STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOME HEALTH CARE INC	**3502 STELLHORN ROAD , FORT WAYNE, Indiana, 46815**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0000	INITIAL COMMENTS This was a fully extended federal and state home health recertification survey with 3 complaints. Complaints: IN00357731 - Allegations: Patient Rights, Nursing Services: Substantiated with findings IN00341253 - Allegation: Patient Rights: Unsubstantiated IN00315841 - Allegation: Infection Control: Substantiated without current findings Survey dates: July 26, 27, 28, 29, 30; August 3, 4, 5, 6 (2021). Facility number: 011096 Provider number: 15K035 Current census: 29 Based on the Condition-level deficiencies during the August 6, 2021 survey, Trinity Home Health Care Inc was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 7/27/21. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, Trinity Home Health Care Inc is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for the two years beginning August 6, 2021 and continuing through August 6, 2023 for being found out of compliance with the Conditions of Participation 42 CFR §484.50 Patient Rights, §484.55 Comprehensive Assessment of Patients, §484.58, Discharge planning, §484.60 Care Planning, Coordination of Services, and Quality of Care, and §484.80 Home Health Aide Services. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.	G0000		
G0406	Patient rights	G0406		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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G0406	Continued from page 1 CFR(s): 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. This CONDITION is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure all patients received the administrator's name in order to receive complaints (G414); failed to ensure all patients received an OASIS [Outcome and Assessment Information Set] privacy notice found on the CMS (Centers for Medicare and Medicaid Services) website to all patients for whom the OASIS data was collected (G416); failed to ensure all patients received the agency's policies for transfer and discharge (G422); failed to ensure it accommodated and respected the patient's (and/or family's) preferences in his or her own home while agency staff was present (G428); failed to ensure all patients participated in, were informed about, and/or consented to any changes in the home care services/treatment provided (G434); the agency failed to ensure all patients received all services as ordered on the plan of care (G436); failed to provide all patients information on their right to be notified prior to the next home health visit, of any changes in the charges for services they received (G440); and failed to ensure it provided all patients with the names, addresses, and telephone numbers of the Agency on Aging/Aging and Disability Resource Center, Center for Independent Living, and Quality Improvement Organization (G446). This practice had the potential to affect all agency patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR §484.50 Patient Rights.	G0406		
G0414	HHA administrator contact information CFR(s): 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name,	G0414		

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G0414	Continued from page 2 business address, and business phone number in order to receive complaints. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure all patients received the administrator's name in order to receive complaints for 3 of 3 home visits observed. Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines agency policy C-380 titled "Home Care Bill of Rights" stated "... shall be advised orally and in writing of their right to voice grievances/complaints and the method of contacting the agency ... This shall include information about the Home Health Agency Hotline ... Additional contacts as required by State statutes will also be provided ...." 2. Review of the agency's master admission packet/home folder received on 7/26/2021 evidenced (but not limited to) a 25 page document dated 8/17/2020 titled "Trinity Home Health Care INC ... Welcome!" evidenced a section titled "Complaints and Grievance", which stated "... Contact our office and ask to speak to the Administrator or the Supervising Nurse ....", but failed to include the name of the administrator. 3. During a home visit on 7/28/2021 at 9:00 AM with patient #1, start of care date 2/12/2013, the patient indicated she didn't know where her home folder was, home health aide (HHA) I indicated she thought it was in the closet, and the director of nursing indicated she knew the patient had a home folder at some point, but she could not locate it. 4. During a home visit on 7/28/2021 at 10:15 AM with patient #2, start of care date 11/30/2020, the home folder evidenced a document dated 5/2/2018 titled "Trinity Home Health Care INC ... Welcome!", which failed to evidence the administrator's name in order to receive complaints. 5. During a home visit on 7/28/2021 at 12:10 PM with patient #3, start of care date 6/5/2020, the home folder evidenced a document dated 5/2/2018 titled "Trinity Home Health Care INC ... Welcome!", which failed to evidence the	G0414		

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G0414	Continued from page 3 administrator's name in order to receive complaints. 6. During an interview on 7/27/2021 at 11:15 AM, the master copy of the patient's home folder was reviewed with the administrator, who indicated there was no evidence of the administrator's name in order to receive complaints documented in the home folder. 7. During an interview on 7/28/2021 at 6:23 PM, patient #5 indicated she just called the office if she had a complaint. 8. During an interview on 8/4/2021 at 4:24 PM, the administrator agreed the agency's admission packets/home folders were incorrect. 9. During an interview on 8/4/2021 at 4:24 PM, the administrator agreed the agency's admission packets/home folders were incorrect, staff was making new admission packets with the correct administrator's name, and stated "... Someone must have just made copies of old stuff ...."	G0414		
G0416	OASIS privacy notice CFR(s): 484.50(a)(1)(iii) (iii) An OASIS privacy notice to all patients for whom the OASIS data is collected. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure all patients received an OASIS [Outcome and Assessment Information Set] privacy notice found on the CMS (Centers for Medicare and Medicaid Services) website to all patients for whom the OASIS data was collected for 3 of 3 home visits observed. Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines agency policy C-380 titled "Home Care Bill of Rights" stated "... Clients/families will be informed of their right to privacy and confidentiality related to personal health care information data collection and transmission (OASIS) ...." 2. Review of a CMS web-based site:	G0416		

