STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K165	A. BUILDING 00 B. WING	11/17/2020

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

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G 0000 Bldg. 00	This visit was for a Federal Recertification and State Re-Licensure Survey of a Medicaid Home Health provider. Survey Date: 11/9/2020 to 11/17/2020 Facility #: 014225 Provider #: 15K165 Medicaid #: 300012386 Unduplicated Admissions last 12 months: 10 Skilled services: 5 Home health aide services (only): 54 Total Census: 59 This deficiency reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. During this Federal Recertification Survey, Visiting Angels Home Healthcare was found to be out of compliance with Conditions of Participation 484.55 Comprehensive Assessments of Patients; 484.60 Care Planning, Coordination of Services, and Quality of Care; 484.65 Quality Assessment and Performance Improvement; 484.70 Infection Prevention and Control; 484.80 Home Health Aide Services; 484.105 Organization and Administration of Services; and 484.110 Clinical Records. Based on the Condition-level deficiencies during the November 17, 2020 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on November 10, 2020. Therefore, and pursuant to	G 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning November 17, 2020 and continuing through November 16, 2022. Quality Review completed 1/19/21 by area 2			
G 0418 Bldg. 00	484.50(a)(2) Patient's or legal representative's signature Obtain the patient's or legal representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities. Based on record review and interview, the agency failed to ensure they obtained a signature from the patient's legal guardians/ patient representative and not from another family member who was working as an agent for the agency for 1 of 1 pediatric records reviewed in a sample of 7. (Patient #3) Findings include: The clinical record for patient #3, start of care 8/17/20, was reviewed and contained an agency document titled "Acknowledgement of Information" signed by Employee E, HHA on 8/17/20. Review of the Acknowledgement of Agreements was signed by Employee E on 8/17/20. Review of the Start of care assessment dated 8/17/20, was signed by Employee E on 8/17/20. Review of the Recertification assessment dated 10/14/20, was signed by Employee E on 10/14/20.	G 0418	**G418** The Agency will update the Admission Service Agreement for patient #3 to obtain the signature of the patient's legal guardian/patient representative. The Clinical Manager/designee will immediately audit 100% of all active clinical records to identify any additional errors or gaps in the documentation of the legal guardian/patient representative on the patient Admission Service Agreement form. Education Provided: The Clinical Manager re-educated all RN Case Managers to identify at the admission assessment if the patient has a legal guardian and to obtain the appropriate signatures on the Admission Service Agreement. All SOC documentation including the Consent Forms will be audited	02/16/2021

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	Review of the Indiana Department of Health Employee Records form that was completed by the Administrator on 11/9/20, confirmed Employee E was an employee of the agency. During an interview with the Administrator and Director of Clinical Services on 11/12/20 at 1:45 p.m., both answered yes when asked if Employee E was a family member of patient #3. The Administrator and Director of Clinical Services had nothing further to add as to why the case manager failed to obtain signatures from the patient's legal guardians/ parents. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-12-3(a)(2)		at time of Admission to ensure there is accurate documentation of any legal guardian, patient representative, or parent on the Admission Service Agreement. The Clinical Manager is responsible for ongoing compliance with G418.	
G 0436 Bldg. 00	484.50(c)(5) Receive all services in plan of care Receive all services outlined in the plan of care. Based on record review and interview, the agency failed to ensure all patients receive all services outlined in the plan of care for 2 of 7 records reviewed. (Patient #5, 6) Findings include: 1. Review of the plan of care for patient #5 (start of care 6/3/20) with a certification period of 10/1/20 to 11/29/20, the order for discipline and treatment indicated "HHA [home health aide] x 8 hours/ day x 5 days / wk [week] ... HHA to assist with all adls	G 0436	**G436** The Agency will ensure all patients receive all services as ordered by the physician. The Clinical Manager will immediately audit all clinical records of patients receiving home health aide services to determine if there are additional gaps in the provision of physician ordered services. The Clinical Manager will	02/16/2021

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	[activities of daily living - bathing/ personal hygiene and grooming; dressing/ undressing; transferring, toileting/ continence related tasks; and eating/ preparing food and feeding], transfers, positioning, bathing, incontinence care, meal prep, linen changes, and light housekeeping." Review of an agency document titled "Aide's Care Plan" last updated on 10/1/20, indicated the patient was bed bound, special equipment hoyer, does not wear dentures, watch for hyper/ hypoglycemia, bleeding precautions, transfer revealed bed rest and hoyer, the Ambulation/ Mobility revealed wheelchair and positioning, Personal Care/ Assistance with ADLs indicated shower, bed chair, shower bench, comb/ brush hair, shampoo, condition, dress, shave, skin care/ grooming, clean dentures, brush teeth, mouthwash, oral swabs, empty catheter/ drainage bag, assist with bedpan/ urinal, catheter care, diapers/ depends, clean bathroom after use, clean kitchen after meal prep, make bed, change bed linens, personal laundry, and medication reminder assistance. Review of the home health aide visit notes evidenced the following: Review of a home health aide note dated 9/28/20 during a previous certification period, the note revealed that the aide made a visit to the store. The aide made a trip to the store which is not permitted under Medicaid PA (prior authorization). On 10/01/20, the home health aide visit note indicated a visit was made from 8:00 a.m. to 4:00 p.m. and failed to evidence the patient had a bath, shave, shampoo/ condition, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep,		re-educate the home health aides on their job responsibilities that include the following: a. The Aide is to arrive on the scheduled day and time of the planned visit. b. The Aide is to follow the Home Health Aide Care Plan providing care and services as ordered by the physician. c. The Aide is to stay with the patient for the duration of the visit assisting the patient with ADL's meal preparation, feeding, meal clean-up, laundry, etc., as outlined on the home health aide care plan. d. The Aide is to document the completion of all tasks as listed on the home health aide care plan. e. The Aide is to report any concerns or changes in the patient's condition to the RN Case Manager immediately. The Agency will audit 100% of all home health aide visit documentation for compliance with the home health aide care plan visit frequency and care plan tasks. The Agency has the established the goal of continually striving for a 100% compliance threshold. After which the Agency will continue to audit 20% of all home health aide visit documentation monthly. The Agency Administrator is responsible for monitoring compliance. Deficiencies and errors in documentation of home health	

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	or medication reminder. The note indicated the home health aide assisted with transfers when the patient had not been out of bed since October of 2019 (per interview below). On 10/02/20, the home health aide visit note indicated a visit was made from 8:00 a.m. to 4:00 p.m. and failed to evidence that the patient had a shave, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, clean dishes, medication reminder, change linen, and laundry. The note did reveal that the home health aide assisted with exercise and went to the store. The aide provided exercise that was not ordered on the plan of care, made a trip to the store which is not permitted under Medicaid PA nor ordered on the plan of care, assisted with transfers, and failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/4/20, only one partial visit was made on 10/08/20, from 1:30 p.m. to 4:00 p.m. and failed to evidence that the patient had a shave, brush/ comb hair, oral care, assist with toileting, meal prep, medication reminder, assist with transfers, clean dishes, change linen, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/11/20, only 3 partial visits were made. Review of a visit note dated 10/13/20 from 8:00 to 10:00 a.m., the visit note failed to evidence that the patient had a shave, brush/ comb hair, oral care, assist with transfers, meal prep, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note on 10/14/20 from 8:00 to 11:02 a.m., failed to evidence that the patient had a		aide visit documentation will be immediately addressed with the home health aides by the Clinical Manager or designee. Home Health Aides who continue to evidence performance and/or documentation errors will be placed in a disciplinary program that places their employment with Visiting Angels Home Health Agency on probation. The program consists of an improvement program with the following steps: 1. Verbal warning. The employee will receive re-education related to the deficient practice areas and an entry will be made in the home health aide's personnel file. 2. The home health aide will receive an unannounced follow-up supervisory visit and if there are no deficiencies in performance or documentation the home health aide will be removed from probation status. 3. If the home health aide demonstrates a second occurrence of poor performance and/or poor documentation, the home health aide will receive a written notice on the Disciplinary Action Form. This action plan will be filed in the home health aide's personnel file. The Clinical Manager/designee will review 100% of the home health aide's documentation on a weekly basis. At this point the home health aide must demonstrate	

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	bath, shave, shampoo hair/condition, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean dishes, change linen, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note on 10/16/20 from 12:00 to 4:00 p.m., failed to evidence that the patient had a shave assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean dishes, clean bathroom, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/18/20, only 4 partial visits were made. Review of a visit note dated 10/19/20 from 12:00 to 3:45 p.m., failed to evidence that the patient had a shave, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean bathroom, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/21/20 from 8:00 to 9:30 a.m., failed to evidence that the patient had a bath, shave, shampoo/ condition, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/22/23 from 8:00 to 11:00 a.m., failed to evidence that the patient had a bath, shave, shampoo hair/ condition, brush/ comb hair, oral care, meal prep, assist with		accurate visit performance and visit documentation. Failure to do so will result in immediate termination of employment with the Agency. The Administrator and RN Clinical Manager are responsible for ensuring ongoing compliance with G436.	

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	transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/23/20 from 8:00 to 11:00 a.m., failed to evidence that the patient had shave, shampoo hair/ condition, brush/ comb hair, oral care, meal prep, assist with transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/25/2020, the patient received partial visits 3 days of the week. Review of a visit note on 10/26/20 from 8:00 to 11:30 a.m., failed to evidence that the patient received a bath, shave, shampoo hair/ condition, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/27/20 from 8:00 to 9:30 p.m., failed to evidence that the patient had a shave, shampoo/ condition hair, assist with clothing/ dressing, oral care, meal prep, assist with transfers, clean living area, clean dishes, clean bathroom, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/28/20 from 8:00 to 9:30 p.m., failed to evidence that the patient had a shave, brush/ comb hair, oral care, meal prep, clean dishes medication reminder, assist with transfers, linen change and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care.			

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	Review of two visit notes dated 10/29/20 and 10/30/20 from 8:00 a.m. to 4:00 p.m., failed to evidence that the patient had a shave, shampoo/ condition hair, assist with clothing/ dressing, oral care, assist with transfers, meal prep, clean living area, clean bathroom, clean dishes, linen change, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 11/2/20 from 8:00 to 9:30 p.m., failed to evidence that the patient had a shave, shampoo/ condition hair, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, assist with transfers, clean living area, clean dishes, clean bathroom, change linen, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 11/5/20 from 9:00 to 11:00 a.m., indicated the patient refused all services with exception to assist with toileting, companionship, clean living area, clean floor, clean kitchen/ wash dishes, clean bathroom, empty garbage,pet care, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note on 11/6/20 from 8:00 to 11:30 a.m., indicated the patient refused all services with exception to assist with toileting, companionship, clean living area, clean floor, clean kitchen/ wash dishes, clean bathroom, empty garbage, pet care, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During a home visit on 11/12/20 from 9:30 to 10:15 a.m., the home health aide failed to shave,			

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	shampoo/ condition hair, oral care, assist with transfer, clean living area, clean floor, clean kitchen/ wash dishes, meal prep, clean bathroom and laundry. The aide arrived at the home around 9:00 a.m. and left by 11:30 a.m. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During a home visit on 11/12/20 from 9:30 to 11:30 a.m., Employee C, CNA, stated she was asked to pick up some hours with patient #5 and traveled 1.5 hours one way to care for the patient. After she left patient #5, she moved on to the next patient. During an interview on 11/12/20 at 10:15 a.m., Person J, patient #5's family member, stated the agency sometimes sent good home health aides and some bad ones. Person J stated they have not had a very good experience with Visiting Angels for it has been "up and down." Person J stated they really liked a former employee because she would get patient #5 out of bed. Person J stated they were to have someone 8:00 a.m. to 4:00 p.m. 7 days a week. Person J stated although she liked the current aide, she was only at the home until 11:30 a.m. Person J also stated that the patient had some really good aides that would take the patient to the doctor or to the store and would let the aide use her car, vacuum the living (although patient has not been up out of bed for over a year), and fix her meal when they cooked for the patient and did all the dishes and dusting. Person J stated they didn't have anyone from October 2019 to June 2020. Person J stated Visiting Angels would send people who didn't know how to get patient #5 out of bed, wouldn't work, and even had one aide that was "fresh out of school" to where the family had to teach them how to do things. Person J stated past home			

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	health aides would throw the patient's sheets away with the briefs and she was constantly having to buy new ones. Person J stated the patient hasn't been out of bed since last October, when they had the employee who was fired. Person J stated they haven't had an aide for 8 hours since the previous month and that was only for two days (10/29/20 and 10/30/20). Person J stated how her health was bad and that another family member who lived in the house was up all night with the patient getting things for them, that they can not keep up with the patient during the day. 2. The clinical record for patient #6, start of care 9/10/20, was reviewed and included a plan of care for the certification period of 9/10/20 to 11/8/20, with orders for home health aide services 4 times a day, 5 days a week to assist with activities of daily living, bathing, meal prep, safety, and light housekeeping. Review of the clinical record failed to evidence any home health aide visit notes. Review of the discharge assessment dated 10/21/20, stated "HHA [home health aide] services never initiated." The agency failed to ensure services were provided per the plan of care. 3. During the entrance conference on 11/9/20 at 9:55 a.m., when queried if the agency had any services they had problems staffing, the Administrator stated home health aides were an issue and they had been utilizing the on-call staff and had to shorten or cancel visits due to lack of staffing. 4. The findings were reviewed with Person S (Governing Body), Administrator, Director of			

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	Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			
G 0510 Bldg. 00	484.55 Comprehensive Assessment of Patients Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on record review, and interview the agency failed to ensure the comprehensive assessments were completely filled out, accurately reflected the patients current health status and past medical history, failed to ensure assessments included patient's strengths, goals, and care preferences, failed to ensure assessments included the patient's medical, nursing, rehabilitative, social, and discharge planning needs, failed to ensure all medications were appropriately reconciled with the patient, health care representative, outside agencies and ordering physicians to ensure drug interactions and duplication is identified, failed to ensure assessments identified the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule, and failed to ensure the assessment included information concerning a patient selected representative. These practices impacted 6 patients (Patients #1, 2, 3 4, 5, 6) out of 7 sampled records reviewed.	G 0510	**G510** Since the November 2020 survey 100% of agency patients have received follow-up assessments at the time of recertification. The nurse with the greatest number of errors resigned her employment and is no longer working for the agency. The Clinical Manager has re-instructed the RN Case Managers on their assessment and documentation responsibilities. A new “comprehensive assessment” audit tool has been implemented that evaluates all components of the comprehensive assessment process. The Clinical Manager/designee is responsible auditing 100% of all comprehensive assessments.	02/16/2021

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	The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services which could result in the agency not providing quality health care, thus being out of compliance with the Condition of Participation 42 CFR 484.55 Comprehensive Assessment. Findings include: 1. The agency failed to evidence the comprehensive assessments were complete and accurately reflected the patients status, including current health, psychosocial, functional, and cognitive status. (See G528) 2. The agency failed to ensure a complete and accurate assessment of the patient's strengths, goals, and care preferences. (See G530) 3. The agency failed to ensure a complete and accurate assessment of the patient's medical, nursing, rehabilitative, social, and discharge planning needs. (See G534) 4. The agency failed to ensure a registered nurse reconciled all medications with the patient, health care representative, outside agencies and ordering physicians. (See G536) 5. The agency failed to ensure the comprehensive assessment identified the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule. (See G538) 6. The agency failed to ensure the assessment included information concerning a patient selected representative. (See G540)		The new audit tool has been adapted to facilitate this process. · Audit results are provided to each RN Case Manager with the direction to correct any gaps or mistakes in the completion and documentation of the assessment. · The RN Case Managers are to make the required corrections and re-submit the assessment to the Agency Clinical Manager within 24-48 hours of receipt. The Clinical Manager/designee will perform random “un-announced supervisory visits of the RN Case Managers performing certification assessments to evaluate the RN’s ability to perform a complete, accurate, thorough comprehensive assessment. A RN Case Manager Supervisory Visit Form has been created to facilitate and document this process. To stress the importance of this process the Agency has instituted a 3-step disciplinary process for the RN Case Managers as it relates to the accurate completion of the comprehensive assessment. All RN Case Managers will be educated on the consequences of not completing and documenting a full patient-specific comprehensive assessment. 1.Failure to complete the patient-specific comprehensive assessment that addresses all	

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			elements of the assessment process will result in re-education of the employee and an entry in their personnel file documenting their non-compliance with a written warning that ongoing non-compliance will result in further consequences. 2.Failure to complete the patient-specific comprehensive assessment a 2nd time will result in further re-education of the employee and the employee being placed on a 30-day action plan. 3.If there is a 3rd occurrence of non-compliance with the completion of the patient-specific comprehensive assessment the employee's employment with Visiting Angels Home Health Agency will be terminated. The Clinical Manager is responsible for ensuring on-going compliance with G510.	
G 0528 Bldg. 00	484.55(c)(1) Health, psychosocial, functional, cognition The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to evidence the comprehensive assessments were complete and accurately reflected the patients status, including current health, psychosocial, functional, and cognitive status in 7 of 7 (Patients #1, 2, 3, 4, 5, 6, 7). Findings included: 1. Review of an undated policy C-155 titled "Client Reassessment/Update of Comprehensive	G 0528	**G528** Since the November 2020 survey 100% of agency patients have received follow-up assessments at the time of recertification. The nurse with the greatest number of errors resigned her employment and is no longer working for the agency. The Clinical Manager has re-instructed the RN Case	02/16/2021

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	Assessment" stated, "Assessments will include OASIS data collection for all Medicare and Medicaid skilled clients. Clients who are not receiving skilled services under the Medicare or Medicaid program be assessed using the OASIS tool or an alternative form identified by the agency ... The assessment will identify the problems, needs, and strengths of the client and the care the family can provide. The initial and ongoing assessments include consideration of the following ... Specific individualized client needs ... Description of any applicable strength the client has including physical, psychosocial, and of spiritual resources ... Involvement of family friends and other individuals or organizations; Appropriateness of the level of care provided by the family or support system ... Condition of the home ... and identified safety needs ...." Review of an undated policy C-148 titled "Pain Assessment/ Management" evidenced "All clients admitted to the Agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment." "If the client has pain that interferes with activity or movement on a daily basis or is determined to be intractable, pain management will be a specific intervention on the plan of care." "The assessment includes a measure of pain intensity and quality (character, frequency, location and duration)." "The nurse/ therapist will use a standardized agency accepted pain assessment tool that evaluates the location, duration, severity (rating scale), alleviating factors, exacerbating factors, current treatment (medication and non-medication) and response to treatment." 2. On 09/09/20, the Indiana Department of Health conducted a post condition re-visit survey and		Managers to ensure their comprehensive assessments address the requirement to assess and document the patient's current health, psychosocial, functional, and cognitive status. Compliance will be monitored via the new "comprehensive assessment" audit tool has been implemented that evaluates all components of the comprehensive assessment process. Compliance is monitored by the Clinical Manager/designee. The Clinical Manager/designee is responsible for auditing 100% of all comprehensive assessments. The new audit tool has been adapted to facilitate this process. · Audit results are provided to each RN Case Manager with the direction to correct any gaps or mistakes in the completion and documentation of the assessment. · The RN Case Managers are to make the required corrections and re-submit the assessment to the Agency Clinical Manager/designee within 24-48 hours of receipt. The Clinical Manager/designee will perform random "un-announced supervisory visits of the RN Case Managers "in the field setting", performing certification assessments. A RN Case Manager Supervisory Visit Form has been created to facilitate and document this process.	

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	cited the agency for failure to ensure Registered Nurses (RN) assessed all wounds, especially with patients shared with other agencies. The plan of correction indicated the agency would be in compliance with the deficiency by 10/09/20 and stated "The clinical Manager will immediately audit all current clinical records of patients receiving services from multiple providers. All nurse will receive education on the performance of a full head to toe assessment that is to be completed at all certification time points. This is to include a full skin examination and ensuring a focus on evaluation of all skin areas. Areas of the body identified as having impaired skin integrity are to be described in detail including location, size, depth, odor, slough, appearance of healing or non-healing, appearance of surrounding skin tissue including the color of the skin, etc. The nurse is to physically examine all wounds and document the above including documentation of the wound sites. In the event the patient's wound care provide is another clinic or home care provider, and upon skin examination the nurse determines the wound site has a non-removable dressing in place, the nurse is to call the clinic or provider and obtain the wound measurements, treatment plan, healing status, etc. from the other provider. The other provider is also to inform the agency of signs/symptoms they want reported to them immediately that may indicate worsening of the condition of the wound. This collaboration is to be documented in the Coordination-of -Care section of the clinical record and on the plan of care." 3. Review of the clinical record for patient #1 evidenced an initial comprehensive assessment dated 9/3/20, time in/out not recorded, with a primary diagnosis of COPD (Chronic Obstructive Pulmonary Disease) and a secondary diagnosis of		To stress the importance of this process the Agency has instituted a 3-step disciplinary process for the RN Case Managers as it relates to the accurate completion of the comprehensive assessment at all required timepoints. All RN Case Managers will be educated on the consequences of not completing and documenting a full patient-specific comprehensive assessment including the assessment of the patient's current health psychosocial, functional, and cognitive status. · Failure to complete the patient-specific comprehensive assessment that addresses all elements of the assessment process will result in re-education of the employee and an entry in their personnel file documenting their non-compliance with a written warning that ongoing non-compliance will result in further consequences. · Failure to complete the patient-specific comprehensive assessment a 2nd time will result in further re-education of the employee and the employee being placed on a 30-day action plan. · If there is a 3rd occurrence of non-compliance with the completion of the patient-specific comprehensive assessment the employee's employment with	

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	CKD (Chronic Kidney Disease). The assessment evidenced patient #1 attended dialysis on Monday, Wednesday, and Friday but failed to include a diagnosis code for End Stage Renal Disease and/or Dependence on Dialysis, failed to include the active diagnoses including Renal Failure, Hypertension, End Stage Renal Disease, Chronic Constrictive Pericarditis, Hypertensive heart and chronic kidney disease, as was evidenced on the form titled "Comorbid Diagnoses Reconciliations," and failed to include the diagnoses including of CHF (Congestive Heart Failure), Neuropathy, Kidney Failure, and Bilateral Cataracts. as documented under pertinent "Patient History and Diagnoses." The comprehensive assessment evidenced the patient was morbidly obese, provided her own self-care, had limited vision and could not see medication labels, had an excoriated abdominal fold and experienced pain, mostly in her back and lower extremities, from 3/10-10/10. The assessment failed to include details related to pain management and relief, failed to include medication reflective of treating moderate to severe pain, and failed to address medication set up by skilled nursing to ensure the patient took the correct medications. Patient #1 was on 3L oxygen via a nasal cannula with diminished breath sounds bilaterally. The assessment revealed Patient #1 reported shortness of breath with minimal exertion however it failed to evidence her self-care needs described in the patient interview. The assessment evidenced multiple assessment categories which contained insufficient information, or were blank, including the reason for home health admission, name/contact information of all physicians actively caring for Patient #1, previous surgeries, prior hospitalizations, all pertinent secondary		Visiting Angels Home Health Agency will be terminated. The Clinical Manager/designee is responsible for ensuring on-going compliance with G528.	

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	diagnoses, risk for hospitalizations, Advance Directives, living arrangements/supportive assistance, communication ability and needs, pain, dialysis information including type of access, care of access port/fistula, transportation needs, patient specific care needs, and all medications the patient was receiving, including medications ordered through the nephrologist, endocrine, hematology, integumentary, cardiopulmonary, respiratory, nutritional, elimination, neurological/emotional, and psychosocial. The assessment evidenced incomplete or blank assessment fields including mobility, fall risk, musculoskeletal and functional abilities/limitations, DME (durable medical equipment), activities/instrumental activities of daily living, medication reconciliation and medication management including ability to set up and take medications properly, medication allergies, fall and safety plans, emergency preparedness, therapy need, transportation needs, education/knowledge of patient and caregivers, and care coordination. The most recent recertification comprehensive assessment evidenced a M0090 date of 10/27/20 (Date Assessment Completed) and evidenced a page heading date of 10/29/20. The time in/out was not recorded. The assessment evidenced the primary diagnosis was COPD (Chronic Obstructive Pulmonary Disease) with a secondary diagnosis was CKD (Chronic Kidney Disease). The recertification assessment failed to evidence the patient received a complete and accurate assessment including the correct date the assessment was completed, name/contact information of physicians actively caring for Patient #1, the primary reason for home health admission, previous surgeries, emergency contact information, prior hospitalizations, all pertinent			

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	secondary diagnoses, risk for hospitalizations, Advance Directives, living arrangements/supportive assistance, self-care status, pain, and communication abilities/needs. The assessment evidenced multiple blank sections and sections with insufficient information including cardiopulmonary, respiratory, psychosocial, fall risk, musculoskeletal, mobility, and failed to include a complete assessment of the patient's functional abilities/limitations , dialysis needs including port/fistula access and care, transportation needs, all DME, activities/instrumental activities of daily living, medication reconciliation, medication allergies, fall and safety plans, emergency preparedness, therapy needs, transportation needs, education/knowledge of patient and caregivers, care coordination, other agencies involved in care, setbacks/improvements since last assessment, and modification of interventions from previous assessments. During an interview on 11/10/20 at 12:12 AM the agency Director/Clinical Manager stated she did not know Patient #1 was receiving dialysis because the RN Case manager who completed the start of care comprehensive assessment did not make her aware. When queried if she reviewed the comprehensive assessments she stated, "It was in the assessment initially, under urinary but it wasn't in the recert (recertification) assessment." When asked again who reviewed the assessments, she stated, "I do, but it must not have clicked when I saw it the first time." The Clinical Manager stated she audited all assessments upon their completion and submission to her. No further information or documentation was provided. 4. Review of a document for Patient #4, titled			

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	"Inquiry for Home Health Services", untimed and dated 6/23/20 revealed Patient #4 had primary diagnoses of COPD (Chronic Obstructive Pulmonary Disease) and Emphysema. No secondary diagnoses was listed. Services Requested/Frequency/Description was blank. A subsection titled "Details and Discussion of Requested Services and Identification of Patient Needs" included untimed and undated handwritten notes that stated, "Lives Alone; Niece makes all decisions ...; IU Health hospice (Indiana University Health Hospice) 2x/week RN 1x/week, high [arrow pointing up] 15 O2 [sic 15 liters] (Oxygen); DNR [Do Not Resuscitate] and DNI [sic], W/C (wheelchair), walker, shower chair, toilet riser, O2, nebulizer ..." A review of a document for patient #4, titled "Case Note", untimed and dated 8/24/20 evidenced "Hospice services provided weekly. Hospice provides wound care for stage II [sic pressure ulcer] on coccyx. Review of the clinical record for Patient #4 evidenced an initial comprehensive assessment dated and timed 6/25/20, 9:30 AM - 10:00 AM, with diagnoses listed as COPD and Memory Loss. Under "Patient History and Diagnoses" the clinician documented "COPD [with] emphysema." The comprehensive failed to evidence documentation of hospice services received by the patient as evidenced on the Inquiry for Home Health Services, and evidenced multiple blank or incomplete assessment sections, including the primary reason for home health admission, previous surgeries, emergency contact information, prior hospitalizations, all pertinent secondary diagnoses, including interstitial lung disease, COPD with emphysema, hypertension, Chronic hypoxemic respiratory failure, s			

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	evidenced on the Medicaid Face to Face Encounter Form risk for hospitalizations, Advance Directives, living arrangements/ supportive assistance, self-care status, communication deficits/needs, pain level and measures to mitigate pain, endocrine/ hematology, integumentary, cardiopulmonary, respiratory, nutritional, elimination, and height/ weight, neurological/ emotional, psychosocial/ end of life, functional abilities/ limitations, hospice related information, DME (durable medical equipment), musculoskeletal, fall risk, activities/ instrumental activities of daily living, mobility, medication reconciliation and medication management including ability to set up and take medications properly, medication allergies, fall and safety plans, emergency preparedness, therapy needs, education/knowledge of patient and caregivers, rehabilitation potential, and care coordination, and other agencies involved in care. Review of the clinical record for Patient #4 evidenced a recertification comprehensive assessment dated 8/24/20 for certification 8/24/20-10/22/20 with diagnoses listed as COPD with Emphysema, Interstitial lung disease, and memory loss. The comprehensive assessments failed to evidence the patient received a complete and accurate assessment including the primary reason for home health admission, previous surgeries, emergency contact information, prior hospitalizations, all pertinent secondary diagnoses as evidenced by the Medicaid Face-to-Face Encounter form, including Interstitial Lung Disease, COPD with emphysema, hypertension, and Chronic hypoxemic respiratory failure, risk for hospitalizations, Advance Directives, living arrangements/ supportive assistance, self-care status, communication deficits/needs, assessment of pain, including pain			

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	management and interventions to mitigate pain, endocrine/hematology, integumentary, cardiopulmonary, respiratory, nutritional, elimination, height/ weight, neurological/ emotional, psychosocial, functional abilities/limitations, hospice and end of life information as indicated on the Inquiry for Home Health Services form, DME (durable medical equipment), musculoskeletal, and fall risk, activities/instrumental activities of daily living, mobility, medication reconciliation and management including ability to set up and take medications properly, medication allergies, fall and safety plans, emergency preparedness, therapy needs, education/ knowledge of patient and caregivers, and care coordination, other agencies involved in care, setbacks/improvements since last assessment, and modification of interventions from previous assessments. The most recent recertification comprehensive assessment dated 10/21/20, for certification period 10/23/20-12/21/20 was reviewed. Diagnoses were listed as COPD, Interstitial lung disease, and memory loss. The comprehensive assessments failed to evidence the patient received a complete and accurate assessment including the primary reason for home health admission, previous surgeries, emergency contact information, prior hospitalizations, all pertinent secondary diagnoses, risk for hospitalizations, Advance Directives, living arrangements/ supportive assistance, self-care status, communication deficits/needs an assessment of pain, endocrine/ hematology, integumentary, diabetic foot care/ assessment, cardiopulmonary, respiratory, nutritional, elimination, height/ weight, neurological/ emotional, psychosocial/ end of life, functional abilities/limitations, hospice related information, DME (durable medical equipment),			

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	musculoskeletal, mobility, and fall risk, activities/ instrumental activities of daily living, medication reconciliation and management including ability to set up and take medications properly, medication allergies, , fall and safety plans, emergency preparedness, therapy needs, education/ knowledge of patient and caregivers, rehabilitation potential, and care coordination, other agencies involved in care, setbacks/improvements since last assessment, and modification of interventions from previous assessments. 5. The clinical record for patient #7, SOC date 8/20/20, evidenced a discharge OASIS assessment dated 10/19/20. The document revealed the assessment was based on visit date 10/12/20. Assessment document is untimed. Primary diagnosis code was "dementia". Multiple assessment sections were incomplete, including: Supportive Assistance, Patient History, and Diagnoses, Pain, Vital Signs, Psychosocial/ Mental and Cognitive Status, Limitations related to Plan of Care Post Discharge, and discharge Status. 6. During a home visit at patient #2's home on 11/10/20 at 1:30 p.m., the patient was observed to be propped up on the couch with pillows and oxygen per nasal cannula. A bath given by the certified nursing assistant was observed and the patient was noted to have a button feeding tube (g-tube = gastric tube) in their left abdomen with a dry dressing around the stoma (insertion) site. Person K, a family member, stated the patient's feeding was Complete Pediatric Organic Blend 300 ml (milliliters)/ 10 ounces at 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m. Person K stated he gave approximately 60 ml of water with each medication pass and tube feedings and would give extra during the day. Person K indicated he managed			

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	the patient's medications (given by the g-tube) and tube feedings, needs nursing during the night due to lack of sleep from the patient's multiple seizures. Person K indicated the patient was put on oxygen approximately 1.5 weeks ago and is on at all times at 1 liters. Person K provided the patient's bottles of medications and a new medication call Cuvposa (used to reduce excessive drooling caused by medical conditions) was started on 10/1/20. The patient also received Epidiolex (cannabidiol medication to help treat seizures), Diazepam (used to treat anxiety, muscle spasms, and seizures), Trazadone (antidepressant medication that can also be used for anxiety and sleep), Gabapentin (anticonvulsant and nerve pain medication), and Baclofen (used to treat muscle spasms). Person K stated he has been told by physicians that the patient just needed one "big" seizure and it would "kill" him. The clinical record for pediatric patient #2, SOC (start of care) 8/19/20, included a plan of care for the certification period of 10/18/20 to 12/16/20 with orders for home health aide services 8 hours a day, 5 days a week to "assist with ADLs (activities of daily living), bathing, transfers, safety, incontinent care, companionship, and light housekeeping. The plan of care listed the patient's primary diagnosis as refractory epilepsy (drug resistant seizures) and other pertinent diagnosis listed were hypertonia (overactive muscle that occurs when communication between the brain and spinal cord is affected by injury or illness). Review of a "Face to Face" document that was signed by the patient's physician on 11/2/20, revealed the patient's medical condition as: Hypoxic ischemic encephalopathy (type of brain dysfunction that occurs when the brain doesn't			

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	receive enough oxygen or blood flow for a period of time), refractory epilepsy, autonomic dysfunction (A dysfunction of the nerves that regulate non-voluntary body functions, such as heart rate, blood pressure, and sweating), has G-tube (tube inserted through the belly that brings nutrition directly to the stomach) and Vagal Nerve Stimulator (A stimulator device that is implanted under the skin in the chest to prevent seizures by sending regular, mild pulses of electrical energy to the brain). Review of a summary note dated 10/16/20 indicated "Five (5) year old ... with dx [diagnosis] refractory epilepsy and hypertonia d/t [due to] near drowning accident ... Fed per g-tube ... New brace for torso d/t abnormal curving of spin. Father & [and] caregiver report multiple seizures daily ...Father reports recent sleep study & pt [patient] may be put on 02 [oxygen] in future ... Reports some difficulty w/ constipation lately. Foot drop noted. No s/sx [signs and symptoms] of pain/ discomfort during visit." Review of a home health aide supervisory visit undated and untimed on page 1, but dated 10/16/20 on page 2, indicated the patient has a "torso brace, apnea monitor at noc [night]." Review of the patient's recertification comprehensive assessment, untimed and dated 10/16/20, revealed that an Adult OASIS (Outcome and Assessment Information Set document) assessment was used versus a pediatric assessment. OASIS questions meant for adults receiving skilled services were answered. The Advance Directives failed to indicate if there was an Advance Directive, failed to include all diagnoses that the physician indicated within the 11/2/20 face to face encounter, failed to include			

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	the symptom control rating for each diagnosis, the immunizations section was blank, pain assessment indicated "seizure activity" when asked if there was a pattern to the pain, but failed to indicate all the pharmacological medications the patient was receiving nor how often breakthrough medication is needed; failed to include information in regards to the disorders of the respiratory system and status as well as the sleep apnea monitor during the night; the abdomen section indicated "g tube" and the nutrition status indicated the patient is NPO (nothing by mouth) but failed to include any information in regards to the name of the tube feeding, the amount given, flow rate (if any), brand of tube feeding, flushes, and who administered this; the urinary elimination failed to include how many diapers/ briefs that was used throughout a 24 hours period; neurology indicated "epilepsy, history of a traumatic brain injury, history of seizures." The assessment failed to include any medication the patient might receive, information about the Vagal nerve stimulator; the cognitive status indicated the patient "Requires considerably assistance to stay focused when attention needs to shift between activities" and is "non-responsive." The mental status indicated the patient was able to make eye contact and was nonverbal. The musculoskeletal indicated "abnormal curvature of spine, hypertonia, foot drop" and contractures to bilateral feet but failed to include the torso brace and when to use it. Fall risk assessment tool failed to identify 3 or more co-existing diagnosis and pain as indicated in the pain assessment. The medication section was left blank and failed to indicate how the patient's medications were given. Functional abilities and goals were answered incorrectly and indicated an attempt to assess when the patient is not able to participate; safety measures failed to identify elevating the head of			

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	bed and lock w/c with transfers since being in a wheelchair was an activity permitted; patient was selected on the question of refusing care; summary of setbacks/ improvements since prior assessment was left blank; and rehab potential was left blank. The assessment failed to evidence a complete and accurate assessment of the patient and their significant and complex medical history as well as failing to include all services involved in the patient's care. During an interview with Employee A, RN on 11/10/20 at 11:30 a.m., when asked about the patient's tube feeding, the employee indicated the information "must be on admission and not recertification," the family was managing the bolus tube feeding and the father administered the medication. 7. The clinical record for patient #3, SOC 8/17/20, revealed the patient was transferred from another home health agency in May 2020, was discharged and readmitted on 8/17/20 due to administrative corrections. Review of a plan of care from a transferring agency evidenced the patient's diagnoses to be Cerebral Palsy (2007), G/J (gastrostomy/jejunostomy) tube placement (2015), Spastic Quadriplegia (2007), Dysphagia (2007), Seizure Disorder (2007), Chronic Respiratory Failure (2018), Obstructive Sleep Apnea (2018), and history of Psueudomonas pneumonia (2018). The medication list included but not limited to: Morphine Sulfate, Miralax, Epinephrine, Lorazepam, Diazepam 20 mg rectal gel, acetaminophen, flush g/j tube with 20 ml of water after medication administration and Complete Reduced Calorie tube feedings to be ran at 60 cc/hr (cubic centimeters per hour) 1320 ml / day			

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	(milliliters per day) via g/j tube. DME and supplies revealed a Mickey 14 Fr (french) feeding tube, enclosed safe bed, bilateral AFO (ankle-foot orthosis boot/ support), enteral feeding pump, nebulizer, and cough assist machine. The 60 day summary indicated the patient was on hospice with Entity C, and Entity M Home services for attendant care services 6 to 75 hours per month. Review of an agency document titled "Personal Emergency Plan" dated 8/17/20, indicated the alternate physician was Entity C, a hospice agency. Review of an agency document titled "Case Note" dated 10/8/20 and 10/21/20, indicated Visiting Angels attempted to contact Entity M to coordinate client's care. Review of an agency document titled "Case Note" dated 10/8/20, indicated Visiting Angels was in contact with Entity C, a hospice agency, for collaboration of services. Review of the aide care plan dated 10/14/20, indicated the patient had an enclosed bed, suction, and a vest. Review of patient #3's recertification comprehensive assessment, untimed and dated 10/14/2020, revealed that an Adult OASIS assessment was used versus a pediatric assessment. OASIS questions meant for adults receiving skilled services were answered. The assessment revealed diagnoses of Cerebral Palsy, g-tube, Spastic quadrapalgic [sic], Dysphasia, and Seizures and failed to include the symptom control rating for each diagnosis. The patient received enteral nutrition, indicated the primary caregivers were family members and they provided			

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	assistance with ADLs/IADLs (activities of daily living and instrumental activities of daily living), willing to assist, and felt safe assisting the patient, but failed to indicate the hours and days a caregiver is available to assist. The Sensory status revealed the patient has normal vision and was total care but the sensory assessment did not indicate if there were limitations or impairments to ears, nose, mouth, or throat. The Cognitive status indicated the patient was non-responsive but the mental status indicated alert to self and the psychosocial status indicated the patient was not able to communicate their needs. Pain assessment indicated no pain but failed to identify which pain assessment was used and failed to include any as needed (PRN) medications that may be used. The Integumentary (skin) status indicated the patient was a skin impairment risk due to immobility and nutritional "ailment" and the Respiratory assessment indicated the patient was receiving continuous oxygen at 4 liters per nasal cannula, had intermittent treatments, yes to productive cough, but failed to include what all treatments the patient received and failed to include the description and amount of productive cough. The Respiratory status revealed it was reported that the patient was short of breath at rest but failed to provide any explanation of the shortness of breath. The height and weight assessments were left blank. The Nutritional Status revealed feeding tube and no alcohol use; ate fewer than 2 meals per day, not always physically able to shop, cook and/ or feed self, but failed to indicate that the patient was NPO (nothing by mouth), type of tubes the patient had, failed to include any information in regards to the name of the tube feeding, the amount given, flow rate (if any), brand of tube feeding, flushes, and who administered. The urinary elimination failed to include how many diapers/ briefs that was used			

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	throughout a 24 hour period. The neurological assessment indicated cerebral palsy, history of seizures, and patient was a quadriplegia, but failed to evidence type of seizures, frequency, or medications for them. The musculoskeletal assessment indicated the patient had contractures to the bilateral upper and lower extremities but not specific if it was toes, fingers, feet, wrists, hands, arms, or legs. The fall risk assessment tool was incomplete and without score. The medication allergies was left blank, question about if the patient had any special needs or problems administering any of their medication by any route was left blank. The functional abilities and goals indicated the patient was "01" (which meant dependent on eating), but the patient actually was NPO. The safety measures failed to include side rails up and elevate the head of bed, and the question in regards to emergency preparedness was left blank; risk factors for hospital admission/ emergency room was left blank; and the question if anyone refused care since last assessment was left blank. Summary of setbacks/ improvements since prior assessment was left blank; Medication Status was left unanswered, and the summary checklist failed to include any documentation for the reason to recertify the patient. During an interview with Person L, the parent of patient #3, when asked what kind of tube feeding the patient was receiving, Person L stated the patient received 250 ml of Complete Pediatric 2 Reduce Calorie, 4 boxes = 1,000 ml at 60 ml/hr for 15 to 16 hours daily, starting late evening. Person L indicated the patient has a g/j- tube and received feedings through the g-tube and medications through the j-tube. Person L indicated they have a suction machine where the patient required frequent oral suctioning throughout the day and the patient had a			

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	percussion vest (inflatable vest that is attached to a machine that vibrates the chest to loosen and thin mucous) that was also done several times a day. Person L stated the patient was a "fragile" patient and it was unknown if the patient understands, has "violent grand mal" seizures and sees a neurologist. Person L indicated the patient cannot have anything by mouth. Person L indicated the patient received a shower via shower chair with 2 hospice aides once a week due to the patient having to be secured in the bath chair due to no trunk support and can easily fall out of shower chair if not put in just right. The patient's head has to be dried very well due to his severe microcephally or the patient will develop dry crusty areas and will bleed. Person L stated the patient had a "scoliosis" insert in a chair. Person L stated the Visiting Angels aide will prepare the patient's bed while he receives a shower and will receive a bed bath all other days by Visiting Angels aide. The recertification comprehensive assessment failed to include all pertinent information, including that the patient was receiving hospice services and other home care services, and details of the patient's care that was provided by Person L. The assessment failed to evidence a complete and accurate assessment of the patient and their significant and complex medical history as well as failing to include all services involved in the patient's care. 8. The clinical record for pediatric patient #5, SOC (start of care) 6/3/20 was reviewed and contained a physician visit note dated 5/20/20, which revealed the patient was recently in the hospital for sepsis related to a urinary tract infection, cholecystitis, diabetes, was started on Diazepam for muscle spasms related to the bilateral lower			

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	extremities (BLE) contractures, still having significant amount of pain to the BLE and was started on Savella for pain management. The patient stated he also has not had a bowel movement for 3 days and that it was becoming more difficult for him to stay regular as he did not have a HHA to assist him. The patient's abdomen appeared to be distended and was having complaints of GERDS (gastroesophageal reflux disease). Drug allergies revealed Tetanus Toxoid. Other surgeries revealed a right lower leg surgery, incise, and drain bladder (supra pubic catheter) and appendectomy. Assessment indicated the patient smokes vapes. The diagnoses include Multiple Sclerosis, Paraplegia, cramps and spasms, Unspecified Cystostomy status, Pressure Ulcer of Unspecified Site and Stage (ankle, buttocks), Major Depressive Disorder, Constipation, GERDs, Chronic Pain Syndrome (worse at night), Polyneuropathy, and Type 2 diabetes. The plan indicated to order a new air mattress for the hospital bed for the patient had multiple stage 2 ulcers and to order a home health aide. The clinical record contained an OASIS start of care comprehensive assessment, untimed and dated 6/3/20, a question asking for the primary reason for the home health admission, only revealed Multiple Sclerosis and failed to include any other pertinent history or information from the physician visit on 5/20/20. The following sections of the assessment failed to evidence any pertinent information (or blanks) as follows: Pertinent history and or previous outcomes, immunizations, prior hospitalizations, all patient diagnosis, symptom control rating for each diagnosis, Advance Directives, self-care status, primary language, understanding of			

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	verbal content, expression of language, ability to use telephone, medication allergies, psychotropic drug use, home environment safety, risk factors/ hospital admission/ emergency room, patient/ caregiver/ representative/ family education and training for care planning, care coordination, current durable medical equipment and supplies, the type of pain assessment used, Integumentary assessment, utilized a pain assessment that is used for advance dementia (in which the patient does not have), incomplete pain assessment, incomplete endocrine assessment, failed to identify the patient vapes (electronic cigarette), incomplete respiratory assessment, failed to identify the patient's suprapubic catheter or the issues with constipation, Neurological/ emotional/ behavioral assessment was incomplete and failed to identify the patients major depressive disorders, mental, psychosocial assessments, incomplete musculoskeletal assessment and failed to identify the patients contractures and multiple sclerosis, failed to be completed and failed to include a discharge goal under functional abilities and goals, and incomplete emergency preparedness care planning.A Home Health Face to Face Encounter document dated 8/21/20, was reviewed and indicated the patient's diagnoses to be Multiple Sclerosis, Diabetes Mellitus, Anemia, Pressure Ulcer,			

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	and Paraplegia. The document indicated nursing was needed for medication administration due to the patient's physical inability to self-administer, medication changes require monitoring and teaching, skin integrity (poor) and requires care as evidenced by breakdown and erythema. Wound care training for patient and/ or caregiver. Wound required skilled care and monitoring for complications. Review of an agency document titled "Case Note" dated 8/3/20, indicated the patient has a diagnosis of Multiple Sclerosis, Paraplegia, Major Depressive Disorder, Chronic Pain Syndrome, Polyneuropathy and Diabetes Mellitus Type 2. The note went on to say " ... hoyer used for transfers, hospital bed with trapeze to assist with positioning and reduce pressure, parapalegic [sic] with contractures to ble [bilateral lower extremities], foot drop to LLE [left lower extremity] with +2 pitting edema. Pain chronic, managed with medication. Muscle spasms reported. Supra pubic cath ... changed monthly by SN [skilled nurse] from other company...wound to (R) [right] foot, dressing in place, changed 2x/ wk [2 times per week] per other company RN. excoriation [sic] with open areas from scratching to (L) [left] hip, area cleansed, barrier cream applied. HHA educated on keeping skin c/d/i [clean/dried/intact], cream use redness to R			

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	armpit, Nystatin cream used daily .... " Review of the OASIS recertification comprehensive assessment, untimed and dated 8/3/20, failed to evidence any pertinent information (or blanks) to the following sections: the diagnoses revealed Multiple Sclerosis, Diabetes Mellitus type 2, Paraplegia, and Major Depressive Disorder, failed to include the symptom control rating for each diagnosis, incomplete pain assessment, type of pain assessment used, Integumentary/ wound assessment and inaccurately indicated that Entity R was providing wound care to the patient's right foot, diabetic foot exam, respiratory assessment, heart sounds, nutritional assessment, elimination assessment, psychosocial, musculoskeletal, fall risk, medications, safety measures, activities permitted, refused cares, risk factors/ hospital admission/ emergency room, patient/ caregiver/ representative family education and training, supervisory visit, summary of setbacks/ improvements, recertification summary, nursing interventions/ instructions, summary checklist, and current durable medical equipment/ supplies. This assessment also failed to include the details from the case note.Review of an agency document titled "Case Note" dated 10/1/20, indicated the patient has a diagnoses of Multiple Sclerosis,			

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	Paraplegia, Major Depressive Disorder, Chronic Pain Syndrome, Polyneuropathy and Diabetes Mellitus type 2. The note went on to say " ... hoyer used for transfers, hosp [hospital] bed with trapeze bar to asst [assist] with positioning utilized, parapalegic [sic] with contractures to ble, foot drop to LLE with +2 pitting edema. Wound to (R) inner ankle scabbed over with no current tx in place. (L) hip excoriated, no open areas noted at this time. Cream applied daily by CNA. Chronic pain managed with medication regimen. Meds managed by patient & [and] CNA. Patient reports "no longer a diabetic" suprapubic cath ... changed monthly per [name of Entity R] ... area dry, with slight redness/ odor. Cream applied to outer area per CNA daily. The record failed to evidence any clarification with the physician on the patient claiming not to be a diabetic, and the specific area that was dry, red, with odor and what cream the aide applied. Review of the OASIS recertification comprehensive assessment, untimed and dated 10/1/20, failed to evidence any pertinent information (or blanks) to the following sections: the diagnoses revealed Multiple Sclerosis, Diabetes Mellitus Type 2, Paraplegia, and Major Depressive Disorder, failed to include the symptom control rating for each diagnosis, pain assessment, integumentary			

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	status, diabetic foot exam, wound assessments, systems review, abdomen, endocrine/ hematology, food/ environmental allergies, nutritional assessment, elimination status, neurological assessment, cognitive status, psychosocial status, musculoskeletal assessment, fall risk assessment, medication allergies, medications, infusion activities permitted, refused cares, risk factors/ hospital admission/ emergency, supervisory visit, recertification summary, summary checklist, and current durable medical equipment and supplies. The assessment revealed the patient had an unhealed pressure ulcer/ injury at Stage 2 or higher, that was partial granulating. The wound care comments indicated the patient had a scabbed area to the right inner foot, open areas of MRSA to the abdomen, open to air, and cream applied daily. The integumentary wound assessment section indicated measurements of 2.5 x 2 cm (centimeters), 2 x 1.5 cm, 0.5 x 0.5 cm, and 2 x 1.5 cm, but failed to indicate the location of these wounds, the appearance of the wounds, and treatment if any. This assessment also failed to include the details from the case note.Person J, a family member of patient #5 was interviewed on 11/12/20 at 10:15 a.m., when queried on who provided skilled nursing services to the patient's suprapubic catheter and wound			

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	management, Person J indicated Entity D.Person Q, Alternate Director of Clinical Services from Entity D, a Medicare Home Health agency, was interviewed and indicated they have had the patient on service since March 2020 for monthly catheter changes. Person Q stated the patient was recently recertified on 11/5/20 and all wounds are healed but skin is fragile. The assessments failed to evidence any documentation that Entity D was the Medicare agency providing catheter and wound care, not Entity R as indicated.9. The clinical record of patient #6 was reviewed and contained an OASIS start of care comprehensive assessment dated 9/10/20. The following sections of the assessment failed to evidence any pertinent information: Immunizations, Prior Hospitalizations, Self-Care Status, Advance Directives, Living arrangements, complete pain assessment describing the type of pain, and medications used, complete assessment of the patient's reported shortness of breath, food/ environmental allergies, cardiopulmonary disease management, complete assessment of the patients Anxiety under the Neurological/ Emotional/ Behavioral Status, psychological history (spiritual, marital, children, drive, jobs, sleep), completed the musculoskeletal assessment, incomplete medication			

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	assessment, home environment safety, emergency preparedness, risk factors/ hospital admission/ emergency room, Patient/ caregiver/ representative education and training for care planning, and current DME/ medical supplies.During an interview on 11/17/20 at 9:08 a.m., patient #6 stated she suffers from anxiety.The assessment failed to evidence a complete and accurate assessment of the patient and their significant and complex medical history 10. During an interview 11/10/20 at 12:12 AM the agency Director/Clinical Manager stated she audits all assessments upon their completion and submission to her. The Director/Clinical Manager stated she does not utilize an audit tool or track specific items for completeness and accuracy but completes the assessment review by memory and notifies the clinician if changes are required.11. During an interview on 11/12/20 at 1:45 p.m., when queried about reviewing content with chart audits, the Director of Clinical Services stated she did not audit admission assessments, she receives patient information from the case manager, and her audits mostly consist of checks and balances. When queried about diagnoses and current health issues on the comprehensive assessment, the Administrator stated they were told to only document what the patients were being admitted for.12. The			

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-14-1(a)(1)(B)			
G 0530 Bldg. 00	484.55(c)(2) Strengths, goals, and care preferences The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview, the agency failed to ensure a complete and accurate assessment of the patient's strengths, goals, and care preferences in 5 of 5 (Patients #1, 2, 3, 4, 5) active records reviewed and 1 of 2 (Patient #6) closed records reviewed in a sample of 7. Findings included: 1. A review of an undated policy C-155 titled "Client Reassessment/ Update of Comprehensive Assessment" stated, "Assessment will include OASIS data collection for all Medicare and Medicaid skilled clients. Clients who are not receiving skilled services under the Medicare or Medicaid program will be assessed using the OASIS tool or an alternative ... Special attention will be paid to client-centered goal setting, clarifying the client's personal goals and his/her expectations of the home care services ...The assessment will identify the problems, needs, and strengths of the client and the care the family can provide ...The initial and ongoing assessments	G 0530	**G530** Since the November 2020 survey 100% of agency patients have received follow-up assessments at the time of recertification. The nurse with the greatest number of errors resigned her employment and is no longer working for the agency. Measures put in place to ensure this deficient practice will not recur includes the following: · The Clinical Manager has re-instructed the RN Case Managers to ensure their comprehensive assessments address the requirement to ensure a complete and accurate assessment of the patient's strengths, goals, and care preferences. · A new "comprehensive assessment" audit tool has been	02/16/2021

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	include consideration of the following ... Specific individualized client needs ... Description of any applicable strength the client has including physical, psychosocial, and or [sic. and/or] spiritual ... Progress toward goals since previous assessment ...." 2. A record review of patient #1, start of care 9/3/20, for certification period 9/3/20-11/2/20 included a start of care comprehensive assessment with diagnoses listed as COPD (Chronic Obstructive Pulmonary Disease) and CKD (Chronic Kidney Disease). The assessment further indicated under the section titled "Care Preferences/Patient Goals: List all the patient's goals", the clinician documented "free from falls, skin intact." Under a subsection labeled "Strengths/ Limitations" the clinician documented "involved in care, knowledable [sic. knowledgeable], family involved." The comprehensive assessment evidenced multiple assessment sections either blank or incomplete, The comprehensive assessment failed to list patient specific goals or measurable outcomes; failed to evidence documentation of specific goals, strengths, or limitations discussed between the clinician and patient or representative; and failed to evidence goals or measurable outcomes related to the patient's diagnoses and reasons for receiving services. A recertification comprehensive assessment, dated 10/29/20 for certification period 11/2/20-12/31/20 indicated diagnoses of COPD (Chronic Obstructive Pulmonary Disease), and CKD (Chronic Kidney Disease) The assessment evidenced Strengths/Limitations stated respectively, "involved in care" and "weakness, pain, dyspnea, fatigues easily." Multiple assessment sections were either blank or		implemented that evaluates all aspects of the comprehensive assessment. · The Clinical Manager/designee is responsible for auditing 100% of all comprehensive assessments. The new audit tool has been adapted to facilitate this process. · Audit results are provided to each RN Case Manager with the direction to correct any gaps or mistakes in the completion and documentation of the assessment. · The RN Case Managers are to make the required corrections and re-submit the assessment to the Agency Clinical Manager within 48 hours of receipt. · The Clinical Manager/designee will perform random “un-announced supervisory visits of the RN Case Managers performing certification assessments to evaluate the RN’s ability to perform a complete, accurate, thorough comprehensive assessment . A RN Case Manager Supervisory Visit Form has been created to facilitate and document this process. Disciplinary Measures include the following: The Agency has instituted a 3-step disciplinary process for the RN Case Managers as it relates to the accurate completion of the comprehensive assessment at all	

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	incomplete. The comprehensive assessment failed to list patient specific goals or measurable outcomes; failed to evidence documentation of specific strengths, care preferences, or goals discussed between the clinician and patient or representative; and failed to evidence goals related to the patient's diagnoses and reasons for receiving services. 3. The clinical record review of Patient #4 included a recertification assessment dated 8/24/20 for certification period 8/24/20-10/22/20 with diagnoses listed as COPD with Emphysema, Interstitial Lung Disease, and Memory Loss. Patient #4 was also receiving hospice services via IU Health Care. The clinician assessed the patient Strengths/Limitations as, "involved family, memory deficit, COPD, dyspnea, pain and weakness, and limited functional mobility." Multiple assessment sections were either blank or incomplete, including Care Preferences and Personal Goals. The comprehensive assessment failed to list patient specific goals or measurable outcomes; failed to evidence documentation of patient specific strengths, care preferences, or goals discussed between the clinician and patient or representative; and failed to evidence goals related to the patient's diagnoses and reasons for receiving services. An additional recertification comprehensive assessment dated 10/21/20 for certification period 10/23/20-12/21/20 included diagnoses listed as COPD, Interstitial Lung Disease, and Memory Loss. Patient #4 was also receiving hospice services via IU Health Care. The clinician documented Strengths/Limitations as "involved family, memory loss, frequent rest needed." Documentation under Care Preferences stated, "Agreed their personal goal was realistic based on		required timepoints. All RN Case Managers will be educated on the consequences of not completing and documenting a full patient-specific comprehensive assessment including the assessment of the patient's current health psychosocial, functional, and cognitive status. · Failure to complete the patient-specific comprehensive assessment that addresses all elements of the assessment process will result in re-education of the employee and an entry in their personnel file documenting their non-compliance with a written warning that ongoing non-compliance will result in further consequences. · Failure to complete the patient-specific comprehensive assessment a 2nd time will result in further re-education of the employee and the employee being placed on a 30-day action plan. · If there is a 3rd occurrence of non-compliance with the completion of the patient-specific comprehensive assessment the employee's employment with Visiting Angels Home Health Agency will be terminated. The Clinical Manager/designee is responsible for ensuring on-going compliance with G530.	

