 proceeded to their bedroom for the wound treatment to their left buttock and indicated they would say when they were ready. At 1:53 PM, LPN 2 asked if Patient #4 was ready, and they indicated they were. LPN 2 created a barrier on Patient #4's bed, hand hygiene performed, and reached into their bag for scissors, alcohol pads, and a marker. LPN 2 reached into a box by Patient #4's bed to retrieve the Negative pressure wound therapy kit (NPWT) (is a broad term used to describe a unique and versatile system that aids the optimization of wound healing through the application of sub-atmospheric pressure to help reduce inflammatory exudate and promote granulation tissue), and without hand hygiene, reached into their nursing bag for the box of gloves and placed them on the foot of Patient #4's bed, performed hand hygiene, donned gloves, placed a barrier under Patient #4's buttock, then touched the clean barrier, and reached into their nursing bag for more barriers. LPN 2 cleaned their scissors with an		required to watch an educational video on the followingtopics: Wound measurement, nutrition andwound healing, Braden Scale and pressure injury staging, dressing selection,and pressure injury prevention. Acknowledgement that these videos were viewed will be documented inwriting. An in-service will be conductedby the Clinical Director and a third party wound vac provider to train currentfield staff on wound vac application and troubleshooting. A pre-test and a post-test will beadministered to test knowledge and there will be an opportunity for returndemonstration for each field nurse. Time will be allotted for questions and answers to ensure understandingand a signed acknowledgment will be obtained for each field clinician involvedin wound care. 2 *Completion Dates:* The hand hygiene and bag techniquecheck-offs will be completed by 7/8/24. The weekly supervisory visits will initiated by 6/18/24. The in-service and acknowledgement of wound	

	alcohol pad, turned the NPWT pump off, doffed their gloves and without hand hygiene donned a pair of gloves and opened gauze dressings and syringes. At 2:03 PM LPN 2 unhooked the tubing from the dressing, with the end that was attached to the machine lying on Patient #4's bed, LPN 2 removed the dressing. Once removed, LPN 2 doffed their gloves, without hand hygiene, reached into their nursing bag, retrieved packaged Q-tips, then performed hand hygiene, and donned gloves. Using a Q-tip and a measuring device to obtain measurements of the wound, doffed their gloves, without hand hygiene, picked up the marker, and marked on the measuring tape the measurements of the wound. LPN #2 without hand hygiene, donned gloves, used normal saline syringes began to cleanse the wound, used gauze to dry the wound, doffed their gloves, and performed hand hygiene. LPN 2 donned gloves, using skin prep around the wound, then doffed their gloves without hand hygiene. While performing that task, a packaged normal saline syringe and 3 skin prep packages slid		educationvideos watched will be completed by 7/12/24. 3 *Prevention for reoccurrence:* It will be required that each new fieldstaff member watch a bag technique video and be checked off on bag techniqueand hand hygiene prior to providing patient care. All new LPNs and RNs will shadow an RN casemanager that has been checked off by the Clinical Supervisor (Clinical Directorin absence of Clinical Supervisor) for a wound vac visit duringorientation. After shadowing for avisit, the new LPN or RN will be accompanied by the Clinical Supervisor(Clinical Director in absence of Clinical Supervisor) for a minimum of twowound vac visits prior to completing a wound vac visit independently. The Clinical Supervisor will check the nurseoff for 100% compliance in infection control and wound vac application duringthe visit. If 100% compliance is notachieved, the Clinical Supervisor will continue to supervise wound vac visitsuntil 100% compliance is achieved prior to allowing LPN or RN to providetreatment independently. Once	

	off the barrier onto the bed. Without hand hygiene, LPN 2 donned a pair of gloves, opened the NPWT kit, cut strips to prepare for placement around the wound, then placed them around the peri-wound.. LPN 2 began cutting a long strip (approximately 12 inches) of the black sponge that was to be placed in the wound bed. As LPN 2 had attempted to place the sponge into the wound bed with their gloved finger, some of the sponge came out, and they pushed it back into the wound, and continued to pack the wound with their finger until it appeared to be full, then proceeded to dress the wound, reapplied the NPWT to the dressing, and turned the pump on. 4. On 06/14/2024 at 2:45 when queried if it was normal to use their finger to try to pack the wound with the sponge, LPN 2 indicated they felt the couldn't stop the dressing change at that point to retrieve a Q-tip from their nursing bag. When queried about hand hygiene, LPN 2 indicated they thought they performed hand hygiene when they should have. When queried if they were to put		100%compliance is achieved, ongoing supervisory visits will occur on a monthlybasis by the Clinical Supervisor (Clinical Director in absence of ClinicalSupervisor). If 100% compliance is notmaintained, the clinician out of compliance will receive education and will besupervised on all wound vac visits until 100% compliance is achieved for atleast two consecutive visits. 4 *Person responsible for implementing andmonitoring:* ClinicalSupervisor. In the absence of theClinical Supervisor, the Clinical Director will be responsible.	