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G0416	Continued from page 4 https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment Instruments/OASIS/Downloads/OASISStatementofPrivacyRights.zip evidenced the CMS OASIS privacy notice document required for all patients for whom the OASIS data was collected. 3. During a home visit on 7/28/2021 at 9:00 AM with patient #1, start of care date 2/12/2013, the patient indicated she didn't know where her home folder was, home health aide (HHA) I indicated she thought it was in the closet, and the director of nursing indicated she knew the patient had a home folder at some point, but she could not locate it. 4. During a home visit on 7/28/2021 at 10:15 AM with patient #2, start of care date 11/30/2020, the home folder failed to evidence an OASIS privacy notice document. 5. During a home visit on 7/28/2021 at 12:10 PM with patient #3, start of care date 6/5/2020, the home folder failed to evidence an OASIS privacy notice document. 6. During an interview on 7/27/2021 at 11:15 AM, the master copy of the patient's home folder was reviewed with the administrator, who agreed there was no OASIS privacy notice document included in the packet.	G0416		
G0422	Written notice within 4 business days CFR(s): 484.50(a)(4) Provide written notice of the patient's rights and responsibilities under this rule and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section to a patient-selected representative within 4 business days of the initial evaluation visit. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure all patients received the agency's policies for transfer and discharge. Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines agency policy C-380 titled "Home Care Bill of Rights" stated "... The agency will provide the	G0422		

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G0422	Continued from page 5 agency's discharge and transfer policies ... within 4 business days after the initial evaluation visit ... It is an expectation that clients/representatives ... received ... the agency's transfer and discharge policies ...." 2. Review of the agency's master admission packet received on 7/26/2021 failed to evidence the agency's policies on discharge or transfers was included. 3. During a home visit on 7/28/2021 at 9:00 AM with patient #1, the patient indicated she didn't know where her home folder was, home health aide (HHA) I indicated she thought it was in the closet, and the director of nursing indicated she knew the patient had a home folder at some point, but she could not locate it. 4. During a home visit on 7/28/2021 at 10:15 AM with patient #2, the home folder was reviewed, which failed to evidence it included the agency's policies for discharge or transfer. 5. During a home visit on 7/28/2021 at 12:10 PM with patient #3, the home folder was reviewed, which failed to evidence it included the agency's policies for discharge or transfer. 6. During an interview on 7/27/2021 a 11:15 AM, the administrator indicated agency policies were not included in the patients' admission packet, and she was unaware the agency must provide discharge and transfer policies to all patients.	G0422		
G0428	Property and person treated with respect CFR(s): 484.50(c)(1) Have his or her property and person treated with respect; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure patients/caregivers were treated with respect regarding preferences in his or her own home while agency staff was present. Findings include: Review of the agency's master admission packet received on 7/26/2021 evidenced an undated document titled "Admissions Review of Additional	G0428		

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G0428	Continued from page 6 Information" stated "... Absolutely no smoking when caregivers are in the home, by patient or family ...." During an interview on 7/27/2021 at 11:15 AM, when asked if prohibiting a patient or family member from smoking in their own home while agency staff was present violated the patient's rights, the administrator and director of nursing indicated they were a smoke free agency, and they did not allow staff to smoke. 17-12-3(b)(4)(B)	G0428		
G0434	Participate in care CFR(s): 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure all patients participated in, were informed about, and/or consented to any changes in the home care services/treatment provided for 7 of 9 records reviewed (#1, 2, 4, 5, 6, 7, 9). Findings include: 1. Review of an undated copyright Briggs	G0434		