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	the patient's health status." Multiple assessment categories were incomplete or blank, including and Care Preferences/Personal Goals. The comprehensive assessment failed to list patient specific goals or measurable outcomes; failed to evidence documentation of patient specific strengths, care preferences, or goals discussed between the clinician and patient or representative; and failed to evidence goals related to the patient's diagnoses and reasons for receiving services. 4. On 11/12/20 at 1:45 PM, the Director of Clinical Services (DOCS) was queried concerning patient goals. The DOCS stated she audited all assessments as soon as they were submitted to her, which is generally was the same day. The DOCS stated she did not utilize an audit tool and completed the assessment review by memory. If corrections were necessary, the clinician was notified. The DOCS stated she did not currently have a method for tracking the accuracy of the comprehensive assessment content.5. The clinical record of patient #2, SOC 8/19/2020, was reviewed and contained an OASIS recertification assessment dated 10/16/20, which the patient's strengths indicated family involvement and limitations indicated no purposeful movements and completely dependent. The Care Preferences/ Patient's Personal Goal section was left blank. 6. The clinical record of patient #3, SOC 8/17/20, was reviewed and contained a start of care comprehensive assessment dated 8/17/20, which the sections for patient's strengths/ limitations were left blank and care preferences/ patient's personal goals section were left blank and only indicated "Agreed their personal goal(s) was realistic based on the patient's health status" but failed evidence what those personal goals for the			

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	patient were. Review of an agency document titled "Case Note" dated 10/8/20, indicated Visiting Angels was in contact with Entity C, a hospice agency, for collaboration of services. Review of an OASIS recertification assessment dated 10/14/2020, the Care Preferences/ patient's personal goals section were left blank and only indicated "Agreed their personal goal(s) was realistic based on the patient's health status" and failed evidence what those personal goals for the patient, especially with the patient being on hospice services. 7. The clinical record of patient #5, SOC 6/3/20, was reviewed and contained an agency document titled "Patient Short Term Goals include the following:" revealed "Patient's/ Client's pain level will be controlled at 4 or less on a scale of 1-10. Patient/ Client will demonstrate compliance with medication regimen AEB [as evidenced by] the patient/ client taking the medications as directed by the physician. Patient/ Client will remain compliant with the use of adaptive equipment. Review of the start of care comprehensive assessment dated 6/3/20. The Care Preferences/ Patient's Personal Goal, Strengths/ Limitations section were all completely blank. The admitting nurse failed to evidence the patient's preferences, strengths and limitations and patient's personal goals were included and measurable. Review of the OASIS recertification comprehensive assessment dated 8/3/20, contained the Goal, Strengths/ Limitations section, that asked what the patient's strengths were. The writing was illegible and remaining			

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	questions were blank. The Care Preferences/ Patient's Personal Goals section indicated "Agreed their personal goal(s) was realistic based on the patient's health status" and the remaining assessment questions were blank. Review of the OASIS recertification comprehensive assessment dated 10/1/20, the Goal, Strengths/ Limitations section, the patient's strengths indicate "involved in care" but the remaining questions were blank. The Care Preferences/ Patient's Personal Goals section indicated "Agreed to and identified actions/ interventions the patient is willing to safely implement, so the patient will be able to meet their goals by the anticipated discharge date" and the remaining assessment questions were blank. 8. The clinical record for patient #6, start of care 9/10/20, was reviewed and included a start of care comprehensive assessment dated 9/10/20 in which page 23-24 of 29, under the Care Preferences/ Patient's Personal Goals asked if the patient communicated any specific personal goal(s) the patient would like to achieve from the home health admission, to which the option to select no or yes was not marked. " ... Patient ... Agreed their personal goal(s) was realistic based on the patient's health status .... " The document failed to evidence what specifically was the patient's personal goals. 9. The findings were reviewed on 11/12/20 at 1:45 p.m. with the DOCS and the Administrator. When queried about who audited the patient records for details and to ensure the assessments were complete, the DOCS indicated she audited the records but did not review the details. When queried about goals being measurable, both indicated they did not know goals were to be			

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	measurable on the plan of care. 10. The findings were reviewed with Person S (Governing Body), Administrator, DOCS, and the Alternate DOCS on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			
G 0534 Bldg. 00	484.55(c)(4) Patient's needs The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the agency failed to ensure a complete and accurate assessment of the patient's medical, nursing, rehabilitative, social, and discharge planning needs in 5 of 5 (Patients #1, 2, 3, 4, 5) active records reviewed and 1 of 2 (Patient #6) closed records reviewed in a sample of 7. Findings included: 1. A review of an undated policy C-155 titled "Client Reassessment/Update of Comprehensive Assessment" stated "Assessment will include OASIS data collection for all Medicare and Medicaid skilled clients. Clients who are not receiving skilled services under the Medicare or Medicaid program will be assessed using the OASIS tool or an alternative ... The assessment will identify the problems, needs, and strengths of the client and the care the family can provide. The initial and ongoing assessments include consideration of the following: Specific individualized client needs pertinent to the care or service being provided; Description of any applicable strength ... including physical, psychosocial, and or [sic and/or] spiritual resources ... Involvement of family friends, and	G 0534	**G534** Since the November 2020 survey 100% of agency patients have received follow-up assessments at the time of recertification. The nurse with the greatest number of errors resigned her employment and is no longer working for the agency. Measures put in place to ensure this deficient practice will not recur includes the following: · The Clinical Manager has re-instructed the RN Case Managers to ensure their comprehensive assessments address the requirement to ensure a complete and accurate assessment of the patient's medical, nursing, rehabilitative, social, and discharge planning needs. · A new "comprehensive assessment" audit tool has been implemented that evaluates all aspects of the comprehensive assessment. · The Clinical	02/16/2021

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	other individuals or organizations; Appropriateness of the level of care provided by the family or support system ... Condition of the home and surrounding environment and identified safety needs ... Progress toward goals since previous assessment and clarify the problems that require continuing home care services; Need for continuing home care services; Ability/willingness of the client/family to assume responsibility for healthcare needs ...." Review of an undated agency policy titled "Discharge Process" C-500, stated "Discharge Planning is initiated for every home care client at the time of the client's admission for home care. When clients are admitted for home health services, the expectation is that the client will be discharged to self-care or care of family when goals are met ... Discharge Procedure: 1. Planning for discharge is provided as part of the ongoing assessment of needs and in accordance with expected are outcomes. The client/ family will participate in this process beginning with the initial assessment visit .... " 2. A review of a clinical record for Patient #1 included a start of care comprehensive assessment dated 9/3/20 for certification period 9/3/20 -11/2/20 (corrected to 11/1/20) with diagnoses listed as COPD (Chronic Obstructive Pulmonary Disease) and CKD (Chronic Kidney Disease). The comprehensive assessment evidenced a "pertinent history and/or previous outcomes" of CHF (Congestive Heart Failure), neuropathy, kidney failure, COPD, cataracts bilateral eyes. The assessment evidenced the patient to be at risk for integumentary problems and falls. Multiple sections in the comprehensive assessment were incomplete, blank, or inaccurate based on patient		Manager/designee is responsible for auditing 100% of all comprehensive assessments. The new audit tool has been adapted to facilitate this process. · Audit results are provided to each RN Case Manager with the direction to correct any gaps or mistakes in the completion and documentation of the assessment. · The RN Case Managers are to make the required corrections and re-submit the assessment to the Agency Clinical Manager within 24-48 hours of receipt. · The Clinical Manager/designee will perform random “un-announced supervisory visits of the RN Case Managers performing certification assessments to evaluate the RN’s ability to perform a complete, accurate, thorough comprehensive assessment . A RN Case Manager Supervisory Visit Form has been created to facilitate and document this process. Disciplinary measures approved by the Governing Body and implemented by the Clinical Manager/designee include the following: To stress the importance of this process the Agency has instituted a 3-step disciplinary process for the RN Case Managers as it relates to the accurate completion of the comprehensive assessment	

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	history including the following: Primary Reason for Home Health Admission and Discharge Goals. The comprehensive assessment failed to include a complete and accurate assessment including therapy needs related to mobility and risk for falls, ongoing pain, reason for weekly skilled nursing and discharge goals. A recertification/follow-up comprehensive assessment dated 10/29/20 for certification period 11/2/20-12/21/20 indicated diagnoses listed as COPD and CKD. Patient #1 had a known diagnosis of Diabetes Type 2 and received dialysis 3 times per week. The assessments for walking were not attempted, and there was no evidence of discharge planning or continuing goals. The assessment failed to address ongoing pain management needs, reason for weekly skilled nursing, dialysis related needs, and discharge goals. 3. A review of the clinical record for Patient #4 included a recertification comprehensive assessment dated 8/24/20, for certification period 8/24/20-10/22/20 with diagnosis codes listed of COPD with Emphysema, Interstitial Lung Disease, and Memory Loss. The assessment indicated "hospice RN week No further documentation was provided concerning hospice. The assessment failed to accurately reflect the patient's medical, nursing, social, rehabilitative, and discharge needs. A review was completed of recertification comprehensive assessment dated 10/21/20 for certification period 10/23/20-12/21/20 with diagnoses listed as COPD, Interstitial Lung Disease, and Memory Loss. The assessment evidenced Patient #4 provided her own total care.		at all required timepoints. All RN Case Managers will be educated on the consequences of not completing and documenting a full patient-specific comprehensive assessment including the assessment of the patient's current health psychosocial, functional, and cognitive status. · Failure to complete the patient-specific comprehensive assessment that addresses all elements of the assessment process will result in re-education of the employee and an entry in their personnel file documenting their non-compliance with a written warning that ongoing non-compliance will result in further consequences. · Failure to complete the patient-specific comprehensive assessment a 2nd time will result in further re-education of the employee and the employee being placed on a 30-day action plan. · If there is a 3rd occurrence of non-compliance with the completion of the patient-specific comprehensive assessment the employee's employment with Visiting Angels Home Health Agency will be terminated. The Clinical Manager is responsible for ensuring on-going compliance with G534.	

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	The assessment failed to accurately reflect the patient's medical, nursing, social, rehabilitative, and discharge needs. 4. The clinical record for Patient #2, contained a start of care comprehensive assessment dated 8/19/20 for certification period of 8/19/20 -10/17/20 with diagnoses listed as Refractory Epilepsy and Hypertonia. Multiple sections of the comprehensive assessment were incomplete, blank, or inaccurate based on patient history. The document failed to evidence a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs. A review of the recertification/ follow-up comprehensive assessment dated 10/16/20 for certification period of 10/18/20-12/16/20 with diagnoses listed as Refractory Epilepsy and Hypertonia. Multiple sections of the recertification assessment were incomplete, blank, or inaccurate based on patient history. The document failed to evidence a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs. 5. The clinical record for Patient #3, contained a start of care comprehensive assessment dated 8/17/20 for certification period of 8/17/20 -10/15/20 with diagnoses listed as Cerebral Palsy, G-tube placement, Spastic Quadriplegia, Dysphagia, and Seizure Disorder. Multiple sections of the comprehensive assessment were incomplete, blank, or inaccurate based on patient history. The document failed to evidence a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs.			

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	A review of the recertification/ follow-up comprehensive assessment dated 10/16/20 for certification period of 10/16/20-12/14/20 with diagnoses listed as Cerebral Palsy, Spastic Quadriplegia, Dysphagia, and Seizure Disorder. Multiple sections of the recertification assessment were incomplete, blank, or inaccurate based on patient history. The document failed to evidence a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs. 6. The clinical record for Patient #5, contained a start of care comprehensive assessment dated 6/3/20 for certification period of 6/3/20 - 12/12/20 [sic] with diagnoses listed as Multiple Sclerosis, Diabetes Mellitus Type 2, Paraplegia, and Macular Degeneration Disease. Multiple sections of the comprehensive assessment were incomplete, blank, or inaccurate based on patient history. The document failed to evidence a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs. A review of the recertification/ follow-up comprehensive assessment dated 08/3/20 for certification period of 8/2/20-9/30/20 (corrected on 10/5/20) with diagnoses listed as Multiple Sclerosis, Diabetes Mellitus Type 2, Paraplegia, and Major Depressive Disorder. Multiple sections of the recertification assessment were incomplete, blank, or inaccurate based on patient history. The document failed to evidence a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs. A review of the recertification/ follow-up comprehensive assessment dated 10/1/20 for			

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	certification period of 10/1/20-11/29/20 with diagnoses listed as Multiple Sclerosis, Paraplegia, and Diabetes Mellitus Type 2. Multiple sections of the recertification assessment were incomplete, blank, or inaccurate based on patient history. The document failed to evidence a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs. 7. The clinical record of patient #6, contained a start of care comprehensive assessment dated 9/10/20, for the certification period of 09/10/20 - 11/08/20 with diagnoses listed as Spinal Stenosis, Anxiety, and Pain. Multiple sections of the comprehensive assessment were incomplete, blank, or inaccurate based on patient history. The document failed to evidence a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs. The document failed to evidence a complete and accurate assessment that included the patient's medical, nursing, rehabilitative, social, and discharge planning needs. 8. During an interview on 11/12/20 at 1:45 p.m., when queried about reviewing content with chart audits, the Director of Clinical Services stated she did not audit admission assessments, she received patient information from the case manager, and her audits mostly consisted of checks and balances. When queried about diagnoses and current health issues on the comprehensive assessment, the Administrator stated they were told to only document what the patients were being admitted for. 9. The findings were reviewed with Person S (Governing Body), Administrator, Director of			

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	Clinical Services (DOCS), and the Alternate DOCS on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-14-1(a)(1)(B)			
G 0536 Bldg. 00	484.55(c)(5) A review of all current medications A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the registered nurse (RN) failed to reconcile all medications with the patient, health care representative, outside agencies and ordering physicians, and medication profiles were maintained accurately in 4 of 5 (Patients #1, 2, 3, 5) active records reviewed in a sample of 7. Findings included: 1. A review of an undated policy C-700 titled "Medication Profile" stated, "The Nurse ... will complete a medication profile for each client at the time of admission; The medication profile shall include all prescriptions and nonprescription drugs .... The profile will be reviewed and updated as needed to reflect current medication the client is taking ... provide a complete list of ALL medications ... and an evaluation of the client's knowledge ... of these medications; ... provide documentation of the comprehensive assessment of all medications ... and identify discrepancies between client profile and the physician and/or	G 0536	**G536** Since the November 2020 survey 100% of agency patients have received follow-up assessments at the time of recertification. The nurse with the greatest number of errors resigned her employment and is no longer working for the agency. The Clinical Manager has re-instructed the RN Case Managers to ensure their comprehensive assessments address the requirement to ensure a complete and accurate medication reconciliation with the patient, health care representative (if any), outside agencies, & ordering physicians. A new “comprehensive assessment” audit tool has been implemented that evaluates all aspects of the comprehensive	02/16/2021

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	agency profile ... identify possible ineffective drug therapy, adverse reactions, significant side effects, drug allergies, and contraindicated medication; ... provide documentation of changes ... identify the effect of medications ... At the time of admission, the admission professional shall check all medications .... The clinician shall promptly report any identified problems to the physician. The Nurse/Therapist shall record on the Medication Profile all prescribed and over the counter (OTC) medications the client is currently taking. The Medication Profile shall document: Allergies, date medication ordered or care initiated, Medication name (full name with no abbreviations), Medication dosage (using only accepted abbreviations), route and frequency, contraindications or special precautions, medication actions and side effects, discontinuation date, appropriate storage directions, drug or food-drug interactions. ... the Nurse must add newly ordered drugs or medication changes to the Medication Profile. The Nurse/Therapist shall review all medications with the client and/or caregiver .... The Nurse shall review all medication effectiveness and interactions to ensure appropriateness and identify potential complications. ... The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication. A copy shall be ... placed in the client's home chart when extended hours ... are being provided." 2. A review of an undated policy C-701 titled "Medication Set Up Policy" stated, "A medication administration record (MAR) or other medication documentation method should be used to set up medication. The 485/plan of care is the nurse's verbal order until it is signed by the physician at		assessment. The Clinical Manager/designee is responsible for auditing 100% of all comprehensive assessments. The new audit tool has been adapted to facilitate this process. · Audit results are provided to each RN Case Manager with the direction to correct any gaps or mistakes in the completion and documentation of the assessment. · The RN Case Managers are to make the required corrections and re-submit the assessment to the Agency Clinical Manager within 24-48 hours of receipt. The Clinical Manager/designee will perform random “un-announced supervisory visits of the RN Case Managers performing certification assessments to evaluate the RN’s ability to perform a complete, accurate, thorough comprehensive assessment . A RN Case Manager Supervisory Visit Form has been created to facilitate and document this process. To stress the importance of this process the Agency has instituted a 3-step disciplinary process for the RN Case Managers as it relates to the accurate completion of the comprehensive assessment at all required timepoints. All RN Case Managers will be educated on the consequences of not completing and documenting a full patient-specific comprehensive	

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	which point it becomes the written order. It is the nurse's responsibility to ensure that it is accurate and without errors. The medication list is current and updated ... as changes occur. The medications are reviewed at each visit ... The nurse should then compare the medication labels to the 485, checklist, and/or MAR before ... filling the med-planner. The nurse ensures that he/she is filling the med-planner correctly ...." 3. A review of an undated policy C-704 titled "Client Information Required for Medication Management" indicated a minimum amount of information was to be available for staff involved in medication management, including "All current medication including over the counter and herbal medications." 4. A review of an undated policy C-705 titled "Medication Management" stated, "Comprehensive client assessment performed at start of care and other defined points in time include review of all medications .... Medications in the home are reviewed with the client/family ... Orders for medication related devices such as nebulizers ... will include the concentration and dose of the medications ... Over the counter medications that clients take ... must be reviewed ...." 5. A review of an undated policy C-706 titled "Medication Orders" stated, "These policies will be followed when setting up medications for self-administration or administering the does to clients; Agency staff will verify with the physician any incomplete, illegible or unclear medication orders prior to administering the medication ... Triturating or tapering orders of medications must clearly state the specific guidelines for use."		assessment including the reconciliation of all medications with the patient, health care representative,(if any), outside agencies, and ordering physicians. · Failure to complete the patient-specific comprehensive assessment that addresses all elements of the assessment process will result in re-education of the employee and an entry in their personnel file documenting their non-compliance with a written warning that ongoing non-compliance will result in further consequences. · Failure to complete the patient-specific comprehensive assessment a 2nd time will result in further re-education of the employee and the employee being placed on a 30-day action plan. · If there is a 3rd occurrence of non-compliance with the completion of the patient-specific comprehensive assessment the employee's employment with Visiting Angels Home Health Agency will be terminated. The Clinical Manager is responsible for ensuring on-going compliance with G536.	

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	6. A review of an undated policy C-709 titled "Medication Reconciliation" stated, "Agency will reconcile all medications taken by the client prior to admission to home care with those ordered at the time of admission, ... at 60 day reassessment visits, ... includes all [medication]... that the client takes in all places of residence; At the time of admission ... document a complete list of medications taken by the client prior to admission; The admission professional will review these medication list with the physician, and confirm those medications that are to be continued or discontinued. The doses will be confirmed ... and changes will be noted in the record and on the Physician Plan of Care ...the clinician doing the reassessment will again review all medications the client is taking, update the records and the plan of care." 7. Review of a Drug Interaction Classification on Drugs. com defines major drug interactions as "Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit." A moderate drug interaction was defined as "Moderately clinically significant. Usually avoid combinations; use it only under special circumstances." 8. On 11/10/20 at 9:45 AM, Employee A (RN), was observed performing a weekly medication set up for patient #1 in the patient's home. Simultaneously during the observation, Employee A was queried concerning the process for correctly preparing a medication planner. She stated, "I have this sheet right here (indicated document titled "Medication Flow Sheet") that I got from the other nurse. This is my first time seeing her (patient #1)." When queried if she had a current plan of care for patient #1 Employee A stated she was using the "med list" (Medication			

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	Flow Sheet) given to her by patient #1's previous nurse, Employee H, but did not have a current plan of care. When queried concerning the procedure if a discrepancy was found during the medication set-up of the medications Employee A stated, "I would look at the bottle and the sheet, and I'd call the MD if need be. Like this one? [Indicated bottle containing Gabapentin]." Employee A stated the label states the dose for Gabapentin was 100 mg three times per day, however patient #1stated she was taking 100 mg daily due to tapering from three times per day for an unknown time. Employee A questioned the patient, "So you're only taking one a day, right?" Patient #1 indicated that was correct. Employee A was observed placing one capsule into the medication planner. At that time patient #1 was queried concerning her dose of Gabapentin. Patient #1 indicated she took 100 mg Gabapentin daily and was weaning from this medication with the intention of stopping it soon. She was unable to state the date she started the wean or give the name of a physician who ordered the decrease. On 11/10/20 at 10:40 AM during an interview with Employee A, she confirmed she received the Medication Flow Sheet from Patient #1's previous nurse but did not compare it to the current orders in the clinical record. Employee A also confirmed the Medication Flow Sheet was missing medication routes of delivery/ purpose/ side effects/ potential side effects, contained ambiguous doses, and did not match the medications on the current plan of care or Medication Profile in the clinical record. Employee A stated, "I should have checked all the meds [medications] against her [Patient #1] chart before I made the visit today." When queried concerning the gabapentin specifically, Employee A indicated she had not contacted the physician to confirm			

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	the correct dosage but had provided what Patient #1 stated she took. When queried concerning resolution for Patient #1's medications Employee A stated, "I need to review all meds [medications] now and call the physician for orders. Then I'll go out and fix the box." On 11/10/20 at 11:43 AM, Employee A stated she spoke with Patient #1's physician representative, clarified all medications, and would return to Patient #1 immediately to correct the medication planner. Employee A provided documentation dated 11/10/20, titled "Physician Order", which stated "Spoke with Amber. Clarification: Gabapentin 100mg i po QD. May have one additional skilled nurse visit this week." Employee A submitted an updated Medication Profile, dated 11/10/20, with "Allergies" as NKDA (no known drug allergies) and medications as follows: Aspirin 81 mg i po QD, Ferrous Sulfate 325 mg i po QD, Levothyroxine 175 mcg i po QD, Omeprazole 40mg i po TID, Sevelamer Carbonate 800 mg ii tabs po TID, Lexapro 5 mg i po QD, Coreg 6.25 mg i po BID, Linzess 145 mcg i po QD, Atorvastatin 40 mg i po QD, Metoclopramide 5 mg i po TID, Montelukast 10 mg i po QD, Cetirizine 10 mg i po QD, Amlodipine 10 mg i po QD, am-50 mg i po QD, Gabapentin 100 mg i po QD, O2 @ 3L per n/c (nasal cannula) Amiodarone 200 mg 1/2 tab po QD, Senna-Docusate 8.6-50 mg i po QD, Gabapentin 100 mg i po QD, O2 @ 3L per n/c continuously, Albuterol i i hal [sic inhale] per neb BID, Lidocaine patch i topical on in AM of PM [sic off PM] QD, trelogy [sic trelegy ellipta] i puff per inhale QD. No changes were made to update the current plan of care/485 and no changes were made to the current Medication Flow Sheet. Employee A stated she did not write a communication/ case coordination note because she had written the order. No further			

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	documentation was available addressing clarification of all medications Patient A was taking, including medications listed on the Medication Profile, Medication Flow Sheet, and Plan of Care/485. On 11/10/2020 at 12:12 PM, Employee A was queried concerning the newly updated Medication Profile for Patient #1, dated 11/10/20 and added to the clinical record at 11:43 AM. The Director of Clinical Service (DOCS)was present during this interview. When queried concerning the absence of dialysis medications in Patient #1's profile, Employee A stated, "So it [medication record] should include anything they give there?" The DOCS stated, "We didn't know this patient was on dialysis until today, or yesterday. The previous RN did not make us aware the patient was in dialysis." When queried concerning who reviewed comprehensive assessments for the agency, the DOCS stated, "I do. It was in the assessment initially, under urinary. But it wasn't in the recert (recertification) assessment. It just must not have clicked when I saw it the first time." The DOCS confirmed there were no case communication notes for this patient and instructed Employee A to include all medications on the Medication Profile, including dialysis medications. The DOCS was queried concerning additional documentation for the patient's record and stated all documentation was in the patient's clinical record. A document titled Medication Flow Sheet (used by Employee A during the visit) was signed/initialed by Employee A and Employee H, dated weekly for 9/22/20, 9/29/20, 10/6/20, 10/13/20, 10/20/20, 10/27/20, and 11/10/20 (documentation not present for 11/3/20) which evidenced the following medications: Aspirin 81 mg (milligrams) QD (every day); Ferrous Sulfate			

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	(Iron supplement) 325 mg QD; Levothyroxine (thyroid medication) 175 mcg (micrograms) QD; Prilosec (treatment for heartburn, stomach ulcers, and reflux) 40 mg QD; Sevolamer [sic Sevelamer] Carb (lowers the amount of phosphorus in the blood for patients receiving dialysis) 800 mg ii TID (three times a day); Lexapro (antidepressant) 5 mg QD; Coreg (treatment of high blood pressure and heart failure) 6-25 mg Bid; Gabapentin (treats neuropathy) 100 mg; Linzess (treats irritable bowel syndrome - IBS) 145 mcg QO [sic]; Atorvastatin (treatment of cholesterol) 40 mg QO [sic]; Metoclopramide (antiemetic and treatment of reflux) 5 mg TiD; Montelukast (treatment of allergies and prevent asthma attacks) 10 mg QD; Certizine (treatment of allergies) 10 mg QD; Amlodipine (antihypertensive) 10 mg QD; Amiodarone (treatment of irregular heart rhythms) 10 mg QD; Allopurinol (treatment for gout) 100 mg QD; Senna/DSS (stool softner) [illegible] Bd. The document did not include trelogy ellipta (treatment for COPD) [sic. Trelegy Ellipta], Lidocaine patch (treatment for pain), Oxygen, or Albuterol (treatment for COPD). The generic name Omeprazole was replaced with Prilosec. Amiodarone had a prescribed dose of 10 mg versus the 200 mg listed on the Medication Profile. The prescribed dose for Senna/DSS was illegible. All medications failed to include the route and accepted medical abbreviation for frequency. No documentation was present to indicate the medications were prepared for 11/3/20. On 11/10/20 a review of the clinical record for patient #1 evidenced the presence of four separate medication lists titled Medication Profile, Medication Flow Sheet, Home Health Certification and Plan of Care dated 9/3/20-11/2/20 (corrected to 9/3/20-11/1/20) and Home Health Certification and			

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	Plan of Care dated 11/2/20-12/31/20. The Home Health Certification and Plan of Care signed by Employee H, no verbal start of care date, and dated 9/3/20-11/2/20 (corrected to 9/3/20-11/1/20), locator 10 stated, "Medications ..." was reviewed and evidenced the following medications: trelogy ellipta [sic. trelegy ellipta] QD; Albuterol InH BID; Aspirin 81 mg QP [sic]; [illegible] sulfate 325mg [illegible]; Levothyroxine 175 mg OD; [illegible] 40 mg PO; Sevelamer [illegible] [illegible]; Lexapro 5 mg QD; [illegible] [illegible] Bid; Gabepentin 100 mg ii tabs bid; Linzess 145 mcg [illegible]; Atorvastatin 40 mg QD; Metoclopramide 5 mg Td [sic]; Monteclukast 10 ng [illegible]; [illegible] 10 mg QD; [illegible] [illegible] [illegible]; Allopurinol [illegible] QO; Senna/[illegible][illegible] Bid. The Medication Profile, The Medication Flow Sheet, and the Physician Ordered Plan of Care failed to evidence consistent medications. A document titled "(Addendum to Comprehensive Assessment) Medication Profile," signed by Employee H on 9/3/20 and 10/29/20, and with an illegible signature dated 11/3/20, revealed the following medications: trelogy ellipta [sic. Trelegy Ellipta] QD; Albuterol Bid; Aspirin 81 mg QD; Ferrous Sulfate 325 mg QD; Levothyroxine 175 mcg QO [sic]; Omperazole 40mg QD; Sevelamer Carbonate 800 mg ii tabs TID; Lidocaine patch QD; Lexapro 5 mg QD; Coreg 6.25 Bid; Gabapentin 100 mg ii tabs Bid (twice a day); Linzess [illegible] mcg QO; Atorvastatin 40 mg QD; Metoclopramide 5 mg, TID; montelukast 10mg QD; Cetlrizine [sic. cetirizine] 10mg QD; Amlodipine 10 mg QD; Amiodarone 200 mg, 1/2 tab OD [sic]; Allopurinol 100 mg QD; Senna/DSS 8.6-50 mg Bid; O2 (oxygen) 3L (liters) via NC (nasal cannula) continuously. All medications listed failed to evidence the medication route, purpose, possible side effects, date ordered, and			

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	medically accepted abbreviations for frequency. Trelogy ellipta [Trelegy Ellipta] and Cetlrizine [cetirizine] were misspelled. Trelogy ellipta [Trelegy Ellipta] and Albuterol failed to evidence an ordered dose. Lidocaine patch failed to evidence an ordered dose or correct frequency (apply up to 3 patches daily for no more than 12 hours within a 24-hour period. Remove patches after 12 hours and before applying new patches.) Coreg failed to evidence a label (mg) for dosing. Linzess failed to evidence a legible dose. Gabapentin was labeled as "tabs", however capsules were observed in the patient home. Levothyroxine and Amiodarone evidenced ordered frequencies of QO and OD respectively. Amiodarone dose was illegible. The Drug Regimen Review stated "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?" and was answered "yes" in columns 1 and 2. Columns 3 and 4 were blank. It further stated, "Describe Problem and Action for any Yes responses" contained responses "interactions 9/3/20" and "interactions 10/29/20", which coincided with the dated signature of Employee H. No drug regimen review was noted for an illegible signature dated 11/3/20. The allergies option was blank. The Home Health Certification and Plan of Care, signed by Employee H, no verbal start of care date, and dated 11/2/20-12/31/20 evidenced at locator 10 "Medications ..." was reviewed and evidenced the following medications: trelogy ellipta [sic trelegy ellipta] OD; Albuterol inH Bid; Aspirin 81 mg QD; Ferrous Sulfate .325 mg (illegible); Levothyroxine 175 mcg QO; oneprazole 40ng (illegible-sic); Sevelamer 800 mg ii tabs TID; Lexapro 5 mg QD; Coreg 6.25 mg Bid; Gabapentin 100 mg QD; Linzess 145 mcg QD; Atorvastatin 40			

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	(illegible) QO; Metoclopromide 5 mg TiD; montklucast [sic Monteclukast] 10 mg QD; Amlodipine 10 mg QD. The Plan of Care, Medication Profile, and Medication flow sheet failed to evidence consistent medications. A document titled "Medication Reconciliation Fax Cover Sheet, dated 9/3/20 from Employee H and signed by the physician on 9/8/20 stated, "This is a Drug Reconciliation Report for [patient name] .... See attached report from drugs.com. Please review the report and make modifications as needed." No fax confirmation was present with the document or medication list. No report was present with the document or in the clinical record. The options "No changes indicated" and "Make the following changes ..." were blank. No comments were made. A document titled "Medication Reconciliation Fax Cover Sheet, dated 10/29/20 evidenced "This is a Drug Reconciliation Report for [patient name] .... See attached report from drugs.com. Please review the report and make modifications as needed." No fax confirmation was present with the document or medication list. No report was present with the document or in the clinical record. An undated document titled "Medication Reconciliation Form" stated "As a result of our drug reconciliation review of your patient's medications the following potential major and/or moderate drug interactions were identified per drugs.com. We are required to notify you ... The fax cover sheet provides you the options to indicate that no changes are recommended or list any changes ...." The document evidenced a "zero" under column "Drugs with potential for major interactions." A column labeled "Drugs with the potential for [illegible] interactions" was blank.			

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	An undated document titled Medication Reconciliation Form stated "As a result of our drug reconciliation review of your patient's medications the following potential major and/or moderate drug interactions were identified per drugs.com. We are required to notify you ... The fax cover sheet provides you the options to indicate that no changes are recommended or list any changes ...." A column labeled "Drugs with the potential for Major Interactions evidenced "Carvedilol/trelogy [sic. trelegy] ellipta" and "amiodarone/lexapro". The column labeled "Drugs with the potential for Moderate Interactions" was blank. On 11/12/20 at 9:25 AM, a phone interview was conducted with Person U, licensed practical nurse (LPN) with Patient #1's primary care physician. Person U stated the agency nurse, Employee A, spoke with Person V and said she was sending a clarification order for gabapentin 100mg daily, however the most recent order they documented was Gabapentin 100 mg tab, 300 mg po (by mouth) 3 times per day. Person U stated, "[Physician name] was not comfortable giving an order to change it (Gabapentin) to 100 mg daily without seeing her first." Person U confirmed Employee A sent the physician a complete medication list on 11/10/20 but the physician could not verify any medications until Patient #1 was seen. Person U confirmed [Physician Name-Person EE] did not manage anything related to Patient #1's dialysis, including medications. Person U denied the physician had knowledge of other medication discrepancies with agency listed medications. On 11/12/20 at 4:00 PM, an interview with Person CC, Dialysis Manager from Entity B, was conducted. Person CC indicated their medication list include Oxycodone 5 mg every 3 hours as			

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	needed for pain and Neurontin (Gabapentin) dose as 400 mg two times a day. The patient's medication profile/ list failed to evidence these medications as prescribed by the dialysis physician. On 11/12/20 at 11:35 a.m., a call was received from Person I, patient #1's POA/ HCR (power of attorney/health care representative). Person I stated all the medications Employee A put into the medication planner for all 3 times, were wrong. Person I stated some pills needed to be broken in half when they were put in whole and some needed more than one pill. Person I stated Employee A came back out to fix the pills and they still were not correct and they had to fix the pill box. Person I stated that Employee A told him/ her (Person I) that the patient didn't have all the medication to fill the pill box. Person I stated the patient did have all the medications and there were in the patient's bathroom. 9. During a home visit at patient #2's (pediatric patient) home on 11/10/20 at 1:30 p.m., Person K, family member, stated he managed the patient's medications (given by the g-tube) and tube feedings. Person K indicated the patient was put on oxygen approximately 1.5 weeks ago and is on it at all times at 1 liter per nasal cannula. Person K provided the patient's bottles of medications, g-tube medications, and reviewed what was written on the plan of care for the certification period of 10/18/20 to 12/16/20. The bottles provided include, but not limited to: Cuvposa (used to reduce excessive drooling caused by medical conditions) 0.4 mg (milligrams), (2 ml - milliliters), give 1 mg/ 5 ml by mouth three times a day was started on 10/1/20; Epidiolex (cannabidiol medication to help treat seizures) 1.2 ml three times a day by g-tube; Diazepam (used to treat anxiety, muscle spasms, and seizures) 5 mg/ ml			

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	bottle, give 0.6 ml three times a day by g-tube; Trazodone (antidepressant medication that can also be used for anxiety and sleep) 5 mg/ ml, give 2.5 ml daily at bedtime; Gabapentin (anticonvulsant and nerve pain medication) 250 mg/ 5 ml, give 3 ml three times a day by g-tube; and Baclofen (used to treat muscle spasms) 10 mg/ ml, give 10 ml three times a day per g-tube. Person K stated the patient was taken off Levetiracetam last year, started on Cuvposa filled on October 1, 2020; been on Baclofen since May, 2020, and was recently started on Gabapentin in October, 2020. Review of the Medication list on the plan of care for the certification period of 10/18/20 to 12/16/20, indicated the following, but not limited to: Levetracetam [sic] 100 mg/ ml, take 4 ml twice a day per g-tube; Trazodone 25 mg/ 5 ml suspension, give 2.5 ml (illegible frequency) g-tube; Diazepam 5 mg/ 5 ml oral solution, take 0.2 ml three times a day; Diazepam 10 mg suppositories as needed for seizures > 10 min, max 1/ 24 hr or 2/7 days; and Epidolex [sic] 100 mg/ 1 ml oral solution, take 1.0 ml three times a day by mouth. Review of the the Medication Profile last updated on 10/16/20, indicated the following, but not limited to: Levetracetam [sic] 100 mg/ ml sol, give 4.0 ml twice a day, Trazodone 25 mg/ 5 ml, give 2.5 ml at bedtime, Diazepam 5 mg/ 5 ml, Give 0.3 ml three times a day, Diazepam suppositories 10 mg per rectum as needed, and Epidolex [sic] 100 mg/ ml, give 1.2 ml by mouth three times daily. The Drug Regimen Review section asks "Have potential adverse effects, significant drug interactions, duplicate ... drug therapy and potential contraindications been identified?" in which the question was answered "No."			

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	Review of Drugs.com, revealed nine (9) moderate drug interactions: Diazepam and Trazadone, Diazepam and Baclofen, Trazadone and Baclofen, Trazodone and Gabapentin, Baclofen and Gabapentin, Diazepam and Epidiolex, Trazadone and Epidiolex, Baclofen and Epidiolex, and Gabapentin and Epidiolex. There were also therapeutic duplication of drug warnings such as Central Nervous System Drugs: Gabapentin, Epidiolex, Diazepam, and Trazodone. The medication profile failed to be consistent with what the patient's father provided and reviewed, failed to be consistent with the plan of care medication list, failed to appropriately be reconciled and checked for drug interactions and duplications, and failed to contain accurate spelling of medications. 10. The clinical record for patient #3 (pediatric patient), SOC 8/17/20, was reviewed on 11/12/20 to 11/13/20 and contained an agency document titled "Medication Profile" which contained a list of the following medications: Albuterol Sulfate every 4 to 6 hours as needed for "resp" [respiratory]; Qvar (corticosteroid used for chronic asthma) 80 mcg/ 2 puffs twice a day for "resp"; Mucinex (expectorant) 100 mg/5 ml per g-tube twice a day for "mucous"; Vimpat (anticonvulsant) 10 mg/ ml, give 15 ml per g-tube twice a day for seizures; Levitracetam [sic] 100 mg/ ml, give 5 ml per g-tube twice a day for seizures; Diazepam 5 mg/ 5 ml, give 5 ml per g-tube three times a day for seizures; Nexium (anti-ulcer drug) 20 mg packet per g-tube twice a day for gerd's (gastroesophageal reflux disease); Montelukast (anti-asthmatic) 5 mg tab per g-tube daily for allergies; Flonase (Corticosteroid used as a preventative maintenance of chronic asthma in patients			

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	requiring oral corticosteroid and use for allergic and non-allergic rhinitis) 50 mcg (micrograms), 1 spray daily for allergies; Azelastine (Antihistamine) 0.1 % 137 mcg 1 spray daily for allergies; sulcralfate [sic] (anti-ulcer-gastrointestinal protectant drug) 1 gm (gram)/10 ml, 10 ml per g-tube every 8 hours for gerd's; and Oxygen via nasal cannula at 4 liters per minute continuously. This document revealed forward slashes with the drug regimen review questions but failed to include a date of when the review was completed in the date box. The questions indicated "No" when asked if there were potential adverse effects, significant drug interactions, duplicate/ ineffective drug therapy, and potential contraindications been identified. Review of an agency document titled "Medication Reconciliation Fax Cover Sheet" dated 10/14/20, indicated there were no changes to the patient's medications. Page two of the Medication Reconciliation Form revealed a forward slash through a zero (indicating none or zero) under "Drugs with potential for Major Interactions" and the section which indicates "Drugs with potential for Moderate Interactions) was left blank. According to Drugs.com interaction checker, Diazepam and Azelastine nasal has a moderate drug interaction and indicates to "Monitor: Central nervous system and / or respiratory-depressant effects may be additively or synergistically increased in patients taking multiple drugs that cause these effects, especially in elderly or debilitated patients. Sedation and impairment of attention, judgment, thinking, and psychomotor skills may increase." Review of an agency document titled "Case Note" dated 10/8/20, indicated Visiting Angels was in contact with Entity C, a hospice agency, for			

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	collaboration of services and a voicemail was left for a return call. On 11/13/20, Person E from Entity C, provided their agency's current medication list which contained the following medications that differed from Visiting Angels Medication list: Acetaminophen 160 mg/ 5 ml 505 mg per g-tube every 4 hours for fever or mild pain; Albuterol Sulfate every 4 hours for bronchospasms/ shortness of breath, then "**Parents are only giving prn [as needed]"; Azelastine HCL 0.1 % Nasal 2 time a day, 2 sprays each nostril once a day for chronic rhinitis; Ibuprofen Children's 100 mg/ 5 ml, give 340 mg per g-tube every 6 hours as needed for fever or mild pain; Montelukast Sodium 5 mg, give 1 tablet per g-tube at bedtime for asthma; MiraLax 8.5 gm per g-tube as needed for constipation (mix in 8 ounces of water or juices give twice daily as needed); Morphine sulfate 10 mg/ 5 ml, give 6.6 mg per g-tube every 4 hours as needed for pain or shortness of breath; lorazepam 1 mg/ ml oral concentration, give 3 mg per g-tube as needed for uncontrolled seizure activity, may repeat 15 min if seizure persist; Oxygen 1 to 4 liters continuously for asthma, restrictive airway, shortness of breath, Beclomethasone Diprop HFA 80 mcg/ Act, administrator 2 puffs twice a day for shortness of breath; and Carafate 1 gm/ 10 ml, give 1 gm every 8 hours as needed for gastric bleed. Patient #2 has been a patient of Entity C since 11/2/18. This document was not found or part of patient #3's clinical record with Visiting Angels. According to Drugs.com, when adding acetaminophen, Ibuprofen, Morphine, Lorazepam revealed 2 major drug interactions between (1) Diazepam and Morphine (2) Lorazepam and Morphine; there were 6 moderate drug			

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	interactions between Diazepam and Azelastine Nasal (as indicated above), Lorazepam and Azelastine Nasal, Morphine and Azelastine Nasal, Morphine and Levetiracetam, Diazepam and Nexium, and between Albuterol and Miralax. There were major interactions between Morphine and Food, moderate interactions between Diazepam and food, Lorazepam and food, Sucralfate and food, Azelastine and food, Levetiracetam and food, and between Esomeprazole and food. There were also therapeutic duplication of drug warnings such as Central Nervous System Drugs: Vimpat, Levetiracetam, Diazepam, and Lorazepam; Anticonvulsant agents: Vimpat, Levetiracetam, Diazepam, Lorazepam; Tranquilizers: Diazepam and Lorazepam; Nasal Preparations: Flonase, Azelastine Nasal, and Beclomethasone Nasal; Nasal Steroids: Flonase and Beclomethasone Nasal; and Benzodiazepine - Anticonvulsant agents: Diazepam and Lorazepam. The medication profile failed to to contain all prescribed medications, failed to appropriately reconciled and checked for drug interactions and duplications, and failed to contain accurate spelling of medications. 11. The clinical record of patient #5 was reviewed and contained a physician visit note dated 5/20/20, which revealed the patient had a drug allergy to Tetanus Toxoid. Review of a home health aide supervisory visit note dated 9/2/20, indicated Mupirocin ointment and antibiotic completed. The "Medication Changes" indicated "Tramadol 50 mg QD PRN [50 milligrams every day as needed]." The medication profile failed to evidence that the profile had been updated to include the Tramadol, Mupirocin or			

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	antibiotics. Review of an agency document titled "Medication Profile" dated 10/1/20, in which the profile listed the following medications: Savella (Antidepressant and to treat nerve pain) 100 mg daily; Baclofen 20 mg, 1 tab three times a day and 20 mg, 2 tabs at bedtime; Xarelto (long acting blood thinner) 20 mg, 1 tab daily; folic acid (supplement) 1 mg daily; Buproprion [sic] HCL XL (antidepressant used for smoking cessation and to treat a variety of mental disorders) 150 mg, 1 every morning; Nystatin 1000,000 U/gm (units per gram) topical, four times a day but failed to evidence the specific affected area to treat; Escitalopram (antidepressant) 10 mg, 1 tab daily; Carvedilol (treat high blood pressure) 3.125 mg, 1 tab twice a day; Miralax 17 gm, 1 dose daily as needed; Atorvastatin (treat high cholesterol) 40 mg, 1 tab daily at bedtime; Vitamin B12 ER (supplement) 10000 mcg daily; Valium 2 mg, 1 tab twice a day; Omeprazole 20 mg, 1 capsule daily; Gabapentin 600 mg; 1 capsule four times daily; and Milnacipran (generic name for Savella) 100 mg, 1 tab daily. The Medication Profile failed to include the patient's allergy to Tetanus Toxoid. Review of the "Drug Regimen Review" under the listed medications, failed to evidence a date for each review after 6/3/20 but evidenced check marks to the 5 questions of the review. Section F indicated "Describe Problem and Action for any Yes responses" in which question E indicated "Yes" to potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified but only a date and "MD notified"			

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	was indicated but failed to describe what the problem was. The Potential side effects" column was left blank for all medications listed.During an interview on 11/13/20 at 2:10 p.m. with Person Q, the Alternate Director of Nursing (DON) from Entity C, the patient's medications were reviewed and the following medications differ between Entity C and Visiting Angels: Savella, Baclofen 20 mg (2 tabs at bedtime), Bupropion HcL XL, Nystatin, Carvedilol, Vit B12 ER, Valium, and Omeprazole. These medications were not on Entity C's medication list. The following medications were on Entity C's medication list that were not on Visiting Angels medication list: Lexapro (antidepressant and antianxiety), Senna (stool softener) as needed, Benadryl (antihistamine), Tylenol (pain/ fever), Colace (stool softener), Vitamin D 3 (supplement), and Catheter irrigations with Sterile water. The medication profile failed to to contain all prescribed medications, failed to appropriately reconciled and checked for drug interactions and duplications12. The clinical record for patient #6 was reviewed and contained an agency document titled "Medication Profile" dated 9/10/20, in which the profile listed the following medications: Gabapentin (used for neuropathy pain), Nitroglycerin (treat chest pain), Clonazepam (anti-anxiety), Prazosin (treat high blood			

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	pressure), Omeprazole, Furosemide (water pill), Klor-con (Potassium supplement), and Lyrica (used for neuropathy pain and depression). The Drug Regimen Review section asks "Have potential adverse effects, significant drug interactions, duplicate ... drug therapy and potential contraindications been identified?" in which the question was answered "No."Review of the OASIS start of care comprehensive assessment dated 9/10/20, page 22 of 29 (M2001) asks if a complete drug regimen review identify potential clinically significant medication issues in which the answer was "0" (No - No issue found during review). A section under this question indicated to check if any, but not limited to, significant drug interactions or duplicate drug therapy were identified, in which these two indications were not checked.Review of Drugs.com drug interactions report indicated there were 6 moderate drug interactions between Furosemide and Clonazepam, Clonazepam and Nitro, Furosemide and Omeprazole, Clonazepam and Omeprazole, Clonazepam and Lyrica, and Gabapentin and Lyrica. The site also indicated there was 1 drug duplication and listed Gabapentin and Lyrica.The medication profile failed to to contain all prescribed medications, failed to appropriately reconciled and checked for drug interactions and duplications13. During			

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	the entrance conference on 11/9/20 at 9:55 a.m., when queried on how the agency coordinated with other agencies, the Administrator stated he and the Director of Nursing made the calls at first then the nurses were to follow up every 60 days. When queried on how the agency checked for severe medication interactions and duplicative drug therapy, the Administrator stated they utilize Drugs.com and document the interactions on the form and send to the physician for review.14. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-14-1(a)(1)(B)			
G 0538 Bldg. 00	484.55(c)(6)(i,ii) Primary caregiver(s), if any The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to ensure the comprehensive assessment identified the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule in in 5 of 5 (Patients #1, 2, 3, 4, 5) active records reviewed and 1 of 2 (Patient #6) closed records reviewed in a sample of 7. Findings included:	G 0538	**G538** Since the November 2020 survey 100% of agency patients have received follow-up assessments at the time of recertification. The nurse with the greatest number of errors resigned her employment and is no longer working for the agency.	02/16/2021

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	1. A review of undated policy C120A, titled "Home Health Care Intake Policy & Process," subsection "Criteria for Client Admission" evidenced the following: "[Intake] shall consider: ... the attitudes of client/caregiver toward care in the home; and Inquiry Process: Availability of caregiver support?" Review of an undated agency policy titled "Admission Policy" C-120 indicated, " ... When determined necessary based on the client's condition, a competent caregiver and/ or family member may assume responsibility for client care with intermittent services provided by the agency...." 2. A review of a clinical record for Patient #1 evidenced a start of care comprehensive assessment dated 9/3/20, for certification period 9/3/20-11/2/20 (corrected to 9/3/20-11/1/20). A section titled "Living Arrangements/Supportive Assistance: Primary Caregiver" evidenced an incomplete assessment that included Patient #1's daughter as a primary caregiver. The comprehensive assessment failed to evidence clear documentation of all available caregivers, failed to include demographic and contact information of all available caregivers, and failed to evidence documentation of a conversation between Patient #1 and/or the caregiver(s) and clinician concerning caregiver(s) willingness, availability, and schedule. A review of recertification/follow-up assessment dated 10/29/20 for certification period 11/2/20-21/31/20. No primary caregiver was identified. The assessment failed to evidence clear documentation of all available caregivers, failed to include demographic and contact information of		The Director of Clinical Service has re-instructed the RN Case Managers to ensure their comprehensive assessments identifies the patient's primary caregiver (if any) and documents their ability to provide care, their availability and schedule. A new "comprehensive assessment" audit tool has been implemented that evaluates all aspects of the comprehensive assessment. The Director of Clinical Service/designee is responsible for auditing 100% of all comprehensive assessments. The new audit tool has been adapted to facilitate this process. · Audit results are provided to each RN Case Manager with the direction to correct any gaps or mistakes in the completion and documentation of the assessment. · The RN Case Managers are to make the required corrections and re-submit the assessment to the Agency Clinical Manager within 24-48 hours of receipt. The Director of Clinical Service/designee will perform random "un-announced supervisory visits of the RN Case Managers performing certification assessments to evaluate the RN's ability to perform a complete, accurate, thorough comprehensive assessment ensuring all medications are documented and reconciled. A RN Case Manager	

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	all available caregivers, and failed to evidence documentation of a conversation between Patient #1 and/or the caregivers and clinician concerning caregivers willingness, availability, and schedule. 3. A review of a clinical record for Patient #4, start of care 6/25/20, for certification period 6/25/20-8/24/20 evidenced a start of care comprehensive assessment with diagnoses listed of COPD and Memory Loss. A section titled "Living Arrangements/Supportive Assistance was marked "family members at least daily." No further information was documented in this section. The comprehensive assessment failed to evidence clear documentation of all available caregivers, failed to include demographic and contact information for all available caregivers, and failed to evidence documentation of a conversation between Patient #4 and/or the caregiver(s) and clinician concerning willingness, availability, and schedule. A review of a recertification comprehensive assessment dated 8/24/20 for certification period 8/24/20-10/22/20. (corrected to 8/24/20-10/21/20) A section titled "Living Arrangements/Supportive Assistance: Primary Caregiver" evidenced "family members" as primary caregivers and willing to assist. The comprehensive assessment failed to evidence clear documentation of all available caregivers, failed to include demographic and contact information of all available caregivers, and failed to evidence documentation of a conversation between Patient #4 and/or the caregivers and clinician concerning caregiver willingness, availability, and schedule. A review of a recertification comprehensive assessment dated 10/21/20, for certification period 10/23/20-12/21/20. A section titled "Living		Supervisory Visit Form has been created to facilitate and document this process. To stress the importance of this process the Agency has instituted a 3-step disciplinary process for the RN Case Managers as it relates to the accurate completion of the comprehensive assessment at all required timepoints. All RN Case Managers will be educated on the consequences of not completing and documenting a full patient-specific comprehensive assessment including the reconciliation of all medications with the patient, health care representative,(if any), outside agencies, and ordering physicians. · Failure to complete the patient-specific comprehensive assessment that addresses all elements of the assessment process will result in re-education of the employee and an entry in their personnel file documenting their non-compliance with a written warning that ongoing non-compliance will result in further consequences. · Failure to complete the patient-specific comprehensive assessment a 2nd time will result in further re-education of the employee and the employee being placed on a 30-day action plan. · If there is a 3rd occurrence	

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	Arrangements/Supportive Assistance: Primary Caregiver" listed "Family Members" as primary caregivers. The comprehensive assessment failed to evidence clear documentation of all available caregivers, failed to include demographic and contact information of all available caregivers, and failed to evidence documentation of a conversation between Patient #4 and/or the caregivers and clinician concerning caregiver willingness, availability, and schedule. 4. The clinical record for Patient #2, contained a recertification comprehensive assessment, untimed and dated 10/16/20, for the certification period of 10/18/20 to 12/16/20, revealed in the Living Arrangements/ Supportive Assistance section identified Person K willingness to assist but failed to evidence what the caregiver is comfortable assisting with and the schedule of availability. The section also failed to evidence the patient's mother willingness when the patient is in her care during visitation. 5. The clinical record for Patient #3, contained a start of care comprehensive assessment dated 8/17/20, for the certification period of 08/17/20 to 10/15/20, revealed in the Living Arrangements/ Supportive Assistance section that the patient lives with other family members in the home but failed to evidence who the patient's primary caregiver was, demographics, willingness to assist, and comfort with assisting, the availability of assistance, and who to contact if a critical situation should happen and if the caregiver is not available. Review of the recertification comprehensive assessment dated 10/14/2020, for the certification period of 10/16/20 to 12/14/20, revealed in the Living Arrangements/ Supportive Assistance section that the primary caregivers were family		of non-compliance with the completion of the patient-specific comprehensive assessment the employee's employment with Visiting Angels Home Health Agency will be terminated. The Director of Clinical Service is responsible for ensuring on-going compliance with G538.	

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	members and they provided assistance with ADLs/IADLs, willing to assist, and felt safe assisting the patient, but failed to evidence the name of family members and their demographics include phone number, the hours and days the caregiver is available to assist. 6. The clinical record for Patient #5, contained an start of care comprehensive assessment dated 6/3/20, for the certification period of 06/03/20 to 12/2/20 [sic], revealed in the Living Arrangements/ Supportive Assistance section that the patient lives with other family members in the home but failed to evidence who the patient's primary caregiver was, demographics, willingness to assist, and comfort with assisting, the availability of assistance, and who to contact if a critical situation should happen and if the caregiver is not available. Review of an agency document titled "Acknowledgement of Information" dated 6/3/20 on page 2, indicated an acknowledgement of agreement by Person J, but Primary Caregiver section was blank and failed to indicate if the family member signing the consents were the primary giver. Review of the OASIS recertification comprehensive assessment dated 8/3/20, for the certification period of 8/3/20 to 10/2/20, revealed in the Living Arrangements/ Supportive Assistance section that the patient lives with other family members in the home but failed to evidence who the patient's primary caregiver was, demographics, the availability of assistance, and who to contact if a critical situation should happen and if the caregiver is not available. Review of the OASIS recertification			

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	comprehensive assessment, untimed and dated 10/1/20, for the certification period of 10/2/20 to 11/29/20, revealed in the Living Arrangements/ Supportive Assistance section that the patient lives with other family members in the home but failed to evidence who the patient's primary caregiver was, demographics, the availability of assistance, and who to contact if a critical situation should happen and if the caregiver is not available. 7. The clinical record of patient #6, contained a start of care comprehensive assessment, dated 9/10/20, for the certification period of 09/10/20 to 11/08/20, revealed in the Living Arrangements/ Supportive Assitance that the patient lived alone and failed to evidence if the patient had a willing caregiver or other paid services other than this home health agency. 8. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			
G 0540 Bldg. 00	484.55(c)(7) The patient's representative (if any); The patient's representative (if any); Based on record review, the agency failed to ensure the assessment included information concerning a patient selected representative in 4 of 5 (Patients #1, 2, 3, 4, 5) active records reviewed and 1 of 2 (Patient #6) closed records reviewed in a sample of 7. Findings included: 1. A review of undated policy C120A, titled	G 0540	**G540** Since the November 2020 survey 100% of agency patients have received follow-up assessments at the time of recertification. The nurse with the greatest number of errors resigned her employment and is no longer working for the agency. The Director of Clinical Service	02/16/2021

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	"Home Health Care Intake Policy & Process," subsection "Criteria for Client Admission" evidenced the following: "[Intake] shall consider: ... the attitudes of client/caregiver toward care in the home; and Inquiry Process: Availability of caregiver support" Review of an undated agency policy titled "Admission Policy" C-120 indicated, " ... When determined necessary based on the client's condition, a competent caregiver and/ or family member may assume responsibility for client care with intermittent services provided by the agency...." 2. A clinical record review for Patient #4, start of care 6/25/20, evidenced an initial comprehensive assessment dated 6/25/20, 9:30 AM - 10 AM, for certification period 6/25/20-8/23/20. The comprehensive assessment failed to evidence the patient was screened concerning a patient representative. A clinical record review for a recertification/follow-up assessment dated 8/24/20 for certification period 8/24/20-10/22/20(Corrected to 8/24/20-10/21/20). Under a subsection titled "Representative Contact Information" the clinician documented a patient selected representative of [Name]. The patient representative demographic/contact information was blank. The recertification assessment failed to evidence a complete and accurate screen for a patient representative. A clinical record review for a recertification/follow-up assessment dated 10/21/20, for certification period 10/23/20-12/21/20. The assessment failed to evidence the patient was screened concerning a patient representative.		has re-instructed the RN Case Managers to ensure their comprehensive assessment documentation identifies who the “patient representative” is for the patient (if any). A new “comprehensive assessment” audit tool has been implemented that evaluates all aspects of the comprehensive assessment. The Director of Clinical Service/designee is responsible for auditing 100% of all comprehensive assessments. The new audit tool has been adapted to facilitate this process. · Audit results are provided to each RN Case Manager with the direction to correct any gaps or mistakes in the completion and documentation of the assessment. · The RN Case Managers are to make the required corrections and re-submit the assessment to the Agency Clinical Manager within 24-48 hours of receipt. The Clinical Manager/designee will perform random “un-announced supervisory visits of the RN Case Managers performing certification assessments to evaluate the RN’s ability to perform a complete, accurate, thorough comprehensive assessment . A RN Case Manager Supervisory Visit Form has been created to facilitate and document this process.	

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	3. The clinical record for Patient #2, contained a recertification comprehensive assessment, untimed and dated 10/16/20, for the certification period of 10/18/20 to 12/16/20, revealed that the emergency contact was Person K and a phone number was provided. The Representative Contact Information section was left completely blank and failed to evidence all legal representative names, demographics, phone number and custody information. The recertification assessment failed to evidence a complete and accurate screen for a patient representative. 4. The clinical record for Patient #3, contained a start of care comprehensive assessment, untimed and dated 8/17/20, for the certification period of 08/17/20 to 10/15/20, failed to evidence an emergency contact, phone number and their demographics under the Emergency Preparedness section, failed to provide name, phone number and demographics under the Patient Representative section revealed in the Living Arrangements/ Supportive Assistance section that the patient lives with other family members in the home but failed to evidence who the patient's primary caregiver wasd, demographics, willingness to assist, anf comfort with assisting, the availability of assistance, and who to contact if a critical situation should happen and if the caregiver is not available. Review of the recertification comprehensive assessment, untimed and dated 10/14/2020, for the certification period of 10/16/20 to 12/14/20, revealed in the Living Arrangements/ Supportive Assistance section that the primary caregivers were parents but failed to include both phone numbers.		To stress the importance of this process the Agency has instituted a 3-step disciplinary process for the RN Case Managers as it relates to the accurate completion of the comprehensive assessment at all required timepoints. All RN Case Managers will be educated on the consequences of not completing and documenting a full patient-specific comprehensive assessment including the reconciliation of all medications with the patient, health care representative,(if any), outside agencies, and ordering physicians. · Failure to complete the patient-specific comprehensive assessment that addresses all elements of the assessment process will result in re-education of the employee and an entry in their personnel file documenting their non-compliance with a written warning that ongoing non-compliance will result in further consequences. · Failure to complete the patient-specific comprehensive assessment a 2nd time will result in further re-education of the employee and the employee being placed on a 30-day action plan. · If there is a 3rd occurrence of non-compliance with the completion of the patient-specific comprehensive assessment the employee's employment with Visiting Angels Home Health	

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	5. The clinical record for Patient #5, contained an start of care comprehensive assessment dated 6/3/20, for the certification period of 06/03/20 to 12/2/20 [sic], revealed that the emergency contact was Person J and a phone number was provided. The Representative Contact Information section was left completely blank and failed to evidence all legal representative names, demographics, phone number and custody information. The recertification assessment failed to evidence a complete and accurate screen for a patient representative. Review of the OASIS recertification comprehensive assessment dated 8/3/20, for the certification period of 8/3/20 to 10/2/20, revealed that the emergency contact was Person J and a phone number was provided without any demographics. The Representative Contact Information section indicated the patient did have a representative, but the remainder of this section was left completely blank and failed to evidence all legal representative names, demographics, phone number and custody information. Review of the OASIS recertification comprehensive assessment, untimed and dated 10/1/20, for the certification period of 10/2/20 to 11/29/20, revealed that the emergency contact was Person J and a phone number was provided without any demographics. The Representative Contact Information section was left completely blank and failed to evidence all legal representative names, demographics, phone number and custody information. 6. The clinical record of patient #6 was reviewed and contained an OASIS start of care comprehensive assessment dated 9/10/20, the Emergency Contact indicated the patient's former		Agency will be terminated. The Director of Clinical Service is responsible for ensuring on-going compliance with G540.	