	unused items that had fallen off the barriers or items that had been placed on the floor or the patient's bed back into their nursing bag, they indicated it was fine. When queried LPN 2 if the inside of the nursing bag was clean, they indicated it was, this writer queried after placing the normal saline syringes, gauze pads, and the box of gloves that had been on the floor and the patient's bed was their nursing bag still clean, LPN 2 indicated it probably was not. On 06/14/2024 at 3:59 PM the Clinical Director indicated they expect clinicians to perform hand hygiene every time gloves are removed, a sterile Q-tip should be used to push the black sponge into the wound, and anytime disposable items fall off the barrier the items should be discarded, not placed back into the nursing bag.			
N0472	Q A and performance improvement 410 IAC 17-12-2(a) Rule 12 Sec. 2(a) The home health agency	N0472	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is	2024-07-12

	must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview the agency failed to ensure their Quality Assessment Performance Improvement program included tracking adverse events, analyzing their cause, and implementing preventive actions. Findings include: 1. Review of an undated agency document titled 'Quality Assessment and Performance Improvement (QAPI) B-260' stated, "POLICY ... HHSCP will maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS ... PURPOSE To monitor the effectiveness and safety of services and the quality of care ... To identify opportunities for improvement ... To use performance improvement activities to track adverse client events, analyze their causes and implement preventive actions ... To measure agency success and ensure improvements are sustained ... SCOPE OF PROGRAM ... 2. The agency will identify, measure, analyze, and track quality indicators that include client adverse events, and other relevant data to		required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **N0472: Q A and Performance Improvement: Agency must develop, implement, maintain, and evaluate a QAPIprogram.**	

	assess processes of care, services, and operations ... STANDARD PROGRAM ACTIVITIES ... 3. The programs activities will lead to an immediate correction of identified problems that directly or potentially threaten health and safety of clients. 4. Adverse events will be tracked and analyzed for cause and document the implementation of preventative actions. 2. Review of an undated agency document titled 'SAFETY MANAGEMENT PROGRAM B-315' stated, "... 10. Documentation of incidents, including follow-up documentation with trends and patterns will be incorporated into the the agency performance improvement plan ..." 3. Review of agency records evidenced a Fall Log, Complaint/Incident Log, and rehospitalization log containing entries of events. The rehospitalization log contained an entry regarding Patient #1, dated 02-19-2024, which stated, "... Reason for Admission ... Husband (sole caregiver) passed at home ..." and failed to detail information on the patient, circumstances leading to hospitalization, or their admitting diagnosis. 4. Review of the agency's QAPI Binder failed to evidence the agency had Performance Improvement Plans (PIPs) in place, indicated action was taken on areas of concern but failed to evidence details of the actions/strategies referred to,		**Agency must take actions thatresult in improvements in the agency's performance across the spectrum of careand must use objective measures.** Surveycites: Agency failed to ensure theirQAPI program included tracking adverse events, analyzing their cause, andimplementing preventative measures. 1 *CorrectiveAction:* Agency will implementmonthly QAPI meetings for the next 6 months to monitor the following: Infection control, Adverse event monitoring,Survey results and implementation of new processes. Additionally, Performance Improvement Planswill be implemented for each topic. ThePIP will include the following: Identifying the problem, establishing measurable goals to improve theissue, delegating specific team members with tasks to track progress,evaluating progress on a monthly basis for 6 months, and documentation. 2 *Completion Dates:* The first monthly QAPI meeting will beheld by 7/12/24, with	