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G0434	Continued from page 7 Healthcare, Home Care Operational Guidelines agency policy C-380 titled "Home Care Bill of Rights" stated "... their [patient] right to make informed decisions regarding their care ... right to be involved in planning and implementing care ...." 2. Review of the agency's master admission packet/home folder received on 7/26/2021 evidenced (but not limited to) a 25 page document dated 8/17/2020 titled "Trinity Home Health Care INC ... Welcome!" evidenced a section titled "Patient's Bill of Rights and Responsibilities" which stated "... Be informed, in advance, of the plan of care ... expected outcomes ... known changes in the care to be furnished ... Participate in the development and planning of your care ... involved in planning changes in your ongoing care ...." 3. Record review for patient #1 was completed on 8/4/2021 at 11:15 AM, start of care date 2/12/2013, for certification period 7/2/2021 - 8/31/2021. A document titled "Home Health Certification and Plan of Care" stated "... Activities Permitted ... Up as Tolerated ... Transfer Bed/Chair ...." The document failed to evidence the patient was required to be on bedrest. During a home visit on 7/28/2021 at 9:00 AM, when asked what her goal was with regard to the services she received from the agency, the patient indicated she wanted to get her wound healed so she could get back up in her chair. During this time, the clinical manager and home health aide (HHA) I indicated the patient was on bedrest until the wound was healed. Agency staff failed inform the patient she could be up in a chair as tolerated per the plan of care. 4. Record review for patient #2 was completed on 8/4/2021, start of care date 11/30/2020, certification period 6/1/2021 - 7/31/2021. A document titled "Home Health Certification and Plan of Care" which evidenced the patient received (but not limited to) home health aide (no frequency) and daily skilled nursing services for wound care and wound(s) were present and being treated by the nurse prior to the certification period reviewed. The clinical record failed to evidence (but not limited to) the patient/family were made aware of or consented to the delay in HHA services, the decrease in skilled nursing frequency, or the agency's inability to perform	G0434		

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G0434	Continued from page 8 blood draws as ordered by a physician. During a home visit on 7/28/2021 at 10:15 AM, the home folder was reviewed, which evidenced a Home Health Certification and Plan of Care for certification dates 4/1/2021 - 5/31/2021, but no care plan for certification dates 6/1/2021 - 7/31/2021. During this time, RN (registered nurse) H inserted a current plan of care and aide care plan into the home folder. Neither was reviewed with the patient or family member, who were both present. Also during this time, the family member asked RN H if she could draw the patient's blood, RN H indicated she needed an order, the family member produced a written order (observed by surveyor), RN H indicated the agency did provide lab draws, but it would be a process, she had no supplies, she would not be able to provide the service today (7/28/2021), and she failed to inform the patient or family when/if she would be able to provide the service. Additionally, during this time, HHA J indicated she just started seeing the patient a couple of weeks ago. Review of a document dated and signed by RN H on 6/1/2021 and family nurse practitioner (FNP) on 7/13/2021 titled "Physician's Order" stated "... Correction to Plan of Care for Wound Care ... 1 visit 3 [times] weekly effective 4/19/2021 ...." The record failed to evidence the patient/family participated in this change and consented to the change in frequency. Review of a document dated 7/1/2021 titled "Clinical Summary/Case Conference" evidenced the patient received HHA services 2 hours daily, 3 times per week. The document failed to evidence patient/family involvement. During an interview on 8/4/2021 at 12:45 PM, the clinical manager did not think it was appropriate to do blood draws in the home, the integrity of the samples could be compromised, the agency nurses did not provide blood draws, and HHA services started on this patient a couple of weeks ago. 5. Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, for certification period 5/14/2021 - 7/14/2021. A document titled "Home Health Certification and Plan of Care" which evidenced the patient received (but not limited to) HHA 2 visits daily for up to 2 hours each visit, 7 days	G0434		

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G0434	Continued from page 9 per week, and skilled nursing visits 4 times weekly for application of lower extremity compression wraps. The record evidenced the patient received 29 out of 52 (56%) of ordered evening HHA visits, with the last evening visit completed on 7/1/2021, and the evening visits were discontinued on 7/5/2021. The record failed to evidence a case conference was held with the patient to discuss the decrease in services, or the patient agreed to the change. Review of a document dated 5/10/2021 titled "Recertification/Follow-Up [comprehensive] Assessment ...." evidenced the patient had self-care deficit and needed (but not limited to) assistance with dressing and bathing, diagnoses of (but not limited to) spina bifida (birth defect of the spine which often causes paralysis of the lower limbs), left below knee amputation, colostomy (surgical opening in abdomen to drain feces), needed help with dressing, bathing, and meals. Review of a document dated 7/5/2021, signed by the clinical manager on 7/9/2021, and signed by physician F on 7/12/2021 titled "Physician's Order" stated "... Discharge 2nd visit [evening] ... [patient] has gained more independence and no longer meets criteria ... for this second visit ...." Review of a document dated 7/12/2021 titled "Recertification/Follow-Up [comprehensive] Assessment ...." evidenced the patient had self-care deficit and needed (but not limited to) assistance with dressing and bathing. During an interview on 7/26/2021 at 5:12 PM, the patient indicated the agency recently fell on hard times with staffing, suddenly cut his evening HHA visits, the clinical manager said she wouldn't leave him hanging, but she did, he needed help for showering, dressing and meals, he was not given very much notice that the service was cut or why it was cut, and he was not involved with a care plan meeting to discuss or consent to the discontinuation of the evening visits. During an interview on 7/27/2021 at 2:00 PM, when asked who determined the patient no longer needed evening visits, the clinical manager indicated the patient refused a lot of the evening visits, and they were discontinued.	G0434		