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	spouse, but the Patient Representative section was blank and failed to evidence if the patient had a Patient Representative. 7. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			
G 0570 Bldg. 00	484.60 Care planning, coordination, quality of care Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review, and interview, the agency failed to ensure they accepted pediatric patients on the reasonable expectation that they were able to meet pediatric patients nursing needs (See G570); failed to	G 0570	**G570** The Governing Body met to discuss the survey concerns. After analysis and discussion the Governing Body determined the	03/16/2021

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	ensure services were provided per the plan of care and failed to ensure each patient received an individualized care plan that identified patient specific and measurable outcomes and goals that was periodically reviewed and signed by a physician (See G572); failed to ensure the individualized plan of care included all pertinent diagnoses, all supplies and equipment, specific frequency and duration of visits, nutritional requirements, all accurate medications and treatments, all safety measures to protect against injury, patient specific interventions, measurable outcomes and goals identified by the home health agency and patient (See G 574); failed to ensure the plan of care was created in conjunction with the primary care physician after an assessment, verbal start of care and recertification orders obtained from the physician (See G580); failed to ensure verbal orders were complete and contained included duties/ services that the home health aides were to provide and the specific education the nurses were to educate to whom, and date and time of when orders when verbal orders were received (See G 584); failed to ensure the physician was notified of the agency's inability to provide services (See G590); failed to ensure the primary care physician, patients, and patient representatives were informed in advance of the agency's intent to discharge and readmit due to administrative correctives (G598); failed to ensure they communicated with the prescribing physician in regards to wrong patient information on a face to face encounter document (See G602; and failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patient's needs . These practices impacted 6 patient (Patient #1, 2, 3, 4, 5, 6) out of 7 sampled records reviewed.		organization is not staffed to meet the needs of pediatric patients & wound care patients with extended hour service needs. The Governing Body identified that the Agency Staff had insufficient knowledge and experience to continue to attempt to meet the needs of pediatric and wound care patients. With the home care staffing shortages in the counties served by Visiting Angels Home Health Agency it was determined the Agency would not be able to hire appropriately qualified staff to meet the needs of pediatric and wound care patients. The Governing Body tasked the Administrator with contacting each of these patients, their families & physicians to discuss their needs and potential transfer-of-service options. All patients, their families, and their physicians agreed their needs would be better met by more qualified pediatric and/or MCA home health agencies experienced in wound care. Once the patients/families & physicians agreed to the transfer process, the Agency authenticated the process with physician orders and sent out 15-day notices of transfer and discharge. The Agency continued to attempt to staff all the cases during the 15-day notice period. The Agency Administrator and clinicians worked with the patients, their families, and the	

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	The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care. In regards to G570: Based on record review and interview, the agency failed to ensure they accepted pediatric patients on the reasonable expectation that they were able to meet pediatric patients nursing needs for 2 (Patient #2 and #3) of 2 pediatric patient records reviewed and failed to ensure the agency was able to meet the patient needs by providing home health aide (HHA) services as ordered in 1 of 5 active records (Patient #5), and 1 of 2 discharged records (Patient #6), in a sample of 7 total records Findings include: 1. Review of an undated agency policy titled "Admission Policy" C-120 indicated, " ... 4. There must be a reasonable expectation that the client's medical, nursing, social, or rehabilitation needs can be adequately met in the client's home. 5. Reasonable expectation shall consider: a. Whether the agency's personnel and resources are adequate and suitable for providing the services the client requires. ... 7. Agency services must be appropriate and available to meet the specific needs and requests of the client and caregiver.... " Review of an undated agency policy titled "Clinical Decision Making" C-115 indicated, "Policy: Agency will base decisions regarding acceptance or discharge of clients on identified client needs and the agency's ability to meet those		receiving providers to ensure a smooth transfer of service by ensuring appropriate, complete transfer information was communicated to the receiving entity at the time of transfer of service. All patients received a Discharge Assessment and Discharge Summary outlining their current course of illness, and treatments, medications, post-discharge goals of care, and treatment preferences. This information was provided to the patient (caregiver) and receiving entity to ensure the safe and effective transition of care. The Director of Clinical Services/designee will oversee employee schedules to ensure the needs of ALL current agency patients are met on a continuous basis. In addition, the Director of Clinical Services/designee will receive “Daily Update Reports” from the RN Case Manager staff that include crucial patient/staff information to ensure all patients receive the care they need. The required Daily Update Report addresses patient care concerns that have occurred in the most recent 24-hour period and include the following areas: · Hha/Nursing Scheduling Issues · Patients experiencing a hypo/hyper glycemic reaction, · Patient Non-Compliance	

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	needs ... Special Instructions: ... 2. Referrals to the agency will be accepted based on the identified client needs and the agency's ability to respond to those needs ...." 2. During a home visit on 11/10/20 at 1:30 p.m., Person K, family member of patient #2 was interviewed and indicated the patient has been with Visiting Angels since late 2019. Person K indicated he needed skilled nursing, especially at night due him not getting enough sleep due to the patient having seizures during the night. Person K stated the patient received skilled nursing waiver services 24 hours per week/ every other weekend. Person K stated he is on disability and Person K stated the patient has 1 to 2 "big seizures" at night. The father said he needs to run errands during the day and is not comfortable leaving the patient with a home health aide. Person K indicated he provided the patient's medications and nutrition throughout the day and evening. During this time, the aide was observed providing a bath to the patient and removed a wet dressing around the patient's g/tube (gastric tube inserted into the stomach to provide nutrition) and replaced it with a dry dressing. The patient was observed to be on oxygen at 1 liter per nasal cannula with a pulse oximeter (measures blood oxygen levels) taped to the left great toe. The patient received his medications through their gastric tube morning, noon, evening and bedtime as well as tube feeding in the morning, noon, evening and bedtime. The patient also needed frequent mouth care. The patient was totally dependent for positioning and wore a diaper for incontinence of bowel and bladder. Person K indicated Visiting Angels did not have any nursing to offer for extended times/ during the night.		concerns, · Patients experiencing a “change-in-condition”, · Patients placed on antibiotics, · Patients who have fallen, · Patients experiencing health and safety concerns, · Patients verbalizing or communicating a complaint/concern, · Patients who have been hospitalized, · Patients who were seen in the ED, · Patients with pain poorly controlled. To ensure the Agency demonstrates on-going compliance with G570 the Agency Intake Process will be monitored by the Administrator to ensure the agency has adequate staffing with the knowledge base to address the patient’s medical, nursing, social, and/or rehabilitation needs in the home setting. The Director of Clinical Services & Administrator are responsible for ensuring ongoing compliance with G570.	

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	Review of the patient #2's recertification comprehensive assessment dated 10/16/20, revealed that an Adult OASIS assessment was used versus a pediatric assessment. The supportive assistance questions only indicated the father, pain assessment indicated "seizure activity" when asked if there was a pattern to the pain, but failed to indicate all the pharmacological medications the patient was receiving nor how often breakthrough medication was needed; failed to include information regarding the disorders of the respiratory system and status; the abdomen section indicated "g tube" (gastrostomy tube) and the nutrition status indicated the patient is NPO (nothing by mouth) but failed to include any information regarding the name of the tube feeding, the amount given, flow rate (if any), brand of tube feeding, flushes, and who administered; the urinary elimination failed to include how many diapers/ briefs that was used throughout a 24 hour period; neurology indicated "epilepsy, history of a traumatic brain injury, history of seizures." The assessment failed to include any medication the patient received, and the Vagal nerve stimulator; the cognitive status indicated the patient "Requires considerably assistance to stay focused when attention needs to shift between activities" and is "non-responsive". The mental status indicated the patient was able to make eye contact and was nonverbal. The musculoskeletal indicated "abnormal curvature of spine, hypertonia, foot drop" and contractures to bilateral feet. Review of the patient #2's clinical record failed to evidence any documentation of the father's request for skilled nursing as well as identifying that the patient needed skilled nursing. 3. The clinical record of patient #3, start of care			

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	8/17/20, included a plan of care from a transferring agency which revealed the patient's diagnoses as Cerebral Palsy (2007), G/J tube placement (2015), Spastic Quadriplegia (2007), Dysphagia (2007), Seizure Disorder (2007), Chronic Respiratory Failure (2018), Obstructive Sleep Apnea (2018), and history of Pseudomonas pneumonia (2018). The medication list included but not limited to: Morphine Sulfate, Miralax, Epinephrine, Lorazepam, Diazepam 20 mg rectal gel, acetaminophen, flush g/J-tube (gastrojejunal tube) with 20 ml of water after medication administration and Complete Reduced Calorie tube feedings to be ran at 60 cc/hr (cubic centimeters per hour) 1320 ml / day (milliliters per day) via G/J tube. DME and supplies revealed a Mickey 14 Fr (french) feeding tube, enclosed safe bed, bilateral AFO (ankle-foot orthosis-brace/ boot), enteral feeding pump, nebulizer, and cough assist machine. The 60 day summary indicated the patient was on hospice with Entity C, and Entity M, Home services for attendant care services 60 to 75 hours per month. Review of the recertification assessment dated 10/14/20 revealed a diagnoses of Cerebral Palsy, G-tube, Spastic quadrapalgic [sic], Dysphasia, and Seizures. The assessment indicated the patient received enteral nutrition, indicated the primary caregivers were family members. The cognitive status indicated the patient was non-responsive and the psychosocial status indicated the patient was not able to communicate their needs. The integumentary (skin) status indicated the patient was a skin impairment risk due to immobility and nutritional "ailment" and the Respiratory assessment indicated the patient was receiving continuous oxygen at 4 liters per nasal cannula, has intermittent and had a productive cough. The respiratory status revealed it was reported that the			

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	patient was short of breath. The nutritional status revealed feeding tube. The neurological assessment indicated cerebral palsy, history of seizures, and was a quadriplegia. The musculoskeletal assessment indicated the patient has contractures to the bilateral upper and lower extremities. Review of plan of care for the certification period of 10/16/20 to 12/14/20, revealed only orders for home health aide services 8 hours/ day, 5 days per week for 40 hours a week for 60 days to provide total care, bathing, grooming, incontinence care, feedings (outside of the scope for a HHA), transfer, passive range of motion, repositioning, bed linen changes and housekeeping. The goals indicated as "Patient will maintain functional ability & have self-care needs met. DC [discharge] when high level of care needed. The agency failed to ensure the patient's plan of care was individualized and identified patient-specific measurable outcome and goals based off a complete comprehensive assessment that identified patient specific needs, including end of life goals in collaboration with hospice. During an interview with Person L, patient's #3's parent on 11/12/20 at 6:54 p.m., when asked what kind of tube feeding the patient was receiving, Person L stated the patient received 250 ml of Complete Pediatric 2 Reduce Calorie, 4 boxes = 1,000 ml at 60 ml/hr(hour) for 15 to 16 hours daily, starting late evening. Person L indicated the patient has a G/J- tube (received feedings through the g-tube and medications through the J-tube. Person L indicated they have a suction machine as the patient required frequent oral suctioning throughout the day and the patient has a percussion vest (inflatable vest that is attached to a machine that vibrates the chest to loosen and			

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	thin mucous) that was also done several times a day. Person L stated the patient has "violent grandmal" seizures and sees a neurologist. Person L indicated the patient cannot have anything by mouth. When asked if any medications were to be administered during Employee E's working hours of 10:00 a.m. to 6:00 p.m., Person L stated medications are given 5 to 6 times per day and all medications were given through the g-tube. Person L also indicated the home health aide also suctions the patient and utilized the percussion vest (not within the scope of a HHA). Person L stated he was told that there was a shortage of nurses and Visiting Angels did not have anyone as to why they were using Employee E, HHA. During an interview on 11/12/20 at 8:41 a.m., with Person N, RN Case Manager from hospice, stated the patient received medications throughout the day through the g-tube and she thought the Visiting Angels home health aide, Employee E, was giving those medications since she was the patient's family member. At 1:19 p.m., Person N called and stated she had spoken to Employee E, and confirmed with Employee E that she was clocking out with Visiting Angels to give the patient his medications, then would clock back in. During an interview with the Administrator and Director of Nursing on 11/12/20 at 1:45 p.m., both denied knowing that the home health aide was clocking out to give the patient his medications. The Administrator pulled up the computer program that shows when home health aide staff clocks in and out, and the computer program failed to evidence that the home health aide was clocking out to give the patient's medications. When queried if the agency is familiar with Indiana regulatory requirements and Family Social			

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	Services Administration (FSSA) under Medicaid Prior Authorization (PA) payment source, that agents of the agency are not permitted to provide services to family members, both stated they were not familiar or aware of the rules. Review of Employee E's personnel record, date of hire 6/1/20, failed to evidence any skills competency check off upon hire or transferred from previous owner. 4. The clinical record for patient #5, start of care 6/2/20, was reviewed and included a plan of care for the certification period of 10/1/20 to 11/29/20, with orders for home health aide services 8 hours a day, 5 days a week to assist with all ADLs, transfers, positioning, bathing, incontinence care, meal prep, linen changes, and light housekeeping. Review of an agency document titled "Home Health Aide Supervisory Visit" dated 10/29/20, revealed that there was no home health aide available for the visit and "noperinant [sic] staff available, poor communication." Review of the home health aide visit notes evidenced the following: One (1) partial visit from 1:30 p.m. to 4:00 p.m. during the week of 10/4/20, from 8:00 to 10:00 a.m. on 10/13/20, from 8:00 to 11:02 a.m. on 10/14/20, 12:00 to 4:00 p.m. on 10/16/20, 12:00 to 3:45 on 10/19/20, 8:00 to 9:30 a.m. on 10/21/20, 8:00 to 11:00 a.m. on 10/22 and 10/23/20, 8:00 to 11:30 a.m. on 10/26 and 11/6/20, 8:00 to 9:30 p.m. on 10/27, 10/28 and 11/2/20, 9:00 to 11:00 a.m. on 11/5/20, and only approximately 2 +/- (9:00-11:00 a.m.) hours during a home visit on 11/12/20. The clinical record failed to evidence that the physician responsible for the plan of care has been notified of the agency's inability to provide services as ordered.			

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	During a home visit on 11/12/20 from 9:30 to 11:30 a.m., Employee C, CNA, stated she was asked to pick up some hours with patient #5 and travels 1.5 hours one way to care for the patient. After she leaves patient #5, she moved on to the next patient. During an interview on 11/12/20 at 10:15 a.m., Person J, family member, stated the agency sometimes sends good home health aides and some bad ones. Person J stated they have not had a very good experience with Visiting Angels for it has been "up and down." Person J stated they really liked former employee because she would get patient #5 out of bed. Person J stated they are to have someone 8:00 a.m. to 4:00 p.m. 7 days a week. Person J stated although she liked the current aide, but is only at the home until 11:30 a.m. Person J stated they didn't have anyone from October 2019 to June 2020. Person J stated Visiting Angels would send people who did not know how to get patient #5 out of bed, wouldn't work, and even had one aide that was "fresh out of school" and the family had to teach her how to do things. Person J stated past home health aides would throw the patient's sheets away with the briefs and she was constantly having to buy new ones. Person J stated the patient hasn't been out of bed since last October, when they had the employee who was fired. Person J stated they haven't had an aide for 8 hours since the previous month and that was only for two days (10/29/20 and 10/30/20). Person J stated how her health was bad and that another family member who lives in the house is up all night with the patient, getting things for him, that they can not keep up with the patient during the day. During an interview on 11/12/20 at 1:45 p.m., when			

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	queried on why patient #5 was not receiving services as ordered, the Administrator stated "It's due to restrictions with staff. We've had discussions with them." The agency failed to ensure services were provided on the basis that the agency was able to meet the patient's needs. 5. The clinical record for patient #6, start of care 9/10/20, was reviewed and included a plan of care for the certification period of 9/10/20 to 11/8/20, with orders for home health aide services 4 times a day, 5 days a week to assist with activities of daily living, bathing, meal prep, safety, and light housekeeping. Review of the clinical record failed to evidence any home health aide visit notes. Review of the discharge assessment dated 10/21/20, stated "HHA [home health aide] services never initiated." The agency failed to ensure services were provided on the basis that the agency was able to meet the patient's needs. During an interview on 11/16/20 at 9:08 a.m., patient #6 stated the agency told her that they had a home health aide to come to her home when she was first admitted, but the aide backed out and she had to wait 3 weeks to get an aide and during this wait time, she had multiple falls. 6. During the entrance conference on 11/9/20 at 9:55 a.m., when queried if they had any services they have problems staffing, the Administrator stated home health aides were an issue and they have been utilizing the on-call staff and have to shorten or cancel visits due to lack of staffing. The Administrator indicated they would have			

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	staff set up to take on a patient upon admittance and then the potential employee would not show up for orientation. The Administrator stated they try to keep their on-call staff on stand-by but that falls through quite often. 7. During an interview with the DON and Administrator on 11/12/20 at 1:45 p.m., when asked about the agency's experience with pediatric patients and if the agency had a seizure protocol, both stated they were not aware of any employees, including themselves, who had any pediatric experience and the Administrator indicated the agency did not have a seizure protocol. When queried about not being able to provide services as ordered per the plan of care, the Administrator stated he does offer to help the patients transfer to other agencies but they always refuse. When queried if there was documentation supporting his conversations with patients/ family members, the Administrator stated he did not document those conversations and the outcomes. 8. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-13-1(a)			
G 0572 Bldg. 00	484.60(a)(1) Plan of care Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which			

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	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 refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Based on record review, and interview, the agency failed to ensure services were provided per the plan of care, failed to ensure each patient received an individualized care plan, frequencies specific to patient needs, and identified patient specific and measurable outcomes and goals for 5 (Patient #1, 2, 3, 4, 5) of 5 active patients and 1 (Patient #6) of 2 discharged records reviewed in a sample of 7. Findings included: 1. Review of an undated policy C-110 titled "Standards of Practice" evidenced "Client care will be provided under the Plan of Care established by a physician ... Agency staff will deliver services based on each client's unique and individual needs ... 2. Review of an undated policy C-560 titled Plan of Care evidenced "... The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members. Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure that the client needs are met ... Purpose: ... to develop a plan of care individualized to meet specific identified needs .... " 3. The clinical record of patient #1 was reviewed	G 0572	G572 The Agency will ensure all patients have an individualized care plan, with visit frequencies specific to meet the patient's need, and the agency will collaborate with each patient to identify patient specific measurable outcomes and goals. The Director of Clinical Services/designee will audit all clinical records to identify any additional agency patients whose care plan is not individualized with visit frequencies specific to their needs and/or is missing patient-specific measurable outcomes and goals. The RN Case Managers will be notified of the gaps/errors and corrections will be made. The Director of Clinical Services/designee will hold a training session with the RN Case Managers to re-educate the nurses to make sure all Plans of Care are individualized with visit frequencies specific to the patients' needs and include "patient-specific" measurable outcomes and goals.	02/16/2021

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	and contained a comprehensive assessment completed on 9/3/20, Patient #1 was homebound, lived alone, had impaired vision, a history of falls, daily anxiety, frequent signs of depression, and pain all the time at 3/10-10/10, affecting functional mobility, safety, and self-care ability. The patient utilized continuous oxygen at 3 liters (3L) via nasal cannula, reported shortness of breath with minimal exertion, had an open area documented as "excoriation, stage 2 pressure ulcer abdominal fold." Review of a document titled Home Health Certification and Plan of Care, start of care 9/3/20, for certification 9/3/20-11/2/20 (corrected to 11/1/20), revealed a primary and secondary diagnoses as COPD (Chronic Obstructive Pulmonary Disease) and CKD (Chronic Kidney Disease); orders for skilled nursing 1 hour weekly for medication set up, education, recertification, and supervisory visits; and home health aide (HHA) 8 hours (hrs)/ day, 5 days/ week (wk) to assist with activities of daily living, meal preparation, bathing, grooming, transfers, housekeeping, medication reminders, incontinence care. Locator 22, Goals/ Rehabilitation/ Potential Discharge Plans evidenced "Patient will maintain functional ability [and] have self care needs met. DC (Discharge) when higher level of care required." The Plan of Care failed to include individualized and measurable outcomes and goals specific to the patient's diagnoses, care needs, and reason for home care admission. Review of a comprehensive assessment 10/27/20 and 10/29/20, Patient #1 had diagnoses COPD and CKD, was homebound, had impaired vision, a history of falls, required supplemental oxygen at 3L, was short of breath with minimal exertion, was		The Director of Clinical Services/designee will audit 100% of all Medical Plans of Care on an on-going basis to ensure the visit frequencies are specific to the patients' needs and the Plan of Care includes "patient-specific" measurable outcomes and goals. The Director of Clinical Services is responsible for ensuring on-going compliance with G572.	

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	independent except for dressing lower body and bathing, was incontinent of urine, was high risk for falls and rehospitalizations, had weakness and fatigued easily. The patient's ability to correctly manage and take oral medications was not assessed. Review of the Plan of Care for the certification period of 11/2/20 - 12/31/20, listed primary and secondary diagnoses of COPD and Renal Failure; Locator 21 evidenced "HHa x 8 hours/ day x 5 days/ wk for 40 hours/ wk x 60 day. HHa to assist with Adls (Activities of daily living), meal prep, housekeeping, bathing, grooming, med reminders. Sn (skilled nurse) x 1 hour/wk for education, assessment [and] med setup." Locator 22, Goals/ Rehabilitation/ Discharge Plans evidenced "Patient will maintain functional ability [and] have self care needs met. DC [discharge] when higher level of care required." The plan of care repeated the identical goal and discharge plan found in the initial plan of care and failed to evidence any new or modified individualized and patient specific, objective, and measurable goals, failed to reflect accurate changes and updates obtained since the last assessment/care plan. Review of the aide care plan dated 9/3/20 revealed duties of bathing, hair care, skin care/ grooming, shave, and oral hygiene with an aide frequency of 8 hours a day 5 days a week. Review of the home health aide visit notes dated 9/14/20 to 9/18/20, 9/21/20 to 9/25/20, 9/28/20 to 10/2/20, 10/05/20 to 10/9/20, 10/12/20 to 10/16/20, 10/19/20 to 10/23/20, 10/26/20 to 10/30/20, and 11/2/20 to 11/6/20 failed to evidence any hands on personal care had been provided by the home health aide. Only companionship, meal prep and household duties were provided. The home			

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	health aide failed to ensure services were provided per the plan of care. During a home visit at patient #1's home on 11/10/20 at 9:25 AM, Employee B, CNA (certified nursing assistant) was interviewed. Employee B stated she was there to help the patient "because she has trouble doing stuff." Upon clarifying her statement, Employee B stated "I run errands mostly, do housekeeping, and make meals and I'm here when she gets into the shower." Employee B confirmed that the patient received dialysis Monday, Wednesday, and Friday. Employee B stated she sometimes picks up the patient's medications and drop them off to her. Employee B stated she does not assist the patient with any bathing. When queried if she performed any stand by assist when the patient gets in and out of the shower, the employee stated "No. I'm just here in case. She does everything alone." During an interview on 11/12/20 at 10:15 AM, Patient #1 stated she gets ready for dialysis at 4:30 AM, their aide, Employee B, meets her at Dialysis at 8:00 AM. The patient stated "She sits in her car until I leave at around 10 then meets me at home because she works an 8 hour day." When queried about aide duties and if the aide helps her with anything during dialysis, the patient responded "No. I said she just sits in the car but she works 8 hours so if she didn't come at 8 and stay in her car, she wouldn't get all her hours." The home health aide frequency and duration on the plan of care failed to be individualized and developed around the patient's dialysis schedule. During an interview on 11/12/20 at 1:45 PM, when queried if they were aware that the home health aide was sitting at dialysis center while the patient			

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	was receiving treatment, the Administrator and Director of Nursing stated "No." During an interview with the Person BB, Dialysis Manager with Entity B on 11/12/20 at 4:00 PM, prior to the COVID pandemic, they initially saw an aide in the lobby that waited 2 hours for the patient but never asked questions. Since COVID, no one is allowed to wait in the lobby. 4. The clinical record for Patient #4, start of care 6/25/20, contained a start of care comprehensive assessment dated 6/25/20, which revealed diagnoses of COPD and Memory Loss with COPD [with] emphysema. The patient had a history of polypharmacy, wore glasses, and had cataracts bilaterally, hard of hearing, had shortness of breath with minimal exertion, was incontinent of urine and bowel, required intermittent assistance, and was confused during the day and evening but not constantly. She reported anxiety daily but not constantly, demonstrated memory loss such that supervision was required. Patient #4's psychosocial status was not assessed, and her functional abilities and discharge goals assessments were incomplete or blank. Safety measures included O2 precautions, Fall precautions, 24-hour supervision, clear pathways, and walker/ cane. The goals section evidenced "free from falls and skin intact." The patient was a high fall risk, required assist with personal care, grooming, toileting reminders and hygiene, and general mobility. The patient required meal set-up only and evidenced no discharge goals on the assessment. Patient #4 was receiving services via a hospice provider who was also providing wound care. Patient #4 had a stage 2 pressure ulcer on her coccyx. Review of a record for Patient #4 evidenced a			

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	document titled Home Health Certification and Plan of Care, start of care 6/25/20 for certification period 6/25/20-8/24/20 (corrected to 8/23/20), revealed diagnoses of COPD with emphysema, memory loss, interstitial lung disease, orders for home health aide 10 hours/ day x 5 days/ week for 50 hours/ week x 60 days for activities of daily living, bathing, grooming, housekeeping, meal prep, bed linen changes, incontinence care, transfers, PROM (Passive Range of Motion), and medication reminders. A section titled Goals/ Rehabilitation Potential/ Discharge Plans evidenced "Patient will maintain functional mobility [and] have self care needs met. DC when higher level of care required. The Plan of care failed to include individualized and measurable outcomes and goals specific to the patient's diagnoses, care needs, with goals being collaborated with hospice to ensure the patient achieves quality of care and dignified death. Review of a recertification assessment certification period 8/24/20-10/22/20, revealed Patient #4 was receiving hospice services via another agency. The clinician assessed the patient to have moderate pain all of the time located in the back, coccyx, and bilateral lower extremities; a stage 2, unhealed pressure ulcer documented as "excoriation, stage 2 to coccyx, continuous oxygen at 6 liters per minute via nasal cannula; shortness of breath at rest; poor appetite; incontinence; intermittent confusion; and requiring assist or greater for activities of daily living and mobility. Patient #4's documented Limitations stated, " ... memory deficit, COPD, dyspnea, pain and weakness, and limited functional mobility." Multiple assessment sections were either blank or incomplete, including Care Preferences and Personal Goals.			

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	Review of a record for Patient #4 evidenced a document titled Home Health Certification and Plan of Care, start of care 6/25/20 for certification period 8/25/20-10/24/20, signed/not dated by Employee H, signed/not dated by the physician, no verbal start of care date, and no date received back signed. The Plan of Care evidenced orders for home health aide 10 hours/day x 5 days/week for 50 hours/week x 60 days for activities of daily living, bathing, grooming, housekeeping, meal prep, bed linen changes, incontinence care, transfers, PROM (Passive Range of Motion), medication reminders. A section titled Goals/ Rehabilitation Potential/ Discharge Plans evidenced "Patient will maintain functional mobility [and] have self care needs met. DC when higher level of care required. The Plan of care failed to include individualized and measurable outcomes and goals specific to the patient's diagnoses, care needs, with goals being collaborated with hospice to ensure the patient achieves quality of care and dignified death. A clinical record review of Patient #4 included a recertification comprehensive assessment dated 10/21/20 for certification period 10/23/20-12/21/20, revealed Patient #4 was receiving hospice services via another agency. The clinician assessed the patient to have moderate to severe pain all the time, located in the back bilateral lower extremities, and coccyx, with breakthrough pain more than 3 times per day; a stage 2 pressure ulcer; shortness of breath when at rest; poor appetite, small frequent meals offered and meal replacement drinks; confusion; and assist or greater with personal care and mobility, set up or clean up assistance for sit to lie, sit to stand, and chair/ bed/ toilet transfer. Documentation under Care Preferences stated, "Agreed their personal goal was realistic based on the patient's health			

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	status." Multiple assessment categories were incomplete or blank, including Care Preferences/ Personal Goals, and Risk Factors. Review of a document titled Home Health Certification and Plan Care for certification period 10/23/20-12/21/20, revealed orders for home health aide 8 hours/day x 5 days/week for 40 hours/week x 60 days for all activities of daily living (ADLs), Instrumental activities of daily living (IADLs), meal prep, bathing, grooming, bed linen changes, incontinence care, PROM, medication reminders. A section titled Goals/ Rehabilitation Potential/ Discharge Plans evidenced "Patient will maintain functional ability [and] have self care needs met. DC when higher level of care required. The Plan of care failed to include individualized and measurable outcomes and goals specific to the patient's diagnoses, care needs, with goals being collaborated with hospice to ensure the patient achieves quality of care and dignified death. 5. The clinical record of patient #2, SOC 8/19/2020, was reviewed and contained an OASIS recertification assessment dated 10/16/20. The pain assessment revealed the patient was unable to communicate but would show signs of pain through grimacing, moaning, crying, and be tense. The pattern to the pain was described as "seizure activity." The integumentary status revealed the patient was incontinent of bowel and bladder, requires repositioning, and has boney prominences. The respiratory assessment revealed the patient received albuterol-sulfate per nebulizer as needed. The abdomen assessment revealed the patient has a g/tube (gastric tube inserted into the stomach where nutrition is provided). The nutritional assessment revealed the patient was NPO (nothing by mouth). The neurological assessment revealed the patient has epilepsy and has seizures daily. The			

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	psychosocial assessment revealed the patient's needs were anticipated by Person K and the home health aide. The musculoskeletal assessment revealed the patient has an abnormal curvature of the spine, hypertonia, and foot drop to their bilateral feet. The functional abilities and goals section to self-care indicated the patient was dependent on eating, oral hygiene, toileting hygiene, rolling left/ right, sit to lying, lying to sitting on side of bed (the patient has no truck control), sit to stand (the patient is unable to bear weight), chair/ bed to chair transfer, and indicated the patient uses a wheelchair. The patient's limitations indicated no purposeful movements and completely dependent. The care preferences and goals section was left blank. Review of plan of care for the certification period of 10/18/20 to 12/16/20, revealed orders for home health aide services 8 hours/ day, 5 days per week for 40 hours a week for 60 days to "assist" with ADLs, bathing, transfers, safety, incontinence care, companionship and light housekeeping. The goals indicated "Remain safe in home, skin C/D/I [clean/dry/intact], free from falls/ injury. DC [discharge] when high level of care needed." The agency failed to ensure the patient's plan of care was individualized and identified patient-specific measurable outcome and goals based off a complete comprehensive assessment that identified patient specific needs. 6. The clinical record of patient #3, SOC 8/17/20, was reviewed and contained a start of care comprehensive assessment dated 8/17/20. The assessment revealed patient diagnosis, but not limited to dysphagia and seizures, patient was totally dependent on care, nothing by mouth, received enteral feedings, was on continuous oxygen, and incontinent of bowel and bladder.			

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	The sections for patient's limitations failed to evidence any information and were mostly left blank. The care preferences/ patient's personal goals section were mostly left blank and only indicated "Agreed their personal goal(s) was realistic based on the patient's health status" but failed evidence what those personal goals for the patient were. Review of plan of care for the certification period of 8/17/20 to 10/15/20, revealed orders for home health aide services 8 hours/ day, 5 days per week for 40 hours a week for 60 days to "assist" with ADLs, bathing, grooming, incontinence care, bed linen changes and passive range of motion. The goals indicated as "Patient will have self-care needs met. DC [discharge] when high level of care needed. The agency failed to ensure the patient's plan of care was individualized and identified patient-specific measurable outcome and goals based off a complete comprehensive assessment that identified patient specific needs. Review of an agency document titled "Case Note" dated 10/8/20, indicated Visiting Angels was in contact with Entity C, a hospice agency, for collaboration of services. Review of an OASIS recertification assessment, dated 10/14/2020. The assessment revealed patient diagnosis, but not limited to dysphagia and seizures, the patient received enteral nutrition, the respiratory assessment indicated the patient was receiving continuous oxygen at 4 liters per nasal cannula, has intermittent treatments, had a productive cough, the respiratory status revealed it was reported that the patient is short of breath at rest, incontinent of bowel and bladder. The musculoskeletal assessment indicated the patient has contractures to the bilateral upper and lower			

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	extremities, and was a fall risk, totally dependent. The care preferences was left blank and only indicated "Agreed their personal goal(s) was realistic based on the patient's health status" and failed to include those personal goals for the patient. Review of plan of care for the certification period of 10/16/20 to 12/14/20, revealed orders for home health aide services 8 hours/ day, 5 days per week for 40 hours a week for 60 days to provide total care, bathing, grooming, incontinence care, feedings, transfer, passive range of motion, repositioning, bed linen changes and housekeeping. The goals indicated as "Patient will maintain functional ability & have self-care needs met. DC [discharge] when high level of care needed. The agency failed to ensure the patient's plan of care was individualized and identified patient-specific measurable outcome and goals based off a complete comprehensive assessment that identified patient specific needs, including end of life goals in collaboration with hospice. 7. The clinical record of patient #5, SOC 6/3/20, was reviewed and contained start of care comprehensive assessment dated 6/3/20. The patient diagnoses include Multiple Sclerosis, Diabetes Mellitus Type 2, Paraplegia, and Major Depressive Disorder. The Care Preferences/ Patient's Personal Goal, Strengths/ Limitations section were all completely blank. Review of an agency document dated 6/2/20, titled "Patient Short Term Goals include the following:" revealed "Patient's/ Client's pain level will be controlled at 4 or less on a scale of 1-10. Patient/ Client will demonstrate compliance with medication regimen AEB [as evidenced by] the			

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	patient/ client taking the medications as directed by the physician. Patient/ Client will remain compliant with the use of adaptive equipment. Reviewed of the plan of care for the certification period of 6/3/20 to 12/2/20 [sic], with an order for "HHA x 8 hrs/ day x 5 days / wk for a total of 40 hrs/ week ... to assist with all ADLs, transfers, positioning, bathing, incontinence care, meal prep, linen changes, and light housekeeping. The goals and Rehabilitation/ Potential/ Discharge Plans indicated "Remain safe in home. DC when higher level of care required." The agency failed to ensure the patient's plan of care was individualized and identified patient-specific measurable outcome and goals based off a complete comprehensive assessment that identified patient specific needs. Review of the OASIS recertification comprehensive assessment dated 8/3/20, revealed a patient diagnoses of Multiple Sclerosis, Diabetes Mellitus Type 2, Paraplegia, and Major Depressive Disorder. Was receiving wound care and suprapubic catheter changes from another home health agency, the Goal, Strengths/ Limitations section, when asked what the patient's strengths were, the writing was illegible and remaining questions were blank. The Care Preferences/ Patient's Personal Goals section indicated "Agreed their personal goal(s) was realistic based on the patient's health status" and the remaining assessment questions were blank. Review of the plan of care for the certification period of 08/03/20 to 10/2/20, with an order for "HHA x 8 hours/ day x 5 days / wk for a total of 40 hrs/ week ... to assist with all adls, transfers, positioning, bathing, incontinence care, meal prep, linen changes, and light housekeeping. The goals			

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	and rehabilitation/ Potential/ Discharge Plans indicated "Patient will preserve and maintain optimal function with minimal complications. DC when higher level of care required." The agency failed to ensure the patient's plan of care was individualized and identified patient-specific measurable outcome and goals based off a complete comprehensive assessment that identified patient specific needs. Review of the OASIS recertification comprehensive assessment dated 10/1/20, the Goal, Strengths/ Limitations section, the patient's strengths indicate "involved in care" but the remaining questions were blank. The Care Preferences/ Patient's Personal Goals section indicated "Agreed to and identified actions/ interventions the patient is willing to safely implement, so the patient will be able to meet their goals by the anticipated discharge date" and the remaining assessment questions were blank. Review of the plan of care for the certification period of 10/1/20 to 11/29/20, with an order for "HHA x 8 hours/ day x 5 days / wk ... HHA to assist with all adls, transfers, positioning, bathing, incontinence care, meal prep, linen changes, and light housekeeping. The goals and rehabilitation/ Potential/ Discharge Plans indicated "Patient will maintain functional ability and have self-care needs met. DC when higher level of care required." The agency failed to ensure the patient's plan of care was individualized and identified patient-specific measurable outcome and goals based off a complete comprehensive assessment that identified patient specific needs. Review of an agency document titled "Home Health Aide Supervisory Visit" dated 10/29/20, revealed that there was no home health aide			

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	available for the visit and "noperinant [sic] staff available, poor communication." Review of the home health aide visit notes evidenced the following: One (1) partial visit from 1:30 p.m. to 4:00 p.m. during the week of 10/4/20, from 8:00 to 10:00 a.m. on 10/13/20, from 8:00 to 11:02 a.m. on 10/14/20, 12:00 to 4:00 p.m. on 10/16/20, 12:00 to 3:45 on 10/19/20, 8:00 to 9:30 a.m. on 10/21/20, 8:00 to 11:00 a.m. on 10/22 and 10/23/20, 8:00 to 11:30 a.m. on 10/26 and 11/6/20, 8:00 to 9:30 p.m. on 10/27, 10/28 and 11/2/20, 9:00 to 11:00 a.m. on 11/5/20, and only approximately 2 +/- (9:00-11:00 a.m.) hours during a home visit on 11/12/20. The clinical record failed to evidence that the physician responsible for the plan of care has been notified of the agency's inability to provide services as ordered. During a home visit on 11/12/20 from 9:30 to 11:30 a.m., Employee C, CNA, stated she was asked to pick up some hours with patient #5 and travels 1.5 hours one way to care for the patient. After she leaves patient#5, she moves on to the next patient. During an interview on 11/12/20 at 10:15 a.m., Person J, family member, stated the agency sometimes sends good home health aides and some bad ones. Person J stated they have not had a very good experience with Visiting Angels for it has been "up and down." Person J stated they really liked former employee because she would get patient #5 out of bed. Person J stated they are to have someone 8:00 a.m. to 4:00 p.m. 7 days a week. Person J stated although she liked the current aide, but is only at the home until 11:30 a.m. Person J stated they didn't have anyone from October 2019 to June 2020. Person J stated Visiting Angels would send people who did not			

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	know how to get patient #5 out of bed, wouldn't work, and even had one aide that was "fresh out of school" and the family had to teach her how to do things. Person J stated past home health aides would throw the patient's sheets away with the briefs and she was constantly having to buy new ones. Person J stated the patient hasn't been out of bed since last October, when they had the employee who was fired. Person J stated they haven't had an aide for 8 hours since the previous month and that was only for two days (10/29/20 and 10/30/20). Person J stated how her health was bad and that another family member who lives in the house is up all night with the patient, getting things for him, that they can not keep up with the patient during the day. 8. The clinical record for patient #6, start of care 9/10/20, was reviewed and included a start of care comprehensive assessment dated 9/10/20 in which page 23-24 of 29, under the Care Preferences/ Patient's Personal Goals asked if the patient communicated any specific personal goal(s) the patient would like to achieve from the home health admission, to which the option to select no or yes was not marked. " ... Patient ... Agreed their personal goal(s) was realistic based on the patient's health status .... " The document failed to evidence what specifically was the patient's personal goals. Review of a progress note from Entity P dated 3/18/20, which indicated the patient "has to war [sic] diapers because she does not know when feces is coming," chronic back pain, anxiety, and had spine surgery in October, 2018. Review of an agency document titled "Case Conference/ Coordination of Care dated 9/10/20, which indicated "Goals set for identified concerns:			

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	No falls, skin c/d/i [clean/ dry/ intact], nutrition." Review of an agency summary note dated 9/10/20, indicated the patient reported recent falls with no injury, reports pain 10/10 (on a scale of 1 to 10 with 10 being the worse pain), shortness of breath with moderate exertion, and wears a brief due to incontinence of bladder, and experiences high level of anxiety. Review of an agency document titled "Physician Notification" dated 9/10/20, indicated the patient has a history of falls, increased anxiety, needs adaptive device for ambulation, gait/ balance/ coordination issues, incontinence urgency, medications affecting blood pressure and level of consciousness, skin exposure to moisture, limited degree of physical activity, level of nutritional intake, limited ability to cook, shop, and feed self. Review of an agency document titled "Visiting Angels Home Health Agency" indicated "Patient Short Term Goals include the following: Patient/ Client to remain safe in his/ her home AEB [as evidenced by] no falls ... Patient/ Client will demonstrate compliance with medication regimen AEB the patient/ client taking the medications as directed by the physician ... Patient/ Client will remain compliant with the use of adaptive equipment ... " Other options of short term goal not indicated were "Patient/ Client will demonstrate safety transfer techniques AEB no falls" and "Patient/ Client will experience no areas of skin breakdown r/t incontinence episodes." Review of the plan of care for the certification period of 9/10/20 to 11/8/20, with orders for home health aide services 4 times a day, 5 days a week to assist with activities of daily living, bathing, meal prep, safety, and light housekeeping. The			

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	goals indicated "Remain safe in home, free from falls or injury, DC when high level of care needed." The agency failed to ensure the patient's plan of care was individualized and identified patient-specific measurable outcome and goals. Review of the clinical record failed to evidence any home health aide visit notes during the 9/10/20 to 11/28/20 certification period. Review of the discharge assessment dated 10/21/20, stated "HHA [home health aide] services never initiated." The agency failed to ensure services were provided per the plan of care. 9. During an interview with the Director of Nursing (DON) and Administrator on 11/12/20 at 1:45 p.m., when queried about the plan of care being individualized to the patient and goals being measurable, both indicated they did not know goals were to be measurable on the plan of care. 10. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-13-1(a)			
G 0574 Bldg. 00	484.60(a)(2)(i-xvi) Plan of care must include the following The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and			

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	cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. Based on observation, record review and interview, the agency failed to ensure the individualized plan of care included all pertinent diagnoses and their onset date, all supplies and equipment, specific frequency and duration of visits, nutritional requirements, all accurate medications, treatments, all safety measures, infection control precautions, a description of the patient's risk for emergency department visits and hospital readmission, services being provided by outside agencies/ facilities, all necessary interventions to address the underlying risk factors and the specific education and training to be provided, and patient specific education to be	G 0574	**G574** The current Medical Plans of Care for patients 1, 2, 3, 4, & 5 have been corrected to contain the following items: all pertinent diagnoses, the patient's mental, psychosocial, and cognitive status, the types of services, supplies, and equipment required, the frequency and duration of visits to be made, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, all	02/16/2021

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	provided by the SN and the SN frequency and duration, measurable outcomes and goals identified by the home health agency and patient, and orders may be received/ accepted by outside physicians for 5 (Patient 1, 2, 3, 4, 5) of 5 active records, in a sample of 7. Findings include: 1. During a home visit at patient #2's home on 11/10/20 at 1:30 p.m., Person K stated he manages the patient's medications (given by the g-tube) and tube feedings. Person K indicated the patient was put on oxygen approximately 1.5 weeks ago and is on it at all times at 1 liter per nasal cannula. Person K provided the patient's bottles of medications g-tube medications and reviewed what was written on the plan of care for the certification period of 10/18/20 to 12/16/20. The bottles provided include, but not limited to: Cuvposa (used to reduce excessive drooling caused by medical conditions) 0.4 mg (milligrams), (2 ml - [milliliters]), give 1 mg/ 5 ml by mouth three times a day was started on 10/1/20; Epidiolex (cannabidiol medication to help treat seizures) 1.2 ml three times a day by g-tube; Diazepam (used to treat anxiety, muscle spasms, and seizures) 5 mg/ ml bottle, give 0.6 ml three times a day by g-tube; Trazodone (antidepressant medication that can also be used for anxiety and sleep) 5 mg/ ml, give 2.5 ml daily at bedtime; Gabapentin (anticonvulsant and nerve pain medication) 250 mg/ 5 mls, give 3 ml three times a day by g-tube; and Baclofen (used to treat muscle spasms) 10 mg/ ml, give 10 ml three times a day per g-tube. The father stated the patient was taken off Levetiracetam last year, started on Cuvposa filled on October 1, 2020; been on Baclofen since May, 2020, and was recently started on Gabapentin in October, 2020. Person K also indicated the patient		medications, and treatments, safety measures to protect against injury, a description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors, patient and caregiver education and training to facilitate timely discharge, patient-specific interventions, and education; measurable outcomes and goals identified by the HHA and the patient, information related to any advanced directives, and any additional items the HHA or MD may choose to include. The Clinical Manager has conducted a 100% review of all active clinical records to audit the Medical Plans of Care for correct content. All identified gaps will be corrected with physicians' verbal orders. To ensure on-going compliance the Clinical Manager/designee will continue to audit all Medical Plans of Care for accurate content. Any gaps or errors will be identified and returned to the RN Case Manager for correction. To stress the importance of this process the Agency has instituted a 3-step disciplinary process for the RN Case Managers as it relates to the accurate completion of the Medical Plan of Care. All RN Case Managers will be educated on the consequences of not completing the Medical Plan of	

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	receives 24 hours/ week of nursing services through a waiver with Entity A. Review of the Medication Profile last updated on 10/16/20, indicated the following, but not limited to: Levetracetam [sic] 100 mg/ ml sol (solution), give 4.0 ml twice a day, Trazodone 25 mg/ 5 ml, give 2.5 ml at bedtime, Diazepam 5 mg/ 5 ml, Give 0.3 ml three times a day, Diazepam suppositories 10 mg per rectum as needed, and Epidolex [sic] 100 mg/ ml, give 1.2 ml by mouth three times daily. Review of the plan of care for the certification period of 10/18/20 to 12/16/20, indicated the following, but not limited to: Diagnoses of Refractory Epilepsy and Hypertonia without an onset date; Nutritional Requirements indicated "Gtube" [tube inserted through the belly that brings nutrition directly to the stomach]; Medication list indicated Levetracetam [sic] 100 mg/ ml, take 4 ml twice a day per g-tube; Trazodone 25 mg/ 5 ml suspension, give 2.5 ml (illegible frequency) g-tube; Diazepam 5 mg/ 5 ml oral solution, take 0.2 ml three times a day; Diazepam 10 mg suppositories as needed for seizures > 10 min, max 1/ 24 hr (1 suppository in a 24 hour period) or 2/7 days (2 suppositories in a 7 day period); and Epidolex [sic] 100 mg/ 1 ml oral solution, take 1.0 ml three times a day by mouth. The interventions indicated for the home health aide to provide 8 hours / day 5 days a week to "assist" with ADLs, bathing, transfers, safety, incontinence care, companionship, and light housekeeping. The goals indicated "Remain safe in home, skin C/D/I [clean/ dry/ intact], free from falls/ injury. DC [discharge] when higher level of care needed. Review of a "Face to Face" document that was signed by the patient's physician on 11/2/20,		Care in accordance with G574. · Failure to complete the Medical Plan of Care in compliance with G574 will result in re-education of the employee and an entry in their personnel file documenting their non-compliance with a written warning that ongoing non-compliance will result in further consequences. · Failure to complete the Medical Plan of Care in compliance with G574 a 2nd time will result in further re-education of the employee and the employee being placed on a 30-day action plan. · If there is a 3rd occurrence of non-compliance with the completion of Medical Plan of Care the employee's employment with Visiting Angels Home Health Agency will be terminated. The Clinical Manager is responsible for ensuring on-going compliance with G574.	

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	revealed the patient's medical condition as "Hypoxic ischemic encephalopathy (type of brain dysfunction that occurs when the brain doesn't receive enough oxygen or blood flow for a period of time), refractory epilepsy, autonomic dysfunction (A dysfunction of the nerves that regulate non-voluntary body functions, such as heart rate, blood pressure, and sweating), has G-tube and Vagal Nerve Stimulator (A stimulator device that is implanted under the skin in the chest to prevent seizures by sending regular, mild pulses of electrical energy to the brain)" The plan of care failed to be individualized, to include the accurate frequency of services (ex. 8 hours a day 5 days a week for 8 weeks then 8 hours a day for 3 days for 1 week) include all pertinent diagnoses and their onset date; name of g-tube feedings; the amount and frequencies of feedings and flushes; the medication list on the plan of care failed to be consistent with what the patient's father provided/ reviewed, including routes; failed to be consistent with the medication profile; failed to contain accurate spelling of medications; failed to include who was managing the patient's medications, tube feedings, and g/tube dressings; goals failed to include interventions and goals for seizure activity. The plan of care failed to evidence that the patient was receiving skilled nursing services through a waiver program with Entity A and a description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors. During an interview with Employee A, RN on 11/10/20 at 11:30 a.m., when asked about the patient's tube feeding, the employee indicated the information "must be on admission and not			

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	recertification," the family was managing the bolus tube feeding and the father administered the medication. 2. The clinical record for patient #3 (pediatric patient), SOC 8/17/20, was reviewed and contained an agency document titled "Medication Profile" signed by the RN on 10/14/20, which contained a list of the following medications: Albuterol Sulfate every 4 to 6 hours as needed for "resp" [respiratory]; Qvar (corticosteroid used for chronic asthma) 80 mcg/ 2 puffs twice a day for "resp"; Mucinex (expectorant) 100 mg/ 15 ml per g-tube twice a day for "mucous"; Vimpat (anticonvulsant) 10 mg/ ml, give 15 ml per g-tube twice a day for seizures; Levitracetam [sic] 100 mg/ ml, give 5 ml per g-tube twice a day for seizures; Diazepam 5 mg/ 5 ml, give 5 ml per g-tube three times a day for seizures; Nexium (anti-ulcer drug) 20 mg packet per g-tube twice a day for gerd's (gastroesophageal reflux disease); Montelukast (anti-asthmatic) 5 mg tab per g-tube daily for allergies; Flonase (Corticosteroid used as a preventative maintenance of chronic asthma in patients requiring oral corticosteroid and use for allergic and non-allergic rhinitis) 50 mcg (micrograms), 1 spray daily for allergies; Azelastine (Antihistamine) 0.1 % 137 mcg 1 spray daily for allergies; sulcralfate [sic] (anti-ulcer-gastrointestinal protectant drug) 1 gm (gram)/10 ml, 10 ml per g-tube every 8 hours for gerd's; and Oxygen via nasal cannula at 4 liters per minute continuously. This document revealed forward slashes with the drug regimen review questions but failed to include a date of when the review was completed in the date box. The questions indicated "No" when asked if there were potential adverse effects, significant drug interactions, duplicate/ ineffective drug therapy, and potential contraindications been identified.			

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	Review of an agency document titled "Personal Emergency Plan" dated 8/17/20, indicated the alternate physician was Entity C, a hospice agency. Review of an agency document titled "Case Note" dated 10/8/20 and 10/21/20, indicated Visiting Angels attempted to contact Entity M to coordinate client's care." Review of an agency document titled "Case Note" dated 10/8/20, indicated Visiting Angels was in contact with Entity C, a hospice agency, for collaboration of services. On 11/13/20, Person E from Entity C, provided their agency's current medication list which contained the following medications that differed from Visiting Angels Medication list: Acetaminophen 160 mg/ 5 ml 505 mg per g-tube every 4 hours for fever or mild pain; Albuterol Sulfate every 4 hours for bronchospasms/ shortness of breath, then "**Parents are only giving prn [as needed]"; Azelastine HCL 0.1 % Nasal 2 time a day, 2 sprays each nostril once a day for chronic rhinitis; Ibuprofen Children's 100 mg/ 5 ml, give 340 mg per g-tube every 6 hours as needed for fever or mild pain; Montelukast Sodium 5 mg, give 1 tablet per g-tube at bedtime for asthma; MiraLax 8.5 gm per g-tube as needed for constipation (mix in 8 ounces of water or juices give twice daily as needed); Morphine sulfate 10 mg/ 5 ml, give 6.6 mg per g-tube every 4 hours as needed for pain or shortness of breath; lorazepam 1 mg/ ml oral concentration, give 3 mg per g-tube as needed for uncontrolled seizure activity, may repeat 15 min if seizure persist; Oxygen 1 to 4 liters continuously for asthma, restrictive airway, shortness of breath, Beclomethasone Diprop HFA			

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	80 mcg/ Act, administrator 2 puffs twice a day for shortness of breath; and Carafate 1 gm/ 10 ml, give 1 gm every 8 hours as needed for gastric bleed. Patient #2 has been a patient of Entity C since 11/2/18. This document was not found or part of patient #3's clinical record with Visiting Angels. Patient #2 has been a patient of Entity C since 11/2/18. This document was not found or part of patient #3's clinical record with Visiting Angels. Review of an agency document titled "Case Conference/ Coordination of Care" dated 10/14/20, revealed the patient g-tube feedings and medications were managed by the family, fall risk concerns was immobility and fall prevention plan was safe transfer techniques, transfer/ ambulation/ mobility concerns include "immobile" and mobility plan indicated "use of assistive devices, safe transfer technique" and patient goals include "continue current goals." Review of the plan of care for the certification period of 10/16/20 to 12/14/20, indicated the following, but not limited to: Diagnoses of Cerebral Palsy; Spastic quadriplegic; Dysphagia; and Seizure disorder within an onset date. Medication list indicated Albuterol Sulfate every 4 to 6 hours as needed; Qvar 80 mcg/ 2 puffs twice a day; Mucinex (expectorant) 100 mg/ 15 ml per g-tube twice a day; Vimpat (anticonvulsant) 10 mg/ ml, give 15 ml per g-tube twice a day; Levitracetam [sic] 100 mg/ ml, give 5 ml per g-tube 9A & 6P; Diazepam 5 mg/ 5 ml, give 5 ml per g-tube three times a day; Nexium 20 mg packet twice a day; sulcralfate [sic] 1 gm /10 ml daily; Flonase 50 mcg daily; and Oxygen via nasal cannula at 4 liters per minute continuously. The interventions indicated for the home health aide 8 hours / day 5 days a week to provide total care			

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	bathing, grooming, incontinence care, "feedings", transfers, passive range of motion, repositioning, bed linen changes, and housekeeping. During an interview on 11/12/20 at 6:54 p.m. with Person L, the family member of patient #3, when asked what kind of tube feeding the patient was receiving, Person L stated the patient received 250 ml of Complete Pediatric 2 Reduce Calorie, 4 boxes = 1,000 ml at 60 ml/hr for 15 to 16 hours daily, starting late evening. Person L indicated the patient has a G/J- tube (gastric and jejunum and receives feedings through the g-tube and medications through the J-tube. Person L indicated they have a suction machine where the patient requires frequent oral suctioning throughout the day and the patient has a percussion vest (inflatable vest that is attached to a machine that vibrates the chest to loosen and thin mucous) that is also done several times a day. Person L stated the patient has "violent grand mal" seizures (a type of seizure that involves a loss of consciousness and violent muscle contractions that is usually caused by epilepsy, very low blood sugar, high fever, or a stroke) and sees a neurologist. Person L indicated the patient could not have anything by mouth. Person L indicated the patient received a shower via shower chair with 2 hospice aides once a week due to the patient having to be secured in the bath chair due to no trunk support and can easily fall out of shower chair if not put in just right and the patient's head has to be dried very well due to his severe microcephaly (A condition in which a baby's head is significantly smaller than expected, often due to abnormal brain development) or the patient will develop dry crusty areas and will bleed. Person L stated the Visiting Angels aide would prepare the patient's bed while he receives a shower and will receive a bed bath all other days			

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	by Visiting Angels aide. The plan of care failed to be individualized, to include the accurate frequency of services (ex. 1- 8 hours a day for 1 week, then 8 hours per day for 5 days a week for 8 weeks then 1-8 hour a day for 1 week) include all pertinent diagnoses and their onset date; name of g-tube feedings; the amount and frequencies of feedings and flushes; the medication list on the plan of care failed to be consistent with what the patient's father provided/ reviewed, including routes; failed to include the medications listed by the Entity C, failed to include Montelukast (anti-asthmatic) 5 mg tab per g-tube daily and Azelastine 0.1 % 137 mcg 1 spray daily; be consistent with the medication profile; failed to include routes of medications to be given, failed to contain accurate spelling of medications; failed to include who was managing the patient's medications, tube feedings, and g-tube dressings; failed to include interventions and goals for fall, seizure activity, oxygen, skin impairment prevention and aspiration prevention; failed to evidence that the patient was receiving skilled nursing and home health aide services through a Entity C and waiver services from Entity M; failed to include all pertinent information that was provided by Person L, including other physicians managing the patient's care, and the hospice services the patient was receiving and a description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors. 3. During an interview with the Director of Nursing (DON) and Administrator on 11/12/20 at 1:45 p.m., when asked about the agency's experience with pediatric patients and if the agency had a seizure protocol, both could not			

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	confirm that any employees, including themselves, had any pediatric experience. When asked about what their seizure protocol was for patient #2 and #3, the Administrator stated the agency did not have one. 4. The clinical record of patient #5 (start of care 6/3/20) was reviewed and contained a physician visit note dated 5/20/20, which revealed the patient was had a drug allergy to Tetanus Toxoid. Review of an agency document titled "Medication Profile" dated 10/1/20, in which the profile listed the following medications: Savella (Antidepressant and to treat nerve pain) 100 mg daily; Baclofen 20 mg, 1 tab three times a day and 20 mg, 2 tabs at bedtime; Xarelto (long acting blood thinner) 20 mg, 1 tab daily; folic acid (supplement) 1 mg daily; Buproprion [sic] HCL XL (antidepressant used for smoking cessation and to treat a variety of mental disorders) 150 mg, 1 every morning; Nystatin 1000,000 U/gm (units per gram) topical, four times a day but failed to evidence the specific affected area to treat; Escitalopram (antidepressant) 10 mg, 1 tab daily; Carvedilol (treat high blood pressure) 3.125 mg, 1 tab twice a day; Miralax 17 gm, 1 dose daily as needed; Atorvastatin (treat high cholesterol) 40 mg, 1 tab daily at bedtime; Vitamin B12 ER (supplement) 10000 mcg daily; Valium 2 mg, 1 tab twice a day; Omeprazole 20 mg, 1 capsule daily; Gabapentin 600 mg; 1 capsule four times daily; and Milnacipran (generic name for Savella) 100 mg, 1 tab daily. Review of an agency document titled "Case Note" dated 10/1/20, indicated the patient has a diagnoses of Multiple Sclerosis, Paraplegia, Major Depressive Disorder, Chronic Pain Syndrome, Polyneuropathy and Diabetes Mellitus type 2.			