	and failed to evidence measurable progress toward established goals. The program failed to evidence the incident regarding Patient #1 had been addressed. 5. Review of the clinical record for Patient #1 indicated the patient was dependent on others for transferring and mobility (the ability to change and control body position). The record evidenced a total of six (6) wounds were being treated by the home health agency. Two (2) of the wounds, the coccyx (tailbone) and left ischium (one of the three bones that make up the pelvis) required the use of specialized equipment. The record contained orders for NPWT (Negative Pressure Wound Therapy also known as 'wound vac': a broad term describing a unique system that aids wound healing through the application of vacuum pressure to reduce inflammatory drainage and promote the growth of healthy tissue) dressing changes 3 times each week to the coccyx and left ischium wounds. Home Health Skilled Nursing was ordered twice weekly for the wound care and wound vac		monthly meetings held for the next 6 months. If after 6 months, goals identified in thePIP are not achieved, the agency will continue to meet on a monthly basis foranother 6 months to monitor and adjust goals as needed to achieve desiredoutcomes. If desired outcomes areachieved after the first six months, QAPI meetings will be held quarterly on anon-going basis. 3 *Prevention for reoccurrence:* Dates for QAPI meetings for the next 6 monthswill be set at the QAPI meeting scheduled for 7/12/24. The Administrator, Clinical Director,Clinical Supervisor, and Intake Coordinator will be present for the meeting andattendance will be documented. Allsubsequent meetings will be added to the calendar of each attendee by theAdministrator to ensure 100% compliance for QAPI meetings.	

	dressing changes, on Mondays and Fridays, and PRN (as needed). Patient #1 visited Entity G, the ordering Provider's wound clinic, for wound vac changes and other wound care every Wednesday. The record evidenced a Missed Skilled Nursing visit note for wound care on Friday, 02-16-2024, and again on Monday, 02-19-2024. Communication notes from the record failed to evidence the agency contacted Entity G on Friday, 02-16-2024 regarding the first missed Skilled Nursing visit for wound care. The record evidenced a well check was requested for Patient #1 on Wednesday, 02-21-2024 when Entity G, reported the patient was a no-show for their weekly visit. 6. Review of a third-party document from Entity F, a local acute care hospital, indicated the patient was found by Entity D, local law enforcement, during the welfare check and had been left in their bed, unattended for 3-7 days. The patient's spouse (who was the primary caregiver) was found deceased in the home. The patient was transported to Entity F and admitted with a urinary tract		4 *Person responsible for implementing andmonitoring:* QAPI/PIP Meetings: TheAdministrator. In the absence of theAdministrator, the Clinical Director will be responsible.	

	infection and infection of the wounds. 7. On 06-13-2024 at 9:23 AM, when queried as to whether the incident regarding Patient #1's two (2) missed skilled nursing visits and subsequent hospitalization would be found in QAPI, the Clinical Director indicated this incident was not in QAPI, as it was not a 'complaint', but was instead likely under 'rehospitalizations'.			
N0522	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:	N0522	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services	2024-07-12

	Based on record review and interview the agency failed to ensure their clinicians obtained a physician order prior to performing wound care in 1 of 6 active record reviews. (Patient #3) Findings include: 2. A review of an undated policy titled 'PHYSICIAN ORDERS C-635' revealed, "... All medications and treatments, ... must be ordered by the physician ...". 3. A review of the clinical record for Patient #3 revealed a document titled "Home Health Care Certification and Plan of Care for the certification periods of 04/11/2024 through 06/09/2024 signed by the Director of Nursing on 04/16/2024. Patient #3 diagnoses included but were not limited to Pressure ulcer of other site Stage 2 (partial thickness loss of dermis [middle layer of skin] presenting as a shallow open area with a red or pink wound bed, without slough or bruising] and Abrasion of lower back and pelvis. For the certification period of		provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **N0522 Patient Care: Medical care shall follow a written medicalplan of care established and periodically reviewed by a physician** Surveycites: Agency failed to ensure theirclinicians obtained a physician order prior to performing wound care. 1 *Correctiveaction*: An in-service will beconducted by the Clinical Director for all clinicians involved in patient careto provide education and reinforcement of regulations regarding scope ofpractice and	