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G0434	Continued from page 10 During an interview on 8/4/2021 at 1:59 PM, the administrator indicated she spoke with the patient and offered to restart the evening aide visits, he declined, and indicated to her that he was upset it took this long to address it. 6. Record review for patient #5 was completed on 8/4/2021, start of care date 8/7/2015, for certification period 7/19/2021 - 9/16/2021. A document titled "Home Health Certification and Plan of Care" which evidenced the patient received (but not limited to) HHA 1 visit up to 9 hours daily Monday-Friday, 1-2 visits daily (up to 5 hours total) on Saturdays and Sundays, the patient was paralyzed from the neck down, needed assistance with personal care, stated "... Goals ... Maintain client at home in optimum health so long as it is safe and feasible ...." The record failed to evidence the patient participated in the determination of the services received. During an interview on 7/28/2021 at 6:23 PM, the patient indicated her personal goals were to know she had a way to get up in the morning, go to bed at night with assist, and not have to worry about being left with no staff coverage. She also indicated staffing her hours was a huge issue, she communicated with the agency on 7/5/2021 to request consistent HHA services (but not limited to) Monday - Friday from 6:00 AM to 8:00 AM to ensure she could get up, dressed, and have breakfast before she had to leave for campus, and those were the most important hours she needed services. During an interview on 7/30/2021 at 3:45 PM, the patient indicated the alternate clinical manager was the last nurse that saw her week ending 7/17/2021, she was not aware the visit was for recertification of home health services, her medications or plan of care was not reviewed, and the nurse was there to perform a supervisory visit (the patient was not allowed to participate in care determinations). 7. Record review for patient #6 was completed on 8/4/2021, start of care date 3/14/2016, for certification period 5/9/2021 - 7/8/2021. An unsigned document dated 6/30/2021 (9:30-10:30 AM) titled "Discharge Assessment Including OASIS Elements for Discharge ...." The document evidenced the patient had impaired decision making which caused failure to perform usual personal	G0434		

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G0434	Continued from page 11 care, she required assistance to shower, and failed to evidence the patient was made aware or consented to the discharge, plans to address her needs discussed, reason for discharge, or the patient's signature and date. The record also evidenced a HHA visit was completed on (but not limited to) 6/30/2021 (8:14 - 10:00 AM), and personal care was provided. The agency failed to ensure the patient was informed and participated in the care received. Review of a letter with agency letterhead, addressed to the patient, dated and signed 6/30/2021 by the clinical manager, stated "... This letter is verification that we have discharged you from our services ...." The record failed to evidence the patient received the notice prior to discharge. Review of a document dated 7/1/2021 titled "Clinical Summary/Case Conference" evidenced the patient was discharged due to not needing personal care, and goals were met, and failed to evidence the patient participated/consented the decision to discharge services. During an interview on 7/27/2021 at 11:11 AM, the administrator indicated Within 48 hours they send a DC (discharge) summary and order to MD, and a letter to the patient with a copy of the DC summary and a satisfaction survey. During an interview on 8/4/2021 at 3:30 PM, the clinical manager indicated RN F completed the discharge assessment document on 6/30/2021, and she didn't know if an actual visit was made. When asked why the patient had a HHA visit on the same day as discharge if she was independent, and the visit times overlapped, she stated "... I don't know." When asked why the patient was discharged if she still needed HHA services for personal care, she stated "... I don't know." During an interview on 8/4/2021 at 4:24 PM, RN H indicated agency nurses were trained they did not have to do discharge visits, they only needed to complete the paperwork, and no actual visits were made. 8. Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, for certification period 4/19/2021 - 6/18/2021. The record evidenced the original order for home care was 12/14/2020, a comprehensive nursing assessment	G0434		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2021