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	The note went on to say " ... hoyer used for transfers, hosp [hospital] bed with trapeze bar to asst [assist] with positioning utilized, parapalegic [sic] with contractures to ble, foot drop to LLE with +2 pitting edema. Wound to (R) inner ankle scabbed over with no current tx in place. (L) hip excoriated, no open areas noted at this time. Cream applied daily by CNA. Chronic pain managed with medication regimen. Meds managed by patient & [and] CNA. Patient reports "no longer a diabetic" suprapubic cath ... changed monthly per [name of Entity R] ... area dry, with slight redness/ odor. Cream applied to outer area per CNA daily. The Goal, Strengths/ Limitations section, the patient's strengths indicate "involved in care" but the remaining questions were blank. The Care Preferences/ Patient's Personal Goals section indicated "Agreed to and identified actions/ interventions the patient is willing to safely implement, so the patient will be able to meet their goals by the anticipated discharge date" and the remaining assessment questions were blank. Review of the OASIS recertification comprehensive assessment dated 10/1/20, revealed diagnoses of Multiple sclerosis, Diabetes Melitis Type 2, Paraplegia, and Major Depressive Disorder, failed to include the symptom control rating for each diagnosis, pain assessment, integumentary status, diabetic foot exam, wound assessments, systems review, abdomen, endocrine/ hematology, food/ environmental allergies, nutritional assessment, eliminiation status, neurological assessment, cognitive status, psychoscial status, musculoskeletal asssessment, fall risk assessment, medication allergies, medications, risk factors/ hospital admission/ emergency, supervisory visit, recertification summary, summary checklist, and current durable			

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	medical equipment and supplies. The assessment revealed the patient had an unhealed pressure ulcer/ injury at Stage 2 or higher, that was partial granualating. The wound care comments indicated the patient had a scabbed area to the right inner foot, open areas of MRSA to the abdomen, open to air, and cream applied daily. The integumentary wound assessment section indicated measurements of 2.5 x 2 cm, 2 x 1.5 cm, .5 x .5 cm, and 2 x 1.5 cm, but failed to indicate the location of these wounds, the appearance of the wounds, and treatment if any. Review of the plan of care for the certification period of 10/1/20 to 11/29/20, revealed diagnoses Multiple sclerosis, Diabetes Melitis Type 2, Paraplegia, and Major Depressive Disorder without an onset date, the medication list indicated Savella (Antidepressant and to treat nerve pain) 100 mg daily; Baclofen 20 mg, 1 tab three times a day and 20 mg, 2 tabs at bedtime; Xarelto (long acting blood thinner) 20 mg, 1 tab daily; folic acid (supplement) 1 mg daily; Bupropion [sic] HCL XL (antidepressant used for smoking cessation and to treat a variety of mental disorders) 150 mg, 1 every morning; Nystatin 1000,000 U/gm (units per gram) topical, four times a day but failed to evidence the specific affected area to treat; Escitalopram (antidepressant) 10 mg, 1 tab daily; Carvedilol (treat high blood pressure) 3.125 mg, 1 tab twice a day; Miralax 17 gm, 1 dose daily as needed; Atorvastatin (treat high cholesterol) 40 mg, 1 tab daily at bedtime; Vitamin B12 ER (supplement) 10000 mcg daily; Valium 2 mg, 1 tab twice a day; Omeprazole 20 mg, 1 capsule daily; Gabapentin 600 mg; 1 capsule four times daily; and Milnacipran (generic name for Savella) 100 mg, 1 tab daily. The order for discipline and treatment indicated "HHA x 8 hours/ day x 5 days / wk ... HHA to assist with all			

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	adls, transfers, positioning, bathing, incontinence care, meal prep, linen changes, and light housekeeping. The goals and rehabilitation/ Potential/ Discharge Plans indicated "Patient will maintain functional ability and have self-care needs met. DC when higher level of care required." The plan of care goals failed to be individualized and the goals/ discharge plans failed to be supported by the comprehensive assessment, failed to include an accurate frequency of services (ex. 8 hours a day for 2 days for 1 week, then 8 hours per day for 5 days a week for 8 weeks), failed to include infection control precautions due to the patient having MRSA in the chest wound, failed to evidence the nutritional requirements, allergies, and skin precautions, and a description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors. During an interview on 11/13/20 at 2:10 p.m. with Person Q, the Alternate Director of Nursing (DON) from Entity C, the patient's medications was reviewed and the following medications differ between Entity C and Visiting Angels: Savella, Baclofen 20 mg (2 tabs at bedtime), Bupropion HcL XL, Nystatin, Carvedilol, Vit B12 ER, Valium, and Omeprazole. These medications were not on Entity C's medication list. The following medications were on Entity C's medication list that were not on Visiting Angels medication list: Lexapro (antidepressant and antianxiety), Senna (stool softener) as needed, Benadryl (antihistamine), Tylenol (pain/ fever), Colace (stool softener), Vitamin D 3 (supplement), and Catheter irrigations with Sterile water. Person Q stated they have had the patient on service since March 2020 for monthly catheter changes and wound care. Person Q stated the patient was			

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	recently recertified on 11/5/20 and all wounds are healed but skin is fragile. The plan of care failed to evidence and be consistent with the medications listed from Entity C, failed to evidence any documentation that Entity D was the Medicare agency providing supra pubic catheter and wound care, and direction on supra pubic and wound care issues/ concerns; the durable medication equipment failed to include wound dressings and catheter supplies used. 5. The clinical record for patient #1, SOC 9/3/20, contained a comprehensive assessment completed on 9/3/20, in which the assessment indicated Patient #1 was homebound, lived alone, had impaired vision, a history of falls, daily anxiety, frequent signs of depression, and pain all the time at 3/10-10/10, affecting functional mobility, safety, and self-care ability. The patient utilized continuous oxygen at 3L via nasal cannula, reported shortness of breath with minimal exertion, had an open area documented as "excoriation, stage 2 pressure ulcer abdominal fold." Review of a document titled "Home Health Certification and Plan of Care," start of care date 9/3/20, for certification period 9/3/20-11/2/20 (corrected to 9/3/20-11/1/20). The plan of care was signed by Employee H, no verbal start of care date, and was signed and dated by the physician, signature illegible, on 9/8/20. The plan of care evidenced primary and secondary diagnoses as COPD (Chronic Obstructive Pulmonary Disease) and CKD (Chronic Kidney Disease), respectively, with no onset dates; DME/Medical Supplies evidenced "walker, O2" (oxygen); Locator 15-Safety Measures and Locator 17-Allergies were unanswered. Locator 21- Orders for Discipline and Treatment evidenced an opening sentence that stated, Locator 21 evidenced "Skilled nursing 1			

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	hour weekly for med (medication) set up, education, recertification, and supervisory visits" and "home health aide 8 hours/ day x 5 days/ week. The plan of care failed to include a complete, accurate, and legible list of current medications including medication name, dose, route, and frequency; failed to include all pertinent diagnoses/ comorbidities with onset dates; failed to include all DME/ medical supplies including shower chair, glucometer/ strips/ lancets/ sharps container, nasal cannula/ oxygen concentrator/ portable oxygen tanks; failed to include complete mental status including anxiety/ depression; frequency and duration failed to be specific to the certification period and excluding time while the patient is at the dialysis center (ex: 1-8 hours day and 1-4 day x 1 week, 2 - 8 hour days on non dialysis days and 3 - 4 hour days on dialysis days x 8 weeks OR 4 hour days 3 days per week on dialysis days and 2- 8 hour days per week on non-dialysis days); failed to include specific procedures and treatments including wound care; failed to include diagnostic tests including A1c, blood sugar and dialysis reports; failed to include surgical procedure(s) including care/ placement of dialysis access; failed to include rehabilitation potential and need for therapy based on functional limitations, endurance, and history of falls; failed to include accurate functional limitations including dialysis and impaired vision; failed to include safety measures including fall and diabetic precautions, use of oxygen, universal and infection control precautions; failed to document allergy status; failed to include accurate homebound affirmation; failed to list all activities/ restrictions; failed to list appropriate dietary/ nutritional requirements related to pertinent diagnoses, including supplements, calorie/fluid/salt restriction; failed to address dialysis needs including scheduling and			

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	transportation; failed to include other agencies involved in care, including dialysis clinic; and failed to include names of all physicians active in patient's care. Locator 22, Goals/ Rehabilitation/ Potential Discharge Plans evidenced "Patient will maintain functional ability [and] have self care needs met. DC (Discharge) when higher level of care required." The plan of care failed to evidence all required elements, failed to be individualized and patient specific, objective, and measurable goals based on Patient #1's comprehensive assessment. Review of a document titled Physician Order for Start-of-Care (#1), signed, undated/untimed by Employee H, signed by the physician, name illegible, untimed, dated 9/8/20 evidenced the following: Verbal Order: Agency to have Registered Nurse perform assessment and evaluation of the client for admission to home health services. Services requested ...: SN x 1 hour weekly for med set up, recerts (recertification), Hha, SV (supervisory visits), education. HHA x 8 hours/day x 5 days/wk. The Registered Nurse will perform a full systems assessment inclusive of vital signs and O2 saturation levels ... Additional Physician Orders/Skilled Services to Perform/Instruct include the following: Assess for environmental ...; Instruct on safety ...; Instruct on Fall Prevention ...; Instruct on Hi-risk [sic. high risk] medications. In addition, the Registered Nurse will contact the physician following the assessment ... with a summary of findings and receive detailed physician orders ...." The agency failed to ensure the tasks/services/assessment orders were incorporated into the plan of care. Review of a recertification comprehensive assessment 10/29/20, Patient #1 had diagnoses			

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	COPD and CKD, was homebound, had impaired vision, a history of falls, no open areas, required supplemental oxygen at 3L, was short of breath with minimal exertion, was independent except for dressing lower body and bathing, had no anxiety, was incontinent of urine, was high risk for falls and rehospitalizations, had weakness and fatigued easily, had a therapy need of "NA", had the previous care plan reviewed, had medications reconciled, and utilized a bath bench, grab bars, nebulizer, and oxygen concentrator. The patient's ability to correctly manage and take oral medications was not assessed. Review of a record for Patient #1 evidenced a Home Health Certification and Plan of Care, start of care 9/3/20, for certification 11/2/20-12/31/20, no verbal start of care date, signed/ not dated by Employee H, and signed/not dated by the physician. (signature illegible) Date received back was blank. The Plan of Care listed primary and secondary diagnoses of COPD and Renal Failure respectively, contrary to previous assessment, no onset dates. DME/Medical Supplies evidenced "Walker, O2 supplies". Safety Measures evidenced "fall, O2." Functional limitations evidenced incontinence, endurance, ambulation, and dyspnea with minimal exertion. Activities Permitted evidenced "Up as tolerated, walker." Mental Status evidenced "Oriented" and Prognosis evidenced "Fair." Locator 21 evidenced "HHa (sic. hha-home health aide) x 8 hours/ day x 5 days/ wk for 40 hours/ wk x 60 day. HHa to assist with Adls, meal prep, housekeeping, bathing, grooming, med reminders. Sn (skilled nurse) x 1 hour/wk for education, assessment [and] med setup." Locator 22 Goals/Rehabilitation/Discharge Plans evidenced "Patient will maintain functional ability [and] have self care needs met. DC when higher level of care			

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	required." The plan of care failed to include a complete, accurate, and legible list of current medications including medication name, dose, route, and frequency; failed to include all pertinent diagnoses/comorbidities with onset dates; failed to include all DME/ medical supplies including grab bars, glucometer/ strips/ lancets/ sharps container, nasal cannula/ oxygen concentrator/ portable oxygen tanks, incontinence pads; failed to include accurate/ specific type, frequency, and duration of all visits/services; failed to include diagnostic tests including A1c, blood sugar, oxygen saturation, and dialysis reports; failed to address dialysis needs; failed to include surgical procedure(s) care/ including placement/ removal of dialysis access; failed to include rehabilitation potential and need for therapy based on functional limitations, endurance, and history of falls; failed to include accurate functional limitations including dialysis and impaired vision; failed to include safety measures including fall and diabetic precautions, use of oxygen, universal and infection control precautions; failed to include accurate homebound affirmation; failed to list all activities/ restrictions; failed to list appropriate dietary/ nutritional requirements related to pertinent diagnoses, including supplements, calorie/fluid/salt restriction; failed to include other agencies/ groups providing care including dialysis clinic; and failed to include names of all physicians active in patient's care. Locator 22, Goals/ Rehabilitation/ Potential Discharge Plans evidenced "Patient will maintain functional ability [and] have self care needs met. DC (Discharge) when higher level of care required." The plan of care repeated the identical goal and discharge plan found in the initial plan of care and failed to evidence any new or modified individualized and patient specific, objective, and measurable goals			

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	based on Patient #1's comprehensive assessment and current physical, psychosocial, emotional, and healthcare needs. The care plan failed to reflect accurate changes and updates obtained since the last assessment/care plan and failed to incorporate orders obtained since the last comprehensive assessment/care plan. Review of a document titled "Recertification Physician Order", signed by Employee H, dated 10/29/20, indicated the physician, patient/ caregiver, and nurse have collaborated in the development of the plan of care to continue home health care services and include the stated services, frequencies, and duration of services. The "Verbal Order" section indicated a Discipline, Frequency, and Duration Hha x 8 hours/day x 5 days/wk and SN (skilled nursing) x 1 hour weekly. Nursing/ Home Health Aide Main Tasks: Hha to assist [with] adls, meal prep, housekeeping, bed linen changes, trash removal, med reminders, bathing, and grooming. SN for education, assessment, and med setup. Treatments: [blank]. Goals: Maintain functional ability [and] have self care needs met. The agency failed to incorporate the orders into the plan of care, and failed to ensure the plan of care was current and updated. On 11/10/20 at 9:30 AM, during an interview on a home visit, Patient #1 stated receives dialysis 3 times /week on Monday, Wednesday, and Friday. She stated the transportation bus arrives around 5:30 AM so she is required to get up by 4:30 AM and complete bathing, personal care, dressing, and breakfast independently.			

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	When queried as to why the aide doesn't come to help her the patient stated, "There's no staff for 4:30 in the morning. But my aide meets me at dialysis at 8:00 AM and sits in the parking lot until I leave around 10:00 AM so that she can get all her hours." The plan of care failed to reflect the patient's dialysis informationOn 11/12/20 at 1:45 p.m., when queried about goals being measurable, the Administrator and DON indicated they did not know goals were to be measurable on the plan of care. When queried how they obtain their diagnoses, the DON stated the case managers obtain their diagnosis codes online and the history and physical from the physician. The Administrator stated the nurses only document diagnoses that the patient is receiving services for. On 11/12/20 at 4:00 PM, an interview with person CC, Dialysis Manager from Entity B, was conducted. Person CC stated Person DD, dialysis physician, writes orders for patient #1. The plan of care failed to include that orders may be received by the dialysis physician.6. The clinical record for Patient #4, contained a start of care comprehensive assessment dated 6/25/20, evidenced Patient #4 had diagnoses listed of COPD and Memory Loss with COPD [with] emphysema documented under Primary Reason for Home Health Admission. Pertinent			

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	history/previous outcomes was blank. The patient had a history of polypharmacy, wore glasses, and had cataracts bilaterally, however M1200 Vision was blank, and no documentation was provided concerning cataract surgery. Patient was hard of hearing, was not assessed for communication deficits, denied pain, had shortness of breath with minimal exertion, was incontinent of urine and bowel, required intermittent assistance, and was confused during the day and evening but not constantly. She reported anxiety daily but not constantly, showed no signs of depression, but demonstrated memory loss such that supervision was required. Patient #4's psychosocial status was not assessed, and her functional abilities and discharge goals assessments were incomplete or blank. Her stated strengths/limitations included "involved family." Safety measures included O2 precautions, Fall precautions, 24-hour supervision, clear pathways, and walker/ cane. She had no grab bars and the assessment evidenced the patient needed grab bars. The goals section evidenced "free from falls and skin intact." Prior to the current illness Patient #4 used a manual wheelchair and a walker. The patient was a high fall risk, required assist with personal care, grooming, toileting reminders and hygiene, and general mobility. The patient			

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	required meal set-up only and evidenced no discharge goals on the assessment. Patient #4 was receiving services via a hospice provider who was also providing wound care. Under Care Coordination, "Collaboration of the care plan with ..." was blank. The assessment evidenced the primary and secondary codes were identified, as well as all pertinent secondary diagnoses. Patient #4 had a stage 2 pressure ulcer on her coccyx with documentation that stated, "Coccyx dressing, dressing changed daily, cutimet sorbact; DME included walker, shower chair, toilet riser, O2, and patient had a nutritional requirement of reg (regular). Review of a document titled Home Health Certification and Plan of Care, start of care 6/25/20 for certification period 6/25/20-8/23/20, signed/ not dated by Employee H, signed by the physician and dated/ not timed 6/25/20, no verbal start of care date, and no date received back signed, revealed the diagnoses of COPD with emphysema, memory loss, interstitial lung disease. Mental Status evidenced "forgetful" and functional limitations evidenced incontinence, hearing, ambulation, endurance, and dyspnea with minimal exertion. The Plan of Care evidenced orders for home health aide 10 hours/ day x 5 days/ week for 50 hours/ week x 60 days for activities of daily living, bathing, grooming,			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	housekeeping, meal prep, bed linen changes, incontinence care, transfers, PROM (Passive Range of Motion), medication reminders. A section titled Goals/ Rehabilitation Potential/ Discharge Plans evidenced "Patient will maintain functional mobility [and] have self care needs met. DC when higher level of care required. The Plan of Care failed to have an accurate and complete medication list, including all medication names, dosages, routes, and frequencies. The Plan of care failed to include individualized and measurable outcomes and goals specific to the patient's diagnoses, care needs, and reason for home care admission.Review of the clinical record for Patient #4 evidenced a recertification comprehensive assessment dated 8/24/20 for certification 8/24/20-10/22/20 with diagnoses listed as COPD with Emphysema, Intersistial [sic. interstitial] lung disease, and memory loss. The comprehensive assessments failed to evidence the patient received a complete and accurate assessment including the primary reason for home health admission, previous surgeries, emergency contact information, prior hospitalizations, all pertinent secondary diagnoses and onset date, risk for hospitalizations, Advance Directives, caregiver information and availability, living arrangements/supportive assistance,			

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	self-care status, communication, pain, endocrine/hematology, integumentary, diabetic foot care/ assessment, cardiopulmonary, respiratory, nutritional, elimination, height/ weight, neurological/emotional, psychosocial/ end of life, functional abilities/ limitations, hospice related information, DME (durable medical equipment), musculoskeletal, patient stated goals, fall risk, activities/ instrumental activities of daily living, mobility, patient specific discharge goals and interventions, medication reconciliation and management including ability to set up and take medications properly, medication allergies, care preferences, fall and safety plans, emergency preparedness, therapy needs, education/knowledge of patient and caregivers, rehabilitation potential, and care coordination, other agencies involved in care, setbacks/improvements since last assessment, progress toward previous goals, discharge plans, and modification of interventions from previous assessments.Review of a document titled Home Health Certification and Plan of Care for certification period 8/25/20-10/24/20 [sic], signed/not dated by Employee H, signed/ not dated by the physician, no verbal start of care date, and no date received back signed. The Plan of Care evidenced orders for home health aide 10 hours/ day x			

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	5 days/week for 50 hours/ week x 60 days for activities of daily living, bathing, grooming, housekeeping, meal prep, bed linen changes, incontinence care, transfers, PROM (Passive Range of Motion), medication reminders. A section titled Goals/ Rehabilitation Potential/ Discharge Plans evidenced "Patient will maintain functional mobility [and] have self care needs met. DC when higher level of care required. The Plan of care failed to include individualized and measurable outcomes and goals specific to the patient's diagnoses, care needs, and reason for home care admission.Review of the clinical record for Patient #4 evidenced a recertification comprehensive assessment dated 10/21/20, for certification period 10/23/20-12/21/20 with diagnoses listed as COPD, Intersistial [sic. interstitial] lung disease, and memory loss. The comprehensive assessments failed to evidence the patient received a complete and accurate assessment including the primary reason for home health admission, previous surgeries, emergency contact information, prior hospitalizations, all pertinent secondary diagnoses and onset date, risk for hospitalizations, Advance Directives, caregiver information and availability, living arrangements/ supportive assistance, self-care status, communication, pain, endocrine/hematology, integumentary,			

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	diabetic foot care/ assessment, cardiopulmonary, respiratory, nutritional, elimination, height/ weight, neurological/ emotional, psychosocial/ end of life, functional abilities/l imitations, hospice related information, DME (durable medical equipment), musculoskeletal, patient stated goals, fall risk, activities/instrumental activities of daily living, mobility, patient specific discharge goals and interventions, medication reconciliation and management including ability to set up and take medications properly, medication allergies, care preferences, fall and safety plans, emergency preparedness, therapy needs, education/knowledge of patient and caregivers, rehabilitation potential, and care coordination, other agencies involved in care, setbacks/ improvements since last assessment, progress toward previous goals, discharge plans, and modification of interventions from previous assessments.Review of a record for Patient #4 evidenced a document titled Home Health Certification and Plan Care, start of care 6/25/20 for certification period 10/23/20-12/21/20 [sic], no verbal start of care date, signed/not dated by Employee H, signed/dated 10/30/20 by the physician, date received by back signed not completed. The Plan of Care evidenced orders for home health aide 8 hours/day x 5			

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	days/week for 40 hours/week x 60 days for all activities of daily living, Instrumental activities of daily living, meal prep, bathing, grooming, bed linen changes, incontinence care, PROM, medication reminders. A section titled Goals/ Rehabilitation Potential/ Discharge Plans evidenced "Patient will maintain functional ability [and] have self care needs met. DC when higher level of care required. The Plan of care failed to include individualized and measurable outcomes and goals specific to the patient's diagnoses, care needs, the hospice agency involved in the patient's care, the comfort medications prescribed, and collaborated goals with the hospice agency.7. During an interview with the Director of Nursing (DON) and Administrator on 11/12/20 at 1:45 p.m., when queried about the plan of care being individualized, supported by the comprehensive assessment, and patient goals being measurable, and including outside agency information within the plan of care, both indicated they did not know goals were to be measurable on the plan of care nor did they know outside agencies needed to be included on the plan of care and verbalizing understanding that the plan of care needed to be supported by a complete comprehensive assessment. 8. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical			

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	Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.17-13-1(a)(1)(C)17-13-1(a)(1)(D)(ii)17-13-1(a)(1)(D)(iii)17-13-1(a)(1)(D)(viii)17-13-1(a)(1)(D)(ix)17-13-1(a)(1)(D)(x)			
G 0580 Bldg. 00	484.60(b)(1) Only as ordered by a physician Drugs, services, and treatments are administered only as ordered by a physician. Based on record review and interview, the agency failed to ensure the plan of care was created in conjunction with the primary care physician after an assessment, verbal start of care and recertification orders obtained from the physician for 4 (Patient #1, 2, 3, 5) of 5 active records reviewed in a sample of 7. Findings include: 1. Review of clinical record #2, SOC 8/19/20, contained start of care and recertification physician orders. Review of the 8/19/20 start of care orders indicated skilled nursing for start of care, recertification, supervisory and prn (as needed) changes of condition. The home health aide orders indicated 8 hours a day 5 days a week. This order failed to indicate specifically what services the home health aide was to provide. Review of the 10/16/20 and untimed recertification comprehensive assessment indicated a verbal order was received for HHA 8 hours a day 5 days a week, but failed to indicate (left blank) the name of physician who was contacted.	G 0580	**G580** All patient care is directed by physician orders. The Clinical Manager will audit 100% of all current active clinical records to audit for missing physician orders. All current clinical records evidencing missing physician orders will be corrected. The Clinical Manager has educated the RN Case Managers and Visit Nurses in the following: · All “home health care services” (medications, treatments, home health aide visits, nurse visits,) require physician orders prior to initiating the service. · The Agency has a packet of “Physician Verbal Order” forms to address the various time points and circumstances when it is necessary to obtain new/modified physician orders: o Start of Care, o Recertification of Care,	02/16/2021

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	Review of an agency document titled "Recertification Physician Order" dated 10/16/20, indicated "[Name of Physician] has been notified of the assessment findings on 10/16/20 at [no time indicated] .... HHA [home health aide] x 8 hours / day x 5 days / week ... HHA to assist with ADLs [activities of daily living such as bathing and hygiene], bathing, transfers, safety, incont [incontinent] care, companionship and light housekeeping ... Goals: Remain safe in home." This fax was sent on 10/21/2020 and returned signed on 11/3/20. 2. Review of clinical record #3, SOC 8/17/20, contained an agency document titled "Physician order for Start of Care [#1]" dated 8/17/20, indicated " ... Verbal Order: Agency to have Registered Nurse perform assessment and evaluation of the client for admission to home health services. Services requested by referral source include the following: SN recertifications, education, supervisory visits. HHA x 8 hours/ day x 5 days/ week .... " The order failed to include specifically the duties/ services the home health aide was to provide. The SN orders failed to include specifically what the SN was to educate and to whom. The physician signed this order on 8/20/20 but at the top left corner of the document indicated a fax date of 9/1/2020 at 11:55 a.m. Review of the plan of care for the certification period of 8/17/20 to 10/15/20, locator 23 included the name of the nurse but no date of when the verbal start of care was received. The physician signed this order on 8/20/20 but at the top left corner of the document indicated a fax date of 9/1/2020 at 11:55 a.m. The SN provided hands on services on 8/17/20 and the home health aide provided services on 8/17/20, 8/18/20, and 8/19/20 before the order was signed on 8/20/20 and		o Transfer to a higher level of care, o Resumption of Care Assessment, o Resumption of Care Follow Up Orders, o Blank Physician Orders to address any change in treatment, visit frequency, services, medications, etc., that occurs during the 60-day certification period. · All verbal order forms require the RN to document their name, the date/time they obtained the physician order, and whom they spoke with at the physician office. · The nurses are to call the physician/physician office immediately following the completion of the home certification assessment visit. The nurse is to provide a verbal report of the assessment findings and collaborate with the physician on the development of the POC. · Following this verbal report to the MD the RN writes the POC including all required elements, and at the bottom of Locator #21 includes a written Clinical Summary which summarizes the assessment findings, the discussion with the MD including patient services, visit frequencies, tasks to be performed throughout the certification period, goals of care, continuing need for care, etc.	

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	provided services on 8/20/20, 8/21/20, 8/24 to 8/28, and 8/31 before receiving the signed faxed order on 9/1/20. Review of an agency document titled "Recertification Physician Order" dated 10/14/20, indicated "[Name of Physician] has been notified of the assessment findings on 10/16/20 at 11A ... Verbal order: Discipline Frequency and duration: HHA x 8 hours/ day x 5 days/ wk. Nursing/ Home health aide main tasks: HHA to provide total care, repositioning, transfers, feedings, bathing, grooming, PROM [passive range of motion] ... Goals: Maintain functional ability & have self-care needs met. The order was signed by the physician and faxed back to the agency on 10/26/20. Review of the plan of care for the certification period of 10/16/20 to 12/14/20, locator 23 included the name of the nurse but failed to evidence a date of when the verbal order was received. The HHA services to be provided indicated "total care, bathing, grooming, incontinence care, feedings, transfer, PROM, repositioning, bed linen changes, housekeeping." Goals indicated "Patient will maintain functional ability & have self-care needs met. DC when higher level of care required." The plan of care was faxed back to the agency on 10/29/20 but failed to evidence a signature by the physician. The plan of care home health aide duties failed to be consistent with the Recertification Physicians Order and the home health aide had provided these additional services on 10/16, 10/19 to 10/23, 10/26 to 10/30. 3. Review of clinical record #5, SOC 6/3/20, contained an agency document titled "Physician order for Start of Care" dated 6/3/20, indicated " ... Verbal Order: Agency to have Agency to have		· The RN is to sign his/her signature with the time and date in Locator #23 of the POC. · The POC is sent to the physician for authentication. · The nurse and Hha make home visits to the patient as ordered by the MD throughout the certification period. · The nurse must immediately notify the MD whenever the patient experiences a change-in-condition, fall, etc. and receive physician orders to direct any changes in care, services, or medications the physician orders. To ensure on-going compliance the Clinical Manager/designee will audit 100% of all certification assessments, physician orders, Skilled Nursing Visit documentation, home health aide care plans, and home health aide visit documentation to ensure patient care is being provided as ordered by the MD. The goal is a 90% compliance threshold. Once the agency achieves a 90% compliance threshold the number of charts audited will decrease to 50% to be performed on an on-going basis. All RN Case Managers will be educated on the consequences of failing to obtain or follow physician orders for the provision of patient care in accordance with G580. · Failure to obtain and/or follow physician orders in	

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	Registered Nurse perform assessment and evaluation of the client for admission to home health services. Services requested by referral source include the following: SN admission, recert assessment, education and prn COC [change of condition]" and "HHA x8 hrs/ day x 5 days/ week." Additional orders include for the SN to assess for environmental, sanitation, and personal safety hazards, Instruct on safety measures identified, instruct on fall prevention, and instruct on Hi-Risk Medications. The order also states "In addition the Registered Nurse will contact the physician following the assessment and evaluation with a summary of findings and receive detailed physician orders to provide care." The order was signed by the Employee A on 6/3/20, untimed and signed by the physician on 6/11/20. The order failed to include the specific duties/ tasks that the home health aide would be providing. Review of the plan of care for the certification period of 6/3/20 to 12/2/20 [sic], locator 23 included the name of the admitting nurse and a 6/3/20 date of when the verbal order was received. Review of the start of care comprehensive assessment dated 6/3/20, on page 27 of 29 failed to evidence that any coordination had been conducted with the ordering physician. On page 29 of 29, the Physician order section failed to evidence if the physician was notified after the assessment and if orders were received. Review of the recertification comprehensive assessment dated 8/3/20, on page 21 of 21, the Physician order section was blank and failed to evidence if the physician was notified after the assessment for continuing orders. The physician electronically signed the page on 8/4/20.		compliance with G580 will result in re-education of the employee and an entry in their personnel file documenting their non-compliance with a written warning that ongoing non-compliance will result in further consequences. · Failure to complete, obtain, and/or follow physician orders in compliance with G580 a 2nd time will result in further re-education of the employee and the employee being placed on a 30-day action plan. · If there is a 3rd occurrence of non-compliance with obtaining and/or following physician orders the employee's employment with Visiting Angels Home Health Agency will be terminated. The Clinical Manager is responsible for ensuring on-going compliance with G580.	

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	Review of the recertification comprehensive assessment dated 10/1/20, on page 20 of 21, revealed the recertifying nurse indicated she coordinated with the certifying physician but failed to include a date and time, and on page 21 of 21, the Physician order section was blank and failed to evidence who the physician was when coordinated/ notified after the assessment for continuing orders. The plan of care for the certification period of 10/1/20 to 11/29/20, failed to evidence a physician signature approving the plan of care orders. Review of the home health aide visit notes evidenced the home health aide provided visits on 10/8/20, from 8:00 to 10:00 a.m. on 10/13/20, from 8:00 to 11:02 a.m. on 10/14/20, 12:00 to 4:00 p.m. on 10/16/20, 12:00 to 3:45 on 10/19/20, 8:00 to 9:30 a.m. on 10/21/20, 8:00 to 11:00 a.m. on 10/22 and 10/23/20, 8:00 to 11:30 a.m. on 10/26 and 11/6/20, 8:00 to 9:30 p.m. on 10/27, 10/28 and 11/2/20, 8:00 a.m. to 4:00 p.m. on 10/29 and 10/30/20, 9:00 to 11:00 a.m. on 11/5/20, and only approximately 2 +/- (9:00-11:00 a.m.) hours during a home visit on 11/12/20. 4. Review of clinical record patient #1, SOC is 9/3/20, contained a physician order dated 9/2/20, which revealed "verbal order: OK to do admission process." The order failed to include a physician signature and a time of when the order was received. Review an agency document titled "Physician order for Start of Care" dated 9/3/20, indicated " ... Verbal Order: Agency to have Agency to have Registered Nurse perform assessment and evaluation of the client for admission to home health services. Services requested by referral source include the following: SN admission,			

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	recert assessment, education and prn COC [change of condition]" and "HHA x8 hrs/ day x 5 days/ week." Additional orders include for the SN to assess for environmental, sanitation, and personal safety hazards, Instruct on safety measures identified, instruct on fall prevention, and instruct on Hi-Risk Medications. The order also states "In addition the Registered Nurse will contact the physician following the assessment and evaluation with a summary of findings and receive detailed physician orders to provide care." The order was signed by the former Employee T, but failed to include a date and time of when the order was received. The order failed to include the specific duties/ tasks that the home health aide would be providing. Review of the plan of care for the certification period of 9/3/20 to 11/2/20 [sic], locator 23 included the name of the admitting nurse but failed to include the date of when the verbal order was received. Review of the start of care comprehensive assessment dated 9/3/20, on pages 27 & 28 of 29 failed to evidence that any coordination had been conducted with the ordering physician. On page 29 of 29, the Physician order section failed to evidence if the physician was notified after the assessment and if orders were received. Review of the recertification comprehensive assessment dated 10/29/20, on page 20 of 21, coordination section and "verbal order obtained" was left blank, and page 21 of 21, the Physician order section was blank. 5. During an interview with the Administrator and Director of Nursing on 11/10/20 at 10:45 a.m., when asked how the agency obtain orders for			

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	start of care and recertification, the Director of Nursing stated that they would get orders first, to go out to do the assessment, and then send the plan of care to the physician for signature. 6. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-13-1(a)			
G 0584 Bldg. 00	484.60(b)(3)(4) Verbal orders (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician in accordance with applicable state laws and regulations, as well as the HHA's internal policies. Based on record review and interview, the agency failed to ensure verbal orders were complete and contained duties/ services that the home health aides were to provide and the specific education the nurses were to educate to whom, and date and time of when orders when verbal orders were	G 0584	**G584** The Agency will ensure the following processes and documentation is implemented to address the concerns identified in G584:	02/16/2021

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	received for 3 (Patient #2, 3, and 5) of 5 active records reviewed in a sample of 7. Findings include: 1. Review of the clinical record #2, SOC 8/19/20, revealed 4 physician orders that were incomplete. Review of the 8/19/20 physician order to "complete the admission assessment on 8/19/20" failed to include a time of when the order was received by the agency's nurse. Review of the 8/19/20 start of care orders indicated skilled nursing for start of care, recertification, supervisory and prn (as needed) changes of condition. The home health aide orders indicated 8 hours a day 5 days a week. This order failed to include a time of when the order was received by the agency's nurse. Review of the 09/30/20 clarification order, this order failed to include a time of when the order was received by the agency's nurse. Review of the 10/16/20 recertification orders indicated "[Name of Physician] has been notified of the assessment findings on 10/16/20 at [no time indicated] .... HHA [home health aide] x 8 hours / day x 5 days / week ... HHA to assist with ADLs [activities of daily living such as bathing and hygiene], bathing, transfers, safety, incont [incontinent] care, companionship and light housekeeping ... Goals: Remain safe in home." This fax was sent on 10/21/2020 and returned signed on 11/3/20. This order failed to include a time of when the order was received by the agency's nurse. 2. Review of clinical record #3, SOC 8/17/20, contained start of care and recertification orders.		· Verbal orders will be complete and list the disciplines furnishing care, their duties, services, and the frequency of ordered services. · When skilled nurse education is ordered; the physician order will specify the type of education and who the skilled nurse is to educate; i.e., patient, family, caregiver, or representative. · All verbal orders will include the date and time the MD order was obtained. · All admission orders will contain what the agency is admitting the patient for. · Home Health Aide orders will include all tasks the aide is to perform at each visit and the visit frequency and duration. The Clinical Manager/designee will audit 100% of the verbal orders of current patients to identify all additional potential missing content of patient physician orders. All identified incomplete or incorrect physician orders will be rewritten with the correct information and re-submitted to the physician for his/her signature. The Clinical Manager will hold a training session for the RN Case Managers and Visit Nurses to re-educate them on the above process to ensure all physician verbal orders are complete, accurate, and include the signature, date, & time of the	

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	Review of an agency document titled "Physician order" dated 8/17/20 indicated/ handwritten "OK to do admission process." The order failed to include specifically what the agency was admitting the patient for. Review of the 8/17/20 and untimed start of care assessment, the care coordination section failed to indicate who the RN coordinated with and the Physician verbal order section was left blank. Review of an agency document titled "Physician order for Start of Care [#1]" dated 8/17/20, indicated " ... Verbal Order: Agency to have Registered Nurse perform assessment and evaluation of the client for admission to home health services. Services requested by referral source include the following: SN (skilled nursing) recertifications, education, supervisory visits. HHA x 8 hours/ day x 5 days/ week .... " The order failed to include specifically the duties/ services the home health aide was to provide. The SN orders failed to include specifically what the SN was to educate and to whom. Review of an agency document titled "Recertification Physician Order" dated 10/14/20, revealed a section that indicates "If applicable. May also accept orders from Dr. [blank line] and Dr. [blank line]." The order failed to include that the agency may accept orders from the hospice physician with Entity C or from any other physician, such as the patient's neurologist, if needed. During an interview on 11/12/20 at 6:54 p.m. with Person L, the parent of patient #3, indicated the patient sees a Neurologist at Entity O and also indicated the services being provided by Entity C.		nurse receiving the verbal order. The Clinical Manager/designee will audit 50% of all physician orders on an ongoing basis to ensure continued compliance with G584. The Clinical Manager is responsible for ensuring ongoing compliance with G584.	

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	3. Review of clinical record #5, SOC 6/3/20, contained start of care and recertification orders. Review of an agency document dated 6/3/20 and untimed start of care assessment, the care coordination section failed to indicate who the RN coordinated with and the Physician verbal order section was left blank. Review of an agency document titled "Physician order for Start of Care [#1]" dated 6/3/20, indicated " ... Verbal Order: Agency to have Registered Nurse perform assessment and evaluation of the client for admission to home health services. Services requested by referral source include the following: SN admission, recertification, assessment, education, and "prn [as needed] coc [change of condition]. HHA x 8 hours/ day x 5 days/ week .... " The order failed to include specifically the duties/ services the home health aide was to provide. The SN orders failed to include specifically what the SN was to educate and to whom. 4. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-14-1(a)(H)			
G 0590 Bldg. 00	484.60(c)(1) Promptly alert relevant physician of changes The HHA must promptly alert the relevant physician(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	G 0590	**G590**	02/16/2021

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	failed to ensure the physician was notified of the agency's inability to provide services in 2 (Patient #5, 6) of 7 records reviewed. Findings include: 1. The clinical record for patient #5, start of care 6/2/20, was reviewed and included a plan of care for the certification period of 10/1/20 to 11/29/20, with orders for home health aide services 8 hours a day, 5 days a week to assist with all ADLs, transfers, positioning, bathing, incontinence care, meal prep, linen changes, and light housekeeping. Review of an agency document titled "Home Health Aide Supervisory Visit" dated 10/29/20, revealed that there was no home health aide available for the visit and "noperinant [sic] staff available, poor communication." Review of the home health aide visit notes evidenced the following: One (1) partial visit from 1:30 p.m. to 4:00 p.m. during the week of 10/4/20, from 8:00 to 10:00 a.m. on 10/13/20, from 8:00 to 11:02 a.m. on 10/14/20, 12:00 to 4:00 p.m. on 10/16/20, 12:00 to 3:45 on 10/19/20, 8:00 to 9:30 a.m. on 10/21/20, 8:00 to 11:00 a.m. on 10/22 and 10/23/20, 8:00 to 11:30 a.m. on 10/26 and 11/6/20, 8:00 to 9:30 p.m. on 10/27, 10/28 and 11/2/20, 9:00 to 11:00 a.m. on 11/5/20, and only approximately 2 +/- (9:00-11:00 a.m.) hours during a home visit on 11/12/20. During a home visit on 11/12/20 from 9:30 to 11:30 a.m., Employee C, CNA, stated she was asked to pick up some hours with patient #5 and travels 1.5 hours one way to care for the patient. After she leaves patient#5, she moves on to the next patient.		The Governing Body has reviewed the survey findings and expressed concerns regarding the agency keeping patients on service they cannot staff and/or are only partially staffing the cases. The Governing Body determined that the Agency Administrator should validate there is adequate staffing available to fully staff the case prior to accepting the case as a potential referral. The Administrator determines the number of hours requested and authorized by the payer during the Intake Process. This allows the Administrator to say yes or no to the potential client as he is aware of his available hours. The Administrator will not accept a case as a referral for service until he is able to ensure it will be fully staffed and the patient's needs will be met. The Governing Body also approved the utilization of auxiliary office staff as float home health aides. The Agency will hire CNA's to perform office functions such as filing, scheduling, answering phones, etc. When scheduled home health aides become ill and cannot work their shift the office staff (float home health aides) will fill in to ensure the patients receive the care that is ordered by the physician. The Administrator will meet with the scheduling department daily to review home health aide	

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	During an interview on 11/12/20 at 10:15 a.m., Person J, family member, stated they have not had a very good experience with Visiting Angels for it has been "up and down." Person J stated they are to have someone 8:00 a.m. to 4:00 p.m. 7 days a week. Person J stated Visiting Angels would send people who don't know how to get patient #5 out of bed, wouldn't work, and even had one aide that was "fresh out of school" to where the family had to teach her how to do things. Person J stated the patient hasn't been out of bed since last October. The family member stated they haven't had an aide for 8 hours since the previous month and that was only for two days (10/29 and 10/30/20). The clinical record failed to evidence that the physician responsible for the plan of care has been notified of the agency's inability to provide services as ordered. 2. The clinical record for patient #6, start of care 9/10/20, was reviewed and included a plan of care for the certification period of 9/10/20 to 11/8/20, with orders for home health aide services 4 times a day, 5 days a week to assist with activities of daily living, bathing, meal prep, safety, and light housekeeping. Review of the clinical record failed to evidence any home health aide visit notes or any documentation that the physician was notified of the lack of services being provided. Review of the discharge assessment dated 10/21/20, stated "HHA [home health aide] services never initiated." The agency failed to evidence that the physician was notified of the agency's inability to provide services.		schedules. The Schedulers are to report the following: · Home Health Aides that have “called-off” for the day, · The number of visits scheduled that are not covered with home health aides, · The float home health aides will be utilized as needed when the scheduled home health aides are ill or off on vacation. The Administrator is responsible for ensuring ongoing compliance with G590.	

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	3. During an interview with the DON and Administrator on 11/12/20 at 1:45 p.m., when queried about not being able to provide services as ordered per the plan of care, the Administrator stated he does offer to help the patients transfer to other agencies but they always refuse. When queried if there is documentation supporting his conversations with patients/ family members, the Administrator stated he did not document those conversations and the outcomes. 4. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-13-1(a)(2)			
G 0598 Bldg. 00	484.60(c)(3)(ii) Discharge plans communication (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). Based on record review and interview, the agency failed to ensure the primary care physician, patients, and patient representatives were informed in advance of the agency's intent to discharge and readmit due to administrative correctives for 2 (Patients #2, 3) of 2 active pediatric records reviewed in a sample of 7.	G 0598	**G598** The Governing Body reviewed the findings and determined the following corrections were to take place. The Governing Body must approve all patients who are discharged for administrative purposes and immediately	02/16/2021

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	Findings include: 1. Person K, family member of patient #2, was interviewed during a home visit on 11/10/20 at 1:30 p.m. When queried if he was made aware of the agency's intent to discharge the patient and readmit, without disrupting service, due to administrative paperwork issues, Person K indicated he was not made aware. 2. The clinical record of patient #3, start of care 8/17/20, was reviewed and contained an agency document titled Acknowledgement of Information, Acknowledgement of Agreements dated 8/17/20, that revealed a signature of Employee E, HHA versus the patient's primary representative. Review of a fax cover sheet, with no date, indicated in the subject line, "[Name of Patient #3] - dc [discharge] d/t [due to] compliance issues with in chart with immediate readmit." Review of an agency document dated 8/17/20, indicated in the Verbal Order section: "DC d/t compliance issues with in chart." Review of an agency document dated 8/17/20, indicated in the Verbal Order section: "OK to do admission process." Review of a discharge OASIS document dated 8/17/20, indicated "DC d/t compliance issues Pt [patient] chart - immediat [sic] readmit." During an interview with Person L, the patient's parent on 11/12/20 at 6:54 p.m., when queried if he was aware of the agency's intent to discharge and readmit the patient, Person L indicated he was not aware.		readmitted without a break in services. To ensure ongoing compliance with patient/caregiver & physician notification of any future "administrative discharge/readmit protocol the process will consist of the following: 1. The patient/caregiver or representative is to be notified by phone and in writing of the pending discharge and immediate readmit. 2. The physician is to be notified by letter of the pending discharge and readmit. 3. The agency contacts the physician to obtain a physician order for the administrative discharge. 4. The agency contacts the physician prior to the readmission process to obtain a physician order to assess the patient for readmission. 5. The patient/caregiver is to be notified to schedule the discharge/readmission visit. 6. The physician is to be contacted following the readmission assessment with a report of the patient's current condition, a communication of the patient's needs, services to be provided, visit frequency, tasks to be performed, education to be provided, goals of care, and anticipated patient-specific measurable outcomes. To ensure ongoing compliance with the above requirements; the	

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	3. During an interview with the Administrator on 11/12/20 at 1:45 p.m., when queried if he notified the families of the agency's intent to discharge and readmit, the Administrator stated he did notify everyone. Both clinical record #2 and #3 failed to evidence any documentation of conversations with the families. 4. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.		Director of Clinical Service/designee will audit 100% of all patient clinical records who are going through a discharge/readmit process on an ongoing basis. The Administrator & Director of Clinical Services are responsible for ensuring ongoing compliance with G598.	
G 0602 Bldg. 00	484.60(d)(1) Communication with all physicians Assure communication with all physicians involved in the plan of care. Based on record review and interview, the agency failed to ensure they communicated with the prescribing physician in regards to wrong patient information on a face to face encounter document for 1 of 1 active patient record of a patient receiving home visiting physician services in a sample of 10. (Patient #5) Finding includes: The clinical record for patient #5 was reviewed and contained a start of care date of 6/3/20. Review of a document titled "Face to Face Encounter" dated 6/15/20, revealed the patient's diagnoses as Multiple Sclerosis, Neuromuscular Dysfunction of bladder, paraplegia, and hypertension. The services ordered were Nursing. The need for services is home health aide.	G 0602	**G602** The Agency Governing Body and Leadership team takes communication with physicians and the accuracy of information in clinical record documents very seriously. The Governing Body ordered the Administrator/designee to audit all Face-to-Face documentation of all active clinical records. Any variances including inaccurate diagnoses, inaccurate service authorizations, etc. will be reviewed with the physician and revised Face-to-Face documentation obtained from the PCP. To ensure these errors do not recur the Administrator/designee will review all Face-to-Face	02/16/2021

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	Review of a document titled "Face to Face Encounter" dated 8/21/20, revealed the patient's diagnoses as Multiple Sclerosis, Diabetes Mellitus, Anemia, Pressure Ulcer, and Paraplegia. The services ordered were Nursing. The need for services is Medication administration is required due to patient's physical inability to self-administer. Medication changes require monitoring and teaching. Skin integrity [poor] requires care as evidenced by breakdown and erythema. Wound care training for patient and/or caregiver. Wound requires skilled care and monitoring for compliance. Review of the clinical record, failed to evidence any communication with the prescribing physician of the patient receiving skilled nursing services with another entity and the services Visiting Angel is providing. Review of a document titled "Face to Face Encounter" dated 10/12/20, revealed the patient's diagnoses as Parkinson's, Hypertension, Ataxia, Hyperlipidemia, and Dementia. The services ordered were Physical Therapy and Occupational Therapy. The need for services indicated "ADL/IADL/self-care [activities of daily living/instrumental activities of daily living] inabilities require therapy. Fall risk [high] requires home safety assessment. Falls [frequent] with single-step transfers and uneven surfaces require therapy. Weakness impairing household tasks requires strength training. Weakness limiting ability to stand without assistance requires strength training." Review of the clinical record failed to evidence any communication with the prescribing physician that the information provided on the Face to Face does not match the patient's physical condition nor medical diagnoses. During an interview on 11/17/20 at 2:10 p.m., when		documentation during the Intake Process to ensure the accuracy of the diagnoses and services authorized by the physician. The Director of Clinical Services will re-educate all nurses in the following areas: · Whenever there is phone or visit contact with the patient and new or different medications, treatments, or services are identified there must be immediate follow-up by the nurse with the primary care physician following the home visit. The physician contact is to be documented on a communication note and any new orders must be documented on the agency Verbal Order Forms and submitted to the physician for authentication. In addition to the verbal order, the identification of new medications must also be documented as an update to the medication profile. The Director of Clinical Services/designee will audit 20% of all SNV documentation & Hha Supervisory Visit Forms on an ongoing basis to ensure compliance with this requirement. The Agency Administrator & Director of Clinical Services are responsible for ensuring ongoing compliance with G602.	

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	queried if the 10//12/20 Face to Face was that of patient #5 and if the physician was notified of the wrong information, both the Administrator and Director of Nursing indicated "No." Review of a document that contained a home health aide supervisory visit note dated 9/2/20, indicated the patient had MRSA (Methicillin-resistant Staphylococcus aureus - a type of bacteria that is resistant to several antibiotics) to the chest, abdominal bandages in place, Mupirocin ointment and antibiotic completed. The "Medication Changes" indicated "Tramadol (pain medication) 50 mg QD PRN [50 milligrams every day as needed]." The clinical record failed to evidence any orders for Tramadol, Mupirocin (antibiotic) ointment or antibiotics or any coordination with the physician in regards to the MRSA to the chest, medication and treatments. 3. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which the Administrator and Director of Clinical Services agreed that the information on the Face to Face was not related to patient #5 and stated they did not notice that the document had incorrect information. 17-14-1(a)(1)(G)			
G 0608 Bldg. 00	484.60(d)(4) Coordinate care delivery Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the agency	G 0608	**G608**	02/16/2021

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	failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patient's needs for 4 of 5 (Patients #1, 2, 3, 4, 5) active patient records reviewed of patients receiving outside services, and 1 of 1 (Patient #7) closed record reviewed of a patient being transferred to a nursing facility in a sample of 7. Findings include: 1. Review of an undated agency policy titled "Coordination of Client Services C-360" indicated, " ... The agency will integrate services ... to assure the identification of client needs and factors that could affect client safety and the effectiveness of treatment ... Coordination of care will include dealing with multiple programs for the complex clients (cardiology, wound care, diabetes, neuro, etc.)" 2. During a home visit on 11/10/20 at 1:30 p.m., the primary caregiver/ parent of patient #2 was interviewed and indicated the patient has been with Visiting Angels since late 2019. The father stated the patient receives skilled nursing waiver services 24 hours per week/ every other weekend. Review of the patient #2's recertification comprehensive assessment dated 10/16/20, failed to evidence that the patient was receiving waiver services from another agency. Review of the plan of care for the certification period of 10/18/20 to 12/16/20, failed to evidence that the patient was receiving waiver services from another agency. Review of a case conference/ coordination note		Due to ongoing challenges in obtaining accurate information from multiple health care providers, the challenges with coordinating care when multiple entities are caring for the patients in the home setting, the Governing Body has recommended the Agency Management team collaborate with the patients and their physicians to evaluate the feasibility of discharging those clients receiving services from multiple healthcare providers to a single provider capable of meeting all their needs. Involved physicians will be notified of the potential pending discharge and must agree to the transfer of services in writing. All patients will receive a 15-day notice of discharge. This Discharge letter will include a list of potential providers and their contact information. The Agency Administrator/Director of Clinical Services will collaborate closely with the patients and families to ensure their needs are met and a safe effective transfer of service occurs. The agency will conduct a Discharge Assessment and provide a Discharge Summary to the patient. This information will also be shared with the entity assuming care of the patient. The Administrator will closely review all “future inquiries for	

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	dated 10/16/20, failed to evidence that the patient was receiving waiver services from another agency. 3. Review of clinical record #3, SOC 8/17/20, contained an agency document titled "Coordination of Care with Other Providers" in which Entity C was listed and a phone number. The date of contact, service provided by the other provider, frequency of services, contact person, concerns & or changes to services provided, clinician signature and date was left blank. Review of an agency document titled "Coordination of Care with Other Providers" indicated Entity M was contacted on 10/09/20, services being provided is waiver, and the frequency varies. The coordination failed to include what discipline of services was being provided. The document also indicated Entity C was contacted on 10/9/20, Hospice RN was the services being provided 1 x / week, did not indicate who the agency spoke with. Review of an agency document titled "Case Note" dated 10/08/20 and 10/21/20, revealed the agency reached out to Entity M and left a message. Review of an agency document titled "Case Note" dated 10/08/20, revealed the agency reached out to Entity C and sent the agreement to their office to be filled out. Review of an agency document titled "Case Note" dated 10/21/20, indicated "Spoke with office manager at [Name of Entity C] who verified that fax with coordination of care agreement was received on 10/09/20 and has been sent to social worker or RN to be filled out. To receive call back with update.		service" to determine if there are multiple providers in the home setting. The Governing Body and the Administrator are responsible for ensuring ongoing compliance with G608.	

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	On 11/13/20, Person E from Entity C, provided their agency's current medication list which contained the following medications that differed from Visiting Angels Medication list: Acetaminophen 160 mg (milligrams)/ 5 ml (milliliters) 505 mg per g-tube every 4 hours for fever or mild pain; Albuterol Sulfate every 4 hours for bronchospasms/ shortness of breath, then "**Parents are only giving prn [as needed]"; Azelastine HCL 0.1 % Nasal 2 time a day, 2 sprays each nostril once a day for chronic rhinitis; Ibuprofen Children's 100 mg/ 5 ml, give 340 mg per g-tube every 6 hours as needed for fever or mild pain; Montelukast Sodium 5 mg, give 1 tablet per g-tube at bedtime for asthma; MiraLax 8.5 gm per g-tube as needed for constipation (mix in 8 ounces of water or juices give twice daily as needed); Morphine sulfate 10 mg/ 5 ml, give 6.6 mg per g-tube every 4 hours as needed for pain or shortness of breath; lorazepam 1 mg/ ml oral concentration, give 3 mg per g-tube as needed for uncontrolled seizure activity, may repeat 15 min if seizure persist; Oxygen 1 to 4 liters continuously for asthma, restrictive airway, shortness of breath, Beclomethasone Diprop HFA 80 mcg/ Act, administrator 2 puffs twice a day for shortness of breath; and Carafate 1 gm (gram)/ 10 ml, give 1 gm every 8 hours as needed for gastric bleed. Patient #2 has been a patient of Entity C since 11/2/18. This document was not found or part of patient #3's clinical record with Visiting Angels. During an interview on 11/12/20 at 8:41 a.m., with Person N, RN Case Manager from Entity C, stated the patient receives weekly nursing visits, music therapy, and 2 home health aides weekly for showers. Person N stated she coordinates with Visiting Angels "once in a while" but coordinates with Employee E, HHA who is also a family			

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	member for patient #3, daily. The patient's clinical record failed to evidence any communication between Person N and Employee E or with Person N and the office. During an interview on 11/12/20 at 6:54 p.m. with Person L, the parent of patient #3, Person L indicated the patient receives a shower via shower chair with 2 hospice aides once a week due to the patient having to be secured in the bath chair due to no trunk support and can easily fall out of shower chair if not put in just right. Person L stated the Visiting Angels aide will prepare the patient's bed while he receives a shower and will receive a bed bath all other days by Visiting Angels aide and also receives home health aide and nursing waiver services with Entity M. 4. The clinical record for patient #5, SOC 6/3/20, contained an agency document titled "Case Conference/ Coordination of Care" dated 8/3/20, in which the document indicated "RN does cath & wound care from [Name of Entity R]. This document was signed by the Director of Clinical Services and Former Employee T, RN. Review of a home health aide supervisory visit note dated 9/2/20, indicated the patient had MRSA to the chest, abdominal bandages in place, Mupirocin ointment and antibiotic completed. The "Medication Changes" indicated "Tramadol 50 mg QD PRN [50 milligrams every day as needed]." The clinical record failed to evidence any coordination with the Medicare agency in regards to the MRSA to the chest, medications, and treatments. Review of a recertification comprehensive assessment dated 10/1/20, revealed the patient had an unhealed pressure ulcer/ injury at Stage 2			

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	or higher, that was partial granulating. The wound care comments indicated the patient had a scabbed area to the right inner foot, open areas of MRSA to the abdomen, open to air, and cream applied daily. The integumentary wound assessment section indicated measurements of 2.5 x 2 cm (centimeters), 2 x 1.5 cm, .5 x .5 cm, and 2 x 1.5 cm, but failed to indicate the location of these wounds. Review of an agency document titled "Case Note" dated 10/20/20, signed by Former Employee T, revealed catheter changes by a nurse from Entity R. The assessment failed to evidence any documentation of where the recertifying nurse obtained these measurements and inaccurately indicated Entity R when Entity D was the Medicare agency providing catheter and wound care. Review of an agency document titled "Case Note" dated 10/8/20, revealed that the agency reached out to Entity D to "collaborate care as they provide monthly RN cath care. Faxed agreement to be filled out." Review of an agency document titled "Coordination of Care with other Providers" dated 10/9/20, revealed a contact person of Director of Nursing at Entity D, indicated catheter care was provided once a month. During an interview on 11/12/20 at 10:15 p.m., when queried about the patient having wounds, Person J, family member, indicated the patient was getting skilled nursing services with Entity D twice a week for wound treatments. Person J indicated she recently received supplies and waiting on the agency to instruct her on what to do with the supplies. During an interview on 11/13/20 at 2:10 p.m., when			

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	queried about the services they provide, coordination of care and a written agreement with Visiting Angels, Person Q, Alternate Director of Clinical Services with Entity D indicated their agency provides suprapubic catheter changes monthly, wounds has recently healed so no further needs for skilled nursing to go out twice weekly, and stated the Director of Clinical Services recalled "some guy" calling about a month prior asking about the services they provided. The 10/8/20 Case Note and the 10/9/20 Coordination of Care note failed to evidence that the agency was also providing wound care twice a week at the time of the inquiry. Patient #5's medications were reviewed and the following medications differ between Entity C and Visiting Angels: Savella, Baclofen 20 mg (2 tabs at bedtime), Bupropion HcL XL, Nystatin, Carvedilol, Vit B12 ER, Valium, and Omeprazole. These medications were not on Entity C's medication list. The following medications were on Entity C's medication list that were not on Visiting Angels medication list: Lexapro (antidepressant and antianxiety), Senna (stool softener) as needed, Benadryl (antihistamine), Tylenol (pain/ fever), Colace (stool softener), Vitamin D 3 (supplement), and Catheter irrigations with Sterile water. 5. During the entrance conference on 11/9/20 at 9:55 a.m., when queried on how the agency coordinates with other agencies, the Administrator stated he and the Director of Nursing makes the calls at first then the nurses are to follow up at every 60 days. 6. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or			

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	documentation to provide. 7. Review of the clinical record for patient #1 evidenced an initial comprehensive assessment dated 9/3/20, time in/out not recorded, with diagnoses listed of COPD (Chronic Obstructive Pulmonary Disease) and CKD (Chronic Kidney Disease), and "pertinent history and/or previous outcomes" as CHF (Congestive Heart Failure), Neuropathy, Kidney failure, COPD, Cataracts bilat [sic bilateral] eyes. The assessment evidenced "Dialysis MWF (Monday, Wednesday, Friday) under the Elimination category. Review of the clinical record for patient #1 evidenced a recertification comprehensive assessment dated 10/29/20 in the page heading and 10/27/20 in M0090 Date Assessment Completed, time in/out not recorded, with diagnoses listed of COPD (Chronic Obstructive Pulmonary Disease) and CKD (Chronic Kidney Disease). On 11/10/2020 at 12:12 PM, Employee A was queried concerning the newly updated Medication Profile for Patient #1, dated 11/10/20 and added to the clinical record at 11:43 AM. The Director/ Clinical Manager was present during this interview. When queried concerning the absence of dialysis medications in Patient #1's profile, Employee A stated, "So it [medication record] should include anything they give there?" The Director/ Clinical Manager stated, "We didn't know this patient was on dialysis until today, or yesterday. The previous RN did not make us aware the patient was in dialysis." When queried concerning who reviews comprehensive assessments for the agency, the Director/ Clinical manager stated, "I do. It was in the assessment initially, under urinary. But it wasn't in the recert (recertification) assessment. It just must not have			

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	clicked when I saw it the first time." The Director/ Clinical Manager confirmed there were no case communication notes for this patient and instructed Employee A to include all medications on the Medication Profile, including dialysis medications. The Director was queried concerning additional documentation for the patient's record and stated all documentation was in the patient's clinical record. On 11/12/20 at 9:25 AM a phone interview was conducted with Person U, LPN with Patient #1's primary care physician. Person U stated the agency nurse, Employee A, spoke with Person V and said she was sending a clarification order for gabapentin 100 mg daily, however the most recent order they documented was gabapentin 100 mg tab, 300 mg po 3 times per day. Person U stated, "[Physician name-Person EE] was not comfortable giving an order to change it [gabapentin] to 100 mg daily without seeing her first." Person U confirmed Employee A sent the physician a complete medication list on 11/10/20 but the physician could not verify any medications until Patient #1 is seen. Person U confirmed [Physician name-Person EE] does not manage anything related to Patient #1's dialysis, including medications. Person U denied the physician had knowledge of other medication discrepancies with agency listed medications. On 11/12/20 at 4:00 PM, an interview with Person CC, Dialysis Manager from Entity B, was conducted. Person CC stated Person DD, dialysis physician, writes orders for patient #1 and also stated they recently received a call from the home health agency but there has been no communication prior to this recent call. 8. The clinical record for patient #4, SOC 6/25/20,			

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	was reviewed and contained an agency document titled "Case Note" dated 10/8/20, with no time documented. The note indicated " Multiple attempts made to contact [Name of patient #4's family member] ...in regards to D/Cing [discharging] her services on 10/23/20 as she currently has hospice services being performed inside the home and there are contractual and payment issues associated with this. Also placed call to [Name of Person AA] who is [Name of patient #4] case manager with CICOA. Voicemail left ...requesting return call. Contacted [Name of Entity Z] to coordinate client's care. Was routed to case manager and left voicemail requesting return call. Review of an agency document titled "Case Note" dated 10/21/20, untimed, signed by Former Employee T and the Director of Clinical Services indicated "Wound Management - Wound to Coccyx, applying corona cream (here someone has written "QD" on top of the word corona cream) and bandage 1x/wk ... Maintain functional ability, heal wound, self care needs met ... coc [change of condition] with hospice services." Review of an agency document titled "Coordination of Care with Other Providers" dated 10/21/20, untimed, indicated Entity Z was providing services: 1 time a week, had the name of the nurse and phone number with the hospice agency, and the "Concerns &/or Changes to Services Provided: Wound care tx & demensiens [sic]" Review of an agency document titled "Case Note" dated 10/21/20, untimed, indicated "Contacted [Name of Entity Z] to collaborate care and send over collaboration of care agreement to be signed. I was directed to [Name of Person Y] at ... did not			

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	receive an answer ... Left voicemail" Review of an agency document titled "Case Note" dated 10/29/20, untimed, indicated "Placed call to [Name of Entity #Z] and was again routed to [Name of Person Y] Case Manager ... Call was unanswered and voicemail left requesting call back with explanation of the situation." Review of an agency document titled "Case Note" dated 11/5/20, untimed, indicated "Called for [Name of Person Y], case manager at [Name of Entity Z] ...No answer, but voicemail left explaining situation. I then called their main line ... and let the receptionist know that I have been trying to get in contact with [Name of Person Y] for some time now. She took my name and contact information and agreed to pass this along to [Name of Person Y] to contact me back." During an interview on 11/16/20 at 9:30 a.m., when queried about the agency's inability to obtain a written agreement with Entity Z, the Administrator stated he has been having difficulty getting in contact with someone with the hospice agency. During an interview on 11/17/20 at 12:02 p.m., Person X, Entity Z Hospice Administrator, stated they were aware Patient #4 was receiving home health services, specifically home health aide (HHA), and at the point that the family decided to use PA services, Entity Z didn't really address the HHA issues anymore because the aide was directed by the home health agency. Person Y, stated case coordination was remiss. Person X stated they did not have a contract with Visiting Angels because services are for a separate payer and separate services and they don't do any instruction, supervision, etc. for another agency's staff, but she would look into this.			