	04/16/2024 through 06/09/2024 Patient #3 was to receive skilled nursing visits 1 time a week to assess pain, assess pressure ulcer status. Further review of the clinical record evidenced a skilled nursing visit conducted on 06/04/2024, from 12:28 PM to 1:03 PM signed by LPN 2, the narrative note evidenced, "SN performed wound care per MD order without complication ... Pt indicates discomfort at right pannus. Upon SN visual assessment pt has stage 2 skin breakdown of area approximation 10 x 8.5x 0.1 ... SN to call MD and request order for tx. SN cleansed area with saline, pat dry, applied saline moistened Puracol sheet and bordered gauze dressing to area ... ". A review of the clinical record of Patient #3 evidenced a document titled "PATIENT CARE ORDER" dated 06/05/2024 signed by LPN 2 evidenced, "Cleanse wound with normal saline, pat dry, apply Puracol to the wound bed, cover with border foam gauze. Effective 06/05/2024, Twice weekly, - read back and confirmed; start		the requirement for obtaining orders prior to providing care by7/12/24. The in-service willinclude: what a clinician should do if anew wound or problem with the patient is identified during a visit, who shouldbe notified, what should be documented, where documentation should be placed,and time set aside for questions and answers. All clinicians will sign acknowledgements that they understand. 2 *Completion dates:* Emailed communication will be distributedby 7/8/24 with in-person in-service completed by 7/12/24. 3 *Prevention for reoccurrence:* All new clinicians will be educated within-service material and sign an acknowledgement of understanding. Clinical Supervisor will review each newwound care order as it is received to ensure that orders are reflected in EMRsystem for 3 months. Clinical Supervisorwill conduct a weekly audit of each wound care patient to ensure the mostrecent visit note treatment matches the most	

	date 06/05/2024". The agency failed to ensure staff obtained physician orders before the treatment of a wound on 06/04/2024. 4. On 06/14/2024 at 2:45 PM, LPN 2 stated, "If a Patient has a new wound, I can look at it but I can't treat it and must notify the physician". When queried if they would notify anyone else, LPN 2 indicated they would notify the office. On 06/14/2024 at 8:25 AM, the Director of Nursing indicated when a new wound is identified during a visit, the clinician should not treat it, maybe cover it, report it to the physician preferably while onsite with the Patient, and obtain physician orders.		recent orders received for 3months. If 100% compliance is not met,this will continue for another 3 months until 100% compliance is met. Once 100%compliance is achieved, ongoing audits will occur on a monthly basis by theClinical Supervisor. If 100% complianceis not maintained, the clinician out of compliance will receive education andwill be audited on a weekly basis for 3 months until 100% compliance isachieved. 4 *Person responsible for implementing andmonitoring:* ClinicalSupervisor. In the absence of theClinical Supervisor, the Clinical Director will be responsible. In the absence of the Clinical Director, theAdministrator will be responsible.	
N0527	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care.	N0527	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is	2024-07-12

	Based on record review and interview the agency failed to notify the ordering provider when a lapse in ordered, regularly scheduled wound care occurred and the agency failed to notify physicians when the agency became aware of possible contamination of wounds had occurred, in 1 of 10 clinical records reviewed (Patient #1) and 2 of 3 home visits observed (Patients #4 and #8) Findings include: 1. Review of an undated agency document titled 'PLAN OF CARE C-580' stated, "... 10. Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ..." 2. Review of an undated agency document titled 'CLINICAL DOCUMENTATION C-680' stated, "... 6. Services not provided and the reason for the		not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance."	

	and reported to the physician ..." 3. Review of an undated agency document titled 'COORDINATION OF CLIENT SERVICES C-360' stated, "POLICY Home Health Services at Compass Park will integrate services ... to assure the identification of client needs and factors that could affect client safety and the effectiveness of treatment. The coordination of care is provided by all disciplines and includes communication with physicians ..." 4. Review of an agency document dated 05-17-2023 titled 'NEGATIVE PRESSURE WOUND THERAPY POLICY' stated, "... Negative pressure wound therapy is an active wound care treatment that uses controlled sub-atmospheric (negative) pressure to assist and accelerate wound healing ... 12. The physician shall be notified of any complications associated with the use of NPWT ..." 5. Review of the clinical record for Patient #1 indicated the patient was dependent on		**N0527 Patient Care: the health care professional staff of theagency shall promptly alert the person responsible for the medical component ofthe patient's care to any changes that suggest a need to alter the medical planof care.** Surveycites: Agency failed to notify theordering provider when a lapse in ordered wound care occurred and agency failedto notify physicians when possible contamination of wounds had occurred. 1 *Corrective action:* Anin-service will be conducted by the Clinical Director for all cliniciansinvolved in patient care to provide education and reinforcement of policiesregarding missed visits by 7/12/24. Thein-service will include: PCP must becontacted at the time the clinician is notified that the visit will be missedor the patient is not available for scheduled visit, the visit should beattempted to be moved to another day to provide care according to the plan ofcare, a communication note should be entered with the date and time that theprovider	