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G0434	Continued from page 12 was completed on 12/16/2020, no further visits were made until patient consents for treatment were signed on 1/4/2021 (with no associated nursing visit), failed to evidence any nursing services were provided until 4/19/2021, or any HHA services were provided 12/16/2020 - 6/21/2021. The record failed to evidence the patient/family were made aware of the agency's inability to provide services from 12/16/2020 - 1/4/2021 and failed to evidence patient/family consented to receive no HHA services from 12/16/2020 - 1/4/2021, and 4/19/2021 - 6/21/2021. Review of a document dated and signed by the alternate director of nursing 12/14/2020 and physician C (patient's certifying physician) on 12/15/2020 titled "Physician's Order", which stated "... Assessment for Home Health Aide with Supervisory Nurse ...." The fax cover sheet document included with this physician's order, also dated and signed 12/14/2020 by the alternate nursing director titled "Fax Transmittal Form" stated "... Patient requesting SN [skilled nurse] services for weekly med set [medication pill planner set up] and hha [sic- home health aide] services daily to assist [with] IADLs [those activities that allow an individual to live independently in a community] ADLs [personal care tasks] and personal care ...." Review of a document dated and signed 12/16/2020 by the alternate director of nursing and the patient, titled "Comprehensive Adult Nursing Assessment", evidenced a comprehensive assessment was completed and the patient needed HHA and nursing services. Review of a document titled "Nursing Progress Notes for Home Health Care" evidenced an entry dated and signed by RN F 1/4/2021 stated "... Provider pending Insurance Authorization, Family able to supplement care ... Client willing to wait approval ....", and an entry dated and signed by RN F on 4/14/2021 which stated "... Writer submitting [plan of care] to be effective 4/19/21 ... Client notified ...." Review of a document dated and signed by RN F and the patient on 1/4/2021 titled "Admission Service Agreement" evidenced the patient consented to home health aide and skilled nursing services. The document also had an unsigned, undated, unauthenticated entry which stated "effective 4/19/2021". The document failed to include the	G0434		

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G0434	Continued from page 13 patient's signature for 4/19/2021. Review of a document signed (signature not dated) by RN F, and signed by physician C on 4/15/2021 titled "Home Health Certification and Plan of Care" for certification period 4/19/2021 - 6/18/2021 stated "... HHA ... 1 visit up to ... [2 hours per day, 5 days per week ....", and evidenced the nurse was ordered (but not limited to) twice daily, 5 days per week to check blood glucose levels, and weekly medication set up. Review of a document signed and dated 7/2/2021 by RN F, and signed/dated 7/6/2021 by physician C, stated "... unable to staff HHA from 4/19/2021 - 6/21/2021 ...." During an interview on 7/27/2021 at 11:11 AM, RN F indicated a comprehensive assessment was done 12/16/2020, the patient was waiting for additional information, then another one was done "on like" 1/4/2021. When asked why no aide services were provided for the entire certification period, RN F stated "... I believe the aide started in May. At that time, we didn't have anyone to staff him ...." When asked again to clarify the 1/4/2021 date (consents signed), she stated "... I can't remember what went on that day ...." During this time, RN F indicated she could not find a comprehensive assessment in the chart for 1/4/2021. Additionally, during this interview, the administrator indicated the alternate clinical manager saw the patient on 2/16/2020 and stated "... then we did eligibility and put him on hold ....", indicated she had no idea what 1/4/2021 was about, agreed there was no nursing visit note for 1/4/2021, and the patient was placed "on hold" as of 12/16/2020. When asked why no aide services were provided for the entire certification period, the administrator indicated no staff was available, and a "lot of that" was the patient refusing to allow someone to come. When asked if the chart evidenced the patient ever refused HHA services, RN F stated "No." 9. Record review for patient #9 was completed on 7/28/2021, start of care date 2/1/2016, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 3/10/2019 - 5/8/2019, which evidenced the patient received non-skilled respite (temporary care of a patient to provide relief for their usual caregiver) HHA services 2-4 hours, 3 times per week. The record also evidenced HHA P saw the patient on (but not	G0434		

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G0434	Continued from page 14 limited to) 3/25/2019, and no further visits were made. Review of a document dated and signed by former administrator D on 4/26/2020 titled "Care Summary ... Discharge Summary" evidenced the patient was discharged from the agency on 3/31/2019, per family request, and the last date of service was 3/31/2019. The clinical record failed to evidence services were provided on 3/31/2019, or the reason for the discharge was family care preferences were not being followed. During an interview on 7/27/2021 at 8:46 AM, family indicated she previously spoke with the agency about concerns with staff and she felt "brushed off", the HHA arrived at her home on 3/25/2019 and was sick, was off sick on 3/26/2019, came back to the patient's house on 3/27/2019 and was still sick, family sent her home, and the patient subsequently admitted to the hospital for influenza. 17-12-3(b)(2)(D)(i)(BB) 17-12-3(b)(2)(D)(ii)(AA) and (BB) 17-12-3(b)(2)(D)(iii)	G0434		
G0436	Receive all services in plan of care CFR(s): 484.50(c)(5) Receive all services outlined in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure all patients received all services as ordered on the plan of care and failed to have a policy to guide agency personnel for 3 of 9 records reviewed (#2, 3, 7). Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines agency policy C-380 titled "Home Care Bill of Rights" failed to evidence the patient's right to receive all services as ordered on the plan of care. 2. Review of an undated copyright Briggs Healthcare, Operational Guidelines: Home Care	G0436		