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	9. The clinical record for patient #7, SOC date of 8/20/20, evidenced a discharge assessment form dated 10/19/20. The reason for discharge stated "The discharge is necessary for the patient's welfare ... because the ... HHA [home health agency] can no longer meet the patient's needs, based on the patient's acuity ... DC [discharge] to nursing home." The patient's record indicated a diagnosis of dementia. Review of an agency document titled "Coordination of Care with Other Providers" was blank and only contained the patient's name and medical record number. The clinical record failed to evidence coordination with the long term care facility where the patient was transferred to. In an interview with the patient's family member on 11/16/20 at 9:20 AM., the family member denied receiving any transfer information involving the patient's medication list, goals met/ unmet, a summary of the patient's condition at transfer, or a summary of the patient's care while on services from the home health agency. In an interview with the Assistant Director of Nursing (ADON) at Entity BB on 11/16/20 at approximately 10:33 AM, stated there was no discharge summary, no home medication list, no list of services provided by the agency. The ADON stated they were unaware the patient had been receiving home health care and accepted the patient based on the request of the physician and the family. 17-14-1(a)(1)(F)			
G 0640	484.65 Quality assessment/performance			

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Bldg. 00	improvement Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.			
	Based on record review and interview, the agency failed to ensure they implemented and maintained an effective Quality Assessment and Performance Improvement (QAPI) program, involved all agency services, utilized quality indicators data, including data from OASIS data, failed to focus on high risk, high volume, or problem prone areas, considered incidence, prevalence, and severity of problems in those area, take immediate corrective actions identified that could directly or potentially threaten the health and safety of patients; failed to ensure performance improvement projects analyze their causes and implemented appropriate actions and tracked the performance to ensure improvements are achieved; failed to ensure they conducted an annual performance improvement projects to ensure measurable progress has been	G 0640	**G640** The Governing Body has directed and reviewed the Agency leadership's approach to QAPI and has directed further education for clinical and administrative leadership, better defined daily QAPI activities, QAPI activities that must be completed at all certification time points and has approved of the two annual QAPI Projects. The QAPI Committee composed of the Agency Administrator, Director of Clinical Services and Alternate Director of Clinical Services will meet monthly. The	02/16/2021

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	achieved; and the Governing Body failed to ensure that the QAPI program reflected the complexity of its organization and services for that a quality improvement, patient safety is defined, implemented, and maintained, addressed priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness, clear expectations for patient safety are established implemented and maintained, and that any findings of fraud or waste were appropriately addressed; all with an emphasis of infection control due to the public health emergency related to COVID-19. The lack of having an effective QAPI program impacts all 59 patients receiving services The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care. Findings include: 1. A review of an undated policy B-260 titled Quality Assessment and Performance Improvement (QAPI) indicated "Agency will develop, implement, evaluate, and maintain an effective, ongoing agency wide, data driven QAPI program. This plan will be based on the organization's mission and goals and designed to improve client outcomes and the perceptions of clients/ families about the quality and value of services. The agency will maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Agency's Performance Improvement Plan is reviewed annually and revised as necessary. Purpose: To design processes, which through collaboration of all services and disciplines, will meet the needs of		Administrator will report QAPI activity progress and outcomes to the Governing Body monthly. The Administrator, Director of Clinical Services and Alternate Director of Clinical Services will receive ongoing education and guidance r/t QAPI responsibilities and methodology to implement and track QAPI activities. The QAPI Committee with Governing Body approval has identified the two Annual QAPI Projects based on the agency's survey deficiencies. The two Projects are as listed below: · Documentation of the Comprehensive Assessment · Medical Plan of Care for Patients o Each of the above projects has a formal "Project Improvement Plan" or (PIP) written with attached audit tools. In addition to the two identified annual QAPI project; the Agency has implemented the following QAPI Project that addresses complaints and grievance reporting: · Processing of Complaints and Grievances o Each of the above projects has a formal "Project Improvement Plan" or (PIP) written with attached audit tools. The Clinical Management Team has been instructed on and implemented the following QAPI activities to address daily	

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	clients, staff and the community. To monitor the effectiveness and safety of services and the quality of care; To identify opportunities for improvement in ... care, treatment, and services; To improve ... outcomes through a coordinated collaborative approach to ... improving ... performance; To evaluate all areas of concern and implement plans to resolve the issues ... The agency's performance improvement program consists of, but is not limited to the following: Outcome based OBQI and OBQM data from OASIS submission documents. OASIS review and evaluation of accuracy and content. Staff performance assessment activities. Staff recruitment orientation and continuing education programs. Case Conferences. Clinical record and utilization review findings. Clinical staff competency evaluation programs. Satisfaction surveys of clients, referral sources, physicians and staff. Risk management program. Sentinel events/ Adverse events. Incident reports, accidents and worker compensation claims. Infection control activities and systems that support them. Annual program evaluation. ... Scope of Program: 1. The program will be capable of showing measurable improvement in indicators that will improve the health outcomes, client safety and quality of care. 2. The agency will identify, measure, analyze, and track quality indicators that include client adverse events, and other relevant data to assess processes of care, services and operations. 3. The frequency and detail of the data collection must be approved by the governing body. ...Special Instructions: 1. ... will be guided by the mission, vision, and strategic goals of the organization ... the agency's governing body must ensure the program reflects the complexity of its organization and services, involves all services including those provided under contract and focuses on indicators related		oversight activities of clinical operations to monitor & correct (as needed) agency operations and clinical staff performance: · RN Case Managers are to submit a weekly schedule of their planned home visits every Thursday for the following week to the Clinical Manager. The Clinical Manager reviews the schedule to ensure all patient visits are scheduled & the RN Case Managers have scheduled time for completing the following activities that ensures the following: o All visits are made, o Daily Update Reports to the Clinical Manager, o Completion of all Visit documentation, Physician Verbal Orders, Plans of Care, Coordination of Services, and Communication Notes, o There is time scheduled for the Coordination of Care Conferences to be held every other week, · The RN Case Managers are to provide a **"Daily Update Report"** to the Clinical Manager by 9 am that identifies any concerns reported in the most recent 24 hours r/t their patient case load: o Names of patients reported with elevated temperatures & s/s of Covid-19, o Staff Members reporting s/s of Covid-19 infections, o Patients experiencing a hypo/hyper glycemic reaction,	

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	to improved outcomes. 3. ... address the agency's performance across the spectrum of care including the prevention and reduction of medical errors. 4. ... maintains documentation of its QAPI program and be able to demonstrate its operation to CMS [Centers for Medicare and Medicaid] ... Performance improvement will focus on high risk, high volume, or problem prone areas specific to the agency. Adverse events will be tracked and analyzed for cause and document the implementation of preventative actions .... " 2. Review of an undated policy titled "Visiting Angels Home Health Agency Quality Improvement Committee (QA/PI) Responsibilities" indicated " ... Objectives of the Program: To assess and evaluate the quality of patient care services provided, appropriateness of services, and satisfaction of patients and families. To improve quality of patient care by strengthening communication systems between caregiver, patients and families, management of staff, and agency and the community it serves. To identify deviations from agency and professional standards and pursue improvement opportunities by assessment, planning and evaluation. To identify, address, track and resolve problems in patient care services and satisfaction to ensure resolution and/ or improvement. To increase the awareness of each staff member of their role within the organization and foster involvement and participation in agency's performance improvement program. To meet state and federal regulatory requirements. To support the organization's process improvement through data collection and outcome measurement in compliance with and OASIS Data Collection required by CMS. To reduce factors that contributes to unanticipated adverse events and/ or outcomes. The agency must have		o Patient non-compliance concerns, o Patient's experiencing a "change of condition", o Patients placed on antibiotics, o Patient falls, o Patient Health & Safety Concerns, o Patients hospitalized, o Patients seen in the emergency department, o Patients with pain poorly controlled. · The Clinical Manager will utilize the above information to prioritize her daily patient follow-up and clinical oversight functions. · The Administrator & Clinical Manager hold **Daily Scheduling Meetings** meeting with the Scheduler(s) to evaluate and address scheduling gaps and concerns. The Scheduler is to report the following: o Any field staff reporting an elevated temperature and/or signs/symptoms of Covid-19, o Home Health Aides who have "called-off" for the day, o RN/LPNs who have "called-off" for the day, o Visits scheduled that are not covered, o Discussion of staffing available for potential referrals and admission, o Discussion of new admissions with the RN Clinical Manager to determine which Hha has the appropriate skill set to meet the	

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	documentation validating the QA/PI committee met their objectives in compliance with policy requirements at each meeting." 3. The QAPI meeting documents/ program for 2017 to present was requested and reviewed on 11/16/20. The binder that was provided by the Administrator failed to evidence any QAPI information prior to September 2020. At 10:00 a.m., when queried about the program meeting documents prior to September 2020, the Administrator indicated they did not have any documentation or meeting minutes and just recently started obtaining data. When reviewing an agency policy and procedure binder, a policy titled "Quality Assessment and Performance Improvement B-260" the policy indicated obtaining "OBQM and OBQI" reports and incorporating them into the QAPI program. During the exit conference on 11/17/2020 from 12:30 to 1:45 p.m., when queried if the agency knew who the OASIS Coordinator for the State of Indiana was and if they knew the OBQM and OBQI has not been in effect for approximately 7 years, and that Casper Reports are the reports that took the place of OBQM and OBQI, the Administrator, Director of Clinical Services, Governing Body/ Owner, and Alternate Director of Clinical Services, all stated they were not made aware, they indicated they did not know who the OASIS Coordinator or that there were changes in reports. 4. In regards to Infection Control, the need to analyze and take immediate corrective actions identified that could directly or potentially threaten the health and safety of patients; A review of the agency's policy and procedure		new patient's needs (process currently on hold as agency has placed a temporary hold on all new admissions). In addition the Agency has implemented multiple "tracking tools and processes" that will provide them quality assessment performance improvement information to ensure patient care operations are meeting all patient needs and they include the following: · Physician Order Tracking Log, · Infection Control Tracking & Reporting Tool, · Patient Infection Report Summary Log, · Incident Report Form · Incident Report Summary Log · Patients seen in ED/Hospitalized Tracking Log · Complaint & Grievance Form · Complaint Log · Inquiry Log · Referral Log Ongoing Clinical Record Audits: · The Clinical Manager/designee is to perform a Medicaid Certification Audit of 100% of all patients at the time of Admission and at all certification time points to evaluate documentation compliance on an ongoing basis. The Governing Body,	

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	binders, failed to evidence a document on an Infection Control Program and failed to evidence a policy on agency protocols for the Coronavirus pandemic. According to the Center for Disease and Control (CDC) website at https://www.cdc.gov/coronavirus/2019, indicated "Who needs to quarantine? People who have been in close contact with someone who has COVID-19 ... What counts as close contact? You were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more. You provided care at home to someone who is sick with COVID-19. You had direct physical contact with the person ... Steps to take: Stay home and monitor you health. Stay home for 14 days after your last contact with a person who has COVID-19. Watch for fever (100.4F), cough, shortness of breath, or other symptoms of COVID-19. If possible, stay away from others, especially people who are at higher risk for getting very sick from COVID-19. A review of the infection control binder failed to evidence a document on an Infection Control Program but revealed a blank agency document titled "Patient Infection Report Summary Log" which contains columns for date, patient number, type and description of infection, date notified physician and family, type and description of actions taken, and follow up/ comments. Review of an agency document titled "Case Note" dated 5/25/20, indicated Employee Z, CNA "Call received evening of 5/22/20 with report of fever and malaise. Employee to get tested for Coronavirus at physician's office on 5/23. Note received for physician 5/25 stating that employee would be on voluntary quarantine until test is		Administrator, & Clinical Manager are responsible for ensuring ongoing compliance with G640.	

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	complete. 5/29/20 - Test came back negative. Employee to return to work 6/1/20. Review of an agency document titled "Infection Control Tracking and Reporting Tool" indicated Employee Z reported the infection on 5/23/20, type of infection was described as flu-like symptoms and diagnosis of infection indicated "unconfirmed." The remaining document was left blank and failed to include an investigation of all clients that the employee has been in contact with, measures that were put into place until the employee's test came back, and recorded the final negative result and date obtained. Review of an agency document titled "Case Note" dated 8/8/20, indicated "Received call from client's daughter stating that [Name of Patient #8] isn't feeling well and running a fever. He will be tested for Coronavirus 8/10/20 if symptoms persist. Care will be on hold until further notice at daughter's request. Received a call from client's daughter informing that symptoms have subsided and test was negative on 8/12/20. Care to resume 8/13/20. Review of an agency document titled "Infection Control Tracking and Reporting Tool" indicated Patient 8, date of reported infection was 8/8/20, type of infection was described as flu-like symptoms and diagnosis of infection indicated "unconfirmed." The remaining document was left blank and failed to include an investigation of the patient's caregiver and self quarantine for possible exposure until the patient's test result came back, and the final negative result and date obtained. Review of an agency document titled "Case Note" dated 11/11/20, indicated a call was received from a county health department informing the agency that patient #9 had tested positive for the			

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	Coronavirus and that the patient has been in contact with Employee ZZ, CNA, Employee J, CNA, and Employee I, RN. The document indicated the employees were "notified to monitor for symptoms, practice good hygiene along with standard precautions, and to continue use of proper PPE [personal protective equipment]. Call placed to client who reports positive test from personally performed at-home test purchased at a drug store. No symptoms present." The Administrator failed to ensure that staff self quarantined during a 14 day period per the CDC guidelines. Review of an agency document titled "Infection Control Tracking and Reporting Tool" indicated Patient 9, date of reported infection was 11/11/20, type of infection reported stated Coronavirus and diagnosis of infection indicated "Confirmed via at-home test." The remaining document was left blank and failed to include an investigation of the patient's caregiver and self quarantine for possible exposure. When queried if the agency should be following the CDC guidelines for exposure to COVID, the Administrator stated "Yes." 5. In regards to incomplete data on complaints and grievances forms from August 25, 2020 to November 11, 2020 Review of the agency's "Report of Concern/ Complaint/ Grievance documents, 12 out of 12 reports reviewed failed to be completely filled out by failing to identify the demographics, classification of type of concern/ complaint, signature, date, and time of individuals reporting concern (if by employee), documentation of the communication of results of investigation to			

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	complainant, and a date, time, and signature of reporting the concern/ complaint to the governing body. 6. In regards to incomplete data on comprehensive assessments: Review of patient's #1, 2, 3 4, 5, and 6 clinical records evidence incomplete OASIS comprehensive assessments that failed to accurately reflected the patients current health status and past medical history, failed to ensure assessments included patient's strengths, goals, and care preferences, failed to ensure assessments included the patient's medical, nursing, rehabilitative, social, and discharge planning needs, failed to ensure all medications were appropriately reconciled with the patient, health care representative, outside agencies and ordering physicians to ensure drug interactions and duplication is identified, failed to ensure assessments identified the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule, and failed to ensure the assessment included information concerning a patient selected representative. 7. In regards to incomplete data and lack of careplanning, coordination, and quality of care: Review of patients #1, 2, 3 4, 5 and 6 clinical records failed to evidence the agency accepted pediatric patients on the reasonable expectation that they were able to meet pediatric patients nursing needs; failed to ensure services were provided per the plan of care and failed to ensure each patient received an individualized care plan that identified patient specific and measurable outcomes and goals that was periodically reviewed and signed by a physician; failed to			

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	ensure the individualized plan of care included all pertinent diagnoses, all supplies and equipment, specific frequency and duration of visits, nutritional requirements, all accurate medications and treatments, all safety measures to protect against injury, patient specific interventions, measurable outcomes and goals identified by the home health agency and patient; failed to ensure the plan of care was created in conjunction with the primary care physician after an assessment, verbal start of care and recertification orders obtained from the physician; failed to ensure verbal orders were complete and contained included duties/ services that the home health aides were to provide and the specific education the nurses were to educate to whom, and date and time of when orders when verbal orders were received; failed to ensure the physician was notified of the agency's inability to provide services; failed to ensure the primary care physician, patients, and patient representatives were informed in advance of the agency's intent to discharge and readmit due to administrative correctives; failed to ensure they communicated with the prescribing physician in regards to wrong patient information on a face to face encounter document; and failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patient's needs . 8. In regards to home health aide services: Based on observation and record review, the agency failed to ensure a home health aide completed a skills competency upon hire, failed to ensure a the agency had a copy of the home health aide skills competency on file, failed to ensure all aides completed a 12 hour in-service			

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	training that was supervised by a Registered nurse and documentation of the in-services were maintain, failed to ensure aide care plans were individualized and specific to the patient needs, outlining the frequency of tasks to be provided, failed to ensure personal hand on care and services were provided as ordered per the plan of care, failed to ensure tasks were not provided that is considered out of scope of practice, failed to ensure supervisory visits contained accurate information and aide visit notes reviewed, and failed to ensure that a home health aide met the competency requirements by providing a skills competency for the tasks/ services they are providing. Review of agency documents titled "Supervisor Tracking" revealed 6 pages of patient names and when their home health aide supervisory visit were due and when they were completed for September, October, and November of 2020. No other information was included for home health aide audits. 9. The agency failed to ensure they had written agreements in place with agencies who they share patients with outlining who has the overall responsibility for all services provided. This concern was identified during a 09/09/20 post condition revisit in which the agency's plan of correction indicated they would be in compliance by 10/09/20. During this survey, the agency continues to fail to evidence compliance during this survey. 10. In regards to qualified staff and aide inservices Review of clinical record #2 and #3, evidenced two pediatric patients with complex needs,			

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	including severe seizure activity. During an interview with the Director of Clinical Services Administrator on 11/12/20 at 1:45 p.m., when asked about the agency's experience with pediatric patients and if the agency had a seizure protocol, both could not confirm that any employees, including themselves, had any pediatric experience. When asked about what their seizure protocol was, the Administrator stated the agency did not have one. When queried about their own experience and training, the Director of Clinical Services stated she did not have any training as a Clinical Supervisor and only had approximately 2 days of training as a case manager. The Director of Clinical Services stated her background consists of Long Term Care and no home health care. The Administrator stated he had 3 years of case management experience with hospice, worked in long term care and hospitals, but did not have experience with home health care. The Administrator indicated he was trained for about a month by the former administrator. During an interview with the Person S, only Governing Body Member/ Owner, on 11/13/20 at 10:15 a.m., when asked how he ensure staff hired were adequately trained to do their job, Person S stated information was sent to the CNAs (certified nurses aides) for continuing educations. During an interview on 11/17/20 at 11:45 a.m., when queried about the tracking for the HHA 12 hour in-service, the Administrator stated he didn't know they were to track the in-services/ hours. 11. In regards to clinical records Review of patients #1, 2, 3, 5 clinical records, the agency failed to ensure that they maintain a			

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	clinical record containing current and accurate information, as well as adhere to current clinical record documentation standards (See G1008); failed to ensure visit notes were incorporated within the clinical record within a timely manner; failed to ensure a discharge summary was written and sent to the primary care physician who is responsible for the patient's care after discharge within 5 business days of the patients discharge and within 2 days of patients being transferred to another facility; and failed to ensure all entries were clear, complete, authenticated, dated, and timed. 11. In regards to Performance Improvement Indicator documents and the agency's inability to identify problem areas through their chart audit tool: Review of an agency document titled "Visiting Angels Home Health Agency Performance Improvement Indicator description form" for September 2020 indicated "Aspect of Care: The agency has identified and area of clinical performance and documentation noncompliance. The agency has not been completing and documenting the required recertification comprehensive assessments of all active home health patients. Head to toe comprehensive assessment. Review and update of all the medications the patient is taking. Assessment and Update of all patient risk factors. Communication/ Reporting and collaboration with the physician r/t the patient's condition, needs, progress, identified concerns, etc. Accurate and complete documentation of all the above items." This document indicated all 61 patient records were reviewed and was in compliance with all the aspects of care. Review of the 61 attached audit tools, all dated 9/16/20, starting at #26 with the			

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	question "The Comprehensive Recertification Assessment occurred within the last 5 days of the certification period." All 61 audited documents had a check mark for "yes". Other sections of the audit tools, such as "Recertification &/or update to the POC [plan of care] questions starting at #29 to #34, Filing of clinical documentation into the clinical record questions #'s 35 and 36, Provision of SN/ Professional Services questions starting at #37 to 45, Home Health Aide Services (including supervisory visits) questions starting at #46 to 56, and Medication Profile" question #57, all these questions were left blank and unanswered. All 61 audit tools were signed by the Administrator. Review of an agency document titled "Visiting Angels Home Health Agency QAPI Indicator: The Communication/ Coordination/ Collaboration of Care with Agency Team Members, Clinical Management, The Physician & Other Service Providers" for September 2020 indicated "Aspects of Care: Failure of SN professionals to assess their patients for coordination of care needs. Failure of the SN to demonstrate, communicate, and document collaboration with members of their team, agency management & other health care entities involved in the patient's care. Specific concerns include the following: Assessment of patient coordination and communication needs. Failure to communicate the assessment, changes in condition, etc., to their team members and agency clinical management. Failure to communication, coordinate, and collaborate with other services providers who are providing services to the patient. Their failure may impede progress toward patient outcomes and/ or contribute to harm for the patient...Audit Process: q. The audit process will consist of a documentation audit process: a. The Audit Tool will be utilized to measure compliance is: 'THE			

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	COMMUNICATION/ COORDINATION/COLLABORATION OF CARE WITH AGENCY TEAM MEMBERS, CLINICAL MANAGEMENT, THE PHYSICIAN, & OTHER SERVICE PROVIDERS' audit tool. Review of the 30 attached, all dated 9/22/20, starting at #59, audit tools had columns, untitled, in which all 30 audits had a check mark in the first column at number "62 under "Communication & Coordination of Care" in which the question asked "The Clinical record evidences documentation of communication with all physicians involved in the POC as often as necessary?" Review of 29 audits had a check mark in the 2nd column starting at number "64. There is documentation of Integration of services to assure identification of patient needs & factors that could impact patient safety & treatment of effectiveness & COC [change of condition] by all disciplines" and 1 check mark in the 2nd column at number "65. Doc [documentation] of any MD ordered treatments and/ or therapy services." All 30 audit tools had a check mark in the 2nd column at number "69. Doc of any MD ordered treatments and/ or therapy services." Other sections of the audit tools, such as "Client discharge of services questions starting at #77 to #84, and Client Transfer of services starting at #85 to #90, all these questions were left blank and unanswered. All 40 audit tools were signed by the Administrator. Although the audits identified the agency nurses were not identifying coordination of care and communication needs during recertification and failed to provide thorough compete documentation and communication of all service providers, the plan was for the Administrator, Clinical Manager, or designee to audit 100% of all skilled nurse documentation for 30 days to assess compliance and goals was to decrease to 1-% quarterly once compliance has been reached. This document			

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VISITING ANGELS HOME HEALTHCARE	3197 S US HWY 231 GREENCASTLE, IN 46135

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	fails to evidence if a meeting was held with the Director of Clinical Services and Person S, Governing Body. Review of an agency document titled "Visiting Angels Home Health Agency Performance Improvement Indicator description form" for October 2020 indicated "Aspect of Care: The agency has identified and area of clinical performance and documentation noncompliance. The agency has not been completing and documenting the required recertification comprehensive assessments of all active home health patients. Head to toe comprehensive assessment. Review and update of all the medications the patient is taking. Assessment and Update of all patient risk factors. Communication/ Reporting and collaboration with the physician r/t the patient's condition, needs, progress, identified concerns, etc. Accurate and complete documentation of all the above items." This document indicated all 56 patient records were reviewed and was in compliance with all the aspects of care. Review of the 56 attached audit tools, all dated 10/20/20, questions starting at #26 and ending with #57, asking the same questions as September: "The Comprehensive Recertification Assessment occurred within the last 5 days of the certification period," and other sections such as "Recertification &/or update to the POC [plan of care] ... Provision of SN/ Professional Services ... Home Health Aide Services (including supervisory visits) ... Medication Profile" were all left blank and unanswered. All 56 audit tools were signed by the Administrator. 12. On 11/12/20 between 1:45 p.m. to 3:20 p.m., when discussing the lack of content in the comprehensive assessments, including			

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	medication profiles and reconciliation, as well as home health aide visit notes, the Administrator and Director of Clinical Services were queried about how the agency was auditing their records for content, in which the Director of Clinical Services responded she did not review the content, that she obtains her information from the case managers after their admissions, and stated the extent of auditing were ensuring documents are turned in and visits are made within the required time frame. When queried the percentage of records audited and the frequency, the Director of Clinical Services indicated approximately 10%, 3 records are reviewed on odd months and 4 records reviewed on the even months. When queried if they do a side by side comparison of notes against the plan of care, the Director of Clinical Services (DOCS) stated they get out the calendar every 3 months or so and compare to the visit note. When asked how to they ensure the orders are being followed and the content is correct, both the Administrator and Director of Clinical Services could not answer the question. When asked if they get out the plan of care and compare it to the visit to ensure the content is present, both the Administrator and Director of Clinical Services could not answer the question. When asked if she audited the records after the start of care, the DON responded "No." 13. During an interview on 11/13/20 at 10:15 AM, when asked how many charts are audited, Person S, Owner/ Governing Body, stated "I assume 100%." When asked if he knew how the DOCS does her audits or was trained to do audits, Person S answered "I think she has a document from [Name of Person E] a sample for audits. Charts are audited quarterly. 14. During an interview on 11/16/20 at 1:44 PM, when asked what was their QA process was, the			

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	DOCS stated "we mark them [notes] as received each week. When asked what quality measures they were currently working on, the Administrator and the DOCS could not answer the question clearly and were unable to verbalize what is being measured, the frequency of tracking, or the percentage of audits. Both Administrator and DOCS stated that QAPI is new to them and they are unaware of what they are supposed to do. The Administrator stated that the Director of Nursing has "input" but the Administrator puts ideas together. 15. On 11/17/20 at 11:20 PM, when asked why only 30 as denominator, when 100% population was chosen and previous PIP had census of 61 for September, the Administrator stated "I don't know. I guess there was some confusion. I don't know why it's like that. Only 9/20 is audited and only 30 patients because we were auditing shared patients with other agencies." When asked to review QAPI meeting minutes for the 2020 fiscal year, the Administrator stated "Oh, that isn't something I knew I should document." 16. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			
G 0680 Bldg. 00	484.70 Infection prevention and control 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.			

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	Based on record review and interview, the agency failed to ensure all staff wear masks while in patients home and failed to ensure the agency developed and maintained an agency wide infection control program and failed to ensure agency staff were instructed to follow CDC guidelines in regards to symptoms and self quarantine when exposed to the Coronavirus. These practices has the potential to affect all 59 patients receiving services from this agency. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients are protected from infectious diseases or improper infection control practices which could result in the agency not providing quality health care. Findings include: The agency failed to ensure all staff wear masks while providing services in a patient's home (See G682) The agency failed to ensure they developed and maintained an agency wide infection control program outlining surveillance, identification, prevention, control, and investigation of all infectious and communicable disease and failed to ensure agency staff were instructed to follow CDC guidelines in regards to symptoms and self quarantine when exposed to the Coronavirus. (See G684)	G 0680	G680	03/16/2021
G 0682 Bldg. 00	484.70(a) Infection Prevention Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of			

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	infections and communicable diseases. Based on observation and interview, the home health aide failed to wear a mask while providing services in a patient's home for 1 of 3 home visits conducted. (Employee C) Finding includes: According to the Centers for Disease and Control website at https://www.cdc.gov/coronavirus/2019, indoor environments with poor ventilation increase the risk of transmission. To prevent infection and to slow transmission of COVID-19, do the following: ... Cover you mouth and nose with a mask when in public settings or around others... " Since July 27, 2020, the Governor of Indiana initiated a mask mandate for anyone over the age of eight years old while inside, in public spaces, and other environments when social distancing is not possible. A review of the agency's policy and procedure binders, failed to evidence a policy on agency protocols for the Coronavirus pandemic. During a home visit with Employee C on 11/12/20 at 9:30 a.m., the employee was observed not wearing a mask while bathing the patient. The employee stated that the mask makes the patient anxious and the patient had asked that she not wear one. During an interview on 11/12/20 at 1:45 p.m., when queried if it was a requirement for the staff to wear masks while providing services during this pandemic, the Administrator stated it was a requirement and masks are provided by the agency.	G 0682	**G682** All Field Staff are required to wear face masks whenever they enter a patient's home and during the provision of all care and service while in the patient's home setting. The mask is not to be removed until the employee exits the home setting. All staff have received training on COVID-19 infection control measures including the wearing of face masks whenever the employee is in a patient home setting. The RN Case Managers will oversee compliance with this requirement through their monthly unannounced supervisory visits. All instances of non-compliance with the face mask requirement will be immediately reported to the Director of Clinical Service/designee for appropriate re-education and potential disciplinary action. The Director of Clinical Service/designee will perform random unannounced supervisory visits of the skilled nurse staff to evaluate their compliance with all required infection control measures including handwashing, glove changes, and appropriate wearing of the face mask. The Director of Clinical Service is responsible for ensuring ongoing compliance with G682.	03/16/2021

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G 0684 Bldg. 00	484.70(b)(1)(2) Infection control Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review, the agency failed to ensure they maintained an agency wide infection control program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases, failed to ensure agency staff were instructed to follow CDC guidelines in regards to symptoms and self quarantine when exposed to the Coronavirus, and failed to have a policy on how to maintain an agency-wide infection control program. Findings include: 1. A review of an undated agency policy titled "Infection Control Surveillance B-402" indicated "Policy: Agency will establish a continuous data monitoring and collecting system to detect infections or identify changes in infection trends	G 0684	**G684** The Agency has implemented an agency-wide infection control program. The Agency follows the guidance of their policy, “Infection Prevention/Control” which states the agency will observe the recommended precautions for home care as identified by the CDC. The precautions cover those clients with documented or suspected infection with highly transmissible or epidemiologically important pathogens that require additional precautions to prevent transmission. The policy directs the agency in the implementation of the following: · Standard Precautions-Tier	03/16/2021

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	... Total Surveillance ... Targeted surveillance ... Outbreak surveillance ... The Agency will implement a process of identifying all infections in the client and/ or employee population and evaluate effectiveness of current control measures or identify an action plan to improve incidence of infections. A review of the agency's policy and procedure binders, failed to evidence a policy on agency protocols for the Coronavirus pandemic. 2. According to the Center for Disease and Control (CDC) website at https://www.cdc.gov/coronavirus/2019, indicated "Who needs to quarantine? People who have been in close contact with someone who has COVID-19 ... What counts as close contact? You were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more. You provided care at home to someone who is sick with COVID-19. You had direct physical contact with the person ... Steps to take: Stay home and monitor you health. Stay home for 14 days after your last contact with a person who has COVID-19. Watch for fever (100.4F), cough, shortness of breath, or other symptoms of COVID-19. If possible, stay away from others, especially people who are at higher risk for getting very sick from COVID-19. 3. A review of the infection control binder failed to evidence a document on an Infection Control Program but revealed a blank agency document titled "Patient Infection Report Summary Log" which contains columns for date, patient number, type and description of infection, date notified physician and family, type and description of actions taken, and follow up/ comments. 4. Review of an agency document titled "Case Note" dated 5/25/20, indicated Employee Z, CNA		1 · Disease-Specific Standard Precautions- Tier 2 At time of hire all staff are tested for TB. Annually all staff will go through the TB screening process and retesting will be required based on answers to the screening questions. The Agency has implemented COVID-19 Screening questions all staff must answer daily as well as the patients receiving care. The Agency utilizes the “Daily Update Report” for reporting of all potential and actual infections. The RN Case Managers are to provide a “Daily Update Report” every morning to the Director of Clinical Services/designee. This report includes the following: Reporting of items as it relates to Infection Control: · Patients experiencing a change-in-condition, · Patients placed on antibiotics in the most recent 24-hr time, · Patients experiencing elevated Temperatures and/or s/s of Covid-19, · Patients seen in either the ED or Hospital in the most recent 24-hour time for an infection When a patient is identified with an actual or potential infection, agency clinical management or the RN Case Manager completes the following report and submits it to the Director of Clinical	

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	"Call received evening of 5/22/20 with report of fever and malaise. Employee to get tested for Coronavirus at physician's office on 5/23. Note received for physician 5/25 stating that employee would be on voluntary quarantine until test is complete. 5/29/20 - Test came back negative. Employee to return to work 6/1/20. Review of an agency document titled "Infection Control Tracking and Reporting Tool" indicated Employee Z reported the infection on 5/23/20, type of infection was described as flu-like symptoms and diagnosis of infection indicated "unconfirmed." The remaining document was left blank and failed to include an investigation of all clients that the employee has been in contact, measures that were put into place until the employee's test came back, and the final negative result and date obtained. 5. Review of an agency document titled "Case Note" dated 8/8/20, indicated "Received call from client's daughter stating that [Name of Patient #8] isn't feeling well and running a fever. He will be tested for Coronavirus 8/10/20 if symptoms persist. Care will be on hold until further notice at daughter's request. Received a call from client's daughter informing that symptoms have subsided and test was negative on 8/12/20. Care to resume 8/13/20. Review of an agency document titled "Infection Control Tracking and Reporting Tool" indicated Patient 8, date of reported infection was 8/8/20, type of infection was described as flu-like symptoms and diagnosis of infection indicated "unconfirmed." The remaining document was left blank and failed to include an investigation of the patient's caregiver and self quarantine for possible exposure until the patient's test result came back		Service/designee: "Infection Control Tracking and Reporting Tool". The Director of Clinical Service/designee follows up on all reports of infections to evaluate if the patients are receiving appropriate treatment of the infection and to determine their current health status. The Director of Clinical Service/designee documents the patient's name on the "Patient Infection Report Summary Log. This tool is utilized in the monthly reporting of infections to the QAPI Committee for trending purposes, remediation education of staff if appropriate, and for identification of the types of infections agency patients are experiencing so the management team can implement education and interventions to decrease the incidence of infections. The Director of Clinical Services/designee and the Administrator are responsible for ensuring ongoing compliance with G684.	

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	and the final negative result and date obtained. 6. Review of an agency document titled "Case Note" dated 11/11/20, indicated a call was received from a county health department informing the agency that patient #9 had tested positive for the Coronavirus and that the patient has been in contact with Employee ZZ/CNA, Employee J/CNA, and Employee I/RN. The document indicated the employees were "notified to monitor for symptoms, practice good hygiene along with standard precautions, and to continue use of proper PPE [personal protective equipment]. Call placed to client who reports positive test from personally performed at-home test purchased at a drug store. No symptoms present." The Administrator failed to ensure that staff self quarantined during a 14 day period per the CDC guidelines. Review of an agency document titled "Infection Control Tracking and Reporting Tool" indicated Patient 9, date of reported infection was 11/11/20, type of infection reported stated Coronavirus and diagnosis of infection indicated "Confirmed via at-home test." The remaining document was left blank and failed to include an investigation of the patient's caregiver and self quarantine for possible exposure. 7. When queried if the agency should be following the CDC guidelines for exposure to COVID, the Administrator stated "Yes." 8. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			

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G 0750 Bldg. 00	484.80 Home health aide services Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Based on record review and interview, the agency failed to ensure a home health aide completed a skills competency upon hire, failed to ensure a the agency had a copy of the home health aide skills competency on file, failed to ensure all aides completed a 12 hour in-service training that was supervised by a Registered nurse and documentation of the in-services were maintain, failed to ensure aide care plans were individualized and specific to the patient needs, outlining the frequency of tasks to be provided, failed to ensure hands on personal care and services were provided as ordered per the plan of care, failed to ensure tasks were not provided that is considered out of scope of practice, failed to ensure supervisory visits contained accurate information and aide visit notes reviewed, and failed to ensure that a home health aide met the competency requirements by providing a skills competency for the tasks/ services they are providing. These practices has the potential to impact all 54 patients who are receiving home health aide services. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate Aide care and services which could result in the agency note providing quality health care. Findings include:	G 0750	G750 The agency, after meetings with leadership and the Governing Body, has chosen to end the employment of the home health aide requiring in-service and competency training, and to no longer employ home health aides that are not CNA certified. All home health aides on staff will be required to maintain their ongoing CNA certification in order to continue employment. New in-services have been implemented for ongoing CNA education that will be required to be completed monthly to meet the 12-hour yearly in-service training requirement. This training will be supervised by the home health aide's RN Case Manager. RN Case Managers are continuously overseeing and updating care plans for each patient via the newly implemented EVV system. Care plans and visit notes are monitored weekly to ensure accuracy of patient needs and compliance of provision of those needs.	02/16/2021

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	1. The agency failed to ensure a home health aide skills competency was observed (See G768); failed to ensure they maintained a copy of the home health aide skills competency (See G772); 2. The agency failed to ensure all home health aides completed 12 hours of in-service training during the year of 2019. (See G774) 3. The agency failed to ensure all in-service training during the year of 2019 was supervised by a Registered Nurse. (See G776) 4. The agency failed to ensure they maintained documentation that all home health aides completed 12 hours of in-service training was supervised by a Registered Nurse. (G778) 5. The Case Manager failed to ensure the aide care plan was individualized and patient specific. (G798) 6. The agency failed to ensure home health aides (HHA) provided services per the plan of care and failed to ensure HHA's did not provide services beyond the scope of their practice. (See G800) 7. The agency failed to ensure all home health aides provides hands on personal care as ordered per the plan of care. (See G802) 8. The agency failed to ensure Case Managers accurately document supervisory visits in regards to inaccurately indicating an aide is following the plan of care and completing tasks assigned. (See G818) 9. The agency failed to ensure that a home health aide met the competency requirements by providing a skills competency for the tasks/			

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	services they are providing. (See G828)			
G 0768 Bldg. 00	484.80(c)(1)(2)(3) Competency evaluation Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. Based on record review and interview, the agency failed to ensure a home health aide skills competency was observed for 1 of 1 employee hired as a home health aide. (Employee E) Finding include:	G 0768	G768 The agency, after meetings with leadership and the Governing Body, has chosen to end the employment of the home health aide requiring in-service training and skills competency, and to no	02/16/2021

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	Review of an undated agency policy titled "Competency Evaluations" indicated " ... Home Health Aide: Unlicensed professionals that will provide direct client care must demonstrate their competency during the orientation program and according to the Agency skills checklist and activities delineated in the competency testing required by CMS and state specific guidelines .... " Review of an undated agency policy titled "Competency Assessment" B-115 indicated "Competency of all staff will be assessed during the interview process, orientation program and ongoing throughout employment ... Special Instructions: 1. All employees will complete a self-assessment of the skills area for their job description. This assessment will be used to determine the orientation and specific training required by each person. 2. The skills assessment checklist and the orientation checklist will be used by the supervisor/ preceptor to document the completion of satisfactory demonstration of skills. .... " Review of an undated agency policy titled "Home Care Staff" D-220 indicated "Policy: 1. The agency will establish a program that allows for objective, measurable, assessment of the person's ability to perform required activities ... 2. The assessment will verify and focus on the individual staff knowledge and skill appropriate to assigned responsibilities, communication skills, and the ability to respond to client needs within their scope of responsibility. a. Competencies will address: Age/ type of client. Scope of services offered by Agency. High risk procedures ... 3. The competency evaluations will be completed by individuals who have the knowledge and skills to assess performance and ability. 4. All		longer employ aides that are not CNA certified. All aides on staff will be required to maintain their ongoing CNA certification to continue employment.	

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	competencies will be documented ... Special Instructions: 1. All new employees will be assessed for competency based on the expected requirements for the position. ... 2. Skills tests including written tests and direct observation of skill will be completed as determined by the agency policies and individual assessments. ... 3. When agency staff are assigned to new areas or procedures, training and return demonstrations or other observed evidence of competency will be documented ... Home Health Aide Competency: 2. Skills competency is evaluated by observing the aide with client or "pseudo" client ... 3. A Home Health Aide will not be permitted to provide Home Health Aide services until evidence of adequate training and/ or competency has been determined .... " Review of the Indiana Department of Health document titled "Employee Records" (completed by agency staff)identified Employee E as a CNA (certified nursing assistant). The personnel record of Employee E, HHA (home health aide) Date of Hire 6/1/20 and first patient contact of 6/2/20, contained an agency document titled "Caregiver Applicant Checklist" dated 6/1/20, which revealed that the employee checked that they have no experience with shaving, hair care (shampoo, dry & style), and medication reminders. The personnel record failed to evidence a home health aide skills competency checklist. The personnel filed revealed a registration card identifying Employee E as a home health aide. Review of the patient #3's clinical record, the home health aide visit notes revealed Employee E provided bathing, grooming, and hygiene services from 8/3/20 to present, especially shampooing the			

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	patient's hair on 8/3, 8/7, 8/17, 8/19, 8/24, 8/28, 8/31, 9/4, 9/11, 9/14, 9/18, 9/21, 9/25, 9/29, 10/2, 10/5 to 10/9, 10/12, 10/16, 10/19, 10/23, 10/26, 10/28, and 10/30/20. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which the Administrator indicated he wasn't aware Employee E was a home health aide. No further information or documentation to provided.			
G 0772 Bldg. 00	484.80(c)(5) Documentation of competency evaluation The HHA must maintain documentation which demonstrates that the requirements of this standard have been met. Based on record review the agency failed to ensure they maintained a copy of the home health aide skills competency for 1 of 1 Employees hired as a home health aide. (Employee E) Findings include: Review of an undated agency policy titled "Competency Evaluations" indicated " ... Home Health Aide: Unlicensed professionals that will provide direct client care must demonstrate their competency during the orientation program and according to the Agency skills checklist and activities delineated in the competency testing required by CMS and state specific guidelines .... " Review of an undated agency policy titled "Competency Assessment" B-115 indicated "Competency of all staff will be assessed during the interview process, orientation program and	G 0772	G772 The agency, after meetings with leadership and the Governing Body, has chosen to end the employment of the home health aide requiring in-service training and skills competency, and to no longer employ aides that are not CNA certified. All aides on staff will be required to maintain their ongoing CNA certification to continue employment.	02/16/2021

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	ongoing throughout employment ... Special Instructions: 1. All employees will complete a self-assessment of the skills area for their job description. This assessment will be used to determine the orientation and specific training required by each person. 2. The skills assessment checklist and the orientation checklist will be used by the supervisor/ preceptor to document the completion of satisfactory demonstration of skills. .... " Review of the Indiana Department of Health document titled "Employee Records" (completed by agency staff)identified Employee E as a CNA (certified nursing assistant). The personnel record of Employee E, HHA (home health aide) Date of Hire 6/1/20 and first patient contact of 6/2/20, contained an agency document titled "Caregiver Applicant Checklist" dated 6/1/20, which revealed that the employee checked that they have no experience with shaving, hair care (shampoo, dry & style), and medication reminders. The personnel record failed to evidence a home health aide skills competency checklist. The personnel filed revealed a registration card identifying Employee E as a home health aide. Review of the patient #3's clinical record, the home health aide visit notes revealed Employee E provided bathing, grooming, and hygiene services from 8/3/20 to present, especially shampooing the patient's hair on 8/3, 8/7, 8/17, 8/19, 8/24, 8/28, 8/31, 9/4, 9/11, 9/14, 9/18, 9/21, 9/25, 9/29, 10/2, 10/5 to 10/9, 10/12, 10/16, 10/19, 10/23, 10/26, 10/28, and 10/30/20. The findings were reviewed with Person S (Governing Body), Administrator, Director of			

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	Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-14-1(1)(2)			
G 0774 Bldg. 00	484.80(d) 12 hours inservice every 12 months Standard: In-service training. A home health aide must receive at least l2 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient. Based on record review and interview, the agency failed to ensure all home health aides completed 12 hours of in-service training during the year of 2019 for 5 of 5 personnel records reviewed of employees working in 2019. (Employees X, BB, CC, DD, EE, and FF) Findings include: The training file for Employee X, date of hire 9/13/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee BB, date of hire 4/25/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee CC, date of hire 6/6/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee DD, date of hire 4/16/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee EE, date of hire	G 0774	**G774** The Director of Clinical Services will immediately have all home health aide personnel files audited for compliance with the required 12-hours of in-service for 2020. Any identified gaps will be addressed. The home health aides who failed to complete the annual 12 hours of home health aide in-services will be scheduled “make-up” in-services and testing which will be completed by February 28, 2021. The Director of Clinical Services/designee will directly oversee all home health aide in-service and testing sessions. Failure of the home health aides to complete the required in-services will result in suspension from work with Visiting Angels Home Health Agency until their required in-services are completed. The Director of Clinical Services/designee is responsible	02/16/2021

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	10/8/18, failed to evidence 12 hours of in-service training for the year of 2019. During an interview with the Person S, only Governing Body Member/ Owner, on 11/13/20 at 10:15 a.m., when asked how he ensure staff hired were adequately trained to do their job, Person S stated information was sent to the CNAs (certified nurses aides) for continuing educations. During an interview on 11/17/20 at 11:45 a.m., when queried about the tracking for the HHA 12 hour in-service, the Administrator stated he didn't know they were to track the in-services/ hours. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-14-1(h)		for the planning, implementation, and oversight of the monthly home health aide in-service program. The Director of Clinical Services is responsible for ensuring on-going compliance with G774.	
G 0776 Bldg. 00	484.80(d)(1) Inservice training supervised by RN In-service training may be offered by any organization and must be supervised by a registered nurse. Based on record review and interview, the agency failed to ensure all in-service training during the year of 2019 was supervised by a Registered Nurse for 5 of 5 personnel records reviewed of employees working in 2019. (Employees X, BB, CC, DD, EE, and FF) Findings include: Review of the training files for the following employees, the agency failed to evidence	G 0776	**G776** The home health aides will be offered 2 opportunities monthly to complete their monthly in-service requirements. The Director of Clinical Services/designee will plan the annual home health aide in-service program including the 12 topics & content that pertain to the work and patient population the home health aides serve.	02/16/2021

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	documentation that a Registered Nursing supervised all in-service training: The training file for Employee X, date of hire 9/13/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee BB, date of hire 4/25/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee CC, date of hire 6/6/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee DD, date of hire 4/16/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee EE, date of hire 10/8/18, failed to evidence 12 hours of in-service training for the year of 2019. During an interview with the Person S, only Governing Body Member/ Owner, on 11/13/20 at 10:15 a.m., when asked how he ensured staff hired was adequately trained to do their job, Person S stated new hires goes through an orientation process and more information was sent to the CNAs (certified nurses aides) for continuing educations. During an interview on 11/17/20 at 11:45 a.m., when queried about how in-services were provided, the Administrator stated education has been provided with paychecks and the aides would complete them and turn them in. The findings were reviewed with Person S (Governing Body), Administrator, Director of		The Director of Clinical Services/designee will approve the content of all in-service presentations and be present for the training sessions. The Director of Clinical Services/designee will oversee the results of the home health aide testing following the training sessions and re-educate and re-train any home health aide failing to pass the in-service post-test. The in-services will be documented in the employees' personnel files and these will be audited annually to ensure on-going compliance with the 12-hour in-service requirement for all home health aides employed in the home health industry. The Director of Clinical Services is responsible for ensuring ongoing compliance with G776.	

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	Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-14-1(k)			
G 0778 Bldg. 00	484.80(d)(2) Documentation of inservice training The HHA must maintain documentation that demonstrates the requirements of this standard have been met. Based on record review and interview, the agency failed to ensure they maintained documentation that all home health aides completed 12 hours of in-service training was supervised by a Registered Nurse, during the year of 2019 for 5 of 5 personnel records reviewed of employees working in 2019. (Employees X, BB, CC, DD, EE, and FF) Findings include: The training file for Employee X, date of hire 9/13/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee BB, date of hire 4/25/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee CC, date of hire 6/6/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee DD, date of hire 4/16/18, failed to evidence 12 hours of in-service training for the year of 2019. The training file for Employee EE, date of hire 10/8/18, failed to evidence 12 hours of in-service	G 0778	**G778** Due to the findings of condition-level deficiencies the Agency is precluded from competency testing of all "new-hire" home health aides. As a result of this finding the Governing Body made the decision to only hire certified nursing assistants (CNA's). The Home Health Aide Annual In-Service Program **(the Hha Inservice Program may be provided by any organization)** has been revamped and is under the direct supervision and guidance of the Director of Clinical Services. The Director of Clinical Services/designee will set up the in-service program including, topics, education material, etc. Educational training sessions will be held by the Director of Clinical Services. Post-tests and evaluations will be maintained in the employees' records. Each training session will be	03/16/2021

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	training for the year of 2019. During an interview with the Person S, only Governing Body Member/ Owner, on 11/13/20 at 10:15 a.m., when asked how he ensured staff hired was adequately trained to do their job, Person S stated new hires goes through an orientation process and more information was sent to the CNAs (certified nurses aides) for continuing educations. During an interview on 11/17/20 at 11:45 a.m., when queried about the tracking for the HHA 12 hour inservice, the Administrator stated he didn't know they were to track the in-services/ hours. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-14-1(k)		overseen by the Director of Clinical Service/designee. There will be a post-test or skills demonstration that is completed by the CNA working as a home health aide following the education provided. Employee in-service files will be maintained by the Personnel Manager and monitored monthly for continued employee compliance. The HR Manager is responsible for providing a monthly report of employee compliance to the Director of Clinical Service/designee. It is a mandatory requirement for all CNA's who are working as home health aides employed by the Agency to attend and successfully complete twelve in-services per calendar year. The Director of Clinical Services/designee is responsible for ensuring in-service records for all CNA's working as home health aides are current, accurate, and complete with the required content; i.e., dates of in-services, # of hours of in-service, topics, and documentation of written test results or skills-competency testing results is maintained. All in-service documentation for the CNA's who are employed as home health aides for the agency is filed and maintained in their employee records. The Personnel Manager/designee will track the compliance of the CNA's with meeting the monthly	

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			in-service requirements and report all employee gaps in training to the Director of Clinical Service/designee. CNA's failing to complete the required 12 hours of in-service per calendar year will have their employment with Visiting Angels Home Health Agency terminated. The Director of Clinical Service is responsible for ensuring ongoing compliance with G778.	
G 0798 Bldg. 00	484.80(g)(1) Home health aide assignments and duties Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on observation, record review and interview, the Case Manager failed to ensure the aide care plan was individualized and patient specific for 2 (Patient #2 and #3) out 2 active pediatrics and 2 (Patient #1, #5) of 3 active adult patient records reviewed in a sample of 7. Findings include: 1. Review of an undated agency policy titled "Home Health Aide Care Plan C-751" indicated " ... A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse ... To provide a means of assigning duties	G 0798	G798 The agency will ensure that all patient care plans are individualized for each specific patient. The Clinical Manager/designee will audit 100% of patient care plans to ensure compliance and will re-educate RN Case Managers on the writing of patient-specific care plans. RN Case Managers are continuously overseeing and updating care plans for each patient via the EVV system. Care plans and visit notes are monitored weekly to ensure	02/16/2021

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	to the Home Health Aide that are clear to the Nurse, Home Health Aide, and to the client/ caregiver being served ... To provide documentation that the client's care is individualized to his/ her specific needs .... " 2. During a home visit at patient #2's home on 11/10/20 at 1:30 p.m., the patient was observed to be propped up on the couch with pillows and oxygen per nasal cannula. A bath given by the certified nursing assistant was observed and the patient was noted to have a button feeding tube (g/tube = gastric tube) in their left abdomen with a dry dressing around the stoma (insertion) site. The patient's father stated the patient's feeding was Complete Pediatric Organic Blend 300 ml (milliliters)/ 10 ounces at 8:00 a.m., 12:00 p.m., 4:00 p.m., 8:00 p.m. The father stated he gives approximately 60 ml of water with each medication pass and tube feedings and will give extra during the day. The father indicated he manages the patient's medications (given by the g-tube) and tube feedings, needs nursing during the night due to lack of sleep from the patient's multiple seizures. The father indicated the patient was put on oxygen approximately 1.5 weeks ago and is on it 24/7 at 1 liters. Review of the plan of care for the certification period of 10/18/20 to 12/16/20, revealed home health aide services to be provided 8 hours a day 5 days a week to assist with ADLs [activities of daily living such as bathing and hygiene], bathing, transfers, safety, incont [incontinent] care, companionship and light housekeeping. Review of the aide care plan dated 10/16/20, indicated the patient was bed bound, had a g/tube, may assist with transfer, ambulation, and mobility, may bathe patient in the tub or bed,		accuracy of patient needs and compliance of provision of those needs.	

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	comb/ brush hair, shampoo and condition hair, dress the patient, skin care/ grooming, brush teeth, mouthwash, and oral swabs, diaper/ depends, clean bathroom after use, clean kitchen after meal prep, make bed, change bed linens, personal laundry, and medication reminder assistance. The aide care plan failed to be individualized to the patient's specific needs and failed to include a frequency of when tasks are to be done and who to ask when deciding a tub or bed bathe. The findings were reviewed with the Director of Nursing (DON) and the Administrator on 11/12/20 at 1:45 p.m., when queried if she (DON) assigned the aides and gave them a report when there are last minute changes, the DON stated the scheduler calls the aides and schedules them and she (DON) would call the aide after the visit to see how things went with the patient/ caregivers in the home. The DON and Administrator agreed that the aide care plan was not individualized to patient #1 and the aide care plans were not detailed like they should be but they were working on it. When asked about the agency's experience with pediatric patients and if the agency had a seizure protocol, both could not confirm that any employees, including themselves, had any pediatric experience and the Administrator indicated the agency did not have a seizure protocol. 3. The clinical record of patient #3 was reviewed and included a plan of care for the certification period of 10/16/20 to 12/14/20, which revealed home health aide 8 hours / day 5 days a week to provide total care bathing, grooming, incontinence care, "feedings", transfers, passive range of motion, repositioning, bed linen changes, and housekeeping.			