	others for transferring and mobility (the ability to change and control body position). The record evidenced a total of six (6) wounds were being treated by the home health agency. Two (2) of the wounds, the coccyx (tailbone) and left ischium (one of the three bones that make up the pelvis) required the use of specialized equipment. The record contained orders for NPWT (Negative Pressure Wound Therapy also known as 'wound vac': a broad term describing a unique system that aids wound healing through the application of vacuum pressure to reduce inflammatory drainage and promote the growth of healthy tissue) dressing changes 3 times each week to the coccyx and left ischium wounds. Home Health Skilled Nursing was ordered twice weekly for the wound care and wound vac dressing changes, on Mondays and Fridays, and PRN (as needed). Patient #1 would then visit Entity G, the ordering Provider's wound clinic, for wound vac changes and other wound care every Wednesday. The record evidenced a Missed Skilled Nursing visit note for wound care on Friday,		was notified. Additionally, thein-service will include: When theprovider should be notified of contamination, where the communication should bedocumented, what steps should be taken to ensure that the contamination issueis resolved. 2 *Completion dates:* Emailed communication will be distributedby 7/8/24 with in-person in-service completed by 7/12/24. 3 *Prevention for reoccurrence:* All new clinicians will be educated within-service material and sign an acknowledgement of understanding. Clinical Director will conduct weekly auditsof missed visits for 3 months to ensure provider is contacted and missed visitis documented. If 100% compliance is notmet, this will continue for another 3 months until 100% compliance is met. Additionally, a weekly audit of the infectioncontrol binder will be conducted by the Clinical Supervisor for 3 months toensure that each infection incident is communicated and documented according topolicy. Once 100% compliance	

	02-16-2024, and again on Monday, 02-19-2024. Communication notes from the record failed to evidence the agency contacted Entity G on Friday, 02-16-2024 regarding the first missed Skilled Nursing visit for wound care. On 06-12-2-024 at 11:59 AM, Nurse Practitioner (NP) H with Entity G, a wound clinic, indicated had cared for Patient #1 for years and indicated Patient #1 was last seen in their office on Wednesday, 02-14-2024 accompanied by the patient's spouse who was also the primary caregiver. Indicated their office did not receive a call from the home health agency on Friday, 02-16-2024 when RN 1 did not see the patient for wound care, but first learned of missed visits when they received a call on Monday, 02-19-2024 from the home health agency who then reported the patient could not be contacted for a second time. Indicated it was abnormal for the spouse not to call, as he/she was very communicative with the wound care clinic. Indicated the wound clinic themselves attempted to reach Patient #1 on Tuesday, 02-20-2024 and		isachieved, ongoing audits will occur on a monthly basis by the Clinical Directorfor missed visits and the Clinical Supervisor for Infection Controlbinder. If 100% compliance is notmaintained, the clinician out of compliance will receive education and will beaudited on a weekly basis for 3 months until 100% compliance is achieved. 4 *Person responsible for implementing andmaintaining:* The ClinicalDirector will be responsible for the missed visits audit. The Clinical Supervisor will be responsiblein the absence of the Clinical Director. The Clinical Supervisor will be responsible for the audit of theinfection control binder. The ClinicalDirector will be responsible in the absence of the Clinical Supervisor.	

	followed up with other providers as well, without success. On Wednesday, 02-21-2024 when Patient #1 did not show up for their weekly appointment, Entity G indicated other providers were again contacted to determine the patient's whereabouts, and it was at that time the police were dispatched to perform a welfare check at the patient's home. NP H indicated was worried about the patient, the wound vac still being in place, and expressed concern for possible infection or sepsis. Indicated had learned of the spouse's demise and that the patient had been transported to a local hospital for care and had since been transferred to a Skilled Nursing Facility. On 06-12-2024 at 6:02 PM, in a telephone interview, when queried as to what actions would be taken if a wound patient were unable to be contacted, Registered Nurse (RN) 1 indicated would contact the agency office, contact the doctor, and would keep the patient on their schedule and adjust their day to accommodate the patient as needed. Indicated further they			