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G0436	Continued from page 15 policy C-100 titled “Services Provided” stated “... Agency will provide ... skilled nursing and home health aide ... [HHA] ... services to clients in their places of residence ....” 3. Review of an undated copyright Briggs Healthcare, Operational Guidelines: Home Care policy C-140 titled “Client Admission Process” stated “... Services will not be initiated until ... client needs can be met by agency ....” 4. Record review for patient #2 was completed on 8/4/2021, start of care date 11/30/2020, certification period 6/1/2021 – 7/31/2021. A document titled "Home Health Certification and Plan of Care" evidenced the patient had orders for (but not limited to) home health aide (HHA) and daily skilled nursing services for wound care. Review of a document “Completed Tasks by Date” for dates 6/1/2021 – 7/31/2021 evidenced home health visits were not started until 6/28/2021 (27 days after the start of the certification period), and additional visits occurred on 7/7/2021, 7/9/2021, 7/16/2021, 7/19/2021, 7/21/2021, and 7/26/2021. During a home visit on 7/28/2021, HHA J and RN H were present, and RN H indicated HHA J started with this patient about a couple of weeks ago. 5. Record review for patient #3 was completed on 8/4/2021, start of care date 6/5/2020, evidenced a document titled "Home Health Certification and Plan of Care", for certification period 6/06/2021 - 8/05/2021, which stated “... Skilled Nursing ... up to 12.5 hours per day ... 7 days per week for 26 weeks ...." The record failed to evidence the patient received skilled nursing services 7 days per week. During a home visit on 7/28/2021 from 12:10 – 1:25 PM, LPN G was present, indicated she saw the patient 11 hours daily, 4 days per week, and family cared for the patient all other times. 6. Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, for certification period 4/19/2021 - 6/18/2021. The record evidenced the original physician's order for home care was dated 12/14/2020, an initial comprehensive nursing assessment was completed on 12/16/2020, and patient consents for treatment forms were signed on 1/4/2021 (with no associated	G0436		

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G0436	Continued from page 16 nursing visit or assessment present in the record for 1/4/2021). After 12/16/2020, the record failed to evidence any nursing services were provided until 4/19/2021, at which time a comprehensive assessment was completed. The record failed to evidence the physician was contacted at any time between 12/16/2020 and 4/14/2021 to notify of the delay in start of care, or to request a different start of care date. Review of a document dated and signed by the alternate director of nursing 12/14/2020 and physician C (patient's certifying physician) on 12/15/2020 titled "Physician's Order", which stated "... Assessment for Home Health Aide with Supervisory Nurse ...." The fax cover sheet document included with this physician's order, also dated and signed 12/14/2020 by the alternate nursing director titled "Fax Transmittal Form" stated "... Patient requesting SN [skilled nurse] services for weekly med set [medication pill planner set up] and hha [sic- home health aide] services daily to assist [with] IADLs [those activities that allow an individual to live independently in a community] ADLs [personal care tasks] and personal care ...." Review of a document dated and signed 12/16/2020 by the alternate director of nursing and the patient, titled "Comprehensive Adult Nursing Assessment", evidenced a comprehensive assessment was completed and the patient needed home health aide (HHA) and nursing services. Review of a document titled "Nursing Progress Notes for Home Health Care" evidenced an entry dated and signed by RN F 1/4/2021 which stated "... Provider pending Insurance Authorization, Family able to supplement care ... Client willing to wait approval ....", and an entry dated and signed by RN F on 4/14/2021 which stated "... Writer submitting [plan of care] to be effective 4/19/21 ... Client notified ...." The entry on 1/4/2021 failed to evidence the physician was notified. Review of a document dated and signed by RN F and the patient on 1/4/2021 titled "Admission Service Agreement" evidenced the patient consented to home health aide and skilled nursing services. The document also had an unsigned, undated, unauthenticated entry which stated "effective 4/19/2021". The document failed to include the patient's signature for the amendment dated	G0436		