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	Review of the aide care plan dated 10/14/20, failed to include an emergency contact, has oxygen, enclosed bed, suction, vest, seizure precaution, g/tube, failed to include activities allowed, selected tub, shower, bed,chair, shower bench, and hand held shower for bather, comb/brush, shampoo, condition, brush teeth, mouthwash, oral swabs, clean bathroom after use, clean kitchen after meal prep, personal laundry, medication reminder assistance, failed to evidence the name of the case manager, aide frequency, supervisory visits, and other special instructions. During an interview with Person L, the parent of patient #3, on 11/12/20 at 6: 54 p.m., Person L stated they totally remodeled their bathroom to where the patient can be in a bath chair and rolled into shower stall to have a shower. Person L stated the patient cannot have anything by mouth, receives a shower via shower chair with 2 hospice aides once a week due to the patient having to be put in and secured just right in the bath chair due to no trunk support or the patient can easily fall out of shower chair if not and the patient's head has to be tried very well due to his severe microcephally or the patient will develop dry crusty areas and will bleed. Person L stated the Visiting Angels aide will prepare the patient's bed while he receives a shower and will receive a bed bath all other days by Visiting Angels aide. The aide care plan failed to be accurate, complete and individualized to the patient's specific needs and failed to include a frequency of when tasks are to be done. 4. The clinical record for patient #5 was reviewed and included a plan of care for the certification period of 10/1/20 to 11/29/20, the order for			

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	discipline and treatment indicated "HHA x 8 hours/ day x 5 days / wk ... HHA to assist with all adls, transfers, positioning, bathing, incontinence care, meal prep, linen changes, and light housekeeping. Review of an agency document titled "Aide's Care Plan" last updated on 10/1/20, indicated the patient was bed bound, special equipment hoyer, does not wear dentures, watch for hyper/ hypoglycemia, bleeding precautions, transfer revealed bed rest and hoyer, the Ambulation/ Mobility revealed wheelchair and positioning, Personal Care/ Assistance with ADLs indicated shower, bed chair, shower bench, comb/ brush hair, shampoo, condition, dress, shave, skin care/ grooming, clean dentures, brush teeth, mouthwash, oral swabs, empty catheter/ drainage bag, assist with bedpan/ urinal, catheter care, diapers/ depends, clean bathroom after use, clean kitchen after meal prep, make bed, change bed linens, personal laundry, and medication reminder assistance. The aide care plan failed to be accurate, complete and individualized to the patient's specific needs and failed to include a frequency of when tasks are to be done. 5. During an interview with the DON and Administrator on 11/12/20 at 1:45 p.m., the Administrator stated they did not know how to complete a home health aide care plan. The Director of Clinical Services stated the care plans should be more detailed and that they are working on it. 6. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of			

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	Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 7. The clinical record of patient #1, SOC 9/3/20, was reviewed and included a plan of care for the certification period of 9/3/20 to 11/2/20, with orders indicating "Patient resides in home alone to provide total care. HHA [home health aide] x 8 hours/ day x 5 days/ wk [week] ... HHA to assist with all adls [activities of daily living - bathing/ personal hygiene and grooming; dressing/ undressing; transferring, toileting/ continence related tasks; and eating/ preparing food and feeding], meal prep, bathing, grooming, transfers, housekeeping, med [medication] reminders, incontinence care .... " Diagnosis include, but not limited to, Renal Failure. Review of the plan of care for the certification period of 11/2/20 [sic] to 12/31/20, revealed orders for HHA 8 hours/ day x 5 days/ wk "to assist with all adls, meal prep, housekeeping, bathing, grooming, med reminders." Diagnosis include, but not limited to, Renal Failure. Review of an agency document titled "Aide's Care Plan" last updated on 9/3/20, indicated the patient was on a regular diet, and the aide was to plan/ prepare meals/ snacks, serve meals, offer fluids; bathing duties included shower, bed, chair, shower bench, and hand held shower; comb/ brush, shampoo, condition hair, dress, shave, skin care/ grooming, brush teeth, mouthwash, oral swabs, assist to commode/ toilet, assist with bedpan/ urinal, diapers/ depends, clean bathroom after use, clean kitchen after meal prep, make bed, change bed linens, personal laundry, and medication reminder assistance. The aide visit frequency indicated 8 hours a day 5 days a week. The aide care plan failed to be individualized			

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	around the patient's dialysis schedule and individualized to the patient's needs as evidenced by the following: Review of the home health aide visit notes dated 9/14/20 to 9/18/20, 9/21/20 to 9/25/20, 9/28/20 to 10/2/20, 10/05/20 to 10/9/20, 10/12/20 to 10/16/20, 10/19/20 to 10/23/20, 10/26/20 to 10/30/20, and 11/2/20 to 11/6/20, from 8:00 AM to 4:00 PM, the visit notes failed to evidence any hands on personal care had been provided by the home health aide. Only companionship, meal prep and household duties were provided. During a home visit at patient #1's home on 11/10/20 at 9:25 AM, Employee B, CNA (certified nursing assistant) was interviewed. Employee B stated she was there to help the patient "because she has trouble doing stuff." Upon clarifying her statement, Employee B stated "I run errands mostly, do housekeeping, and make meals and I'm here when she gets into the shower." Employee B confirmed that the patient receives dialysis Monday, Wednesday, and Friday. Employee B stated she sometimes picks up the patient's medications and drop them off to her. Employee B stated she does not assist the patient with any bathing. When queried if she performs any stand by assist when the patient gets in and out of the shower, the employee stated "No. I'm just here in case. She does everything alone." During an interview on 11/12/20 at 10:15 AM, Patient #1 stated she gets ready for dialysis at 4:30 AM, their aide, Employee B, meets her at Dialysis at 8:00 AM. The patient stated "She sits in her car until I leave at around 10 then meets me at home because she works an 8 hour day." When queried about aide duties and if the aide helps her with anything during dialysis, the			

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	patient responded "No. I said she just sits in the car but she works 8 hours so if she didn't come at 8 and stay in her car, she wouldn't get all her hours." 17-14-1(m)			
G 0800 Bldg. 00	484.80(g)(2) Services provided by HH aide A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review, and interview, the agency failed to ensure home health aides (HHA) provided services per the plan of care and failed to ensure HHA's did not provide services beyond the scope of their practice for 1 (Patient #2) of 1 pediatric observation in a sample of 3 and 1 (Patient #3) of 1 interview with a family member of a active pediatric patient receiving hospice services and failed to provide services as ordered on the plan of care for 2 of 3 (Patients #1, 5) active records reviewed of adult patients receiving home health aide services in a sample of 7. Findings include: 1. Review of an undated policy titled "Home Health Aide Services C-220" indicated " Policy: ... The duties of a home health aide include the provision of hands-on personal care and performance of simple procedures ... Special Instructions: ... 3. The Aide will follow the care plan and will not initiate new services or	G 0800	**G800** All home health aide care plans are now loaded on the EVV system. This ensures accurate reporting of time on the job and tasks to complete. All agency home health aides have completed a re-training session to re-address the following: · Scope of Practice-activities and services the home health aide is “allowed” to perform, and “NOT” allowed to perform, · The necessity of performing only the activities as listed on their home health aide care plan, · The necessity of arriving and leaving on-time for all clients, · Activities the Hha is not allowed to perform, such as the provision of nursing care, · Home health aides are not	02/16/2021

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	discontinue services without contacting the supervising Nurse. .... " 2. Review of an undated policy titled "Home Health Aide Documentation C-800" indicated "Policy: Home Health Aides will document care/ services provided on the home health aide charting form. Care/ services provided should be in accordance with direction provided in the Home Health Aide Care Plan ... Special Instructions: ... 3. The designated Registered Nurse ... or designated person is responsible for reviewing the Home Health Aide's charting before it is placed in the chart." 3. The clinical record for patient #2 was reviewed and contained an aide care plan dated 10/16/20, which indicated the patient was bed bound, had a g/tube, may assist with transfer, ambulation, and mobility, may bathe patient in the tub or bed, comb/ brush hair, shampoo and condition hair, dress the patient, skin care/ grooming, brush teeth, mouthwash, and oral swabs, diaper/ depends, clean bathroom after use, clean kitchen after meal prep, make bed, change bed linens, personal laundry, and medication reminder assistance and there were seizure precautions but no direction included. Review of the plan of care for the certification period of 10/18/20 to 12/16/20, revealed home health aide services to be provided 8 hours a day 5 days a week to assist with ADLs [activities of daily living such as bathing and hygiene], bathing, transfers, safety, incont [incontinent] care, companionship and light housekeeping. Review of the home health aide visit notes on 11/09/20 from 10/19/20 to 10/23/2020, the visit notes indicated the aide "assisted" with bathing		allowed to run errands or transport patients during PA hours, · Home Health Aides are expected to perform to perform the tasks as outlined on the HHA Care Plan. · Home Health Aides are expected to report the following immediately to the RN Case Manager or designee overseeing the case: o Patient refusal of tasks or services, o Patient requests that are outside scope of practice, o Any change in patient condition, o Any change in condition of the patient's skin, o Any negative change or concerns r/t the patient's home environment and/or support system (Examples: no heat in the home, electricity shut off, combative family members, etc.). To ensure ongoing compliance the RN Case Managers make Hha Supervisory Visits every 30 days to observe the provision of care and evaluate Hha task performance, collaborate with the patient and aide to coordinate care, assess the safety of the patient, and identify any new care needs. In addition the Director of Clinical Services/designee will initiate additional random un-announced home supervisory visits of the aides to evaluate their compliance	

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	when the patient is totally dependent; shampoo hair on Monday, Wednesday, Friday; provided medication reminders when the father/ caregiver manages the patient's medications; "assisted" with transfers and exercise when the patient is totally dependent and no orders to conduct exercises; cleaned kitchen/ washed dishes when the patient is nothing by mouth and receives nutrition through a gastric tube; and no laundry or bed made/ linens changed. No other visit notes was found within the record. During a home visit with employee D, HHA , on 11/10/20 at 1:30 p.m., employee D was observed to give patient #2 a bath. After the bath, employee D was observed removing the patients dressing around their feeding tube and replace it with a clean and dry dressing. During this time, when asked about an aide care plan to review, the employee stated she just recently started with the patient, this was her 2nd or 3rd visit, and the agency did not provide her with a report or an aide care plan. The employee stated she didn't know that this patient was a pediatric patient until she got here. The employee stated the caregiver has been educating her on what she needs to do. The findings were reviewed with the Director of Nursing (DON) and the Administrator on 11/12/20 at 1:45 p.m., in which they agreed the HHA should not have changed the patient's dressing around the feeding tube and indicated the home should have a folder with the aide care plan. When queried if she (DON) assigned the aides and gave them a report when there are last minute changes, the DON stated the scheduler calls the aides and schedules them and she (DON) would call the aide after the visit to see how things went with the patient/ caregivers in the home.		with the Hha Care Plan and execution of assigned tasks. Home Health Aides failing to comply with the instructions on the Home Health Aide Care Plan will be subject to the following disciplinary plan: All Home Health Aides will be re-educated on the consequences of failing to follow the Hha Care Plan and failing to show up and stay with the patient for the ordered # of hours. · Failure to provide care and service in compliance with G800 will result in re-education of the employee and an entry in their personnel file documenting their non-compliance with a written warning that ongoing non-compliance will result in further consequences. · Failure to provide care and service in compliance with the home health aide care plan in compliance with G800 a 2nd time will result in further re-education of the employee and the employee being placed on a 30-day action plan. · If there is a 3rd occurrence of non-compliance with the provision of home health aide services, the employee's employment with Visiting Angels Home Health Agency will be terminated. The Director of Clinical Service is responsible for ensuring ongoing compliance with G800.	

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	4. The clinical record for patient #3 was reviewed and contained a plan of care for the certification period of 10/16/20 to 12/14/20, revealed home health aide 8 hours / day 5 days a week to provide total care bathing, grooming, incontinence care, "feedings", transfers, passive range of motion, repositioning, bed linen changes, and housekeeping. Review of the aide care plan dated 10/14/20, which indicated the patient was on oxygen, enclosed bed, suction, vest, seizure precautions, g/tube, selected tub, shower, bed,chair, shower bench, and hand held shower for bathe, comb/brush, shampoo, condition, brush teeth, mouthwash, oral swabs, clean bathroom after use, clean kitchen after meal prep, personal laundry, medication reminder assistance. Review of the home health aide visit notes dated 10/16/20, 10/19/20, 10/23/20, 10/26/20, 10/28/20 and 10/30/20 revealed an "R" for prepare meal/ snack, feed client, medication reminders, clean kitchen/ wash dishes. The bathing failed to evidence if a tub, shower, bed,chair, shower bench, or hand held shower was provided, failed to indicate if incontinence care was given, if hair was conditioned, bed linen changed. The home health aide failed to follow the plan of care. Review of the home health aide visit notes dated 10/21/20, revealed an "R" (refused) for assist with bathing, shampoo hair, prepare meal/ snack, feed client, medication reminders, clean kitchen/ wash dishes. The visit note failed to evidence if incontinence care was given and if bed linen changed. The home health aide failed to follow the plan of care. Review of the home health aide visit notes dated			

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	10/20/20, 10/22/20, 10/27/20 and 10/29/20 revealed an "R" for shampoo, prepare meal/ snack, feed client, medication reminders, clean kitchen/ wash dishes. The bathing failed to evidence if a tub, shower, bed,chair, shower bench, or hand held shower was provided, failed to indicate if incontinence care was given and bed linen changed. The home health aide failed to follow the plan of care. During an interview on 11/12/20 at 8:41 a.m., with Person N, RN Case Manager from hospice, stated the patient receives medications throughout the day through the g/tube. At 1:19 p.m., Person N called and stated she had spoken to Employee E, HHA and who is also a family member with patient #3, confirmed with Employee E that she was clocking out with Visiting Angels to give the patient his medications, then would clock back in. During an interview with the Administrator and Director of Nursing on 11/12/20 at 1:45 p.m., both denied knowing that the home health aide was clocking out to give the patient his medications. The Administrator pulled up the computer program that shows when home health aide staff clocks in and out, and the program failed to evidence that the home health aide was clocking out to give medications. During an interview with Person L, patient's #3's parent on 11/12/20 at 6:54 p.m., when asked if any medications were to be administered during Employee E's working hours of 10:00 a.m. to 6:00 p.m., Person L stated medications are given 5 to 6 times per day and all medications were given through the g/tube. Person L also indicated the home health aide also suctions the patient and utilizes the percussion vest.			

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	5. The clinical record for patient #5 was reviewed and contained a plan of care for the certification period of 10/1/20 to 11/29/20, with orders for "HHA x 8 hours/ day x 5 days / wk ... HHA to assist with all adls, transfers, positioning, bathing, incontinence care, meal prep, linen changes, and light housekeeping. Review of an agency document titled "Aide's Care Plan" last updated on 10/1/20, indicated the patient was bed bound, special equipment hoyer, does not wear dentures, watch for hyper/ hypoglycemia, bleeding precautions, transfer revealed bed rest and hoyer, the Ambulation/ Mobility revealed wheelchair and positioning, Personal Care/ Assistance with ADLs indicated shower, bed chair, shower bench, comb/ brush hair, shampoo, condition, dress, shave, skin care/ grooming, clean dentures, brush teeth, mouthwash, oral swabs, empty catheter/ drainage bag, assist with bedpan/ urinal, catheter care, diapers/ depends, clean bathroom after use, clean kitchen after meal prep, make bed, change bed linens, personal laundry, and medication reminder assistance. Review of the home health aide visit notes evidenced the following: Review of a home health aide note dated 9/28/20 during a previous certification period, the note revealed that the aide made a visit to the store. The aide made a trip to the store that is not permitted under Medicaid PA. On 10/01/20, the home health aide visit note indicated a visit was made from 8:00 a.m. to 4:00 p.m. and failed to evidence that the patient had a bath, shave, shampoo/ condition, brush/ comb hair, assist with clothing/ dressing, oral care, meal			

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	prep, medication reminder. The note indicated the home health aide assisted with transfers when the patient has not been out of bed since October of 2019. On 10/02/20, the home health aide visit note indicated a visit was made from 8:00 a.m. to 4:00 p.m. and failed to evidence that the patient had a shave, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, clean dishes, medication reminder, change linen, and laundry. The note did reveal that the home health aide assisted with exercise and went to the store. The aide provided exercise that was not ordered on the plan of care, made a trip to the store that is not permitted under Medicaid PA nor ordered on the plan of care, assisted with transfers, and failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/4/20, only one partial visit was made on 10/08/20, from 1:30 p.m. to 4:00 p.m. and failed to evidence that the patient had a shave, brush/ comb hair, oral care, assist with toileting, meal prep, medication reminder, assist with transfers, clean dishes, change linen, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/11/20, only 3 partial visits were made. Review of a visit note dated 10/13/20 from 8:00 to 10:00 a.m., the visit note failed to evidence that the patient had a shave, brush/ comb hair, oral care, assist with transfers, meal prep, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note on 10/14/20 from 8:00 to 11:02 a.m., failed to evidence that the patient had a			

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	bath, shave, shampoo hair/condition, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean dishes, change linen, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note on 10/16/20 from 12:00 to 4:00 p.m., failed to evidence that the patient had a shave assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean dishes, clean bathroom, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/18/20, only 4 partial visits were made. Review of a visit note dated 10/19/20 from 12:00 to 3:45 p.m., failed to evidence that the patient had a shave, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean bathroom, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/21/20 from 8:00 to 9:30 a.m., failed to evidence that the patient had a bath, shave, shampoo/ condition, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/22/23 from 8:00 to 11:00 a.m., failed to evidence that the patient had a bath, shave, shampoo hair/ condition, brush/ comb hair, oral care, meal prep, assist with			

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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VISITING ANGELS HOME HEALTHCARE	3197 S US HWY 231 GREENCASTLE, IN 46135

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	transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/23/20 from 8:00 to 11:00 a.m., failed to evidence that the patient had shave, shampoo hair/ condition, brush/ comb hair, oral care, meal prep, assist with transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/25/2020, the patient received partial visits 3 days of the week. Review of a visit note on 10/26/20 from 8:00 to 11:30 a.m., failed to evidence that the patient received a bath, shave, shampoo hair/ condition, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/27/20 from 8:00 to 9:30 p.m., failed to evidence that the patient had a shave, shampoo/ condition hair, assist with clothing/ dressing, oral care, meal prep, assist with transfers, clean living area, clean dishes, clean bathroom, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/28/20 from 8:00 to 9:30 p.m., failed to evidence that the patient had a shave, brush/ comb hair, oral care, meal prep, clean dishes medication reminder, assist with transfers, linen change and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care.			

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	Review of two visit notes dated 10/29 and 10/30/20 from 8:00 a.m. to 4:00 p.m., failed to evidence that the patient had a shave, shampoo/ condition hair, assist with clothing/ dressing, oral care, assist with transfers, meal prep, clean living area, clean bathroom, clean dishes, linen change, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 11/2/20 from 8:00 to 9:30 p.m., failed to evidence that the patient had a shave, shampoo/ condition hair, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, assist with transfers, clean living area, clean dishes, clean bathroom, change linen, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 11/5/20 from 9:00 to 11:00 a.m., indicated the patient refused all services with exception to assist with toileting, companionship, clean living area, clean floor, clean kitchen/ wash dishes, clean bathroom, empty garbage,pet care, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note on 11/6/20 from 8:00 to 11:30 a.m., indicated the patient refused all services with exception to assist with toileting, companionship, clean living area, clean floor, clean kitchen/ wash dishes, clean bathroom, empty garbage, pet care, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During a home visit on 11/12/20 from 9:30 to 10:15 a.m., the home health aide failed to shave,			

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	shampoo/ condition hair, oral care, assist with transfer, clean living area, clean floor, clean kitchen/ wash dishes, meal prep, clean bathroom and laundry. The aide arrive at the home around 9:00 a.m. and left by 11:30 a.m. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During a home visit on 11/12/20 from 9:30 to 11:30 a.m., Employee C, CNA, stated she was asked to pick up some hours with patient #5 and travels 1.5 hours one way to care for the patient. After she leaves patient #5, she moves on to the next patient. During an interview on 11/12/20 at 10:15 a.m., patient #5's family member stated the agency sometimes sends good home health aides and some bad ones. The family member stated they have not had a very good experience with Visiting Angels for it has been "up and down." The family member stated they really liked a former employee because she would get patient #5 out of bed. The family member stated they are to have someone 8:00 a.m. to 4:00 p.m. 7 days a week. The family member stated although she likes the current aide, she is only at the home until 11:30 a.m. The family member also stated that the patient has some really good aides that would take her to the doctor or to the store and she would let the aide use her car, vacuum the living (although patient has not been up out of bed for over a year), and fix her meal when they cook for the patient and do all the dishes and dusting. The family member stated they didn't have anyone from October 2019 to June 2020. The family member stated Visiting Angels would send people who don't know how to get patient #5 out of bed, wouldn't work, and even had one aide that was "fresh out of school" to where the family had to teach her how to do			

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	things. The family member stated past home health aides would through the patient's sheets always with the briefs and she was constantly having to buy new ones. The family member stated the patient hasn't been out of bed since last October, when they had the employee who was fired. The family member stated they haven't had an aide for 8 hours since the previous month and that was only for two days (10/29 and 10/30/20). The family member stated how her health was bad and that another family member who lives in the house is up all night with the patient, getting things for him, that they can not keep up with the patient during the day. 6. The clinical record of patient #1, SOC 9/3/20, was reviewed and included a plan of care for the certification period of 9/3/20 to 11/2/20, with orders indicating "Patient resides in home alone to provide total care. HHA [home health aide] x 8 hours/ day x 5 days/ wk [week] ... HHA to assist with all adls [activities of daily living - bathing/ personal hygiene and grooming; dressing/ undressing; transferring, toileting/ continence related tasks; and eating/ preparing food and feeding], meal prep, bathing, grooming, transfers, housekeeping, med [medication] reminders, incontinence care .... " Diagnoses include COPD (chronic obstructive pulmonary disease) and Renal Failure. Review of the plan of care for the certification period of 11/2/20 [sic] to 12/31/20, revealed orders for HHA 8 hours/ day x 5 days/ wk "to assist with all adls, meal prep, housekeeping, bathing, grooming, med reminders." Diagnoses include COPD (chronic obstructive pulmonary disease) and Renal Failure. Review of the aide care plan dated 9/3/20 revealed duties of bathing, hair care, skin care/ grooming,			

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	shave, and oral hygiene with an aide frequency of 8 hours a day 5 days a week. Review of the home health aide visit notes dated 9/14/20 to 9/18/20, 9/21/20 to 9/25/20, 9/28/20 to 10/2/20, 10/05/20 to 10/9/20, 10/12/20 to 10/16/20, 10/19/20 to 10/23/20, 10/26/20 to 10/30/20, and 11/2/20 to 11/6/20 failed to evidence any hands on personal care had been provided by the home health aide. Only companionship, meal prep and household duties were provided. During a home visit at patient #1's home on 11/10/20 at 9:25 AM, Employee B, CNA (certified nursing assistant) was interviewed. Employee B stated she was there to help the patient "because she has trouble doing stuff." Upon clarifying her statement, Employee B stated "I run errands mostly, do housekeeping, and make meals and I'm here when she gets into the shower." Employee B confirmed that the patient receives dialysis Monday, Wednesday, and Friday. Employee B stated she sometimes picks up the patient's medications and drop them off to her. Employee B stated she does not assist the patient with any bathing. When queried if she performs any stand by assist when the patient gets in and out of the shower, the employee stated "No. I'm just here in case. She does everything alone." During an interview on 11/12/20 at 10:15 AM, Patient #1 stated she gets ready for dialysis at 4:30 AM, their aide, Employee B, meets her at Dialysis at 8:00 AM. The patient stated "She sits in her car until I leave at around 10 then meets me at home because she works an 8 hour day." When queried about aide duties and if the aide helps her with anything during dialysis, the patient responded "No. I said she just sits in the car but she works 8 hours so if she didn't come at			

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	8 and stay in her car, she wouldn't get all her hours." During an interview on 11/12/20 at 1:45 PM, when queried if they were aware that the home health aide was sitting at dialysis center while the patient was receiving treatment, the Administrator and Director of Nursing "No." During an interview with the Person CC, Dialysis Manager with Entity B on 11/12/20 at 4:00 PM, prior to the COVID pandemic, they initially saw an aide in the lobby that waited 2 hours for the patient but never asked questions. Since COVID, no one is allowed to wait in the lobby. 7. During an interview on 11/12/20 at 1:45 p.m., when asked if they do a side by side comparison of notes against the plan of care, the Director of Clinical Services stated they get out the calendar every 3 months or so and compare to the visit note. When asked how to they ensure the orders are being followed and the content is correct, both the Administrator and Director of Clinical Services could not answer the question. When asked if they get out the plan of care and compare it to the visit to ensure the content is present, both the Administrator and Director of Clinical Services could not answer the question. 8. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide			
G 0802 Bldg. 00	484.80(g)(3) Duties of a HH aide The duties of a home health aide include:			

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	(i) The provision of hands-on personal care; (ii) The performance of simple procedures as an extension of therapy or nursing services; (iii) Assistance in ambulation or exercises; and (iv) Assistance in administering medications ordinarily self-administered. Based on record review and interview, the agency failed to ensure all home health aides provided hands on personal care as ordered per the plan of care for 1 of 1 active records reviewed of a patient receiving dialysis services in a sample of 7. (Patient #1) Findings include: Review of an undated policy titled "Home Health Aide Services" C-220, indicated " Policy: ... The duties of a home health aide include the provision of hands-on personal care and performance of simple procedures ... Special Instructions: ... 3. The Aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising Nurse. .... " The clinical record of patient #1, SOC 9/3/20, was reviewed and included a plan of care for the certification period of 9/3/20 to 11/2/20, with orders indicating "Patient resides in home alone to provide total care. HHA [home health aide] x 8 hours/ day x 5 days/ wk [week] ... HHA to assist with all adls [activities of daily living - bathing/ personal hygiene and grooming; dressing/ undressing; transferring, toileting/ continence related tasks; and eating/ preparing food and feeding], meal prep, bathing, grooming, transfers, housekeeping, med [medication] reminders, incontinence care .... " Diagnoses include COPD (chronic obstructive pulmonary disease) and Renal Failure.	G 0802	**G802** The Agency does not contest the validity of this finding and will implement immediate actions to correct the deficiency and put audit measures in place to prevent a recurrence of this problem. Implementation of EVV will assist with ensuring compliance. The Director of Clinical Service/designee will meet with all agency home health aides and the home health aide scheduler. The purpose of the meeting is to re-educate the home health aides on their home visit responsibilities and their documentation requirements. The education will consist of the following: · The requirement to provide Hha care and service as ordered on the Care Plan. · How to read and follow the directions of the Care Plan. · The requirement to document the provision of care, or the refusal of care as indicated by the patient, and/or documentation the patient had already completed the required task prior to the para-professional's assigned home visit time.	02/16/2021

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	Review of the plan of care for the certification period of 11/2/20 [sic] to 12/31/20, revealed orders for HHA 8 hours/ day x 5 days/ wk "to assist with all adls, meal prep, housekeeping, bathing, grooming, med reminders." Diagnoses include COPD (chronic obstructive pulmonary disease) and Renal Failure. Review of the aide care plan dated 9/3/20 revealed duties of bathing, hair care, skin care/ grooming, shave, and oral hygiene with an aide frequency of 8 hours a day 5 days a week. Review of the home health aide visit notes dated 9/14/20 to 9/18/20, 9/21/20 to 9/25/20, 9/28/20 to 10/2/20, 10/05/20 to 10/9/20, 10/12/20 to 10/16/20, 10/19/20 to 10/23/20, 10/26/20 to 10/30/20, and 11/2/20 to 11/6/20 failed to evidence any hands on personal care had been provided by the home health aide. Only companionship, meal prep and household duties were provided. During a home visit at patient #1's home on 11/10/20 at 9:25 AM, Employee B, CNA (certified nursing assistant) was interviewed. Employee B stated she was there to help the patient "because she has trouble doing stuff." Upon clarifying her statement, Employee B stated "I run errands mostly, do housekeeping, and make meals and I'm here when she gets into the shower." Employee B confirmed that the patient receives dialysis Monday, Wednesday, and Friday. Employee B stated she sometimes picks up the patient's medications and drop them off to her. Employee B stated she does not assist the patient with any bathing. When queried if she performs any stand by assist when the patient gets in and out of the shower, the employee stated "No. I'm just here in case. She does everything alone."		· The necessity to document any change in patient condition, any patient concern, and/or any identified areas of reddened skin or any other changes in the patient's skin condition. · Clinical Management will review the above requirements with 100% of the paraprofessional and scheduling staff. · Clinical Management will stress that failure to complete the documentation of the home visit correctly will result in a potential delay in visit reimbursement for the paraprofessional employee. Payment will be held until all documentation is completed and documented correctly. · Paraprofessional errors in documentation will be tracked and continued non-compliance will result in disciplinary action up to and including termination. To ensure compliance with the above requirements there will be a 3-step audit process. · **Step #1** will entail the Scheduler(s) reviewing 100% of all paraprofessional documentation for compliance with the Care Plan. This is to be completed daily and submitted weekly to the Director of Clinical Services/designee. o Failure of the Scheduler to perform the audits of the paraprofessional visit documentation will result in	

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	During an interview on 11/12/20 at 10:15 AM, Patient #1 stated she gets ready for dialysis at 4:30 AM, their aide, Employee B, meets her at Dialysis at 8:00 AM. The patient stated "She sits in her car until I leave at around 10 then meets me at home because she works an 8 hour day." When queried about aide duties and if the aide helps her with anything during dialysis, the patient responded "No. I said she just sits in the car but she works 8 hours so if she didn't come at 8 and stay in her car, she wouldn't get all her hours." During an interview on 11/12/20 at 1:45 PM, when queried if they were aware that the home health aide was sitting at dialysis center while the patient was receiving treatment, the Administrator and Director of Nursing "No." During an interview with the Person CC, Dialysis Manager with Entity B on 11/12/20 at 4:00 PM, prior to the COVID pandemic, they initially saw an aide in the lobby that waited 2 hours for the patient but never asked questions. Since COVID, no one is allowed to wait in the lobby. 17-14-1(h)(1)(9)		disciplinary action up to and including termination. · **Step #2** will entail the Biller performing a follow-up audit of 100% of all Hha documentation prior to submitting the bill for services proved. o Any additional errors identified by the Biller will be reported directly to the Administrator. · **Step #3** will entail a review of the Paraprofessional chart documentation by the Director of Clinical Services/designee at all certification timepoints to ensure ongoing compliance. · The Audit results will be reported on a weekly basis to the Director of Clinical Services, and the Administrator. · The QAPI Committee will receive a monthly progress report. The Director of Clinical Services is responsible for ensuring on-going compliance with G802.	
G 0818 Bldg. 00	484.80(h)(4)(i-vi) HH aide supervision elements Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication			

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	process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on record review and interview, the agency failed to ensure Case Managers accurately documented supervisory visits in regards to inaccurately indicating an aide was following the plan of care and completing tasks assigned for 2 out of 5 active records reviewed in a sample of 7. (Patient #1, 5) Findings include: 1. Review of an undated agency policy titled "Supervision of Staff C-315" indicated "Policy: All staff providing home care services will be supervised as outlined by federal and state regulations and accepted standards of practice .... " 2. Review of an undated agency policy titled "Home Health Aide Supervision C-340" indicated " ... 3. Supervision: ... c. Supervision includes a review of compliance with instructions, documentation review, appropriateness and timeliness of reporting to the supervisor and effectiveness of the plan .... " 3. The clinical record for patient #5 was reviewed and included a Home Health Aide Supervisory visit dated 10/29/20, in which the note indicated there was no aide available, no permanent staff available, and poor communication. A section titled "The Home Health Aide performs the	G 0818	**G818** The Agency has implemented the EVV system for documentation of the home health aide care plan, documentation of the arrival and departure time of the Hha at the patient's home, and documentation of all tasks the Hha completed while making the home visit. The additional identified gap with home health aide supervision addresses the RN Case Manager's responsibilities at the time of the Hha supervisory visit. The Agency has adopted a new Home Health Aide Supervisory Visit Form that addresses many of the questions outlined at G818. The Director of Clinical Services will re-educate all RN Case Managers in the utilization of the form and completion of all Hha supervisory visit tasks to include the following: The RN Case Manager is to ask the patient/caregiver the following questions and observe the aide in the provision of care for validation of compliance with the Hha Care Plan and an ongoing assessment	02/16/2021

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	following: [Answer questions based on observation and interview of client/ caregiver]" indicated all "Yes" when asked if the aide: " ... Implements & follows the Home Health Aide Care Plan; ... Arrives on time, stays the required length of time and is reliable; Demonstrates competency & performs assigned tasks per standard care protocol; Performs talks as request by client and/ or caregiver within his/ her job description .... " The supervisory visit failed to answer the home health aide performance accurately as evidenced by the following: Review of the plan of care for the certification period of 10/1/20 to 11/29/20, the order for discipline and treatment indicated "HHA x 8 hours/ day x 5 days / wk ... HHA to assist with all adls, transfers, positioning, bathing, incontinence care, meal prep, linen changes, and light housekeeping. Review of an agency document titled "Aide's Care Plan" last updated on 10/1/20, indicated the patient was bed bound, special equipment hoyer, does not wear dentures, watch for hyper/ hypoglycemia, bleeding precautions, transfer revealed bed rest and hoyer, the Ambulation/ Mobility revealed wheelchair and positioning, Personal Care/ Assistance with ADLs indicated shower, bed chair, shower bench, comb/ brush hair, shampoo, condition, dress, shave, skin care/ grooming, clean dentures, brush teeth, mouthwash, oral swabs, empty catheter/ drainage bag, assist with bedpan/ urinal, catheter care, diapers/ depends, clean bathroom after use, clean kitchen after meal prep, make bed, change bed linens, personal laundry, and medication reminder assistance. Review of the home health aide visit notes		of the Hha's competency. · Does the Hha implement and follow the Hha Care Plan? · Does the Hha comply with Agency infection prevention/control policies and procedures? · Does the Hha arrive on time, stay, the required length of time and demonstrate reliability? · Does the Hha demonstrate competency & perform assigned tasks per standard care protocol? · Does the Hha follow the Care Plan? · Does the Hha maintain an open communication process with the patient, representative, caregivers, & family? · Does the Hha follow the Agency dress code? · Does the Hha immediately report all concerns/issues, changes in client condition and/or problems to the RN Case Manager? · Does the Hha demonstrate concern and a caring attitude toward the client? · Does the Hha treat the client and caregiver with respect and honor patient rights? In addition to the above questions and observations the RN Case Manager is to assess the home health aide's performance in the following areas · Observation of a component of home care service provided by the Hha; i.e.,	

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	evidenced the following: Review of a home health aide note dated 9/28/20 during a previous certification period, the note revealed that the aide made a visit to the store. The aide made a trip to the store that is not permitted under Medicaid PA. On 10/01/20, the home health aide visit note indicated a visit was made from 8:00 a.m. to 4:00 p.m. and failed to evidence that the patient had a bath, shave, shampoo/ condition, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, medication reminder. The note indicated the home health aide assisted with transfers when the patient has not been out of bed since October of 2019. On 10/02/20, the home health aide visit note indicated a visit was made from 8:00 a.m. to 4:00 p.m. and failed to evidence that the patient had a shave, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, clean dishes, medication reminder, change linen, and laundry. The note did reveal that the home health aide assisted with exercise and went to the store. The aide provided exercise that was not ordered on the plan of care, made a trip to the store that is not permitted under Medicaid PA nor ordered on the plan of care, assisted with transfers, and failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/4/20, only one partial visit was made on 10/08/20, from 1:30 p.m. to 4:00 p.m. and failed to evidence that the patient had a shave, brush/ comb hair, oral care, assist with toileting, meal prep, medication reminder, assist with transfers, clean dishes, change linen, and laundry. The home health aide failed to provide all		grooming, showering, dressing, transfers, assistance with ambulation, etc., · Observation of client satisfaction, · Assessment of client safety with transfers, · Assessment of client mobility and assistance requirement, · Assessment of DME for obvious signs of malfunction · Assessment of Oxygen Safety if applicable, To ensure RN Case Manager compliance with their supervisory visit responsibilities the Agency will implement a 2-step approach: · The Director of Clinical Services & designee will audit the supervisory visit forms as a component of the 60-day chart review. · The Senior Management Team (comprised of the Director of Clinical Services, the Alternate Director of Clinical Services, and the Administrator) will make random unannounced supervisory visit observations of the RN Case Managers to evaluate their compliance with their Hha Supervisory visit responsibilities. The Director of Clinical Services is responsible of ensuring ongoing compliance with G818.	

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	ADL tasks as ordered per the plan of care. During the week of 10/11/20, only 3 partial visits were made. Review of a visit note dated 10/13/20 from 8:00 to 10:00 a.m., the visit note failed to evidence that the patient had a shave, brush/ comb hair, oral care, assist with transfers, meal prep, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note on 10/14/20 from 8:00 to 11:02 a.m., failed to evidence that the patient had a bath, shave, shampoo hair/condition, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean dishes, change linen, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note on 10/16/20 from 12:00 to 4:00 p.m., failed to evidence that the patient had a shave assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean dishes, clean bathroom, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/18/20, only 4 partial visits were made. Review of a visit note dated 10/19/20 from 12:00 to 3:45 p.m., failed to evidence that the patient had a shave, brush/ comb hair, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean bathroom, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care.			

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	Review of a visit note dated 10/21/20 from 8:00 to 9:30 a.m., failed to evidence that the patient had a bath, shave, shampoo/ condition, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/22/23 from 8:00 to 11:00 a.m., failed to evidence that the patient had a bath, shave, shampoo hair/ condition, brush/ comb hair, oral care, meal prep, assist with transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/23/20 from 8:00 to 11:00 a.m., failed to evidence that the patient had shave, shampoo hair/ condition, brush/ comb hair, oral care, meal prep, assist with transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During the week of 10/25/2020, the patient received partial visits 3 days of the week. Review of a visit note on 10/26/20 from 8:00 to 11:30 a.m., failed to evidence that the patient received a bath, shave, shampoo hair/ condition, assist with clothing/ dressing, oral care, meal prep, medication reminder, assist with transfers, clean living area, clean dishes, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/27/20 from 8:00 to 9:30 p.m., failed to evidence that the patient had a shave, shampoo/ condition hair, assist with			

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	clothing/ dressing, oral care, meal prep, assist with transfers, clean living area, clean dishes, clean bathroom, change linen and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of a visit note dated 10/28/20 from 8:00 to 9:30 p.m., failed to evidence that the patient had a shave, brush/ comb hair, oral care, meal prep, clean dishes medication reminder, assist with transfers, linen change and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. Review of two visit notes dated 10/29 and 10/30/20 from 8:00 a.m. to 4:00 p.m., failed to evidence that the patient had a shave, shampoo/ condition hair, assist with clothing/ dressing, oral care, assist with transfers, meal prep, clean living area, clean bathroom, clean dishes, linen change, and laundry. The home health aide failed to provide all ADL tasks as ordered per the plan of care. During an interview on 11/12/20 at 10:15 a.m., patient #5's family member stated the agency sometimes sends good home health aides and some bad ones. The family member stated they have not had a very good experience with Visiting Angels for it has been "up and down." The family member stated they really liked a former employee because she would get patient #5 out of bed. The family member stated they are to have someone 8:00 a.m. to 4:00 p.m. 7 days a week. The family member stated although she likes the current aide, she is only at the home until 11:30 a.m. The family member also stated that the patient has some really good aides that would take her to the doctor or to the store and she would let the aide use her car, vacuum the living (although patient has not			

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	been up out of bed for over a year), and fix her meal when they cook for the patient and do all the dishes and dusting. The family member stated they didn't have anyone from October 2019 to June 2020. The family member stated Visiting Angels would send people who don't know how to get patient #5 out of bed, wouldn't work, and even had one aide that was "fresh out of school" to where the family had to teach her how to do things. The family member stated past home health aides would through the patient's sheets always with the briefs and she was constantly having to buy new ones. The family member stated the patient hasn't been out of bed since last October, when they had the employee who was fired. The family member stated they haven't had an aide for 8 hours since the previous month and that was only for two days (10/29 and 10/30/20). The family member stated how her health was bad and that another family member who lives in the house is up all night with the patient, getting things for him, that they can not keep up with the patient during the day. 4. The clinical record of patient #1, SOC 9/3/20, was reviewed and included a plan of care for the certification period of 9/3/20 to 11/2/20, with orders indicating "Patient resides in home alone to provide total care. HHA [home health aide] x 8 hours/ day x 5 days/ wk [week] ... HHA to assist with all adls [activities of daily living - bathing/ personal hygiene and grooming; dressing/ undressing; transferring, toileting/ continence related tasks; and eating/ preparing food and feeding], meal prep, bathing, grooming, transfers, housekeeping, med [medication] reminders, incontinence care .... " Review of the aide care plan dated 9/3/20 revealed duties of bathing, hair care, skin care/ grooming, shave, and oral hygiene with an aide frequency of 8 hours a day 5 days a week.			

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	Review of a recertification comprehensive assessment dated 10/29/20, on page 19 of 21, revealed a supervisory visit was conducted and indicated "yes" to the aide following the plan of care. The note failed to include if any observation of care had been observed. Review of the home health aide visit notes dated 9/14/20 to 9/18/20, 9/21/20 to 9/25/20, 9/28/20 to 10/2/20, 10/05/20 to 10/9/20, 10/12/20 to 10/16/20, 10/19/20 to 10/23/20, 10/26/20 to 10/30/20, and 11/2/20 to 11/6/20 failed to evidence any hands on personal care had been provided by the home health aide. Only companionship, meal prep and household duties were provided. During a home visit at patient #1's home on 11/10/20 at 9:25 AM, Employee B, CNA (certified nursing assistant) was interviewed. Employee B stated she was there to help the patient "because she has trouble doing stuff." Upon clarifying her statement, Employee B stated "I run errands mostly, do housekeeping, and make meals and I'm here when she gets into the shower." Employee B confirmed that the patient receives dialysis Monday, Wednesday, and Friday. Employee B stated she sometimes picks up the patient's medications and drop them off to her. Employee B stated she does not assist the patient with any bathing. When queried if she performs any stand by assist when the patient gets in and out of the shower, the employee stated "No. I'm just here in case. She does everything alone." During an interview on 11/12/20 at 1:45 PM, when queried if they were aware that the home health aide was sitting at dialysis center while the patient was receiving treatment, the Administrator and Director of Nursing "No."			

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	5. During an interview on 11/12/20 at 1:45 p.m., when asked if they do a side by side comparison of notes against the plan of care, the Director of Clinical Services stated they get out the calendar every 3 months or so and compare to the visit note. When asked how to they ensure the orders are being followed and the content is correct, both the Administrator and Director of Clinical Services could not answer the question. When asked if they get out the plan of care and compare it to the visit to ensure the content is present, both the Administrator and Director of Clinical Services could not answer the question. 6. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-14-1(n)			
G 0828 Bldg. 00	484.80(i) Medicaid personal care aide-only services Standard: Individuals furnishing Medicaid personal care aide-only services under a Medicaid personal care benefit. An individual may furnish personal care services, as defined in §440.167 of this chapter, on behalf of an HHA. Before the individual may furnish personal care services, the individual must meet all qualification standards established by the state. The individual only needs to demonstrate competency in the services the individual is required to furnish. Based on observation, record review and interview, the agency failed to ensure that a home health aide met the competency requirements by	G 0828	**G828** The Senior Leadership Team in consultation with the Governing	03/16/2021

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	providing a skills competency for the tasks/ services they are providing for 1 (Employee E) of 1 personnel records reviewed of an employee registered as a home health aide and 10 (Employee D, H, J, K, L, M, N, S, T, U) of 10 Certified Nurses Aides who indicated on their self-assessment checklist that they had no experience with some or all skills. Findings include: 1. Review of an undated agency policy titled "Competency Evaluations" indicated " ... Home Health Aide: Unlicensed professionals that will provide direct client care must demonstrate their competency during the orientation program and according to the Agency skills checklist and activities delineated in the competency testing required by CMS and state specific guidelines .... " 2. Review of an undated agency policy titled "Competency Assessment" B-115 indicated "Competency of all staff will be assessed during the interview process, orientation program and ongoing throughout employment ... Special Instructions: 1. All employees will complete a self-assessment of the skills area for their job description. This assessment will be used to determine the orientation and specific training required by each person. 2. The skills assessment checklist and the orientation checklist will be used by the supervisor/ preceptor to document the completion of satisfactory demonstration of skills. .... " 3. During a home visit with employee D, HHA , on 11/10/20 at 1:30 p.m., employee D was observed to give patient #2 a bath. After the bath, employee D was observed removing the patients dressing		Body has made the administrative decision to **only employ CNA's who are currently in good standing on the ISDH Certified Nurse Aide Registry as defined at 484.80(a)(1) under item #3.** These individuals have completed a nurse aide training and competency evaluation program approved by the State of Indiana prior to their employment with Visiting Angels Home Health Agency. To ensure that all Certified Nursing Assistants employed by the agency are knowledgeable of all required work tasks these individuals will also complete the following orientation and testing at time of hire: · General employee orientation, · The CNA will complete the new-employee skills self-assessment form, · The CNA will take a competency exam upon hire, · · The CNA must be able to demonstrate competency in any required skill sets that are determined to be insufficient prior to being assigned to any patients, · Copies of the written test and the self-assessment form will be retained in the employees' file, · All CNA's hired as home health aides will receive a patient-specific orientation by an RN regarding the assigned	

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	around their feeding tube and replaced it with a clean and dry dressing. During this time, the employee stated she just recently started with the patient, this was her 2nd or 3rd visit, the agency did not provide her with a report and she didn't know that this patient was a pediatric patient until she got here. The employee stated the caregiver had been educating her on what she needed to do. The personnel record of Employee D, CNA, DOH (date of hire) 9/3/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, all communication and social activities, and "I need to review again" medication reminders. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 9/8/20. 4. Review of the Indiana Department of Health document titled "Employee Records" (completed by agency staff) identified Employee E as a CNA		patients' care needs and the services/tasks the CNA will be performing in the home setting with the patient(s) they are assigned to. The Personnel Manager has been re-educated on his/her responsibilities for ensuring complete, current, accurate personnel files for all employees, including their application, testing, hire, orientation, in-services etc. The Personnel Manager will conduct monthly audits of personnel files to ensure all files remain current and accurate. All CNA's working for Visiting Angels Home Health Agency will be required to maintain their ongoing CNA certification to ensure continued employment with the Agency. Ongoing competency will be assessed by the Registered Nurses at the time of Hha Supervisory Visits. The Director of Clinical Services and the Administrator are responsible for ensuring ongoing compliance with G828.	

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	(certified nursing assistant). The personnel record of Employee E, HHA (home health aide) DOH 6/1/20 and first patient contact of 6/2/20, contained an agency document titled "Caregiver Applicant Checklist" dated 6/1/20, which revealed that the employee checked that they have no experience with shaving, hair care (shampoo, dry & style), and medication reminders. The personnel record failed to evidence a home health aide skills competency checklist or any information on how to care for children with seizures. The personnel filed revealed a registration card identifying Employee E as a home health aide. Review of the patient #3's clinical record, the home health aide visit notes revealed Employee E provided bathing, grooming, and hygiene services from 8/3/20 to present, especially shampooing the patient's hair on 8/3, 8/7, 8/17, 8/19, 8/24, 8/28, 8/31, 9/4, 9/11, 9/14, 9/18, 9/21, 9/25, 9/29, 10/2, 10/5 to 10/9, 10/12, 10/16, 10/19, 10/23, 10/26, 10/28, and 10/30/20. 5. The personnel record of Employee H, CNA, DOH 10/19/20, contained an agency document titled "Home Health Aide Applicant Checklist" in which the all of the self assessment of work experience was left blank. 6. The personnel record of Employee J, CNA, DOH 11/5/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating			

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	assistance, hair care (shampoo, dry & style), hand washing techniques, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, all communication and social activities, and "I need to review again" medication reminders. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 11/7/20. 7. The personnel record of Employee K, CNA, DOH 10/16/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, medication reminders, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, and all communication and social activities. The			

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	personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 10/23/20. 8. The personnel record of Employee L, CNA, DOH 9/18/20, contained an agency document titled "Home Health Aide Applicant Checklist" in which the all of the self assessment of work experience was left blank. 9. The personnel record of Employee M, CNA, DOH 8/7/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, medication reminders, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, and all communication and social activities. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 8/15/20. 10. The personnel record of Employee N, CNA, DOH 8/7/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA indicated "I need to review			

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	again" ambulation (assist client with cane, walker or crutches), shaving assistance, hair care (shampoo, dry and style), Nail care (clean/paint/file), oral hygiene assistance (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, transfer assistance with gait belt or transfer bench, meal preparation (actual cooking, not frozen or fast food), mopping, vacuum (room client uses), Converse/ communicate with client, follow verbal and written instruction, write/ print legibly, read aloud, and transportation. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 8/15/20. 11. The personnel record of Employee S, CNA, DOH 9/18/20, contained an agency document titled "Home Health Aide Applicant Checklist" in which the all of the self assessment of work experience was left blank. 12. The personnel record of Employee T, CNA, DOH 10/13/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, medication reminders, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence			

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	products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, and all communication and social activities. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 10/14/20. 13. The personnel record of Employee U, CNA, DOH 10/14/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, medication reminders, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, and all communication and social activities. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 10/16/20. 14. During a home visit on 11/10/20 at 1:30 p.m., Person K, family member, stated he routinely assess and guide the home health aides while they provide care to patient #2.			

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	15. During an interview on 11/12/20 at 10:15 a.m., Person K, family member, stated the agency sometimes sends good home health aides and some bad ones. Person K member stated they have not had a very good experience with Visiting Angels for it has been "up and down." Person K stated they really liked a former employee because she would get patient #5 out of bed. Person K stated Visiting Angels would send people who don't know how to get patient #5 out of bed, wouldn't work, and even had one aide that was "fresh out of school" to where the family had to teach her how to do things. Person K stated past home health aides would through the patient's sheets always with the briefs and she was constantly having to buy new ones. 16. During an interview with the Director of Nursing (DON) and Administrator on 11/12/20 at 1:45 p.m., when asked about the agency's experience with pediatric patients and if the agency had a seizure protocol, both could not confirm that any employees, including themselves, had any pediatric experience. When asked about what their seizure protocol was, the Administrator stated the agency did not have one. 17. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			
G 0852 Bldg. 00	484.100(a) Information to the state survey agency Standard: The HHA also must disclose the following information to the state survey agency at the time of the HHA's initial			

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	request for certification, for each survey, and at the time of any change in ownership or management: Based on record review and interview, the agency failed to ensure they notified the Indiana Department of Health in advance of the changes of the Alternate Director of Clinical Services. Findings include: During the entrance conference on 11/9/20 at 9:55 a.m., when queried on who the Alternate Clinical Supervisor was, the Administrator stated that Employee A, RN was the alternate and the information was recently submitted to Indiana Department of Health. Review of the Indiana Department of Health agencies report that was completed by the Administrator, indicated Employee A, RN, was the new Alternate Director of Nursing. Review of Employee A's personnel record failed to evidence that the employee was appointed to their position by the Governing Body and/ or Administrator and that she has accepted the position of Alternate Director of Nursing. By the end of the exit conference on 11/17/20 at 1:45 p.m., the IDOH had not received any information from the agency on the changes of the Alternate Director of Clinical Services. 410 IAC 17-10-1(d)	G 0852	**G852** The Governing Body and the Administrator met to discuss the transition of the RN to the Alternate Director of Clinical Services position. It was determined the individual met the requirements for the position and the individual accepted the promotion. The ISDH was notified in advance of the change of the agency's Alternate Director of Clinical Services. A formal "written" request was sent to the ISDH along with the resume and background check. The ISDH had not responded to the Agency's request at the time of the onsite survey. The Alternate Director of Clinical Services has accepted the position and a copy of the signed job description has been placed in her personnel file. A letter of acceptance has since been received from the ISDH appointing the Alternate Director of Clinical Services into her current role. The Personnel Manager is responsible for ensuring all personnel file documents are current, accurate, and filed correctly in the employees' personnel files. The Administrator is responsible	02/16/2021

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			for ensuring ongoing compliance with G852.	
G 0940 Bldg. 00	484.105 Organization and administration of services Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on record review and interview, the agency failed to ensure all Governing Body and Administrative staff were knowledgeable in the Federal and State regulations, were qualified to organize, manage, and ensure staff provided quality of care to achieve goals and outcomes that would be identified through a complete accurate assessments and plans of care, failed to ensure they only admitted patients on the basis that the agency can meet their needs, failed to the ensure the agency had qualified staff to meet the patient needs, failed to ensure the agency had an effective QAPI (Quality Assessment Performance Improvement) Program and an effective Infection Control Program which includes the Director of Clinical Services, Case Managers, and Home Health aides and failed to ensure the agency uphold Professional Documentation Standards. These practices has the potential to impact all 59	G 0940	G940 The agency Governing Body has reviewed the operating requirements put forth by the ISDH in 2018. Federal and state regulations also reviewed. Governing Body has assumed full legal authority and responsibility for the agency's overall management and operation. Governing Body meeting minutes with administrator are being recorded weekly. Governing Body is taking an active role in new QAPI plan and PIP being put in place. Consultant contract presented to ISDH during previous survey.	02/16/2021

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	patients who received services from the agency. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate care and services which could result in the agency not providing quality health care. Findings include: 1. The Governing Body failed to ensure they periodically reviewed the written bylaws and ensure that it contained an outline of the agency's organization, operational procedures, and assuming the full legal authority and responsibility for the operation of the home health agency, failed to ensure they were fully aware of Federal and State Regulations, failed to ensure the Administrator and Alternate were officially appointed and adequately trained to manage and operate the home health agency, failed to ensure governing body meeting minutes were documented for the home health agency, failed to ensure policies were agency specific and up to date with the new 2018 Federal regulations; failed to ensure the agency had a seizure protocol/ policy; failed to ensure the QAPI (Quality Assessment Performance Improvement) met regulatory requirements, and failed to ensure they had a copy of a contract on hand with the consultant. (See G942) 2. The agency failed to ensure there was evidence of the Administrator being appointed by the Governing Body. (See G946) 3. The Administrator failed to ensure they were responsible for the day to day operation of the home health agency in regards to incomplete documentation on comprehensive assessments			

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	and medication profiles, lack of individualization of care plans, coordination of care, and services being provided to meet the patient's needs, lack of competency, training, documentation, and services being provided beyond scope of practice, ensuring staff hired is qualified to provide services, an effective Quality Assessment Performance Improvement Program (QAPI), an effective Infection Control Program, and clinical records are complete and contain accurate information, legible signatures, dates, and correct spellings. (See G948) 4. The Administrator failed to ensure the agency followed their agency policies when ensuring staff hired is qualified to provide services. (See G952) 5. The agency failed to ensure there was a qualified, pre-designated person authorized in writing by the Administrator and Governing Body to assume the same responsibilities and obligations as the administrator. (See G954) 6. The Director of Clinical Services (DOCS) failed to ensure personnel assignments were directed by her, patient assignments were based on employee experience and knowledge, and failed to ensure part-time staff were knowledgeable about the patient's medical history and their expected duties. (G 960) 7. The Director of Clinical Services failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patient's needs. (See G962) 8. The Director of Clinical Services failed to ensure patient needs are continuously assessed.			

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	(G966) 9. The Director of Clinical Services failed to ensure the Registered Nurse accurately developed and updated an individualized plan of care and failed to ensure services were provided as ordered per the plan of care. (See G968) 10. The agency failed to ensure they had written agreements in place with agencies who they share patients with. (See G978) 11. The agency failed to ensure they had written agreements with agencies who they share patients with, outlining who has the overall responsibility for all services provided. (See G980)			
G 0942 Bldg. 00	484.105(a) Governing body Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the Governing Body failed to ensure they periodically reviewed the written bylaws and ensure that it contained an outline of the agency's organization, operational procedures, and assuming the full legal authority and responsibility for the operation of the home health agency, failed to ensure they were fully aware of Federal and State Regulations, failed to ensure the Administrator and Alternate were officially appointed and adequately trained to manage and operate the home health agency, failed to ensure governing body meeting minutes	G 0942	**G942** Agency leadership has reviewed the Governing Body responsibilities as defined by the Federal Regulations and State Rules. The Agency has immediately made the following corrections: The Governing Body has reviewed their written bylaws effective: 2/12/21, · The Governing Body	03/16/2021

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	were documented for the home health agency, failed to ensure policies were agency specific and up to date with the new 2018 Federal regulations; failed to ensure the agency had a seizure protocol/ policy and infection control program, failed to ensure policy and procedures to manage patients and staff during the Coronavirus pandemic, failed to ensure that the QAPI program reflected the complexity of its organization and services for that a quality improvement, patient safety is defined, implemented, and maintained, addressed priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness, clear expectations for patient safety are established implemented and maintained, and that any findings of fraud or waste are appropriate addressed and failed to ensure they had a copy of a contract on hand with the consultant. Findings include: Review of an undated agency policy titled "Governing Body B-100" indicated "The Governing Body {or designated persons so functioning} shall assume full legal authority and responsibility for the overall management and operation of Agency. This includes the provision of home health services, fiscal operations, review of the agency's budget and its operational plans as well as the Quality Assessment and Performance Improvement Program. New governing body members/ designees are oriented to the agency as appropriate to responsibilities. The roles of the Governing Body may not be delegated. ... Special Instructions: The duties and responsibilities of the Governing Body shall include: 1. Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the day to day operations of the agency to include provision of home care services		documents contain an updated "Organizational Chart", · The Governing Body has implemented the operational procedure that clearly defines that the Governing Body assumes full legal authority and responsibility for the operation of the home health agency, · The Administrator and Director of Clinical Services continue to receive guidance and training on the Federal and State Regulations and training on management and operation of a home health agency from the Agency Consultant and the Agency is now a member of IAHHC, as members of IAHHC the management staff have access to additional relevant training material. · The Administrator was officially appointed to his position, · The Director of Clinical Services was officially appointed to her position, · The Governing Body President maintains minutes of Governing Body meetings, · The Agency has received and implemented the updated Briggs Operational Policy Manual, · The Agency seizure protocol policy indicates the clinicians will immediately contact the patient's physician if the patient is "experiencing active seizure activity" or has a "history of seizure activity" to determine	

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	in accordance with state and federal regulations ... 2. The Administrator ... This position must be approved by the Governing Body ... 3. Approves the Clinical Manager who will provide oversight of all patient care services and personnel. 4. Provide direction and leadership and be directly involved in the agency's Quality Assessment and Performance Improvement Program [QAPI] ... " Review of an undated agency policy titled "Orientation Guidelines for Advisory Board and Governing Body Members" B-200 indicated "Agency shall provide effective orientation to members of its Advisory Board and Governing Body. This orientation shall minimally include: ... 2. Roles and Responsibilities: a. Federal guidelines and state guidelines ... 3. Orientation to the Agency: i. Quality improvement plan and activities. 4. ... c. Quality improvement measures." Review of an undated agency policy titled "Governing Body Guidelines and Orientation" indicated " ... The Governing Body is made up of Agency Ownership serving as the Governing Body President and Governing Body members who are appointed to their positions by the President. The Governing Body shall assume full legal authority and responsibility for the operation of Agency. New governing body members are oriented to the agency as appropriate to responsibilities. Purpose: To ensure lines of authority are established. To ensure clients are provided with appropriate, quality of services. The duties and responsibilities of the Governing Body shall include: Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the provision of home care services in accordance with state and federal regulations, and Agency mission.		what the specific seizure protocol will consist of. This will be documented on the patient's Medical Plan of Care and on the Hha Care Plan and all clinicians and caregivers will be instructed on the specific plan. · The agency Administrator has written the "Infection Control Plan" to address the Coronavirus Pandemic, · The agency Administrator, QAPI Team, and Governing Body has approved and implemented multiple QAPI Projects to measure and monitor progress that include the following: o Documentation of the Comprehensive Assessment o Plan of Care for Patients o Processing Complaints and Grievances · The agency has defined a "Patient Safety" policy. · The agency Governing Body will oversee the program to ensure there is no fraud or waste and this will be reflected in Governing Body meeting minutes, · The agency has a copy of the Consultant's Contract. · The Governing Body has disbanded the Professional Advisory Board, · The Governing Body has dictated that the QAPI Committee responsibilities include the following: evaluation of the appropriateness, adequacy, and effectiveness of services. To	

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	Appoint the Professional Advisory Board as required by state licensure and/ or Medicare Conditions of Participation to guide the organization in the formulation and review of policies and procedures and ensure the highest quality of client care ... Define the corporate structure and clearly indicate the lines of authority .... " On January 13, 2018, new Federal Regulations went into affect and eliminated the need for a Professional Advisory Board. Review of an undated agency policy titled "Quality Assessment and Performance Improvement [QAPI] B-260" indicated " ... The agency performance improvement program consist of, but is not limited to the following: Outcome based OBQI and OBQM data from OASIS submission documents .... The governing body is responsible for ensure the following: I. An ongoing program for quality improvement and patient safety is defined, implemented, and maintained. II. The agency wide assessment and performance improvement efforts address priorities for improved quality of care and client safety. III. All improvement actions will be evaluated for effectiveness. IV. Clear expectations for client safety are established, implemented and maintained. V. Any findings of fraud or waste are appropriately addressed." The OBQI and OBQM data has not been utilized by Centers for Medicare and Medicaid for over 7 years." Review of an undated agency policy titled "Quality Improvement Committee Responsibilities [QA/PI]" indicated "Purpose: The QA/PI committee is a sub-committee of the Professional Advisory Committee. To review and advise agency on the quality of care provided by the agency. To evaluate the appropriateness,		ensure the QAPI Committee has the tools to measure and monitor the above requirements several tracking processes have been implemented and include the following: o Complaint & Grievance Form o Complaint Summary Log o Infection control Tracking and Reporting Tool o Patient Infection Report Summary Log o Incident Report o Incident Report Tracking Log o ED/Hospitalization Patient Tracking Tool o Inquiry Log o Referral Log o Clinical Record Audit Tool · The Governing Body meetings will have a meeting agenda and minutes of the meetings will be documented. · The Governing Body President has been provided a copy of federal regulations and state rules. The Consultant has provided the Governing Body President with a Power-Point presentation that explains the federal regulations and the Governing Body President has access to the Consultant r/t any regulatory and/or operational questions. The Governing Body President and Agency Administrator are responsible for ensuring ongoing compliance with G942.	

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	adequacy, and effectiveness of services. To identify over or under utilization of services. To identify gaps in agency services, and need for in-service education, staffing consultation services, and agency policies. To ensure records reflect care and/ or service provided, the patient's current condition, and the patient's progress towards goals and conditions at the time of discharge. To ensure documentation is complete, accurate, and timely. To ensure compliance with OASIS data collection and utilization of assessment data in ongoing plans of care. To evaluate adverse outcome reports and identify documentation limitation or the need for a focused plan to improve patient outcomes through targeted interventions. To review and determine if patient care is being provided per agency policy and in compliance with federal regulations and state rules. To participate in the annual program evaluation. Review of the agency's Bylaws dated 6/30/17, on 11/17/20 at 11:00 a.m., failed to evidence a signature and date of a Governing Body/ Board of Director but revealed that a former administrator signed off on the agency Bylaws as a "secretary." The Bylaws failed to be reviewed and updated to be specific to the agency's organization, operational procedures, and assuming the full legal authority and responsibility for the operation of the home health agency. Review of the Organizational chart that was provided by the Administrator, revealed a Medical Advisory Committee that consisted of 4 physicians. The chart also listed the name of a former employee as the Alternate Director of Nursing and having the certified nursing assistants and home health aides report to Employee X, a CNA/ Billing Manager/ Scheduler.			