	often worked holidays 'because wound vacs can't be moved'. When queried as to what would occur if a wound vac patient could not be reached after multiple attempts, RN 1 indicated 'never had that happen' but if it did, they would call the office or for a 'well visit' especially if it was an outlier or out of the normal for the patient. When asked to define a 'well visit', indicated this meant calling the police. Indicated had called for 'well visits' in the past for other patients, and would 'stay until they (police) get there, to find out what happens' (to the patient). When queried as to the events surrounding Patient #1, indicated it was not uncommon for Patient #1's spouse to cancel nursing visits and perform the wound care themselves, often telling staff 'I got it, don't worry about it'. When queried as to what happened when Patient #1 could not be reached for their wound care visit on 02-16-2024, RN 1 indicated could not recall dates, but recalled the last time he/she went back to the home, no one answered so they told the Director of Nursing to call 'well check' and indicated 'that's			

	when they found what they found'. On 06-13-2024 at 9:13 AM, in a follow-up telephone interview, when queried as to how often a wound vac dressing ought to be changed, RN 1 indicated 'for Monday, Wednesday, and Friday usually' and indicated the consequences of overdue wound vac changes were infection or sepsis. Indicated that the Friday, 02-16-2024 visit for Patient #1 was missed as the patient could not be reached by phone or by knocking on the door. When queried as to why a 'well check' was not requested, indicated would not call for a well check on every missed visit, and reiterated that it was not abnormal for the spouse to remove the wound vac and apply a wet-to-dry dressing instead. Indicated there was no need for a well check because the spouse knew how to care for the wound. On 06-13-2024 at 9:23 AM, when queried as to Patient #1's missed visits for care and what had transpired afterward, the Clinical Director indicated that she and RN 1 had spoken at length, but there was no			

	documentation of that conversation nor of what was discussed. Indicated RN 1 did not call the doctor because they were not prompted to call the doctor by the agency's Electronic Medical Record (EMR) system, but then indicated RN 1 'still' should have called the doctor the same day. On 6-13-2024 at 1:08 PM, in an in-person interview, RN 1 was asked to clarify what was meant by 'I would have never gone in the back' as stated in the previous interview. RN 1 indicated 'I am not creeping around houses' 'for my safety'. Then indicated on Friday, 02-16-2024, had gone to Patient's #1 home and called from the home while on-site, and could hear the phone ringing inside, believed the patient answered the phone and thought the patient and spouse could both be heard speaking to each other but the sound was muffled, and they did not answer/address the nurse. RN 1 attempted to call back a few times, but 'kept getting busy signals' and suspected the patient and spouse had not properly hung			

	up/disconnected their cordless phone handset. RN 1 indicated had returned to the home the following Monday, 02-19-2024, but this time could hear the phone just continuing to ring from the outside. When queried as to a back-up plan when the patient could not be reached the first time, the Clinical Director indicated there was not a plan, and a follow-up nursing visit was not attempted over that weekend, nor had a follow-up nursing visit been considered. When queried as to whether there was concern in light of the fact the caregiver, who was normally communicative (by the agency's account and by the account of Entity G), could not be readily reached, should have alerted the agency and prompted further action or follow-up on the agency's part, RN 1 and the Clinical Director indicated affirmatively this should have alerted the agency. RN 1 then indicated, 'I wouldn't have changed anything' they had done. On 06-14-2024 at 2:22 PM, LPN 1 was interviewed after a home visit for a wound vac dressing			

	queried as to how often wound vacs needed to be changed indicated according to doctors orders but that this was usually ordered as three times per week, Mondays, Wednesdays, and Fridays. When queried as to why it was important the wound vac dressing changes were performed timely indicated there would be risk for the good tissue to grow into the black foam, infection, or the machine could malfunction. And when queried as to what actions would be taken if a wound vac patient could not be reached for a regularly scheduled skilled nursing visit, LPN 1 indicated would look in the system for other contacts, call the office, call the physician, look for a vehicle at the home, ask for a welfare check to be done, and seek guidance from their supervisor. 6. On 06-14-2024 at 4:57 PM, the Clinical Director and the Alternate Clinical Director were informed of infection prevention breaches that occurred during the home observations for Patient #4 and Patient #8, related to poor aseptic technique during wound			