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G0436	Continued from page 17 4/19/2021. Review of a document signed (signature not dated) by RN F, and signed by physician C on 4/15/2021 titled "Home Health Certification and Plan of Care" for certification period 4/19/2021 - 6/18/2021 stated "... HHA ... 1 visit up to ... [2 hours per day, 5 days per week] ....", and evidenced the nurse was ordered (but not limited to) twice daily, 5 days per week to check blood glucose levels, and weekly medication set up. The plan of care was signed by the physician 5 days prior to the completion of the initial comprehensive assessment on 4/19/2021. Review of a document dated and signed by RN F on 7/2/2021 and physician C on 7/6/2021 titled "Notice of Interruption of Services" stated "... Reason for Interruption ... unable to staff HHA from 4/19/21 – 6/21/21 ...." During an interview on 7/27/2021 at 11:11 AM, RN F indicated a comprehensive assessment was done 12/16/2020, the patient was waiting for additional information, then another one was done "on like" 1/4/2021. When asked again to clarify the 1/4/2021 date (consents signed), she stated "... I can't remember what went on that day ...." and indicated she could not find a comprehensive assessment in the chart for 1/4/2021. Additionally, during this interview, the administrator indicated the alternate clinical manager saw the patient on 12/16/2020, then stated "... then we did eligibility and put him on hold ...." She also indicated she had no idea what 1/4/2021 was about, agreed there was no nursing visit note for 1/4/2021, the patient was placed "on hold" as of 12/16/2020, the agency used a 4-page assessment note for the initial visit, then within five days, they did the OASIS and comprehensive assessment. The record failed to evidence a physician's order to place services on hold.	G0436		
G0440	Payment from federally funded programs CFR(s): 484.50(c)(7)(i, ii, iii, iv) Be advised, orally and in writing, of- (i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA,	G0440		

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G0440	Continued from page 18 (ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA, (iii) The charges the individual may have to pay before care is initiated; and (iv) Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f). This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to provide all patients information on their right to be notified prior to the next home health visit, of any changes in the charges for services they received. Findings include: Review of the agency's master admission packet/home folder received on 7/26/2021 evidenced (but not limited to) a 25 page document dated 8/17/2020 titled "Trinity Home Health Care INC ... Welcome!" evidenced a section titled "Patient's Bill of Rights and Responsibilities", which stated "... Be informed of, both written and oral, of ... charges for services ... any charges you may have to pay plus any changes in charges for services ... as soon as possible ... but ... no later than thirty (30) calendar days from the date ... [agency] ... becomes aware of the change ...." During an interview on 7/27/2021 at 11:15 AM, during review of the agency's master admission packet/home folder, when asked if the patients should be notified any sooner than 30 days of any changes in charges for services, the administrator indicated the agency had 30 days to notify the patients.	G0440		
G0446	Contact info Federal/State-funded entities CFR(s): 484.50(c)(10)(i,ii,iii,iv,v) Be advised of the names, addresses, and telephone numbers of the following Federally-funded and	G0446		

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G0446	Continued from page 19 state-funded entities that serve the area where the patient resides: (i) Agency on Aging (ii) Center for Independent Living (iii) Protection and Advocacy Agency, (iv) Aging and Disability Resource Center; and (v) Quality Improvement Organization. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure it provided all patients with the names, addresses, and telephone numbers of the Agency on Aging/Aging and Disability Resource Center, Center for Independent Living, and Quality Improvement Organization. Findings include: 1. Review of an Indiana Department of Health (IDOH) form submitted by the administrator on 7/26/2021 evidenced the agency provided services to patients in Adams, Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wabash, Wells, and Whitley counties. 2. Review of the agency's master admission packet/home folder received on 7/26/2021 evidenced (but not limited to) a 25 page document dated 8/17/2020 titled "Trinity Home Health Care INC ... Welcome!" evidenced a section titled "Patients Bill of Rights and Responsibilities" stated "... [patient has] ... The right to be advised of the names, addresses, and telephone numbers of the following federally-funded and state-funded entities that serve the area where you reside ...." The document failed to provide correct information for: Agency on Aging/Aging and Disability Resource Center, Center for Independent Living, and Quality Improvement Organization. 3. Review of the Indiana Association of Area Agencies on Aging web-site reference: http://www.iaaaa.org/wp-content/uploads/2021/01/AAA-Map-Plus-Flyer-121520.pdf evidenced Planning and Service Area 2 (REAL Services, Inc.) included (but not limited to) Kosciusko county; Area 3 (Aging and In-Home Services of Northeast Indiana, Inc.) included Adams, Allen, DeKalb, Huntington,	G0446		