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	Review of the Administrator's personnel record, failed to evidence that the Administrator was appointed to his position by the Governing Body and that he had accepted the position of Administrator. Review of the Director of Nursing's (DON) personnel record, failed to evidence that the DON was appointed to their position and as the Alternate Administrator by the Governing Body and/ or Administrator and that she had accepted the position of Alternate Administrator/ Director of Nursing. Review of the Indiana Department of Health agencies report that was completed by the Administrator, indicated Employee A, RN, was the new Alternate Director of Nursing. Review of Employee A's personnel record failed to evidence that the employee was appointed to their position by the Governing Body and/ or Administrator and that she had accepted the position of Alternate Director of Nursing. On 11/12/20 at 3:30 p.m., the Governing Body Minutes going back to 2017 were requested. On 11/13/20, the weekly Governing Body minutes dated 8/17, 8/31, 9/8, 9/14, 9/28, 10/5, 10/12, 10/19, 10/21, 10/26, and 11/2/20. "Senior Management Training Needs" indicated on 8/17, 8/24, and 9/28/20 "ongoing with consultant", on 8/31/20 "To continue with consultant at rate of 1 to 3 hours per wk [week] depending on need", on 9/8/20 "Ongoing - re-reading policy manuals currently before proceeding with consultant", on 9/14/20 on 9/21/20 "Continued wait for state report", on "Waiting until after newest POC [plan of correction] completed", on 10/5 and 10/26/20 "Ongoing", on 10/12/20, "To resume once POC			

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	approved", on 10/19/20 "Contact maintained with consultant", and 11/2/20 "Continued with consultant." These Governing Body minutes failed to evidence any discussion in regards to audits, QAPI program, nor resolutions to staffing and patient problems documented. The Administrator failed to provide Governing Body minutes prior to 8/17/20. During the entrance conference on 11/9/20 at 9:55 a.m., when queried who was on the Governing Body, the Administrator stated only the owner, Person S, was the sole Governing Body member. The policy failed to be updated to reflect that only the owner of the agency was the sole Governing Body member. Review of clinical record #2 and #3, evidenced two pediatric patients with complex needs, including severe seizure activity. During an interview with the Director of Clinical Services Administrator on 11/12/20 at 1:45 p.m., when asked about the agency's experience with pediatric patients and if the agency had a seizure protocol, both could not confirm that any employees, including themselves, had any pediatric experience. When asked about what their seizure protocol was, the Administrator stated the agency did not have one. During an interview on 11/12/20 at 1:45 p.m., when queried about experience and training, the Director of Clinical Services stated she did not have any training as a Clinical Supervisor and only had approximately 2 days of training as a case manager. The Director of Clinical Services stated her background consists of Long Term Care and no home health care. The Administrator stated he had 3 years of case management experience with hospice, worked in long term care			

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	and hospitals, but did not have experience with home health care. The Administrator indicated he was trained for about a month by the former administrator. During an interview with the Person S, only Governing Body Member/ Owner, on 11/13/20 at 10:15 a.m., when queried how he ensured staff hired was adequately trained to do their job, Person S stated new hires went through an orientation process and more information was sent to the CNAs (certified nurses aides) for continuing educations. When queried if he participated in QAPI, Person S stated he does participate, that he and the Administrator met 1/2 hour to 1 hour every morning and they discussed coordination of care, patient charts, they discussd complaints/ recently implemented documentation and resolution documentation, and CNA training. When queried for specific information that is discussed about chart audits, Person S was not able to provide any details and stated he and the Administrator did not "dig down" and the Administrator should have a list of audits. When queried about the frequency of chart audits, Person S, stated he did not know how often chart audits were completed but thought they charts are audited quarterly. When queried if there was a percentage of charts audited, Person S stated he didn't know, he assumed 100% and he thought the Director of Clinical Services has an audit tool from Person E, Consultant. When queried if he was familiar with Article 17 of the Indiana Administrator Code or the Federal Regulations, Person S responded that he had Person E, since 3 years ago when the agency needed help getting started. Person S indicated Person E conducted mock surveys and stated he did not know the Indiana Administrative Code or the Federal Regulations, he would go through the			

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	Administrator or Person E if he had any questions. When discussing the Administrator and Director of Nursing lack of knowledge/ experience with home health and their inability to go to someone for questions, Person S stated the Administrator and DON always had Entity F, a home health association within the state of Indiana, and Person E to go to for questions. When informed Person S that Person E was only reinstated around August (2020) and the Administrator stated the agency was no longer engaged with Entity F, Person S then confirmed he hired Person E to work with the agency a few months ago and has recently re-instated Entity F two days prior. Person S then questioned Person E's qualifications and knowledge of the regulations. When queried if Person S found the contract with Person E, that was requested on 11/12/20, Person S stated per Person E's attorney, it was instructed not to provide the contract. Person S was informed that Person E's attorney was representing her and not the agency, therefore, the attorney's instruction did not pertain to this agency and to provide the contract for surveyor review. Person S continued to state that he will reach out to Person E and find out why a contract should not be provided. Person S again, was informed that the attorney only represented Person E and that this agency must be transparent and provide all documents requested during a survey. Lack of cooperation would result in a phone to the Indiana Department of Health, Family & Social Services Administration, and Centers for Medicare and Medicaid for impeding this survey. When queried about the agency accepting complex pediatric patients and the lack of qualified home health aides and skilled nursing needed, Person S stated the decision to start accepting pediatric patients happened "naturally" but had no answer on the			

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	complex needs of the pediatric patients and the need for skilled nursing versus home health aide services. When queried on how he seen himself and his role as the Governing Body, Person S stated he seen himself as "Managing the Manager", but the "buck stops at this desk." Person S stated he would heavily relay on Person E and Entity F for regulatory guidance. When asked if he knew where to look for regulations, Person S stated he has seen the regulations but they were hard to follow and he would rather pay someone to tell him than for him to learn it. On 11/17/20 at 9:08 a.m., Person S was asked again for the contract with Person E. Person Y again, stated the attorney instructed not to provide the contract and asked if a call was placed to Person E to verify her assistance with the agency. On 11/17/20 at 9:12 a.m., Person E was called and a message was left. At 9:37 a.m., Person E returned the call and indicated she was only engaged with the agency when they applied for their initial license and was not engaged thereafter. Person E confirmed that a new contract was created back in August 2020 and the extent of assistance is via phone and email. Person E stated she had instructed Employee Y to provide the contract and whatever documents was requested. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m., when discussing the agency's QAPI policy, the administration was queried if they were aware of OBQM and OBQI data not being utilized for over 7 years in which they had indicated they were not aware. When asked about the lack of OASIS submissions for the 2020 year, the Director			

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	of Clinical Services stated they were using an old program and was not able to transmit, but just started transmitting into the new program in September. No further information or documentation were provided during the exit conference. 17-12-1(b)			
G 0946 Bldg. 00	484.105(b)(1)(i) Administrator appointed by governing body (i) Be appointed by and report to the governing body; Based on record review, the agency failed to ensure there was evidence of the Administrator being appointed by the Governing Body. Finding includes: Review of an undated agency policy titled "Governing Body B-100" indicated "The Governing Body {or designated persons so functioning} shall assume full legal authority and responsibility for the overall management and operation of Agency. ... Special Instructions: The duties and responsibilities of the Governing Body shall include: 1. Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the day to day operations of the agency to include provision of home care services in accordance with state and federal regulations ... 2. The Administrator ... This position must be approved by the Governing Body .... " Review of the Administrator's personnel record, failed to evidence documentation that the Administrator was appointed to his position by the Governing Body and that he has accepted the position of Administrator.	G 0946	**G946** The Administrator and Director of clinical Services will have documentation placed in their personnel records to show that the Governing Body appointed them to their position and that acceptance of those positions was made. The Governing Body has adopted a meeting agenda “template” that will be utilized for Governing Body meetings. One of the potential agenda items listed on the template relates to the Administrator and the appointment of an individual to fill this position. Therefore, utilizing the template there will always be documentation of the Administrator’s status with the organization documented in the Governing Body minutes. The Governing Body is responsible for ensuring ongoing compliance with **G946.**	02/16/2021

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	The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-12-1(b)(1)			
G 0948 Bldg. 00	484.105(b)(1)(ii) Responsible for all day-to-day operations (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the Administrator failed to ensure they were responsible for the day to day operation of the home health agency in regards to incomplete documentation on comprehensive assessments and medication profiles, lack of individualization of care plans, coordination of care, and services being provided to meet the patient's needs, lack of competency, training, documentation, and services being provided beyond scope of practice, ensuring staff hired is qualified to provide services, an effective Quality Assessment Performance Improvement Program (QAPI), an effective Infection Control Program, and clinical records are complete and contain accurate information, legible signatures, dates, and correct spellings. Findings include: 1. In regards to incomplete comprehensive assessment and medication reconciliation by Registered Nurses Based on record review, and interview the agency failed to ensure the comprehensive assessments	G 0948	**G948** The Administrator and Governing Body met to discuss the concerns listed in G948. The Governing Body has made the decision to limit the agency's scope of practice to Skilled Nursing Services and Home Health Aide Services. Due to the learning needs of the staff employed by the agency, the Governing Body has further limited the agency's scope of practice to include only the following types of patients: Skilled Nursing Services: Medication Set-Up & Disease-State Management for the adult population of the community served. Certified Nursing Assistants providing Home Health Aide Services: Provision of hands-on personal care services for the adult population of the community served. Hands-on personal care services include the provision of	03/16/2021

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	were completely filled out, accurately reflected the patients current health status and past medical history, failed to ensure assessments included patient's strengths, goals, and care preferences, failed to ensure assessments included the patient's medical, nursing, rehabilitative, social, and discharge planning needs, failed to ensure all medications were appropriately reconciled with the patient, health care representative, outside agencies and ordering physicians to ensure drug interactions and duplication is identified, failed to ensure assessments identified the patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule, and failed to ensure the assessment included information concerning a patient selected representative. 2. In regards to lack of individualized care planning, coordination of services, and quality of care The Administrator failed to ensure they accepted pediatric patients on the reasonable expectation that they were able to meet pediatric patients nursing needs; failed to ensure services were provided per the plan of care and failed to ensure each patient received an individualized care plan that identified patient specific and measurable outcomes and goals that was periodically reviewed and signed by a physician; failed to ensure the individualized plan of care included all pertinent diagnoses, all supplies and equipment, specific frequency and duration of visits, nutritional requirements, all accurate medications and treatments, all safety measures to protect against injury, patient specific interventions, measurable outcomes and goals identified by the home health agency and patient; failed to ensure the plan of care was created in conjunction with		services or assistance with services involving bathing, dressing, grooming, light meal preparation, medication reminders, assistance with transfers, ambulation, toileting, etc. Training for all skilled nurses and certified nursing assistants functioning as home health aides has addressed the following areas: · Completion of the comprehensive assessment, and medication profile including documentation of all physicians providing services, · Individualization of the Medical Care Plan for each patient, · Coordination of Care with team members and physicians, · Services provided to meet patient needs, · Training to ensure staff restrict their services to the performance of only the tasks as assigned on the Aide Care Plan or on the Medical Plan of Care, · Validation of the skill sets of all newly hired staff to ensure all staff can perform their assigned tasks. The Administrator with the approval of the Governing Body has implemented the following QAPI Projects: · **"Documentation of the Comprehensive Assessment"** that includes an audit tool to ensure all assessment information is correctly and completely	

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	the primary care physician after an assessment, verbal start of care and recertification orders obtained from the physician; failed to ensure verbal orders were complete and contained included duties/ services that the home health aides were to provide and the specific education the nurses were to educate to whom, and date and time of when orders when verbal orders were received; failed to ensure the physician was notified of the agency's inability to provide services; failed to ensure the primary care physician, patients, and patient representatives were informed in advance of the agency's intent to discharge and readmit due to administrative correctives; failed to ensure they communicated with the prescribing physician in regards to wrong patient information on a face to face encounter document; and failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patient's needs. 3. In regards to lack of competency, training, documentation, and personal hands on care and services being provided beyond scope of practice The administrator failed to ensure a home health aide completed a skills competency upon hire, failed to ensure a the agency had a copy of the home health aide skills competency on file, failed to ensure all aides completed a 12 hour in-service training that was supervised by a Registered nurse and documentation of the in-services were maintain, failed to ensure aide care plans were individualized and specific to the patient needs, outlining the frequency of tasks to be provided, failed to ensure hands on personal care and services were provided as ordered per the plan of care, failed to ensure tasks were not provided that		documented. · **"Medical Plan of Care for Patients"** that includes an audit tool to ensure all the required components of G574 are clearly documented. · **"Processing of Complaints & Grievances"** to ensure all complaints are addressed timely and thoroughly. In addition, the Administrator/designee will be tracking the following processes utilizing newly created forms to ensure the tracking of any potential concerns and these documents include the following: · Concern/Complaint Investigation Form and Process · Complaint/Grievance Tracking Log · Infection Control Tracking & Reporting Tool · Patient Infection Summary Log · Incident Report Form · Incident Report Summary Log · Log tracking patients seen in the ED or Hospital · Inquiry Log · Referral Log The Administrator and Director of Clinical Services has established a clinical record audit tool and process to ensure all clinical records are reviewed a minimum of once every 60 days to ensure all records are completed and contain	

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	is considered out of scope of practice, failed to ensure supervisory visits contained accurate information and aide visit notes reviewed, and failed to ensure that a home health aide met the competency requirements by providing a skills competency for the tasks/ services they are providing. 4. The Administrator failed to ensure the agency did not accept patients when there are no qualified personnel or Skilled Nursing (SN) to provide SN services Clinical record review of Patient #2 and 3 evidence both patients are pediatric patients with complex needs and both with severe seizures with one utilizing a Vagal stimulator, both have gastric/ jejunostomy (g/j-tube) feedings, medications to be given per g/j-tubes, both on oxygen, percussion vest, frequent oral suctioning, and both family representatives stating a need for skilled nursing. Both (Patient #1 and 2) plans of cares indicates seizure protocols and patients are being cared for by home health aides. During an interview with the DON and Administrator on 11/12/20 at 1:45 p.m., when asked about the agency's experience with pediatric patients and if the agency had a seizure protocol, both stated they were not aware of any employees, including themselves, who has any pediatric experience and the Administrator indicated the agency did not have a seizure protocol. 5. In regards to an effective QAPI Program The Administrator failed to ensure they implemented and maintained an effective Quality Assessment and Performance Improvement		accurate and complete information, legible signatures, and dates. All Certified Nursing Assistants employed by the agency will complete the following orientation and testing at time of hire: · General employee orientation, · The CNA will complete the new-employee skills self-assessment form, · The Certified Nursing Assistant will also take a competency exam, · A Registered Nurse will evaluate and provide training to the Certified Nursing Assistant as needed, · The CNA must be confident of competency in all the required skill sets prior to being assigned to any patients, · Copies of the written test and any skills-set competency will be maintained in the employees' file. · All CNA's hired as home health aides will receive a patient-specific orientation by an RN regarding the assigned patients' care needs and the services/tasks the CNA will be performing in the home setting with the patient(s) they are assigned to. The Personnel Manager will conduct monthly audits of personnel files to ensure all files	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	(QAPI) program, involved all agency services, utilized quality indicators data, including data from OASIS data, failed to focus on high risk, high volume, or problem prone areas, considered incidence, prevalence, and severity of problems in those area, take immediate corrective actions identified that could directly or potentially threaten the health and safety of patients; failed to ensure performance improvement projects analyze their causes and implemented appropriate actions and tracked the performance to ensure improvements are achieved; failed to ensure they conducted an annual performance improvement projects to ensure measurable progress has been achieved. 6. In regards to an effective Infection Control Program The Administrator failed to ensure all staff wear masks while in patients home and failed to ensure the agency developed and maintained an agency wide infection control program and failed to ensure agency staff were instructed to follow CDC guidelines in regards to symptoms and self quarantine when exposed to the Coronavirus. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 7. In regards to Clinical Records The Administrator failed to ensure that they maintain a clinical record containing current and accurate information, as well as adhere to current clinical record documentation standards; failed to		remain current and accurate. All Certified Nursing Assistants working for Visiting Angels Home Health Agency will be required to maintain their ongoing CNA certification to ensure continued employment with the Agency. Ongoing competency will be assessed by the Registered Nurses when they make Hha Supervisory Visits. All the above processes have built in monitoring tools. The Administrator is responsible for ensuring ongoing compliance with G948.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K165	A. BUILDING 00 B. WING	11/17/2020

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	ensure visit notes were incorporated within the clinical record within a timely manner; failed to ensure a discharge summary was written and sent to the primary care physician who is responsible for the patient's care after discharge within 5 business days of the patients discharge and within 2 days of patients being transferred to another facility; and failed to ensure all entries were clear, complete, authenticated, dated, and timed. 17-12-1(c)(1)			
G 0952 Bldg. 00	484.105(b)(1)(iv) Ensure that HHA employs qualified personnel (iv) Ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies. Based on record review and interview, the Administrator failed to ensure the agency followed their agency policies when ensuring staff hired is qualified to provide services. Findings include: 1. Review of an undated agency policy titled "Clinical Supervision B-105" indicated " ... Special Instructions ... 7. When a clinical supervisor does not have experience in the clinical specialty area, the supervisor will consult with the Agency Director or appropriate consultant." 2. Review of an undated agency policy titled "Home Care Staff D-220" indicated "Policy: 1. The agency will establish a program that allows for objective, measurable, assessment of the person's ability to perform required activities ... 2. The assessment will verify and focus on the individual staff knowledge and skill appropriate to	G 0952	**G952** The Administrator and Governing Body met to discuss the concerns listed in G952. The Governing Body has made the decision to limit the agency's scope of practice to Skilled Nursing Services and Home Health Aide Services. Due to the learning needs of the staff employed by the agency the Governing Body has further limited the agency's scope of practice to include only the following types of patients: Skilled Nursing Services: Medication Set-Up & Disease-State Management for the adult population of the community served. Home Health Aide Services: Provision of hands-on personal	02/16/2021

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	assigned responsibilities, communication skills, and the ability to respond to client needs within their scope of responsibility. a. Competencies will address: Age/ type of client. Scope of services offered by Agency. High risk procedures ... 3. The competency evaluations will be completed by individuals who have the knowledge and skills to assess performance and ability. 4. All competencies will be documented ... Special Instructions: 1. All new employees will be assessed for competency based on the expected requirements for the position. ... 2. Skills tests including written tests and direct observation of skill will be completed as determined by the agency policies and individual assessments. ... 3. When agency staff are assigned to new areas or procedures, training and return demonstrations or other observed evidence of competency will be documented ... Registered Nurse ... 1. Competencies will be assessed for selected activities/ procedures/ skills on a regular and as needed basis ... Home Health Aide Competency: 2. Skills competency is evaluated by observing the aide with client or "pseudo" client ... 3. A Home Health Aide will not be permitted to provide Home Health Aide services until evidence of adequate training and/ or competency has been determined .... " 3. Review of an undated agency policy titled "Competency Assessment B-115" indicated "Competency of all staff will be assessed during the interview process, orientation program and ongoing throughout employment ... Special Instructions: 1. All employees will complete a self-assessment of the skills area for their job description. This assessment will be used to determine the orientation and specific training required by each person. 2. The skills assessment checklist and the orientation checklist will be used		care services for the adult population of the community served. Hands-on personal care services include the provision of services or assistance with services involving bathing, dressing, grooming, light meal preparation, medication reminders, assistance with transfers, ambulation, toileting, etc. Training for all skilled nurses and home health aides has addressed the following areas: · Completion of the comprehensive assessment, and medication profile including documentation of all physicians providing services, · Individualization of the Medical Care Plan for each patient, · Coordination of Care with team members, physicians, · Services provided to meet patient needs, · Validation of home health aide competency to perform assigned tasks, · Training to ensure staff restrict their services to the performance of only the tasks as assigned on the Aide Care Plan or on the Medical Plan of Care. · Validation of the skill sets of all newly hired staff to ensure all staff is able to perform their assigned tasks, All Home Health Aides and Certified Nursing assistants applying for employment with the	

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	by the supervisor/ preceptor to document the completion of satisfactory demonstration of skills. .... " 4. Review of an undated agency policy titled "Employee Orientation B-150" indicated "Policy: Each employee of the Agency who provides direct care, supervision of direct care, or management of services, will participate in an orientation program specific to his/ her educational background, experience, position in the agency, and the roles and responsibilities as an employee of the Agency ... 2. Specific skills will be assessed and observed by qualified individuals before employee is allowed to perform specialty services. Observation visits will be made by a clinical supervisor to assess skills demonstrated by new personnel and to reinforce the information presented during the classroom orientation program. 3. Home Health Aides will complete a competency testing prior to providing client care ... 4. All employees will be assessed for competency prior to providing care. 5. When the initial orientation is completed, the employee will sign the orientation checklist and a copy will be retained in the personnel record .... " 5. In regards to skilled nursing personnel record and a skilled nursing checklist Review of an undated agency document titled "Skilled Nursing Checklist" is a document for Registered Nurses (RN) and Licensed Practical Nurses (LPN) to identify their "Current Experience, Need Refresher, Never Performed" in regards to assessment skills and clinical experience to certain tasks such as but not limited to tracheal suction, oxygen administration, use of inhalers, pulse oximeter; enteral feedings, insertion of gastrostomy tube, care of		agency MUST complete all questions on the application forms including the “Skills Self-Assessment” form. Failure to complete all forms will result in the application not being processed for employment with the agency. The Personnel Manager is responsible for the initial review of all new applicant files. This individual is responsible for ensuring all blanks are filled in. The Administrator/designee will not process any application with missing information. All Certified Nursing Assistants & Home Health Aides employed by the agency will complete the following orientation and testing at time of hire: · General employee orientation, · The CNA’s & Hha’s will complete the new-employee skills self-assessment form, · The Certified Nursing Assistant & Hha will also take a competency exam. A Registered Nurse will review any errors on the exam with the new employee, · Copies of the written test will be retained in the employee’s personnel file, · All CNA’s & Hha’s hired as home health aides will receive a patient-specific orientation by a RN regarding the assigned patients’ care needs and the services/tasks the CAN &/or Hha will be performing in the home	

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	gastrostomy tube, ostomy care, gastric suction; bowel/ bladder programs; skin care such as application of skin barriers, measurement and staging of wounds, wound care procedures and treatment options, sterile dressing change, non-sterile dressing change; enema administration, bowel program, removal of fecal impaction colostomy/ ileostomy care; foley catheter insertion, irrigation, tube care for suprapubic catheters; specimen collection; and IV therapy. The document failed to evidence any information about pediatric care. Review of the personnel records of the Administrator, Director of Clinical Services, Employees A and I, RNs, failed to evidence documentation of the Skilled Nursing Checklist. 6. In regards to hiring qualified staff to care for pediatric patients Review of clinical record #2 and #3, evidenced two pediatric patients with complex needs, including severe seizure activity. Review of the Administrators, Director of Clinical Services, Employees A and I, RNs, and Employees D and E, failed to evidence any competency documentation of experience with managing pediatric patients and their complex needs. During an interview with the Director of Clinical Services Administrator on 11/12/20 at 1:45 p.m., when asked about the agency's experience with pediatric patients and if the agency had a seizure protocol, both could not confirm that any employees, including themselves, had any pediatric experience. 7. In regards to new registered home health aides		setting with the patient(s) they are assigned to. The Personnel Manager has been re-educated on his/her responsibilities for ensuring complete, current, accurate personnel files for all employees. All CNA's working for Visiting Angels Home Health Agency will be required to maintain their ongoing CNA certification to ensure continued employment with the Agency. Ongoing competency will be assessed by the Registered Nurses when they make Hha Supervisory Visits. All the above processes have built in monitoring tools. The Administrator will report the results monthly to the QAPI Committee and the Governing Body. The Administrator is responsible for ensuring ongoing compliance with G952.	

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	and certified nursing assistant skills competency a. Review of the Indiana Department of Health document titled "Employee Records" identified Employee E as a CNA (certified nursing assistant). The personnel record of Employee E, HHA (home health aide) Date of Hire 6/1/20 and first patient contact of 6/2/20, contained an agency document titled "Caregiver Applicant Checklist" dated 6/1/20, which revealed that the employee checked that they have no experience with shaving, hair care (shampoo, dry & style), and medication reminders. The personnel record failed to evidence a home health aide skills competency checklist. The personnel filed revealed a registration card identifying Employee E as a home health aide. Review of the patient #3's clinical record, the home health aide visit notes revealed Employee E provided bathing, grooming, and hygiene services from 8/3/20 to present, especially shampooing the patient's hair on 8/3, 8/7, 8/17, 8/19, 8/24, 8/28, 8/31, 9/4, 9/11, 9/14, 9/18, 9/21, 9/25, 9/29, 10/2, 10/5 to 10/9, 10/12, 10/16, 10/19, 10/23, 10/26, 10/28, and 10/30/20. b. The personnel record of Employee D, CNA, DOH 9/3/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, medication reminders, nail care (clean, paint, file), oral hygiene (brushing, flossing,			

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	dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, and all communication and social activities. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 9/8/20. c. The personnel record of Employee H, CNA, DOH 10/19/20, contained an agency document titled "Home Health Aide Applicant Checklist" in which the all of the self assessment of work experience was left blank. d. The personnel record of Employee J, CNA, DOH 11/5/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping			

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	skills, all safety measures, all communication and social activities, and "I need to review again" medication reminders. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 11/7/20. e. The personnel record of Employee K, CNA, DOH 10/16/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, medication reminders, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, and all communication and social activities. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 10/23/20. f. The personnel record of Employee L, CNA, DOH 9/18/20, contained an agency document titled "Home Health Aide Applicant Checklist" in which the all of the self assessment of work experience was left blank. g. The personnel record of Employee M, CNA,			

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	DOH 8/7/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, medication reminders, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, and all communication and social activities. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 8/15/20. h. The personnel record of Employee N, CNA, DOH 8/7/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA indicated "I need to review again" ambulation (assist client with cane, walker or crutches), shaving assistance, hair care (shampoo, dry and style), Nail care (clean/paint/file), oral hygiene assistance (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, transfer assistance with gait belt or transfer bench, meal preparation (actual cooking, not frozen or fast food), mopping, vacuum (room			

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	client uses), Converse/ communicate with client, follow verbal and written instruction, write/ print legibly, read aloud, and transportation. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 8/15/20. i. The personnel record of Employee S, CNA, DOH 9/18/20, contained an agency document titled "Home Health Aide Applicant Checklist" in which the all of the self assessment of work experience was left blank. j. The personnel record of Employee T, CNA, DOH 10/13/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, medication reminders, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, and all communication and social activities. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 10/14/20. k. The personnel record of Employee U, CNA,			

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	DOH 10/14/20, contained an agency document titled "Home Health Aide Applicant Checklist" which revealed that the CNA has no experience with: ambulation (assist with cane, walker, crutches, and wheelchair), back rubs, bathing assistance (shower and sponge), shaving assistance, body mechanics, catheter assistance (drain bag only), dressing assistance, eating assistance, hair care (shampoo, dry & style), hand washing techniques, medication reminders, nail care (clean, paint, file), oral hygiene (brushing, flossing, dentures), oxygen (place or adjust mask or cannula only), assist client with repositioning in chair, bed and care, range of motion exercises (active only), temperature, toileting (incontinence products, bedpan/ urinal, client to and from commode or toilet), transfer techniques, transfer assistance with gait belt or transfer bench, transfer assistance using hoyer lift, all housekeeping skills, all safety measures, and all communication and social activities. The personnel record failed to evidence that the employee had training and competencied prior to first patient contact on 10/16/20. 8. During an interview on 11/12/20 at 10:15 a.m., Person K, family member stated the agency sometimes sends good home health aides and some bad ones. Person K stated Visiting Angels would send people who don't know how to get patient #5 out of bed, "wouldn't work, and even had one aide that was fresh out of school to where the I had to teach her how to do things." 8. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			

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G 0954 Bldg. 00	484.105(b)(2) Ensures qualified pre-designated person When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. Based on record review and interview, the agency failed to ensure there was a qualified, pre-designated person authorized in writing by the Administrator and Governing Body to assume the same responsibilities and obligations as the administrator for 1 of 1 agency. Finding includes: Review of Employee W, Director of Clinical Services (DOCS), personnel record, failed to evidence that the DOCS was appointed to their position by the Administrator and Governing Body and that she has accepted the position of DOCS. Review of an agency document titled "Statement of Responsibility: Administrator" A - 120, dated 12/2/19, indicated if Employee G, Administrator, be unavailable, that Employee W would assume the duties and responsibilities of the Administrator. This document failed to be signed in conjunction with the Governing Body member, Person S. Review of the Indiana Department of Health agencies report that was completed by the Administrator, indicated Employee A, was the	G 0954	G954 The Governing Body and administrator met and meeting minutes reflect the approval and appointment of the Director of Clinical Services as the Alternate Administrator whenever the Administrator is not available to perform his functions and Employee “W” as the new alternate Director of Clinical Services to perform the Director of Clinical Services responsibilities whenever the Director is unavailable. The Agency applied to the ISDH to have the Alternate Director of Clinical Services approved prior to the the most recent survey. The ISDH has approved Employee "W" as the Alternate Director of Clinical Services. The Governing Body also approved the agency Organization Chart which lists all agency positions from the Governing Body down to the patient level.	02/16/2021

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

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	new Alternate Director of Nursing. Review of an agency document titled "Statement of Responsibility: Director of Clinical Services" A-130, dated 12/19/20, indicated if Employee W, DOCS, be unavailable, that Former Employee T, RN, would assume the duties and responsibilities of the DOCS. Review of Employee A's personnel record failed to evidence that the employee was appointed to their position by the Governing Body and/ or Administrator and that she has accepted the position of Alternate Director of Nursing. During the entrance conference on 11/9/20 at 9:55 a.m., when queried on who the Alternate Clinical Supervisor was, the Administrator stated that Employee A, RN was the alternate and the information was recently submitted to Indiana Department of Health. As of 11/17/20, IDOH have not received an information from the agency on the changes of the Alternate Director of Clinical Services. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-12-1(d)(8)		The Governing Body standardized meeting agenda items includes appointment of all management positions as a component of their routine meeting agenda and will always be addressed timely at all future Governing Body Meetings. The Governing Body is responsible for ensuring ongoing compliance with G954.	
G 0960 Bldg. 00	484.105(c)(1) Make patient and personnel assignments, Making patient and personnel assignments, Based on observation, record review and interview, the Director of Clinical Services (DOCS) failed to ensure personnel assignments were	G 0960	**G960** The Director of Clinical Services meets every am with the Agency	02/16/2021

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	directed by her, patient assignments were based on employee experience and knowledge, and failed to ensure part-time staff were knowledgeable about the patient's medical history and their expected duties. Findings include: 1. Review of an undated agency policy titled "Clinical Manager B-105" indicated " ... 4. The oversight provided by the clinical manager(s) includes: a. Making client and personnel assignments .... " 2. Review of an undated agency policy titled "Position: Staffing Coordinator" C-230, indicated " ... Maintains schedule for services requested and provided to agency clients. ... 2. Provides direction to direct care employees and communicates with supervisors as needed to assure safe and effective coverage of client needs. 2. Provides direction to direct care employees and communicates with supervisors as needed to assure safe and effective coverage of client needs. a. Assigns Agency staff to clients as directed by the licensed professional staff, care plan and service request. b. Assures employees receive complete and accurate directions and information about client needs as directed by licensed professional staff, care plan and service request. 3. During a home visit at patient #2's home on 11/10/20 at 1:30 p.m., when queried about her experience taking care of a pediatric patient with seizures/ medically complex and if she received a report or an aide care plan outlining her duties, employee D, CNA indicated she was contacted by the scheduler, no one gave her a report or gave her an aide care plan, she was not aware that patient #2 was a pediatric patient and she had no		Scheduler to making scheduling assignments for home health aides. Assignment of home health aides to specific patients is a decision made by the Director of Clinical Services based on the employees work experience, knowledge, and availability. The assignment is communicated to the Hha by the scheduler who provides the Hha with a copy of the patient's care plan. If the Hha has any concerns and/or questions she/he is to discuss them with the Director of Clinical Services prior to accepting the assignment. The RN Case Managers perform follow-up evaluations of the Hha at all Hha Supervisory Visits. Their questions and observations are directed to ensure the patient's needs are being met. A "Patient Satisfaction Survey" of all patients is performed by the RN Case Managers during recertification visits and all concerns and/or negative comments are communicated to the Director of Clinical Services at the monthly QAPI meeting. The Director of Clinical Services is responsible for ensuring ongoing compliance with G960.	

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	experience with complex pediatric patients. During an interview with the DON and Administrator on 11/12/20 at 1:45 p.m., when queried who makes out the patient assignments and ensure the home health aides are qualified to take care of the assigned patient, the DON stated the scheduler decides the assignment, gives report to the home health aides, and aide care plans should be in the home. When asked how the agency ensures a CNA is qualified to care for a special needs child with seizures or any other patient who are medically complex, the Administrator stated he didn't know, that there was no special training. The DON then asked how she was to supposed to know what the home health aides capabilities/ comfort levels/ experience was. 4. During a home visit at patient #5's home on 11/12/20 at 9:30 a.m., the family member was interviewed around 10:15 a.m., and stated the agency wound sometimes send good home health aides and some bad ones. The family member stated they have not had a very good experience with Visiting Angels for it has been "up and down." The family member stated they really liked former employee because she would get patient #5 out of bed. The family member stated they are to have someone 8:00 a.m. to 4:00 p.m. 7 days a week. The family member stated although she likes the current aide, she is only at the home until 11:30 a.m. The family member stated they didn't have anyone from October 2019 to June 2020. The family member stated Visiting Angels would send people who don't know how to get patient #5 out of bed, wouldn't work, and even had one aide that was "fresh out of school" to where the family had to teach her how to do things. The family member stated past home health aides would through the			

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	patient's sheets always with the briefs and she was constantly having to buy new ones. The family member stated the patient hasn't been out of bed since last October, when they had the employee who was fired. The family member stated they haven't had an aide for 8 hours since the previous month and that was only for two days (10/29 and 10/30/20). The family member stated how her health was bad and that another family member who lives in the house is up all night with the patient, getting things for him, that they can not keep up with the patient during the day. 5. Review of the complaint binder, a complaint dated 11/5/12, indicated a Person K requested that Employee M, certified nursing assistant (CNA) not return due to Employee M tries to tell the family member "how to run his household." The action taken and reported to the family member indicated "[Name of Employee X, CNA/ scheduler] contacted [Name of family member] 11/6/20 to inform of caregiver change. New caregiver [Name of Employee D, CNA] to begin providing care 11/9/20. 6. During an interview on 11/17/20 at 9:08 a.m., patient #6 stated although she felt the home health aide she had was a good person, the home health aide's mental state was questionable. The home health aide had anxiety issues and frequent panic attacks, broke down crying, and was always upset. Patient #6 stated she had a friend who would always come at unwanted times and the home health aide wanted the patient to get a no-contact order, blocked emails and phone calls from this friend, intercepted mail to where the patient almost missed documents with her Section 8. The patient stated she suffered anxiety as well and the home health aide anxiety perpetuated her			

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	own. The patient stated she fired the home health aide and the agency offered another aide but she declined for it was 3 weeks after her admission before she got this aide and felt it would be another 3 weeks before she got another. Review of the patient's plan of care for the certification period of 09/10/20 to 11/8/20, the patient had a diagnosis of anxiety. 7. During an interview on 11/12/20 at 1:45 p.m., when queried if she (DON) assigned the aides to the patients, the DON stated the scheduler calls the aides and schedules them and she (DON) would call the aide after the visit to see how things went with the patient/ caregivers in the home. When asked about the agency's experience with pediatric patients, both could not confirm that any employees, including themselves, had any pediatric experience and the Administrator indicated the agency did not have a seizure protocol. 8. During an interview with Employee X on 11/17/20 at 9:15 a.m., when queried if she assigned the home health aides to the patients, the scheduler answered yes. 9. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-14-1(a)(1)(k)			
G 0962 Bldg. 00	484.105(c)(2) Coordinate patient care Coordinating patient care,			

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	Based on record review and interview, the Director of Clinical Services failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patient's needs for 4 of 5 active patient records reviewed of patients receiving outside services in a sample of 7. (Patient #1, 2, 3, 5) Findings include: 1. Review of an undated agency policy titled "Clinical Manager B-105" indicated " ... 4. The oversight provided by the clinical manager(s) includes: ... b. Coordinating client care .... " 2. During a home visit on 11/10/20 at 1:30 p.m., the primary caregiver/ parent of patient #2 was interviewed and indicated the patient has been with Visiting Angels since late 2019. The father stated the patient receives skilled nursing waiver services 24 hours per week/ every other weekend. Review of the patient #1's recertification comprehensive assessment dated 10/16/20, failed to evidence that the patient was receiving waiver services from another agency. Review of the plan of care for the certification period of 10/18/20 to 12/16/20, failed to evidence that the patient was receiving waiver services from another agency. Review of a case conference/ coordination note dated 10/16/20, failed to evidence that the patient was receiving waiver services from another agency. 3. Review of clinical record #3, SOC 8/17/20,	G 0962	G962 The Agency has determined that their coordination of care processes have not been sufficient to meet the needs of patients in all circumstances. The Director of Clinical Services has audited 100% of patient clinical records to determine if appropriate coordination-of-care has been performed and documented. The Director of Clinical Services has re-educated the RN Case Managers r/t their “Coordination of Care” responsibilities and this has been a prime focus of the Agency. The RN Case Managers are contacting all other providers involved in each patient’s care whenever there is a change-in-condition or concern and at least once every 60 days to coordinate care. Newly admitted patients are questioned about other providers involved in their care during the Inquiry Process and again during the Admission Process to determine all physicians and providers involved in the patient’s care. Medications are reconciled at each nursing visit and other physicians and/or providers are contacted if changes are made or a change-in-condition occurs, and/or at least once every 60 days during the recertification process. To ensure ongoing compliance	02/16/2021

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	contained an agency document titled "Coordination of Care with Other Providers" in which Entity C was listed and a phone number. The date of contact, service provided by the other provider, frequency of services, contact person, Concerns & or changes to services provided, clinician signature and date was left blank. Review of an agency document titled "Coordination of Care with Other Providers" indicated Entity M was contacted on 10/09/20, services being provided is waiver, and the frequency varies. The coordination failed to include what discipline of services was being provided. The document also indicated Entity C was contacted on 10/9/20, Hospice RN was the services being provided 1 x / week, did not indicate who the agency spoke with. Review of an agency document titled "Case Note" dated 10/08/20 and 10/21/20, revealed the agency reached out to Entity M and left a message. Review of an agency document titled "Case Note" dated 10/08/20, revealed the agency reached out to Entity C and sent the agreement to their office to be filled out. Review of an agency document titled "Case Note" dated 10/21/20, indicated "Spoke with office manager at [Name of Entity C] who verified that fax with coordination of care agreement was received on 10/09/20 and has been sent to social worker or RN to be filled out. To receive call back with update. On 11/13/20, Person E from Entity C, provided their agency's current medication list which contained the following medications that differed from Visiting Angels Medication list:		with the Coordination of Care elements; the Director of Clinical Services performs a full chart audit once every 60 days to ensure all Coordination of Care elements are documented in the clinical record. Any identified gaps in documentation of Coordination of Care are immediately returned to the RN Case Manager for immediate follow-up and correction. The Director of Clinical Services is responsible for ensuring ongoing compliance with G962.	

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	Acetaminophen 160 mg/ 5 ml 505 mg per g-tube every 4 hours for fever or mild pain; Albuterol Sulfate every 4 hours for bronchospasms/ shortness of breath, then "**Parents are only giving prn [as needed]"; Azelastine HCL 0.1 % Nasal 2 time a day, 2 sprays each nostril once a day for chronic rhinitis; Ibuprofen Children's 100 mg/ 5 ml, give 340 mg per g-tube every 6 hours as needed for fever or mild pain; Montelukast Sodium 5 mg, give 1 tablet per g-tube at bedtime for asthma; MiraLax 8.5 gm per g-tube as needed for constipation (mix in 8 ounces of water or juices give twice daily as needed); Morphine sulfate 10 mg/ 5 ml, give 6.6 mg per g-tube every 4 hours as needed for pain or shortness of breath; lorazepam 1 mg/ ml oral concentration, give 3 mg per g-tube as needed for uncontrolled seizure activity, may repeat 15 min if seizure persist; Oxygen 1 to 4 liters continuously for asthma, restrictive airway, shortness of breath, Beclomethasone Diprop HFA 80 mcg/ Act, administrator 2 puffs twice a day for shortness of breath; and Carafate 1 gm/ 10 ml, give 1 gm every 8 hours as needed for gastric bleed. Patient #2 has been a patient of Entity C since 11/2/18. This document was not found or part of patient #3's clinical record with Visiting Angels. During an interview on 11/12/20 at 8:41 a.m., with Person N, RN Case Manager from Entity C, stated the patient receives weekly nursing visits, music therapy, and 2 home health aides weekly for showers. Person N stated she coordinates with Visiting Angels "once in a while" but coordinates with Employee E, HHA who is also a family member for patient #3, daily. The patient's clinical record failed to evidence any communication between Person N and Employee E or with Person N and the office.			

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	During an interview on 11/12/20 at 6:54 p.m. with Person L, the parent of patient #3, Person L indicated the patient receives a shower via shower chair with 2 hospice aides once a week due to the patient having to be secured in the bath chair due to no trunk support and can easily fall out of shower chair if not put in just right. Person L stated the Visiting Angels aide will prepare the patient's bed while he receives a shower and will receive a bed bath all other days by Visiting Angels aide and also receives home health aide and nursing waiver services with Entity M. 4. The clinical record for patient #5, SOC 6/3/20, contained an agency document titled "Case Conference/ Coordination of Care" dated 8/3/20, in which the document indicated "RN does cath & wound care from [Name of Entity R]. This document was signed by the Director of Clinical Services and Former Employee T, RN. Review of a home health aide supervisory visit note dated 9/2/20, indicated the patient had MRSA to the chest, abdominal bandages in place, Mupirocin ointment and antibiotic completed. The "Medication Changes" indicated "Tramadol 50 mg QD PRN [50 milligrams every day as needed]." The clinical record failed to evidence any coordination with the Medicare agency in regards to the MRSA to the chest, medications, and treatments. Review of a recertification comprehensive assessment dated 10/1/20, revealed the patient had an unhealed pressure ulcer/ injury at Stage 2 or higher, that was partial granulating. The wound care comments indicated the patient had a scabbed area to the right inner foot, open areas of MRSA to the abdomen, open to air, and cream applied daily. The Integumentary wound			

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	assessment section indicated measurements of 2.5 x 2 cm, 2 x 1.5 cm, .5 x .5 cm, and 2 x 1.5 cm, but failed to indicate the location of these wounds. Review of an agency document titled "Case Note" dated 10/20/20, signed by Former Employee T, revealed catheter changes by a nurse from Entity R. The assessment failed to evidence any documentation of where the recertifying nurse obtained these measurements and inaccurately indicated Entity R when Entity D was the Medicare agency providing catheter and wound care. Review of an agency document titled "Case Note" dated 10/8/20, revealed that the agency reached out to Entity D to "collaborate care as they provide monthly RN cath care. Faxed agreement to be filled out." Review of an agency document titled "Coordination of Care with other Providers" dated 10/9/20, revealed a contact person of Director of Nursing at Entity D, indicated catheter care was provided once a month. During an interview on 11/12/20 at 10:15 p.m., when queried about the patient having wounds, Person J, family member, indicated the patient was getting skilled nursing services with Entity D twice a week for wound treatments. Person J indicated she recently received supplies and waiting on the agency to instruct her on what to do with the supplies. During an interview on 11/13/20 at 2:10 p.m., when queried about the services they provide, coordination of care and a written agreement with Visiting Angels, Person Q, Alternate Director of Clinical Services with Entity D indicated their agency provides suprapubic catheter changes			

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	monthly, wounds has recently healed so no further needs for skilled nursing to go out twice weekly, and stated the Director of Clinical Services recalled "some guy" calling about a month prior asking about the services they provided. The 10/8/20 Case Note and the 10/9/20 Coordination of Care note failed to evidence that the agency was also providing wound care twice a week at the time of the inquiry. Patient #5's medications were reviewed and the following medications differ between Entity C and Visiting Angels: Savella, Baclofen 20 mg (2 tabs at bedtime), Bupropion HcL XL, Nystatin, Carvedilol, Vit B12 ER, Valium, and Omeprazole. These medications were not on Entity C's medication list. The following medications were on Entity C's medication list that were not on Visiting Angels medication list: Lexapro (antidepressant and antianxiety), Senna (stool softener) as needed, Benadryl (antihistamine), Tylenol (pain/ fever), Colace (stool softener), Vitamin D 3 (supplement), and Catheter irrigations with Sterile water. 5. During the entrance conference on 11/9/20 at 9:55 a.m., when queried on how the agency coordinates with other agencies, the Administrator stated he and the Director of Nursing makes the calls at first then the nurses are to follow up at every 60 days. 6. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			
G 0966 Bldg. 00	484.105(c)(4) Assure patient needs are continually assessed			

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	Assuring that patient needs are continually assessed, and Based on record review, and interview the Director of Clinical Services failed to ensure patient needs were continuously assessed for 5 (Patient #1, 2, 3, 4, 5) of 5 active records and 1 (Patient #6) of 1 closed records reviewed in a sample of 7. Findings include: Review of an undated agency policy titled "Clinical Manager B-105" indicated " ... 4. The oversight provided by the clinical manager(s) includes: ... d. Assuring the client needs are continually assessed .... " The Director of Clinical Services failed to ensure the comprehensive assessment of Patients #1, 2, 3, 4, 5, and 6 were completely filled out, accurately reflected each patient's current health status and past medical history, failed to ensure each assessment included each patient's strengths, goals, and care preferences, failed to ensure each assessment included each patient's medical, nursing, rehabilitative, social, and discharge planning needs, failed to ensure all medications were appropriately reconciled with each patient/ health care representative, outside agencies and ordering physicians to ensure drug interactions and duplication is identified, failed to ensure each assessment identified each patient's primary caregivers, their willingness and ability to provide care, and their availability and schedule, and failed to ensure each assessment included information concerning each patient's selected representative. During an interview on 11/12/20 at 1:45 p.m., when queried about reviewing content with chart audits, the Director of Clinical Services stated she did not	G 0966	**G966** The Director of Clinical Services has audited 100% of patient recertification assessments to ensure accurate and complete documentation of ongoing assessments. As part of the audit, focus has been placed on ensuring that assessment documentation includes all pertinent diagnoses, measurable goals, medication reconciliation, and documentation of the patient's primary caregiver (if any) and their willingness to provide care when agency personnel is not present in the home. The Director of Clinical Services provided re-education of the RN Case Managers r/t the requirement to assess and document all patient representative information when the patient does select a "patient representative. To ensure ongoing compliance the Agency has made "Documentation of the Comprehensive Assessment" a QAPI project. All comprehensive assessments will be audited at all certification timepoints. Any gaps and/or errors will be returned to the RN Case Managers for correction. Outcome results will be reported to the QAPI committee and Governing Body monthly. The	02/16/2021

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VISITING ANGELS HOME HEALTHCARE	3197 S US HWY 231 GREENCASTLE, IN 46135

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	audit admission assessments, she receives patient information from the case manager, and her audits mostly consist of checks and balances. When queried about diagnoses and current health issues on the comprehensive assessment, the Administrator stated they were told to only document what the patients were being admitted for. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.		goal is to continuously strive for 100% compliance. The Director of Clinical Services is responsible for ensuring ongoing compliance with G966.	
G 0968 Bldg. 00	484.105(c)(5) Assure implementation of plan of care Assuring the development, implementation, and updates of the individualized plan of care. Based on record review and interview, the Director of Clinical Services failed to ensure the Registered Nurse accurately developed and updated an individualized plan of care and failed to ensure services were provided as ordered per the plan of care for 5 (Patients #1, 2, 3, 4, 5) active records and 1 (Patient #6) of 1 closed record reviewed in a sample of 7. Findings include 1. Review of an undated agency policy titled "Clinical Manager B-105" indicated " ... 4. The oversight provided by the clinical manager(s) includes: ... 3. Assuring the development, implementation, and updates to the individualized plans of care .... " 2. The Clinical Manager failed to ensure the agency accepted pediatric patients on the	G 0968	G968 The agency will ensure that all patient care plans are individualized for each specific patient. The Clinical Manager/designee will audit 100% of patient care plans to ensure compliance and will re-educate RN Case Managers on the writing of patient-specific care plans. RN Case Managers are continuously overseeing and updating care plans for each patient via the EVV system. Care plans and visit notes are monitored weekly to ensure accuracy of patient needs and compliance of provision of those needs. RN Case Managers educated by Director of Clinical Services to	02/16/2021

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	reasonable expectation that they were able to meet pediatric patients nursing needs. (See G570) 3. The Clinical Manager failed to ensure services were provided per the plan of care and failed to ensure each patient received an individualized care plan that identified patient specific and measurable outcomes and goals that was periodically reviewed and signed by a physician. (See G572) 4. The Clinical Manager failed to ensure the individualized plan of care included all pertinent diagnoses, all supplies and equipment, specific frequency and duration of visits, nutritional requirements, all accurate medications and treatments, all safety measures to protect against injury, patient specific interventions, measurable outcomes and goals identified by the home health agency and patient. (See G 574) 5. The Clinical Manager failed to ensure the plan of care was created in conjunction with the primary care physician after an assessment, verbal start of care and recertification orders obtained from the physician. (See G580) 6. The Clinical Manager failed to ensure verbal orders were complete and contained included duties/ services that the home health aides were to provide and the specific education the nurses were to educate to whom, and date and time of when orders when verbal orders were received. (See G 584) 7. The Clinical Manager failed to ensure the physician was notified of the agency's inability to provide services (See G590); 8. The Clinical Manager failed to ensure the		contact patient's primary physician's office after assessments and recertifications to provide a report of patient's condition and needs and to determine plan of care. Agency Clinical Manager and RN Case Managers review services being performed for each client by their home health aides during weekly meetings. If it is determined that services are not being performed as ordered on the care plan, new orders are obtained from the physician by the RN Case Managers to match client needs and services being performed. Agency Clinical Manager is responsible for ongoing compliance with G968.	

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	primary care physician, patients, and patient representatives were informed in advance of the agency's intent to discharge and readmit due to administrative correctives. (G598) 9. The Clinical Manger failed to ensure the agency communicated with the prescribing physician in regards to wrong patient information on a face to face encounter document. (See G602 10. The Clinical Manager failed to ensure patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patient's needs . 11. During the entrance conference on 11/9/20 at 9:55 a.m., when queried on how the agency coordinates with other agencies, the Administrator stated he and the Director of Nursing makes the calls at first then the nurses are to follow up at every 60 days. 12. During an interview with the Administrator and Director of Nursing on 11/10/20 at 10:45 a.m., when asked how the agency obtain orders for start of care and recertification, the Director of Nursing stated that they would get orders first, to go out to do the assessment, and then send the plan of care to the physician for signature. 13. During an interview with the Director of Nursing (DON) and Administrator on 11/12/20 at 1:45 p.m., when queried about goals being measurable, both indicated they did not know goals were to be measurable on the plan of care. When queried how they obtain their diagnoses, the DON stated the case managers obtain their diagnosis codes online and the history and physical from the physician. The Administrator			

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	stated the nurses only document diagnoses that the patient is receiving services for. When queried about not being able to provide services as ordered per the plan of care, the Administrator stated he does offer to help the patients transfer to other agencies but they always refuse. When queried if there is documentation supporting his conversations with patients/ family members, the Administrator stated he did not document those conversations and the outcomes. 12. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which the Administrator and Director of Clinical Services agreed that the information on the Face to Face was not related to patient #5 and stated they did not notice that the document had incorrect information. No other information or documentation was provided. 17-14-1(a)(1)(c)			
G 0978 Bldg. 00	484.105(e)(2)(i-iv) Must have a written agreement An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid;			

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	(iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program. Based on record review and interview, the agency failed to ensure they had written agreements in place with agencies who they share patients with in 4 of 4 active records reviewed of patient's receiving in a sample of 7. (Patients #2, 3, 4, 5) Findings include: 1. On 09/09/20, the Indiana Department of Health conducted a survey and cited the agency for failure to ensure they had written agreements with shared agencies entailing who will be the primary agency/ maintain overall responsibility of the patient and the manner in which services will be provided between both agencies. The plan of correction indicated the agency will be in compliance with this deficiency by 10/09/20. 2. During a home visit on 11/10/20 at 1:30 p.m., Person K, family member of patient #2, was interviewed and indicated the patient had been with Visiting Angels since late 2019. The father stated the patient receives skilled nursing waiver services 24 hours per week/ every other weekend through Entity A. Review of the patient #2's recertification comprehensive assessment dated 10/16/20, failed to evidence that the patient was receiving waiver services from Entity A. Review of the plan of care for the certification period of 10/18/20 to 12/16/20, failed to evidence that the patient was receiving waiver services from Entity A.	G 0978	**G978/G980** Visiting Angels Home Health Agency made multiple attempts to acquire/facilitate “Services Under Arrangement” contracts with providers. The entities were contacted multiple times and all providers refused to sign the contracts. The Administrator contacted the patients’ physicians to make them aware of this regulation and the agency’s inability to acquire the required contracts. Each physician agreed the agency would need to discharge services due to a lack of the signed contract. All patients/families were contacted by phone prior to receiving the notice of agency discharge to explain the regulatory requirement and the inability of the agency to acquire the required contracts. Following this oral notification, all patients received a 15-day notice of discharge. The Agency worked with the patients and their families to ensure a smooth transfer of services to other providers. The RN Case Managers performed the Discharge Assessments and completed the Discharge Summaries which were sent to the physicians and the receiving entities. The RN Case Managers	02/16/2021

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	Review of a case conference/ coordination note dated 10/16/20, failed to evidence the patient was receiving waiver services from Entity A. The agency failed to ensure they had a written agreement with another agency providing services to patient #2 per their plan of correction compliance date of 10/09/20. 3. Review of clinical record #3, SOC 8/17/20, contained an agency document titled "Coordination of Care with Other Providers" indicated Entity M was contacted on 10/09/20, services being provider is waiver, and the frequency varies. The coordination failed to include what discipline of services was being provided. Review of an agency document titled "Case Note" dated 10/08/20 and 10/21/20, revealed the agency reached out to Entity M and left a message. During an interview with Person L, legal guardian for patient #3 on 11/12/20 at 6:54 p.m., stated the patient receives skilled nursing and home health aide waiver services through Entity M. The agency failed to ensure they had a written agreement with another agency providing services to patient #3 per their plan of correction compliance date of 10/09/20. 4. The clinical record for patient #5, SOC 6/3/20, contained an agency document titled "Case Conference/ Coordination of Care" dated 8/3/20, in which the document indicated "RN does cath & wound care from [Name of Entity R]. This document was signed by the Director of Clinical Services and Former Employee T, RN. Review of a recertification comprehensive assessment dated 10/1/20, revealed the patient		also provided verbal reports to the receiving entities as requested. The Agency will coordinate services with “outside” entities (i.e. PSA companies, Dialysis Centers) through the utilization of form entitled “Coordination of Care with other Providers”. The Agency has experienced moderate success with this process. Some providers will return the calls to provide patient-specific progress reports including information r/t medications, treatment progress, etc. The other providers frequently do not return the phone calls-even when multiple messages are left for them. Going forward, to ensure ongoing compliance, the Agency will strive to identify all patients at time of “Inquiry for Service” who are receiving services from a Hospice or a MCA Home Health Provider. The Agency Governing Body has made the decision to place these “Inquiries for Service” on hold until the patient successfully completes their active MCA episode and will not admit patients who are currently receiving Hospice Services. To ensure the Agency’s ongoing compliance with Coordination of Care responsibilities 100% of all clinical records are audited every 60 days for compliance with the “Coordination of Care Team Conference” documentation responsibilities and any	

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	had an unhealed pressure ulcer/ injury at Stage 2 or higher, that was partial granulating. The wound care comments indicated the patient had a scabbed area to the right inner foot, open areas of MRSA to the abdomen, open to air, and cream applied daily. The Integumentary wound assessment section indicated measurements of 2.5 x 2 cm, 2 x 1.5 cm, .5 x .5 cm, and 2 x 1.5 cm, but failed to indicate the location of these wounds. Review of an agency document titled "Case Note" dated 10/20/20, signed by Former Employee T, revealed catheter changes by a nurse from Entity R. The assessment failed to evidence any documentation of where the recertifying nurse obtained these measurements and inaccurately indicated Entity R when Entity D was the Medicare agency providing catheter and wound care. Review of an agency document titled "Case Note" dated 10/8/20, revealed that the agency reached out to Entity D to "collaborate care as they provide monthly RN cath care. Faxed agreement to be filled out." Review of a document titled "Collaboration/ Coordination of Care Agreement between Service Providers" dated 10/8/20, identified Entity D and patient #5, failed to evidence the patient's demographics and diagnoses, Visiting Angels payer source is Medicaid PA, indicated both entities will coordinate services and visit schedules with each other to accommodate the needs of the patient. Review of an agency document titled "Coordination of Care with other Providers" dated 10/9/20, revealed a contact person of Director of Nursing at Entity D, indicated catheter care was provided once a month.		"Coordination of Care with other Providers" documentation. This is a component of the Medical Record Audit that is conducted every 60 days. The Director of Clinical Services is responsible for ensuring ongoing compliance with G978/G980.	

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	Review of an agency document titled "Case Note" dated 10/21/20, indicated a call was placed to Entity D to check on the status of the collaboration of care agreement that was faxed on 10/9/20 and a voicemail was left with Entity D's Director of Clinical Services. Review of an agency document titled "Case Note" dated 10/29/20, indicated a call was placed to Entity D to check on the status of the collaboration of care agreement, in which another voicemail was left with Entity D's Director of Clinical Services. Review of an agency document titled "Case Note" dated 11/5/20, indicated a call was placed to Entity D to check on the status of the collaboration of care agreement, in which the Administrator was informed Entity D did not have the agreement and was asked to fax the agreement again to the number indicated on this document. The note indicated the forms was sent immediately. The agreement was signed by the Administrator of Visiting Angels on 10/8/20 but has yet to be returned signed by Entity D as of date of exit on 11/17/20. During an interview on 11/12/20 at 10:15 p.m., when queried about the patient having wounds, the family member indicated the patient was getting skilled nursing services with Entity D twice a week for wound treatments. The family member indicated she recently received supplies and waiting on the agency to instruct her on what to do with the supplies. During an interview on 11/13/20 at 2:10 p.m., when queried about the services they provide, coordination of care and a written agreement with			

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	Visiting Angels, Person Q, Alternate Director of Clinical Services with Entity D indicated their agency provides suprapubic catheter changes monthly, wounds has recently healed so no further needs for skilled nursing to go out twice weekly, and stated the Director of Clinical Services recalled "some guy" calling about a month prior asking about the services they provided. The 10/8/20 Case Note and the 10/9/20 Coordination of Care note failed to evidence that the agency was also providing wound care twice a week at the time of the inquiry. On 11/16/20 at 11:08 a.m., when queried if the agency had fax confirmations to verify that the written agreement was sent to Entity, the Administrator stated he did not. 5. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.6. The clinical record for patient #4, SOC 6/25/20, was reviewed and contained an agency document titled "Case Note" dated 10/8/20, with no time documented. The note indicated " Multiple attempts made to contact [Name of patient #4's family member] ...in regards to D/Cing [discharging] her services on 10/23/20 as she currently has hospice services being performed inside the home and there are contractual and payment issues associated with this. Also placed call to [Name of Person AA] who is [Name of patient #4] case manager with CICOA. Voicemail left ...requesting return call. Contacted [Name of Entity Z] to coordinate client's care. Was routed to case manager and left voicemail requesting return call.			