	Clinical Director indicated understanding that there were now two potentially contaminated wounds in the field and then indicated to the Alternate Clinical Director they 'needed to get those changed'. On 06-17-2024 at 11:30 AM, the Administrator, Clinical Director, and Alternate Clinical Director were queried as to actions taken and outcome for Patients #4 and #8 after being notified of breaches in infection prevention during the wound care provided three days prior. The Clinical Director indicated that the patient's physicians had not been notified, the patients had not been seen, and could not answer if either patient was currently receiving antibiotic therapy. The Clinical Director indicated the patients' physicians should have been contacted on Friday, but indicated both patients were scheduled for nursing visits today.			
N0544	Scope of Services 410 IAC 17-14-1(a)(1)(E)	N0544	"Home Health Services by CompassPark (the "Agency") is submitting the following Plan of Correction/Plan ofRemoval in response to the 2567 issued by	2024-07-12

	Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on record review and interviews, the agency failed to ensure clinicians followed the agency's policy on completion of the documentation of services they provided on the day the service was rendered in 4 of 6 active clinical records reviewed. (Patients #3, 4, 6, and 10) Findings include: Further review of the clinical record for Patient #3 evidenced skilled nursing visits and when the clinicians completed the visit notes: on 04/11/2024 signed by RN 1 on 04/16/2024, on 05/07/2024 signed by RN1 on 05/09/2024, on 05/09/2024 signed by LPN 2 on 05/11/2024, on 05/16/2024 signed by LPN 2 on 05/23/2024, on 05/23/2024 signed by LPN 2 on 05/28/2024, on 06/4/2024 signed by LPN 2 on 06/06/2024, and on 06/07/2024 signed by RN 1 on 06/11/2024.		ISDH and/or CMS as it is required todo by applicable state and federal regulations. The submission of thisPlan of Correction/Plan of Removal is not intended as an admission, does notconstitute an admission by and should not be construed as an admission by theAgency that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of theAgency. The Agency does not, at this time, have an avenue at which to challengethese findings and, therefore, the Agency's failure to dispute or challenge thealleged deficiencies cannot be taken as an admission that the alleged factsoccurred as presented in the statements. Compliance has been and will beachieved no later than the last completion date identified in the Plan ofCorrection. The Agency desires this Plan of Correction to be considered itsAllegation of Compliance." **N0544 Scope of Services: Except where services are limited to therapyonly, for**	

	The Clinical Record failed to evidence the skilled nursing documentation was completed on the day services were rendered. 2. A review of the clinical record for Patient #4 revealed two (2) documents titled "Home Health Care Certification and Plan of Care" for the certification periods of 04/10/2024 through 06/08/2024 signed by the Clinical Director on 04/16/2024 and the 2nd for the certification period of 06/09/2024 through 08/07/2024 signed by the Alternate Clinical Director on 06/11/2024. Patient #4's diagnoses included but were not limited to Cellulitis of the buttock (a deep infection of the skin), Pressure ulcer of left buttock stage 4 (Full-thickness skin loss extends through the fascia[thin casing of connective tissue that surrounds and holds every organ, blood vessel, bone, nerve fiber and muscle in place] with considerable tissue loss), and Pressure ulcer of Left heel, stage 3 (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed). Patient #4 was to receive skilled nursing		**home health setting, the registered nurseshall do the following- Prepare clinical notes.** Surveycites: Agency failed to ensureclinicians followed agency's policy on completion of the documentation ofservices they provided on the day the services was rendered. 1 *Corrective action:* An updated Agency policy will beimplemented effective 6/18/24 that states that documentation will be completedwithin 24-48 hours of services rendered. An in-service to discuss the updated policy with all field staff memberswill be conducted by the Clinical Director by 7/12/24. During in-service, all staff members will beeducated regarding the expectation for documentation to be completed within 48hours of services rendered and will sign acknowledgement of understanding. A daily audit (business week days) will beconducted by the Administrator for a period of 3 months to ensure 100%compliance. 2 *Completion Dates:*	