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	Review of an agency document titled "Case Note" dated 10/21/20, untime, signed by Former Employee T and the Director of Clinical Services indicated "Wound Management - Wound to Coccyx, applying corona cream (here someone has written "QD" on top of the word corona cream) and bandage 1x/wk ... Maintain functional ability, heal wound, self care needs met ... coc [change of condition] with hospice services." Review of an agency document titled "Coordination of Care with Other Providers" dated 10/21/20, untimed, indicated Entity Z was providing services: 1 time a week, had the name of the nurse and phone number with the hospice agency, and the "Concerns &/or Changes to Services Provided: Wound care tx & demensiens [sic]" Review of an agency document titled "Case Note" dated 10/21/20, untimed, indicated "Contacted [Name of Entity Z] to collaborate care and send over collaboration of care agreement to be signed. I was directed to [Name of Person Y] at ... did not receive an answer ... Left voicemail" Review of an agency document titled "Case Note" dated 10/29/20, untimed, indicated "Placed call to [Name of Entity #Z] and was again routed to [Name of Person Y] Case Manager ... Call was unanswered and voicemail left requesting call back with explanation of the situation." Review of an agency document titled "Case Note" dated 11/5/20, untimed, indicated "Called for [Name of Person Y], case manager at [Name of Entity Z] ...No answer, but voicemail left explaining situation. I then called their main line ... and let the receptionist know that I have been trying to get in contact with [Name of Person Y]			

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	for some time now. She took my name and contact information and agreed to pass this along to [Name of Person Y] to contact me back." During an interview on 11/16/20 at 9:30 a.m., when queried about the agency's inability to obtain a written agreement with Entity Z, the Administrator stated he has been having difficulty getting in contact with someone with the hospice agency. During an interview on 11/17/20 at 12:02 p.m., Person X, Entity Z Hospice Administrator, stated they were aware Patient #4 was receiving home health services, specifically home health aide (HHA), and at the point that the family decided to use PA services, Enity Z didn't really address the HHA issues anymore because the aide was directed by the home health agency. Person Y, stated case coordination was remiss. Person X stated they did not have a contract with Visiting Angels because services are for a separate payor and separate services and they don't do any instruction, supervision, etc. for another agency's staff, but she would look into this. 17-12-2(d)			
G 0980 Bldg. 00	484.105(e)(3) Primary HHA is responsible for patient care The primary HHA is responsible for patient care, and must conduct and provide, either directly or under arrangements, all services rendered to patients. Based on record review and interview, the agency failed to ensure they had written agreements with agencies who they share patients with, outlining who has the overall responsibility for all services provided in 4 of 4 active records reviewed of patients receiving services from outside agencies in a sample of 7. (Patient #2, 3, 4, 5)	G 0980	**G978/G980** Visiting Angels Home Health Agency made multiple attempts to acquire/facilitate “Services Under Arrangement” contracts with providers. The entities were contacted multiple times and all	02/16/2021

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	Findings include: 1. The agency failed to ensure they had a written agreement with another agency providing services to patient #2 as evidenced by the following: During a home visit on 11/10/20 at 1:30 p.m., the primary caregiver/ parent of patient #2 was interviewed and indicated the patient has been with Visiting Angels since late 2019. The father stated the patient receives skilled nursing waiver services 24 hours per week/ every other weekend. Review of the patient #2's recertification comprehensive assessment dated 10/16/20, failed to evidence that the patient was receiving waiver services from another agency. Review of the plan of care for the certificaiton period of 10/18/20 to 12/16/20, failed to evidence that the patient was receiving waiver services from another agency. Review of a case conference/ coordination note dated 10/16/20, failed to evidence that the patient was receiving waiver services from another agency. 2. Review of an agency document titled "Visiting Angels Home Health Agency Collaboration/ Coordination of Care Agreement Between Service Providers" with Entity C, hospice provider, in regards to patient #3 services, failed to include all services being provided by Entity C and which agency has the primary responsibility of the patient. During an interview on 11/12/20 at 8:41 a.m., with		providers refused to sign the contracts. The Administrator contacted the patients' physicians to make them aware of this regulation and the agency's inability to acquire the required contracts. Each physician agreed the agency would need to discharge services due to a lack of the signed contract. All patients/families were contacted by phone prior to receiving the notice of agency discharge to explain the regulatory requirement and the inability of the agency to acquire the required contracts. Following this oral notification, all patients received a 15-day notice of discharge. The Agency worked with the patients and their families to ensure a smooth transfer of services to other providers. The RN Case Managers performed the Discharge Assessments and completed the Discharge Summaries which were sent to the physicians and the receiving entities. The RN Case Managers also provided verbal reports to the receiving entities as requested. The Agency will coordinate services with "outside" entities (i.e. PSA companies, Dialysis Centers) through the utilization of form entitled "Coordination of Care with other Providers". The Agency has experienced moderate success with this process. Some providers will return the calls to	

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	Person N, RN Case Manager from Entity C, stated the patient receives weekly nursing visits, music therapy, chaplain, medical social worker services, and 2 home health aides weekly for showers. When asked who was the primary agency responsible for the patient's care, Person N stated Entity C was. Review of the clinical record failed to evidence a schedule of when Entity C services/ disciplines will be provided, failed to evidence Entity C's medications, interventions, and goals so that both services together has a patient centered goal while the patient is on hospice. 3. Review of a document titled "Visiting Angels Home Health Agency Collaboration/ Coordination of Care Agreement Between Service Providers" dated 10/8/20, with Entity D, medicare home care provider in regards to patient #5, failed to evidence the patient's demographics and diagnoses, failed to include all services being provided by Entity D, which agency has the primary responsibility of the patient. Review of the clinical record failed to evidence a schedule of when Entity D services/ disciplines will be provided, failed to evidence Entity D's medications, interventions, and goals so that both services together has a patient centered goals. During an interview on 11/12/20 at 10:15 p.m., when queried about the patient having wounds, the family member indicated the patient was getting skilled nursing services with Entity D twice a week for wound treatments. The family member indicated she recently received supplies and waiting on the agency to instruct her on what to do with the supplies.		provide patient-specific progress reports including information r/t medications, treatment progress, etc. The other providers frequently do not return the phone calls-even when multiple messages are left for them. Going forward, to ensure ongoing compliance, the Agency will strive to identify all patients at time of "Inquiry for Service" who are receiving services from a Hospice or a MCA Home Health Provider. The Agency Governing Body has made the decision to place these "Inquiries for Service" on hold until the patient successfully completes their active MCA episode and will not admit patients who are currently receiving Hospice Services. To ensure the Agency's ongoing compliance with Coordination of Care responsibilities 100% of all clinical records are audited every 60 days for compliance with the "Coordination of Care Team Conference" documentation responsibilities and any "Coordination of Care with other Providers" documentation. This is a component of the Medical Record Audit that is conducted every 60 days. The Director of Clinical Services is responsible for ensuring ongoing compliance with G978/G980.	

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	During an interview on 11/13/20 at 2:10 p.m., when queried about the services they provide, coordination of care and a written agreement with Visiting Angels, Person Q, Alternate Director of Clinical Services with Entity D indicated their agency provides suprapubic catheter changes monthly, wounds has recently healed so no further needs for skilled nursing to go out twice weekly, and stated the Director of Clinical Services recalled "some guy" calling about a month prior asking about the services they provided. When queried who had the primary responsibility of the patient, Person Q indicated their agency did. 5. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.6. The clinical record for patient #4, SOC 6/25/20, was reviewed and contained an agency document titled "Case Note" dated 10/8/20, with no time documented. The note indicated " Multiple attempts made to contact [Name of patient #4's family member] ...in regards to D/Cing [discharging] her services on 10/23/20 as she currently has hospice services being performed inside the home and there are contractual and payment issues associated with this. Also placed call to [Name of Person AA] who is [Name of patient #4] case manager with CICOA. Voicemail left ...requesting return call. Contacted [Name of Entity Z] to coordinate client's care. Was routed to case manager and left voicemail requesting return call. Review of an agency document titled "Case Note" dated 10/21/20, untimed, signed by Former Employee T and the Director of Clinical Services			

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	indicated "Wound Management - Wound to Coccyx, applying corona cream (here someone has written "QD" on top of the word corona cream) and bandage 1x/wk ... Maintain functional ability, heal wound, self care needs met ... coc [change of condition] with hospice services." Review of an agency document titled "Coordination of Care with Other Providers" dated 10/21/20, untimed, indicated Entity Z was providing services: 1 time a week, had the name of the nurse and phone number with the hospice agency, and the "Concerns &/or Changes to Services Provided: Wound care tx & demensiens [sic]" Review of an agency document titled "Case Note" dated 10/21/20, untimed, indicated "Contacted [Name of Entity Z] to collaborate care and send over collaboration of care agreement to be signed. I was directed to [Name of Person Y] at ... did not receive an answer ... Left voicemail" Review of an agency document titled "Case Note" dated 10/29/20, untimed, indicated "Placed call to [Name of Entity #Z] and was again routed to [Name of Person Y] Case Manager ... Call was unanswered and voicemail left requesting call back with explanation of the situation." Review of an agency document titled "Case Note" dated 11/5/20, untimed, indicated "Called for [Name of Person Y], case manager at [Name of Entity Z] ...No answer, but voicemail left explaining situation. I then called their main line ... and let the receptionist know that I have been trying to get in contact with [Name of Person Y] for some time now. She took my name and contact information and agreed to pass this along to [Name of Person Y] to contact me back."			

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	During an interview on 11/16/20 at 9:30 a.m., when queried about the agency's inability to obtain a written agreement with Entity Z, the Administrator stated he has been having difficulty getting in contact with someone with the hospice agency. During an interview on 11/17/20 at 12:02 p.m., Person X, Entity Z Hospice Administrator, stated they were aware Patient #4 was receiving home health services, specifically home health aide (HHA), and at the point that the family decided to use PA services, Entity Z didn't really address the HHA issues anymore because the aide was directed by the home health agency. Person Y, stated case coordination was remiss. Person X stated they did not have a contract with Visiting Angels because services are for a separate payer and separate services and they don't do any instruction, supervision, etc. for another agency's staff, but she would look into this. 17-12-2(e)			
G 1008 Bldg. 00	484.110 Clinical records Condition of participation: Clinical records. The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically. Based on record review and interview, the agency failed to ensure that they maintain a clinical record	G 1008	G1008 Director of Clinical Services has	02/16/2021

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	containing current and accurate information, as well as adhere to current clinical record documentation standards (See G1008); failed to ensure visit notes were incorporated within the clinical record within a timely manner (See G1012); failed to ensure a discharge summary was written and sent to the primary care physician who is responsible for the patient's care after discharge within 5 business days of the patients discharge and within 2 days of patients being transferred to another facility (See G1022); and failed to ensure all entries were clear, complete, authenticated, dated, and timed (See G1024). The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care. In regards to G1008, Based on record review and interview, the agency failed to ensure that they maintain a clinical record containing current and accurate information, as well as adhere to current clinical record documentation standards for 3 (Patients #2, 3, 5) of 5 active records reviewed in a sample 7 Findings include: 1. During a home visit at patient #2's (pediatric patient) home on 11/10/20 at 1:30 p.m., Person K, family member, stated he manages the patient's medications (given by the g-tube) and tube feedings. Person K indicated the patient was put on oxygen approximately 1.5 weeks ago and is on it 24/7 at 1 liter per nasal cannula. Person K provided the patient's bottles of medications g-tube medications and reviewed what was		audited 100% of patient charts to determine if records are accurate and complete. Re-education has been provided by Director of Clinical Services to RN Case Managers with a focus on ensuring that all documents are complete and legible. Instructions are clear to not leave portions of documentation blank, and to be sure that all documentation is readily readable along with having correct spelling. Education also provided in regards to continued medication reconciliation. Each physician involved in patient's care will be contacted at least every 60 days in order to reconcile any new medications and/or orders. A new EVV system has been implemented in order to improve visit notes being documented timely. A few patients do not have an internet connection at their home or in the vicinity, so in these instances, caregivers will continue filling out handwritten visit notes. In this case, visit notes are audited weekly and immediately incorporated into the patient's chart. Director of Clinical Services has re-educated RN Case Managers on the importance of writing and sending discharge and/or transfer of services summaries to the patient's physician for review within 5 business days of discharge and within 2 business days of transfer. Discharged and	

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	written on the plan of care for the certification period of 10/18/20 to 12/16/20. The bottles provided include, but not limited to: Cuvposa (used to reduce excessive drooling caused by medical conditions) 0.4 mg (milligrams), (2 ml - [milliliters]), give 1 mg/ 5 ml by mouth three times a day was started on 10/1/20; Epidiolex (cannabidiol medication to help treat seizures) 1.2 ml three times a day by g-tube; Diazepam (used to treat anxiety, muscle spasms, and seizures) 5 mg/ ml bottle, give 0.6 ml three times a day by g-tube; Trazodone (antidepressant medication that can also be used for anxiety and sleep) 5 mg/ ml, give 2.5 ml daily at bedtime; Gabapentin (anticonvulsant and nerve pain medication) 250 mg/ 5 ml, give 3 ml three times a day by g-tube; and Baclofen (used to treat muscle spasms) 10 mg/ ml, give 10 ml three times a day per g-tube. Person K stated the patient was taken off Levetiracetam last year, started on Cuvposa filled on October 1, 2020; been on Baclofen since May, 2020, and was recently started on Gabapentin in October, 2020. Review of the Medication list on the plan of care for the certification period of 10/18/20 to 12/16/20, indicated the following, but not limited to: Levetracetam [sic] 100 mg/ ml, take 4 ml twice a day per g-tube; Trazodone 25 mg/ 5 ml suspension, give 2.5 ml (illegible frequency) g-tube; Diazepam 5 mg/ 5 ml oral solution, take 0.2 ml three times a day; Diazepam 10 mg suppositories as needed for seizures > 10 min, max 1/ 24 hr or 2/7 days; and Epidolex [sic] 100 mg/ 1 ml oral solution, take 1.0 ml three times a day by mouth. Review of the the Medication Profile last updated on 10/16/20, indicated the following, but not limited to: Levetracetam [sic] 100 mg/ ml sol, give		transferred patients are reviewed by the Director of Clinical Services and RN Case Managers within 24 hours to ensure these are completed in a timely manner. Director of Clinical Services educated the RN Case Managers on importance of documentation being legible, complete, authenticated, dated, and timed. 100% of RN Case Manager documentation is reviewed by the Director of Clinical Services to ensure that each entry is readily readable, each section is complete, and that each document is dated and timed appropriately. Director of Clinical Services will audit 100% of clinical documentation to ensure that information is current and accurate until it is determined that compliance with clinical documentation standards is achieved. Director of Clinical Services is responsible for ongoing compliance with G1008.	

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	4.0 ml twice a day, Trazodone 25 mg/ 5 ml, give 2.5 ml at bedtime, Diazepam 5 mg/ 5 ml, Give 0.3 ml three times a day, Diazepam suppositories 10 mg per rectum as needed, and Epidolex [sic] 100 mg/ ml, give 1.2 ml by mouth three times daily. The recertifying nurse failed to ensure the patient's medication record contained a complete and accurate list of medications that were being prescribed and taken, failed to ensure medications were spelled correctly, and failed to ensure entries were legible. 2. The clinical record for patient #3 (pediatric patient), SOC 8/17/20, was reviewed on 11/12 to 11/13/20 and contained an agency document titled "Medication Profile" which contained a list of the following medications: Albuterol Sulfate every 4 to 6 hours as needed for "resp" [respiratory]; Qvar (corticosteroid used for chronic asthma) 80 mcg/ 2 puffs twice a day for "resp"; Mucinex (expectorant) 100 mg/5 ml per g/tube twice a day for "mucous"; Vimpat (anticonvulsant) 10 mg/ ml, give 15 ml per g/tube twice a day for seizures; Levitracetam [sic] 100 mg/ ml, give 5 ml per g/tube twice a day for seizures; Diazepam 5 mg/ 5 ml, give 5 ml per g/tube three times a day for seizures; Nexium (anti-ulcer drug) 20 mg packet per g/tube twice a day for gerd's (gastroesophageal reflux disease); Montelukast (anti-asthmatic) 5 mg tab per g/tube daily for allergies; Flonase (Corticosteroid used as a preventative maintenance of chronic asthma in patients requiring oral corticosteroid and use for allergic and non-allergic rhinitis) 50 mcg (micrograms), 1 spray daily for allergies; Azelastine (Antihistamine) 0.1 % 137 mcg 1 spray daily for allergies; sulcralfate [sic] (anti-ulcer-gastrointestinal protectant drug) 1 gm (gram)/10 ml, 10 ml per g/tube every 8 hours for gerd's; and Oxygen via nasal cannula at 4 liters			

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	per minute continuously. On 11/13/20, Person E from Entity C, provided their agency's current medication list which contained the following medications: Acetaminophen 160 mg/ 5 ml 101 mg per g/tube every 4 hours for fever or mild pain; Albuterol Sulfate every 4 hours for bronchospasms/ shortness of breath, then "**Parents are only giving prn [as needed]"; Azelastine HCL 0.1 % Nasal 2 time a day, 2 sprays each nostril once a day for chronic rhinitis; Ibuprofen Children's 100 mg/ 5 ml, give 340 mg per g/tube every 6 hours as needed for fever or mild pain; Keppra 100 mg/ ml, give 500 mg per g/tube two times a day for seizure control; Montelukast Sodium 5 mg, give 1 tablet per g/tube at bedtime for asthma; Nexium 20 mg, give 20 mg per g/tube twice a day for gerd's; Vimpat 10 mg/ ml, give 150 mg per g/tube twice a day for seizures; MiraLax 8.5 gm per g/tube as needed for constipation (mix in 8 ounces of water or juices give twice daily as needed); Morphine sulfate 10 mg/ 5 ml, give 6.6 mg per g/tube every 4 hours as needed for pain or shortness of breath; lorazepam 1 mg/ ml oral concentration, give 3 mg per g/tube as needed for uncontrolled seizure activity, may repeat 15 min if seizure persist; Oxygen 1 to 4 liters continuously for asthma, restrictive airway, shortness of breath, Beclomethason Diprop HFA 80 mcg/ Act, administrator 2 puffs twice a day for shortness of breath; Diazepam 5 mg/ ml, give 5 mg three times a day for seizures and muscle tone; and Carafate 1 gm/ 10 ml, give 1 gm every 8 hours as needed for gastric bleed. Patient #2 has been a patient of Entity C since 11/2/18. This document was not found or part of patient #3's clinical record with Visiting Angels. The recertifying nurse failed to ensure the patient's medication record contained a complete and accurate list of medications that			

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	were being prescribed and taken and failed to ensure medications were spelled correctly. 3. The clinical record of patient #5 was reviewed and contained a physician visit note dated 5/20/20, which revealed the patient was had a drug allergy to Tetanus Toxoid. Review of an agency document titled "Medication Profile" dated 10/1/20, in which the profile listed the following medications: Savella (Antidepressant and to treat nerve pain) 100 mg daily; Baclofen 20 mg, 1 tab three times a day and 20 mg, 2 tabs at bedtime; Xarelto (long acting blood thinner) 20 mg, 1 tab daily; folic acid (supplement) 1 mg daily; Buproprion [sic] HCL XL (antidepressant used for smoking cessation and to treat a variety of mental disorders) 150 mg, 1 every morning; Nystatin 1000,000 U/gm (untis per gram) topical, four times a day but failed to evidence the specific affected area to treat; Escitalopram (antidepressant) 10 mg, 1 tab daily; Carvedilol (treat high blood pressure) 3.125 mg, 1 tab twice a day; Miralax 17 gm, 1 dose daily as needed; Atorvastatin (treat high cholesterol) 40 mg, 1 tab daily at bedtime; Vitamin B12 ER (supplement) 10000 mcg daily; Valium 2 mg, 1 tab twice a day; Omeprazole 20 mg, 1 capsule daily; Gabapentin 600 mg; 1 capsule four times daily; and Milnacipran (generic name for Savella) 100 mg, 1 tab daily. The Medication Profile failed to include the patient's allergy to Tetanus Toxoid. During an interview on 11/13/20 at 2:10 p.m. with Person Q, the Alternate Director of Nursing (DON) from Entity C, the patient's medications was reviewed and the following medications differ between Entity C and Visiting Angels: Savella, Baclofen 20 mg (2 tabs at bedtime), Bupropnon HcL XL, Nystatin, Cardvedilol, Vit B12 ER, Valium,			

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	and Omeprazole. These medications were not on Entity C's medication list. The following medications were on Entity C's medication list that were not on Visiting Angels medication list: Lexapro (antidepressant and antianxiety), Senna (stool softener) as needed, Benedryl (antihistamine), Tylenol (pain/ fever), Colace (stook softener), Vitamin D 3 (supplement), and Catheter irrigations with Sterile water. The recertifying nurse failed to ensure the patient's medication record contained a complete and accurate list of medications that were being prescribed and taken and failed to ensure medications were spelled correctly. Review of a home health aide supervisory visit note dated 8/3/20, indicated the patient was bed bound. The "Oxygen Safety Assessment and Instructions" indicated "bed baths tues [Tuesday] & thurs [and Thursday] & weekends. The "Durable Medical Equipment" section was not complete and questions were left unanswered/ blank. Review of a home health aide supervisory visit note dated 9/2/20, indicated the patient had MRSA to the chest, abdominal bandages in place, Mupirocin ointment and antibiotic completed. The "Medication Changes" indicated "Tramadol 50 mg QD PRN [50 milligrams every day as needed]." The clinical record failed to evidence any orders for Tramadol, Mupirocin ointment or antibiotics or any coordination with the agency in regards to the MRSA to the chest and treatments. The "Durable Medical Equipment" section indicated "No" to the question of obvious equipment malfunction. Review of a home health aide supervisory visit dated 10/1 (no year), indicated there was an			

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	assessment of an assested transfer to a wheelchair, and "Yes" was indicated to obvious equipment malfunction and indicated "battery, hoyer" but failed to evidence that the malfunction had been reported. Review of a home health aide supervisory visit dated 10/29/20, the "Durable Medical Equipment" section indicated "No" to the question of obvious equipment malfunction. During an interview on 11/12/20 at 10:15 a.m., Person J, family member, stated the patient hasn't been out of bed since last October, when they had the employee who was fired. Person J stated the patient's battery to the wheelchair has been dead since June and they have been trying to get Medicaid to provide him with another battery.4. On 11/10/20 at 9:45 AM RN, Employee A, was observed performing a weekly medication set up for patient #1 in the patient's home. Employee A was queried concerning the process for correctly preparing a medication planner. She stated, "I have this sheet right here (indicated document titled "Medication Flow Sheet) that I got from the other nurse. This is my first time seeing her. (patient #1)" When queried if she had a current plan of care/485 for patient #1 Employee A stated she was using the "med list" (Medication Flow Sheet) given to her by patient #1's previous nurse, Employee H, but did not have a current plan of care/485. A document titled Medication Flow Sheet (used by Employee A during the visit) and signed/initialed by Employee A and Employee H, dated weekly for 9/22, 9/29, 10/6, 10/13, 10/20, 10/27, and 11/10 (documentation not present for 11/3) evidenced the following medications: Aspirin 81 mg QD; ferrous sulfate 325 mg QD; levothyroxine 175 mcg QD; Prilosec 40 mg QD; Sevelamer carb 800 mg ii TiD; lexapro 5 mg QD;			

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	Coreg 6-25 mg Bid; Gabapentin 100 mg; Linzess 145 mcg QO; Atorvastatin 40 mg QO; metoclopramide 5mg TiD; montelukast 10mg QD; certizine 10mg QD; Amlodipine 10mg QD; Amiodarone 10mg QD; allopurinol 100mg QD; senna/dss [illegible] Bd. The document did not include trelogy ellipta [sic. Trelegy Ellipta], lidocaine patch, oxygen, or albuterol. The generic name omeprazole was replaced with Prilosec. Amiodarone had a prescribed dose of 10mg versus the 200mg listed on the Medication Profile. The prescribed dose for senna/dss was illegible. All medications failed to include the route and accepted medical abbreviation for frequency. No documentation was present to indicate the medications prepared for 11/3/20. On 11/10/20 a review of the clinical record for patient #1 evidenced the presence of four separate medication lists titled Medication Profile, Medication Flow Sheet, Home Health Certification and Plan of Care dated 9/3/20-11/2/20 (corrected to 9/3/20-11/1/20) and Home Health Certification and Plan of Care dated 11/2/20-12/31/20. The Home Health Certification and Plan of Care signed by Employee H, no verbal start of care date, and dated 9/3/20-11/2/20 (corrected to 9/3/20-11/1/20), locator 10 "Medications ..." was reviewed and evidenced the following medications: trelogy ellipta [sic. trelegy ellipta] QD; Albuterol InH BiD; aspirin 81mg QP; [illegible] sulfate .325mg [illegible]; levothyroxine 175mg OD; [illegible] 40mg PO; sevelamer [illegible] [illegible]; lexapro 5mg QD; [illegible] [illegible] Bid; gabepentin 100mg ii tabs bid; linzess 145mcg [illegible]; Atorvastatin 40mg QD; metoclopramide 5mg Td; monteclukast 10ng [illegible]; [illegible] 10mg QD; [illigible] [illegible] [illegible]; Allopurinol [illegible] QO; senna/[illegible][iollegible] Bid. The Medication Profile, The Medication Flow Sheet,			

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	and the Physician Ordered Plan of Care failed to evidence consistent medications. A document titled "(Addendum to Comprehensive Assessment) Medication Profile," signed by Employee H on 9/3/20 and 10/29/20, and with an illegible signature dated 11/3/20, revealed the following medications:: trelogy ellipta [sic. Trelegy Ellipta] QD; Albuterol Bid; Aspirin 81 mg QD; ferrous sulfate 325mg QD; levothyroxine 175mcg QO [sic]; omperazole 40mg QD; sevelamer carbonate 800mg ii tabs TID; lidocaine patch QD; lexapro 5mg QD; coreg 6.25 Bid; gabapentin 100mg ii tabs Bid; linzess [illegible] mcg QO; Atorvastatn 40mg QD; metoclopramide 5mg,TiD; montelukast 10mg QD; Cetlrizine [sic. cetirizine] 10mg QD; Amlodipine 10mg QD; Amiodarone 200mg, 1/2 tab OD [sic]; Allopurinol 100mg QD; senna/dss 8.6-50mg Bid; O2 3L via NC continuously. All medications listed failed to evidence the medication route, purpose, possible side effects, date ordered, and medically accepted abbreviations for frequency. Trelogy ellipta [Trelegy Ellipta] and Cetlrizine [cetirizine] were misspelled. Trelogy ellipta [Trelegy Ellipta] and Albuterol failed to evidence an ordered dose. Lidocaine patch failed to evidence an ordered dose or correct frequency (apply up to 3 patches daily for no more than 12 hours within a 24 hour period. Remove patches after 12 hours and before applying new patches.) Coreg failed to evidence a label (mg) for dosing. Linzess failed to evidence a legible dose. Gabapentin was labeled as "tabs". Levothryoxine and Amiodarone appeared to have ordered frequencies of QO and OD respectively. Amiodarone appeared to have an ordered dose of 200 mg. Letter E, The Drug Regimen Review stated "Have potential adverse effects, significant drug interactions, duplicate/ineffective drug therapy and potential contraindications been identified?"			

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	and was answered "yes" in columns 1 and 2. Columns 3 and 4 were blank. Letter F, "Describe Problem and Action for any Yes responses" contained responses "interactions 9/3/20" and "interactions 10/29/20", which coincided with the dated signature of Employee H. No drug regimen review was noted for an illegible signature dated 11/3/20. The allergies option was blank. The Home Health Certification and Plan of Care, signed by Employee H, no verbal start of care date, and dated 11/2/20-12/31/20 locator 10 "Medications ..." was reviewed and evidenced the following medications: trelogy ellipta [sic trelegy ellipta] OD; albuterol inH Bid; Aspirin 81mg QD; ferrous sulfate .325mg (illegible); levothyrooxine 175mcg QO; oneprazole 40ng (illegible); sevelamer 800mg ii tabs TID; lexapro 5mg QD; coreg 6.25mg Bid; gabapentin 100mg QD; linzess 145mcg QD; atorvastatin 40 (illegible) QO; metoclopromide 5mg TiD; montklucast {sic monteclukast] 10mg QD; amlodipine 10mg QD. The Plan of Care, Medication Profile, and Medication flow sheet failed to evidence consistent medications. On 11/10/20 at 9:45 AM Patient #1 was interviewed during a home visit to observe medication set-up. When queried concerning her dose of Gabepentin. Patient #1 stated she took 100 mg gabepentin daily and was weaning from this medication with the intention of stopping it soon. She was unable to state the date she started the wean or give the name of a physician who ordered the decrease. When the agency nurse queried her as to whether she took 1 tablet [refers to the capsule] daily, patient #1 answered yes. On 11/10/20 at 9:55 AM Employee A was observed performing a medication set up for Patient A. When queried as to whether she had a			

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	plan of care/485 for Patient A she sstated no. When queried concerning how she knows what to give, or what to place in the patient's medication planner, Employee A stated, "I have this sheet right here. (confirmed as "Medication Flow Sheet") that I got from the other nurse. This is my first time seeing her. (Patient #1) When queried concerning the procedure if a discrepency was found during set up of the medications Employee A stated, "I would look at the bottle and the sheet. And I'd call the MD if need be. Like this one? (Indicated bottle containing Gabepentin.)" Employee A stated the label states the dose for Gabepentin was 100 mg three times per day, however patient #1stated she was taking 100 mg daily due to tapering from three times per day for an unknown time. Employee A questioned the patient, "So you're only taking one a day, right?" Patient #1 stated yes. Employee A was observed placing one capsule into the medication planner. On 11/10/20 at 10:40 AM during an interview with Employee A, she confirmed she received the Medication Flow Sheet from Patient A's previous nurse but did not compare it to the current orders in the clinical record. Employee A also confirmed the Medication Flow Sheet was missing medication routes of delivery/ purpose/ side effects/ potential side effects, contained ambiguous doses, and did not match the medications on the current plan of care or Medication Profile in the clinical record. Employee A stated, "I should have checked all the meds [medications] against her (Patient #1) chart before I made the visit today." When queried concerning the gabapentin specifically, Employee A stated she had not contacted the physician to confim the correct doseage, but had provided what Patient #1 stated she took. When queried concerning resolution for Patient #1's medications Employee			

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	A stated, "I need to review all meds [medications] now and call the physician for orders. Then I'll go out and fix the box." On 11/10/20 at 11:43 AM, Employee A stated she spoke with Patient #1's physician representative, clarified all medications, and would return to Patient #1 immediately to correct the medication planner. Employee A provided documentation dated 11/10/20, titled "Physician Order", which stated "Spoke with Amber. Clarification: Gabapentin 100mg i po QD. May have one additional skilled nurse visit this week." Employee A submitted an updated Medication Profile, dated 11/10/20, with with "Allergies" as NKDA and medications as follows: aspirin 81mg i po QD, ferrous sulfate 325 mg i po QD, levothyroxine 175 mcg i po QD, omeprazole 40 mg i po TID, sevelamer carbonate 800 mg ii tabs po TID, lexapro 5 mg i po QD, coreg 6.25 mg i po BID, linzess 145 mcg i po QD, atorvastatin 40 mg i po QD, metoclopramide 5 mg i po TID, montelukast 10 mg i po QD, cetirizine 10 mg i po QD, amlodipine 10 mg i po QD, am-50 mg i po QD, gabapentin 100 mg i po QD, O2 @ 3L per n/c Amiodarone 200 mg 1/2 tab po QD, senna-docusate 8.6-50 mg i po QD, gabapentin 100 mg i po QD, O2 @ 3L per n/c continuously, albuterol i i hal [sic inhale] per neb BID, lidocaine patch i topical on in AM of PM [sic off PM] QD, trelogy [sic trelegy ellipta] i puff per inhale QD. No changes were made to update the curent plan of care and no changes were made to the current Medication Flow Sheet. Employee A stated she did not write a communication/case coordination note because she had written the order. No further documentation was available addressing clarification of all medications Patient A was taking, including medications listed on the Medication Profile, Medication Flow Sheet, and			

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	Plan of Care. Review of a physician order dated 11/10/20, revealed "verbal order: spoke with [Name Person V at physician office] Gabapentin 100 mg 1 po [by mouth] QD [every day]. May have one additional skilled nurse visit this week. Thank you. Please sign & return." On 11/10/2020 at 12:12 PM, Employee A was queried concerning the newly updated Medication Profile for Patient #1, dated 11/10/20 and added to the clinical record at 11:43 AM. The Director/Clinical Manager was present during this interview. When queried concerning the absence of dialysis medications in Patient #1's profile, Employee A stated, "So it [medication record] should include anything they give there?" The Director/Clinical Manager stated, "We didn't know this patient was on dialysis until today, or yesterday. The previous RN did not make us aware the patient was in dialysis." The Director/Clinical Manager confirmed there were no case communication notes for this patient and instructed Employee A to include all medications on the Medication Profile, including dialysis medications. On 11/12/20 at 9:25 AM, a phone interview was conducted with Person U, LPN with Patient #1's primary care physician. Person U stated the agency nurse, Employee A, spoke with Person V and said she was sending a clarification order for gabapentin 100 mg daily, however the most recent order they documented was gabapentin 100 mg tab, take 3 tabs (=300 mg) 3 times per day. Person U stated, "[Name of Person EE, patient's primary care physician] was not comfortable giving an order to change it [gabapentin] to 100 mg daily without seeing her first." Person U confirmed			

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	Employee A sent the physician a complete medication list on 11/10/20 but the physician could not verify any medications until Patient #1 is seen. Person U confirmed [Physician name] does not manage anything related to Patient #1's dialysis, including medications. Person U denied the physician had knowledge of other medication discrepancies with agency listed medications. On 11/12/20 at 4:00 PM, an interview with person CC, Dialysis Manager from Entity B, was conducted. Person CC indicated their medication list include oxycodone 5 mg every 3 hours as needed for pain and neurotin (gabapentin) dose as 400 mg two times a day. The patient's clinical record failed to evidence an accurate medication profile/ list and failed to ensure the registered nurse discussed all medication discrepancies between the primary care physician listed on the plan of care and the dialysis physician. 5. During an interview 11/10/20 at 12:12 AM the agency Director/Clinical Manager stated she audited all assessments upon their completion and submission to her. The Director/Clinical Manager stated she did not utilize an audit tool or track specific items for completeness and accuracy, but completes the assessment review by memory and notifies the clinician if changes are required. 6. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			

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G 1012 Bldg. 00	484.110(a)(1) Required items in clinical record The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician orders; Based on record review and interview, the agency failed to ensure visit notes were incorporated within the clinical record within a timely manner for 2 out of 5 active records reviewed in a sample of 7. (Patients #2, 6) Findings include: 1. Review of an undated policy titled "Home Health Aide Services" C-220, indicated " ... Special Instructions ... 5. Home health aides must document each visit at the time care is provided and submit documentation to the agency within five (5) days ... 8. All services provided by the Home Health Aide shall be documented in the clinical record." 2. During the entrance conference with the Administrator and Director of Nursing (DON) on 11/9/20 at 9:55 a.m., when queried on the timeframe allowed for clinicians to turn in documentation following a visit, the Administrator stated the home health aides mail in the visit notes the day of or turn in the next day and for case managers, allow 48 to 72 hours after admission or recertifications, and the notes are filed daily. 3. The clinical record for patient #2's was reviewed on 11/09/2020, and contained a plan of care for the certification period of 10/18/20 to 12/16/20, with orders for home health aide services 8 hours a day, 5 days a week. The clinical record failed to evidence home health aide visits after	G 1012	G1012 A new EVV system has been implemented in order to improve visit notes being documented timely. A few patients do not have an internet connection at their home or in the vicinity, so in these instances, caregivers will continue filling out handwritten visit notes. In this case, visit notes are audited weekly and immediately incorporated into the patient's chart. Director of Clinical Services along with RN Case Managers will audit 100% of visit notes during their weekly meetings to ensure that home health aides are abiding by the medical plan of care and that documentation is being provided for each visit. Any handwritten notes will be incorporated into the patient's chart weekly. Director of Clinical Services is responsible for ongoing compliance with G1012.	02/16/2021

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	10/23/2020. 4. The clinical record for patient #6, ,start of care 9/10/20, was reviewed and included a plan of care for the certification period of 9/10/20 to 11/8/20, with orders for home health aide services 4 times a day, 5 days a week to assist with activities of daily living, bathing, meal prep, safety, and light housekeeping. Review of the clinical record failed to evidence any home health aide visit notes. Review of the discharge assessment dated 10/21/20, stated "HHA [home health aide] services never initiated." Review of a physician's order dated 10/21/20, indicated the patient was discharged from services as of 10/21/20 due to refusal of services. During an interview on 11/16/20 at 9:08 a.m., patient #6 stated she had home health aide services and described how the varied due to the home health aide going back to school. 5. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-15-1(a)(1)(4)			
G 1022 Bldg. 00	484.110(a)(6)(i-iii) Discharge and transfer summaries (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be			

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	responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the agency failed to ensure a discharge summary was written and sent to the primary care physician who is responsible for the patient's care after discharge within 5 business days of the patients discharge (Patient #6) and within 2 days of patients being transferred to another facility (Patient #7) for 2 of 2 discharged records reviewed. Findings include: 1. Review of an undated agency policy titled "Discharge Summary" indicated, "A Discharge Summary will be completed for clients discharged from Agency ... To record a summary of care received by the client from the start of care through discharge. To document client status at the time of discharge, identified unmet needs, and referrals initiated. To document instructions given to the client/ family regarding medications, treatment, referrals, and necessary follow-up ... If the client is being transferred to another agency or facility, a Transfer Summary form shall also be completed .... "	G 1022	G1022 Director of Clinical Services has re-educated RN Case Managers on the importance of writing and sending discharge and/or transfer of services summaries to the patient's physician for review within 5 business days of discharge and within 2 business days of transfer. Discharged and transferred patients are reviewed by the Director of Clinical Services and RN Case Managers within 24 hours to ensure these are completed in a timely manner. Daily meetings are held between the Director of Clinical Services and RN Case Managers with updates on discharge and/or transfer requirements. Scheduling of these activities is performed by the Director of Clinical Services during these daily meetings. Documentation of these discharges and/or transfers is	02/16/2021

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	2. Review of an undated agency policy titled "Discharge Process" C-500, indicated " ... Discharge Criteria: .... 5. Agency staff will complete a discharge summary that includes the following information: a. Initial reason for referral to home health agency. b. Client status [clinical,mental, psychological, cognitive and functional] at the start of care. c. Description of all services provided by the agency to the clients. d. The start and end dates of care. e. A description of the client's clinical, mental, psychological, cognitive and functional status at the end of care. f. The client's most recent drug profile. g. Any recommendations for follow-up care. h. Name of person or organization assuming responsibility for care. i. Instructions and referrals given to the client/ family/ caregiver. 3. Review of an undated policy titled "Home Health Agency Client Transfer Policy C-840" indicated " ... 3. A Transfer Summary shall be completed by the Registered Nurse/ ... This summary will be based on data collected on the last visit and shall include documentation of services received, reason for transfer/ discharge from agency, the client's physical and psychosocial status, current medications, continuing symptom management needs, instruction and referrals provided to the client, summery [sic] of care, any existing advance directives, and any relevant changes in caregiver support ... 4. The original Transfer Summary form shall be sent to the new provider or facility, and a copy shall be retained for the client's chart ... 7. ... Requires a completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or 8. ... Requires a completed transfer summary that is sent within 2 business days of becoming aware of an		audited by the Director of Clinical Services before being placed in chart. Director of Clinical Services is responsible for ongoing compliance with G1022.	

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. 9. The contents of the Transfer Summary a. Admission and discharge dates; b. Physician responsible for the home health Plan of Care; c. Reason for admission to home health; d. Type of services provided and frequency of services; e. Laboratory data; f. Medications the patient is on at the time of transfer; g. Patient's condition at time of transfer; h. Patient outcomes in meeting the goals in the plan of care; and i. Reason for admission to home health ... " 4. The clinical record for patient #6 was reviewed and contained a discharge OASIS assessment dated 10/21/20 and physician orders to discharge services on 10/21/2020. The clinical record failed to evidence a discharge summary that summarized the patient's care while on service with the agency, goals achieved or not achieved, and if the patient was discharged to the community or if the patient was going to receive services with another agency.5. The clinical record for patient #7, SOC date of 8/20/20, evidenced a discharge assessment form dated 10/19/20. The reason for discharge stated "The discharge is necessary for the patient's welfare ... because the ... HHA [home health agency] can no longer meet the patient's needs, based on the patient's acuity ... DC [discharge] to nursing home." The patient's record indicated a diagnosis of dementia. Review of an agency document titled "Physician Order" dated 10/20/20, revealed the patient was discharged from the home health agency on 10/19/20 and to transfer to a long term care facility. Review of an agency document titled "Coordination of Care with Other Providers" was			

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	blank and only contained the patient's name and medical record number. The clinical record failed to evidence coordination with the long term care facility where the patient was transferred to. Review of the miscellaneous section of the patient's record evidenced fax confirmation sheets to the patient's physician, but failed to evidence that a discharge summary had been sent to the long term care facility where the patient was transferred to. In an interview with the patient's family member on 11/16/20 at 9:20 AM., the family member denied receiving any transfer information involving the patient's medication list, goals met/ unmet, a summary of the patient's condition at transfer, or a summary of the patient's care while on services from the home health agency. In an interview with the Assistant Director of Nursing (ADON) at Entity BB on 11/16/20 at approximately 10:33 AM, stated there was no discharge summary, no home medication list, no list of services provided by the agency. The ADON stated they were unaware the patient had been receiving home health care and accepted the patient based on the request of the physician and the family. 6. During an interview 11/10/20 at 12:12 AM the agency Director/Clinical Manager stated she audits all assessments upon their completion and submission to her. The Director/Clinical Manager stated she does not utilize an audit tool or track specific items for completeness and accuracy, but completes the assessment review by memory and notifies the clinician if changes are required. 7. The findings were reviewed with Person S			

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	(Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-15-1(a)(6)			
G 1024 Bldg. 00	484.110(b) Authentication Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure all entries were clear, complete, authenticated, dated and timed for 4 of 5 (Patients #1, 2, 3, 5) active records reviewed and 1 of 2 (Patient #6) closed records reviewed in a sample of 7. Findings include: 1. The clinical record of patient #2 was reviewed and contained a recertification assessment dated 10/16/20. The assessment failed to evidence a time in and out as well as pages 2 through 20 failed to evidence the name of the patient or a patient identifier. Review of a home health aide supervisory visit signed on 10/16/20 failed to evidence a time in and time out along with the date of the visit. The Interdisciplinary Care Coordination Meeting section failed to evidence a time for the meeting.	G 1024	G1024 Director of Clinical Services educated the RN Case Managers on importance of documentation being legible, complete, authenticated, dated, and timed. 100% of RN Case Manager documentation is reviewed by the Director of Clinical Services to ensure that each entry is readily readable, each section is complete, and that each document is dated and timed appropriately. Further education provided to ensure that RN Case Managers are documenting times in and out, and also including patient name or identifier on each page of assessment. Educated that legible signature must also be present in the proper sections.	02/16/2021

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	2. The clinical record of patient #3 was reviewed and contained an agency document titled "Inquiry/Referral Form" which was found to be incomplete and left the following information blank: Referral Contact, phone number, Admittance date, MD order start of care date, actual start of care date, religious culture considerations, primary caregiver, relationship, primary caregiver address, phone number, emergency contact, referring physician and phone number, primary care physician phone number, secondary diagnoses, other services involved in care such as durable medical equipment, pharmacy, emergency response vendor and/ or other services. Review of a start of care assessment dated 8/19/20. The assessment failed to evidence a time in and out as well as pages 2 through 28 failed to evidence the name of the patient or a patient identifier. Review of the home health aide supervisory visit note dated 9/16/20, failed to evidence a time in and time out, and the Interdisciplinary Care Coordination Meeting section failed to evidence a time for the meeting. Review of the home health aide supervisory visit note dated 10/14/20, failed to evidence a time in and time out, whether the client was receiving skilled or non-skilled services\, if the home health aide was present, and the Interdisciplinary Care Coordination Meeting section failed to evidence a time for the meeting. Review of a recertification assessment dated 10/14/20, failed to evidence a time in and out as well as pages 2 through 20 failed to evidence the name of the patient or a patient identifier.		Director of Clinical Services re-educated RN Case Managers that verbal and other physician orders must be dated, timed, and signed by clinician. New audit tool being utilized by Director of Clinical Services to ensure these items are accounted for during routine audits. Director of Clinical Services will require RN Case Managers to adhere to standards of documentation being legible, complete, authenticated, dated, and timed within 48 hours after audit is performed. After required adjustments are made to documentation, it will be placed in patient's chart. Director of Clinical Services is responsible for ongoing compliance with G1024.	

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	Review of patient #3's plan of care for the certification period of 10/16/20 to 12/14/20, locator 23 included the name of the nurse but no date of when the verbal order was received. The plan of care was faxed back to the agency on 10/29/20 but failed to evidence a signature and date by the physician. Review of agency documents titled "Case Notes" dated 10/08/20 (x2), 10/21/20, 10/29/20 (x2), 11/5/20, Coordination of Care with Other Providers dated 10/9/20, and Collaboration/ Coordination of Care Agreement between service Providers failed to evidence a clear and legible signature. Review of agency documents titled "Case Note" dated 10/21/20 (1 of 2 documents) failed to evidence a signature of the person who transcribed on the note. 3. The clinical record of patient #5 was reviewed and contained an agency document titled "Inquiry/Referral Form" dated 5/28/20, was found to be incomplete and left the following information blank: Religious cultural considerations, Primary caregiver address, Primary Diagnoses related to home care reason for admission, secondary diagnoses, services requested, frequency/ duration, description of services, and signature of person completing the form. Review of a secondary referral document dated 6/3/20, failed to indicate if the patient was admitted, referral contact, phone number, MD ordered start of care date, Actual start of care date, the relationship and demographics of the listed Primary caregiver, Emergency contact if different that Primary Caregiver, Primary insurance, diagnoses, failed to list the personal			

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	care needs, description of services, assistive devices used/ recommended include, past history, referral source/ contact,homebound status, physician verbal order obtained to evaluate the patient for services, , comments, when should be seen and ordered/ recommended visit frequency. Review of several agency documents titled "Personal Emergency Plan", "Patient Short Term Goals .... " dated by the admitting nurse on 6/2/20, "Acknowledgement of Information" dated by the admitting nurse on 6/3/20, failed to evidence that the family member who signed the documents included a date with their signature. Review of a start of care assessment dated 6/3/20. The assessment failed to evidence a time in and out as well as pages 2 through 28 failed to evidence the name of the patient or a patient identifier. Review of a recertification assessment dated 08/03/20 and 10/01/20, failed to evidence a time in and out as well as pages 2 through 20 failed to evidence the name of the patient or a patient identifier. Review of the home health aide supervisory visit note dated 8/3/20, 9/2/20, and 10/1/20, failed to evidence a time in and time out. The 10/1/20 note failed to evidence a signature and date of the home health aide observed. Review of patient #3's plan of care for the certification period of 10/01/20 to 11/29/20, locator 23 included the name of the nurse but no date of when the verbal order was received failed to evidence a signature and date by the physician. Review of agency documents titled "Case Notes"			

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	dated 10/08/20, 10/21/20, 11/5/20 and "Coordination of Care with Other Providers" dated 10/9/20 failed to evidence a clear and legible signature. Review of agency documents titled "Case Note" dated 10/29/20 failed to evidence a signature of the person who transcribed on the note. 4. The clinical record for patient #6 was reviewed and contained a start of care assessment dated 9/10/20. The assessment failed to evidence a time in and out as well as pages 2 through 28 failed to evidence the name of the patient or a patient identifier. Review of a discharge assessment dated 10/21/20 failed to evidence a time in and out as well as pages 2 to 15 failed to evidence the name of the patient or a patient identifier. 5. The clinical record for patient #1 was reviewed and contained a physician order dated 9/2/20, revealed "verbal order: OK to do admission process." The order failed to include a time of when the order was received. Review of a "Physician Order for Start of Care" failed to evidence a date and time of when the order was received. Review of a start of care assessment dated 9/3/20. The assessment failed to evidence a time in and out as well as pages 2 through 28 failed to evidence the name of the patient or a patient identifier. Review of an "Addendum to Home Care POC [plan of care]" signed and dated by the physician on 10/29/20, failed to evidence the name/ signature of the clinician writing/ accepting the			

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	order as well as the date and time of when the order was received. Review of skilled nursing visit notes dated 9/22/20, 9/29/20, 10/06/20, 10/13/20, 10/20/20, 10/27/20, and 11/3/20, all the visit notes times were left blank and failed to evidence a time in and time out of the visits. Review of a physician order signed and dated by the physician on 10/29/20, failed to evidence the clinician signature/ name of who took this order, accurate date and time the order was received. Review of a recertification assessment dated 10/29/20, failed to evidence a time in and out as well as pages 2 through 20 failed to evidence the name of the patient or a patient identifier. Review of a physician order dated 11/3/20, revealed "verbal order: incorrect 60 day episode dates should be 9/3 - 11/1/20 & 11/2 - 12/31/20. The date of birth line was blank and the order failed to include a time of when the order was received. Review of a physician order dated 11/10/20, revealed "verbal order: spoke with [Name Person V at physician office] Gabapentin 100 mg 1 po [by mouth] QD [every day]. May have one additional skilled nurse visit this week. Thank you. Please sign & return." The order failed to include a time of when the order was received. 6. During an interview 11/10/20 at 12:12 AM the agency Director/Clinical Manager stated she audits all assessments upon their completion and submission to her. The Director/Clinical Manager stated she does not utilize an audit tool or track specific items for completeness and accuracy, but			

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	completes the assessment review by memory and notifies the clinician if changes are required. 7. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide. 17-15-1(a)(7)			
N 0000 Bldg. 00	This visit was for a State Re-Licensure Survey of a Medicaid Home Health provider. Survey Date: 11/9/2020 to 11/17/2020 Facility #: 014225 Provider #: 15K165 Medicaid #: 300012386 Unduplicated Admissions last 12 months: 10 Skilled services - 5 Home health aide services (only) - 54 Total Census: 59	N 0000		
N 0462 Bldg. 00	410 IAC 17-12-1(h) Home health agency administration/management Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical			

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	examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on record review, the Administrator failed to ensure they did not complete the New Employee Health Certificate, including signature and date as the examining physician for multiple new employee physical exam forms in 18 of 18 employees hired within the last 5 months. Findings include: 1. The medical personnel record of Employee B, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, revealed a height and weight, date of exam dated 10/25/20 and the name of the examining physician revealed the administrator's signature. 2. The medical personnel record of Employee C, CNA, contained an agency document titled "New Employee Health Certificate" dated 11/4/20, revealed a height and weight, and the name of the examining physician revealed the administrator's signature. 3. The medical personnel record of Employee D, CNA, contained an agency document titled "New Employee Health Certificate" dated 9/3/20, revealed a height and weight, and the name of the examining physician revealed the administrator's signature. 4. The medical personnel record of Employee E, HHA, contained an agency document titled "New Employee Health Certificate" revealed a height and weight, date of exam dated 6/1/20 and the name of the examining physician revealed the	N 0462	N462 Agency administrator will ensure that all newly hired employees receive a physical exam by a qualified physician or nurse practitioner. This requirement has been suspended due to state of emergency caused by Coronavirus. Governing Body has approved of sending newly hired employees to nearby Greencastle physician's office to receive physical exams upon hire once this state of emergency has been lifted. Agency administrator will not review, sign, or perform any activities related to physical exams for newly hired employees. These forms will be filled out by nurse practitioner or MD as physicals are performed.	02/16/2021

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	administrator's signature. 5. The medical personnel record of Employee F, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, revealed a height and weight, dated 6/6/20 and the name of the examining physician revealed the administrator's signature. 6. The medical personnel record of Employee H, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, revealed a height and weight, dated 10/19/20 and the name of the examining physician revealed the administrator's signature. 7. The medical personnel record of Employee J, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 11/5/20 and the name of the examining physician revealed the administrator's signature. 8. The medical personnel record of Employee K, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 10/16/20 revealed a height and weight and the name of the examining physician revealed the administrator's signature. 9. The medical personnel record of Employee L, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 9/18/20, revealed a height and weight and the name of the examining physician revealed the administrator's signature. 10. The medical personnel record of Employee M, CNA, contained an agency document titled "New Employee Health Certificate" identifying the			

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	employee as a CNA, dated 8/7/20, revealed a height and weight and the name of the examining physician revealed the administrator's signature. 11. The medical personnel record of Employee N, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 8/25/20, revealed a height and weight and the name of the examining physician revealed the administrator's signature. 12. The medical personnel record of Employee O, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 9/21/20, revealed a height and weight and the name of the examining physician revealed the administrator's signature. 13. The medical personnel record of Employee P, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 8/6/20, revealed a height and weight and the name of the examining physician revealed the administrator's signature. 14. The medical personnel record of Employee Q, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 8/13/20, revealed a height and weight and the name of the examining physician revealed the administrator's signature. 15. The medical personnel record of Employee R, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 10/30/20, revealed a height and weight and the name of the examining physician revealed the administrator's signature. 16. The medical personnel record of Employee S,			

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	CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 9/18/20, revealed a height and weight and the name of the examining physician revealed the administrator's signature. 17. The medical personnel record of Employee U, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 10/14/20, revealed a height and weight and the name of the examining physician revealed the administrator's signature. 18. The medical personnel record of Employee W, CNA, contained an agency document titled "New Employee Health Certificate" identifying the employee as a CNA, dated 8/9/20, revealed a height and weight and the name of the examining physician revealed the administrator's signature. 19. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			
N 0468 Bldg. 00	410 IAC 17-12-1(k) and (l) Home health agency administration/management Rule 12 Sec. 1(k) The following records shall be made available, on request, to the department for review: (1) Personnel records and policies that document the home health agency's compliance with subsection (f). (2) Records of physical examinations that document the agency's compliance with subsection (h). (3) Records of the following:			

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	15K165	A. BUILDING 00 B. WING	11/17/2020

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	(A) Tuberculosis evaluations. (B) Appropriate clinical follow-up for positive findings. (C) Any other records that document the home health agency's compliance with subsection (i). (l) The department shall: (1) treat the information described in subsection (k) as confidential medical records; and (2) use it only for the purposes for which it was obtained. Based on record review, the agency failed to ensure staff completed the an annual TB (tuberculosis) symptom evaluation form for 4 out of 4 personnel records reviewed that had a TB annual document in their personnel record. Findings include: The medical personnel record of Employee L, CNA, DOH (date of hire) 9/18/20 and first patient contact 9/28/20, revealed a document titled "Annual TB Symptoms Evaluation" which failed to evidence answers to yes and no questions and no signature of the employee. The personnel record of Employee N, CNA, DOH 8/7/20 and first patient contact 8/15/20, revealed a document titled "Annual TB Symptoms Evaluation" which failed to evidence answers to yes and no questions and no signature of the employee. The personnel record of Employee S, CNA, DOH 9/18/20 and first patient contact 8/20/20, revealed a document titled "Annual TB Symptoms Evaluation" which failed to evidence answers to yes and no questions and no signature of the	N 0468	N468 All newly hired agency employees are required to complete the TB symptom evaluation form. This requirement has been recently added for newly hired employees along with employees receiving yearly TB testing. In some cases the symptom evaluation form is being used in lieu of the PPD test during the state of emergency declared due to Coronavirus. Once this is lifted, employees will receive one or two step PPD testing depending on need to meet state requirements. Employee files will be audited by agency administrator to ensure symptom evaluation form has been completed. Upon hire of new employees, the agency administrator will review that the TB symptom evaluation form has been filled out by the newly hired employee during their	02/16/2021

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	employee. The Administrator personnel record revealed a document titled "Annual TB Symptoms Evaluation" dated 8/24/20 which failed to evidence answers to yes and no questions. The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.		orientation. This form will be required to be filled out at the time of initial TB testing.	
N 0518 Bldg. 00	410 IAC 17-12-3(e) Patient Rights Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on record review, the agency failed to ensure their admission packets contained the most up to date Advance Directives information. Finding includes: Review of the Admission packet on 11/13/20, the agency's admission packet revealed Advance Directive information dated 2013. Review of the Indiana Department of Health Database, the Indiana Advance Directives was updated in November 2018.	N 0518	N518 The agency has recognized that an outdated Advance Directives form has been used in admission packets. This form was updated in 2018. The newest version of this form has been received from consultant working with the agency and implemented in reformed admission packets. The agency's Director of Clinical Services has placed this form in admission packets and educated	02/16/2021

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	The findings were reviewed with Person S (Governing Body), Administrator, Director of Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.		RN Case Managers on its information and implementation. This new document will also be provided to RN Case Managers to take with them to their next visit with each active patient. The patients who choose to implement an advance directive will have this new form integrated into their chart after completion. The Clinical Manager is responsible for ongoing compliance with N518.	
N 9999 Bldg. 00	Based on record review and interview, the agency failed to ensure they randomly drug tested 50% of their home health aides annually and failed to ensure immediate family members did not provide services while working as an agent of the agency for 1 of 1 records reviewed for this agency. Findings include 1. SECTION 8. IC 16-27-2.5-2 IS ADDED TO THE INDIANA CODE AS A NEW CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2017 updated 2019]: Chapter 2.5. Drug Testing of Employees Sec. 0.5. This chapter does not apply to a home health employee licensed under IC 25. Sec. 1. " ... (2)(b) A home health agency shall randomly test: (1) at least fifty percent (50%) of the home health agency's employees who: (A) have direct contact with patients; and (B) are not licensed by a board or commission under IC 25; at	N 9999	N9999 The agency has implemented random drug testing in the amount of 50% or more of all staff yearly. Employees are randomly chosen to come into the agency's office, or RN Case Managers are performing drug testing during supervisory visits. An average of 2-3 employees are randomly tested monthly. This action is monitored by the agency administrator. Family member who was performing as home health aide for one client at the agency has been informed that she will no longer be an employee of the agency after the 15-day notice of discharge	02/16/2021

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	least annually ...." Review of the agency's drug testing records, the agency failed to conduct 50% yearly. The records evidenced the agency started conducting random drug testing in 8/2020. During an interview on 11/16/20 at 2:00 p.m., about evidence of random testing prior to August, the Administrator stated the agency did not conduct the tests until after the complaint survey in July, 2020. 2. The 410 IAC 17-9-16 states: "Home health aide means an individual who provides home health aide services. The term does not include the following: (1) A health care professional. (2) A volunteer who provides home health aide services without compensation. (3) An immediate member of the patient's family." During an interview on 11/12/20 at 8:41 a.m., with Person N, RN Case Manager from hospice, stated Employee E, HHA is also a family member of patient #3. 3. During a home visit on 11/12/20 from 9:30 to 11:30 a.m., Employee C, CNA, stated she provides care and services to her grandmother, who is also a patient with Visiting Angels. 4. During an interview with the Administrator and Director of Nursing on 11/12/20 at 1:45 p.m., both denied knowing of the IAC 17-9-16 in regards to immediate members of the family could not provide home health aide services while working as an agent of the agency providing the services. 5. The findings were reviewed with Person S (Governing Body), Administrator, Director of		period provided to her family member. This caregiver will then no longer be employed with the agency. A review of all patients and employees will be conducted by the agency Clinical Manager/designee to determine if any other employees are providing care to family members at the agency. If an employee is determined to be providing care for a family member, an alternative caregiver will be arranged immediately by the Clinical Manager/designee and the agency scheduler. The Clinical Manager/designee is responsible for ongoing compliance with N9999.	

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	Clinical Services, and the Alternate Director of Clinical Services on 11/17/20 from 12:30 to 1:45 p.m. in which they had no further information or documentation to provide.			