	visits for the certification period of 04/10/2024 through 06/08/2024 3 times a week and for the certification period of 06/09/2024 through 08/07/2024 wound care was to be performed 2 times a week. Further review of the clinical record for Patient #4 evidenced the following skilled nursing visits and when the clinicians completed the visit notes were: on 04/10/2024 signed by RN 1 on 04/15/2024, on 04/15/2024 signed by RN 1 on 04/16/2024, on 04/19/2024 signed by LPN 2 on 04/22/2024, on 04/22/2024 signed by LPN 2 on 04/23/2024, on 04/26/2024 signed by LPN 2 on 04/30/2024, on 04/29/2024 signed by LPN 1 on 05/03/2024, on 05/03/2024 signed by LPN 1 on 05/07/2024, 0n 05/06/2024 signed by LPN 1 on 05/11/2024, on 05/08/2024 signed by RN 3 on 05/09/2024, on 05/10/2024 signed by LPN 1 on 05/14/2024, on 05/13/2024 signed by LPN 1 on 05/14/2024, on 05/17/2024 signed by RN 3 on 05/18/2024, on 05/20/2024 signed by LPN 1 on 05/30/2024, on 05/24/2024 signed by LPN 1 on 05/30/2024, on 05/27/2024 signed by LPN 1 on 05/28/2024, on 05/31/2024 signed by LPN 1 on 06/03/2024,		In-service and acknowledgment of newpolicy will be conducted by 7/12/24. Daily audits will be conducted effective 7/12/24. 3 *Prevention for reoccurrence:* All new employees will be provided with acopy of the new policy for documentation and sign acknowledgement ofreceipt/understanding of policy. A dailyaudit will be conducted by the Administrator of outstanding visit documentationfor 3 months to achieve 100% compliance. If 100% compliance is not achieved, the audit will continue for anadditional 3 months until 100% compliance is achieved. Once 100% compliance is achieved, theAdministrator will continue to conduct weekly audits of outstanding documentationon-going. Any clinician out ofcompliance will receive education and daily audits until 100% compliance isachieved. 4 *Person responsible for implementing andmonitoring:* Administrator will beresponsible. Clinical Director will beresponsible.	

on 06/03/2024 signed by LPN 1 on 06/06/2024, on 06/07/2024 signed by RN 3 on 06/11/2024, and on 06/12/2024 signed by RN 3 on 06/13/2024.

The Clinical Record failed to evidence the skilled nursing documentation was completed on the day services were rendered.

3. A review of the clinical record for Patient #6 revealed a document titled "Home Health Care Certification and Plan of Care" signed by the Alternate Clinical Director and dated 04/25/2024 for the certification period of 04/25/2024 through 06/23/2024. Patient #6's diagnoses included but were not limited to Disruption of external operation (surgical) wound (surgical complication where a surgery wound reopens, either internally or externally). Patient #6 was to receive skilled nursing visits 2 times a week for wound care/dressing change.

Further review of the clinical record evidenced the following skilled nursing visits and when the clinician completed the visit notes were: on 04/25/2024

signed by RN 1 on 04/29/2024, on 04/29/2024 signed by RN 1 on 05/01/2024, on 05/06/2024 signed by RN 1 on 05/08/2024, on 05/17/2024 signed by LPN 1 on 05/18/2024, on 05/24/2024 signed by RN 1 on 05/25/2024, on 05/27/2024 signed RN 1, on 05/31/2024 signed by RN 1 on 06/01/2024, on 06/03/2024 signed by RN 1 on 06/05/2024, and on 06/10/2024 signed by LPN 2.

The Clinical Record failed to evidence the skilled nursing documentation was completed on the day services were rendered.

4. A review of the clinical record for Patient #10 revealed a document titled "Home Health Care Certification and Plan of Care" signed by the Alternate Clinical Director and dated 05/30/2024 for the certification period of 05/27/2024 through 07/25/2024. Patient #10's diagnoses included but were not limited to Encounter for change or removal of surgical wound dressing and Encounter for orthopedic aftercare following surgical amputation. Patient #6 was to receive skilled

nursing visits 2 times a week for wound care assessment.

Further review of the clinical record evidenced the following skilled nursing visits and when the clinicians completed the visit notes were: on 05/27/2024 signed by RN 1 on 05/28/2024, on 05/29/2024 signed by RN 1 on 06/02/2024, on 06/10/2024 signed by RN 1 on 06/11/2024, and on 06/12/2024 signed by RN 1 on 06/14/2024,

The Clinical Record failed to evidence the skilled nursing documentation was completed on the day services were rendered.

On 06/14/2024 at 8:39 AM, RN 3 indicated they were to have their documentation completed within 24-48 hours.

On 06/14/2024 at 2:45 PM, LPN 2 indicated they were to have their documentation completed within 24-48 hours.

On 06/14/2024 at 9:03 AM, RN 1 indicated they were to have their documentation completed within 24-48 hours.

On 06/17/2024 at 11:39 AM, the Clinical Director indicated all

	clinicians should have their documentation completed within 24-48 hours.			

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
Candice McKinnie	Administrator	7/10/2024 2:07:28 PM