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G0446	Continued from page 20 LaGrange, Noble, Steuben, Wells, and Whitley counties; Area 5 (Area 5 Agency on Aging and Community Services, Inc.) included (but not limited to) Wabash county. 4. Review of (Indiana) Center for Independent Living (CILs) Listing by County web-site: https://www.in.gov/fssa/ddrs/files/CIL_Listing_by_County.pdf evidenced the following contact information for the counties the agency provided services: The League, 5821 S. Anthony Boulevard, Fort Wayne, IN 46816, 260-441-0551 (Adams, Allen, DeKalb, Huntington, Kosciusko, LaGrange, Noble, Steuben, Wells, and Whitley counties) and; the League and Future Choices, 420 S. High Street, Muncie, IN 47305, 765-741-8332 (Wabash county). 5. Review of Indiana's Quality Improvement Organization (QIO) web-site: https://www.livantaqio.com/en/states/indiana evidenced the help line phone number was (888) 524 - 9900. 6. Review of an IDOH web-site: https://www.in.gov/health/long-term-carenursing-homes/comprehensive-care-facility-nursing-homes-licensing-and-certification-program/quality-improvement-organization-information/ evidenced the following: The Beneficiary and Family Centered Care (BFCC) QIO for Indiana is (to handle complaints and case reviews) : Livanta LLC, 10820 Guilford Road, Suite 202, Annapolis Junction, MD 20701-1105; Toll Free Beneficiary Helpline: 1-888-524-9900, TTY 1-888-985-8775; Website: https://www.livantaqio.com/en/states/indiana. 7. During an interview on 7/27/2021 at 11:15 AM, the master admission packet/home folder was reviewed, and the administrator acknowledged the acknowledged information for the federally-funded and state-funded entities was incorrect or not complete, and she was unaware that Livanta was the current QIO for Indiana.	G0446		
G0510	Comprehensive Assessment of Patients CFR(s): 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA	G0510		

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G0510	Continued from page 21 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. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the registered nurse failed to ensure a patient assessment was completed within 48 hours of referral (G514); failed to ensure all comprehensive assessments evidenced all patients' strengths, goals, and/or care preferences (G530); failed to ensure the comprehensive assessment/re-assessment evidenced the patient's rehabilitative and/or discharge planning needs (G534); failed to review all medications the patient was currently taking (both prescription and non-prescription), failed to evidence indications for PRN (as needed) medications, failed to evidence a drug regimen review (DRR) was completed, and/or failed to evidence the physician was notified for potential major drug interactions (G536); failed to ensure the comprehensive assessment/re-assessment included all required information regarding the patient's primary caregiver (G538); failed to ensure the comprehensive assessment/re-assessment evidenced the patient's representative (G540); failed perform a comprehensive re-assessment when the patient's condition warranted (G544); failed to ensure comprehensive re-assessments were completed during the last 5 days of every 60 days beginning with the start-of-care date (G546); failed to ensure a comprehensive assessment was performed and completed at discharge, and failed to ensure it included a summary of the patient's progress in meeting the care plan goals (G550). This practice had the potential to affect all agency patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR §484.55 Comprehensive Assessment of Patients. This practice had the potential to affect all agency patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR §484.55 Comprehensive Assessment of Patients.	G0510		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/06/2021

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G0510 G0514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the registered nurse failed to ensure a patient assessment was completed within 48 hours of referral for 1 of 1 records reviewed where the initial certification period was reviewed (#7), in a total sample of 9 records. Findings include: Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, for certification period 4/19/2021 - 6/18/2021. The record evidenced the original physician's order for home care was dated 12/14/2020, an initial comprehensive nursing assessment was completed on 12/16/2020, and patient consents for treatment forms were signed on 1/4/2021 (with no associated nursing visit or assessment present in the record for 1/4/2021). After 12/16/2020, the record failed to evidence any nursing services were provided until 4/19/2021, at which time a comprehensive assessment was completed. The record failed to evidence the physician was contacted at any time between 12/16/2020 and 4/14/2021 to notify of the delay in start of care, or to request a different start of care date. Review of a document dated and signed by the alternate clinical manager 12/14/2020 and physician C (patient's certifying physician) on 12/15/2020 titled "Physician's Order", which stated "... Assessment for Home Health Aide with Supervisory Nurse ...." The fax cover sheet document included with this physician's order, also dated and signed 12/14/2020 by the alternate clinical manager titled "Fax Transmittal Form" stated "... Patient requesting SN [skilled nurse]	G0510 G0514		

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G0514	Continued from page 23 services for weekly med set [medication pill planner set up] and hha [sic- home health aide] services daily to assist [with] IADLs [those activities that allow an individual to live independently in a community] ADLs [personal care tasks] and personal care ...." Review of a document dated and signed 12/16/2020 by the alternate clinical manager and the patient, titled "Comprehensive Adult Nursing Assessment", evidenced a comprehensive assessment was completed and the patient needed home health aide (HHA) and nursing services. Review of a document titled "Nursing Progress Notes for Home Health Care" evidenced an entry dated and signed by RN F 1/4/2021 which stated "... Provider pending Insurance Authorization, Family able to supplement care ... Client willing to wait approval ....", and an entry dated dated and signed by RN F on 4/14/2021 which stated "... Writer submitting [plan of care] to be effective 4/19/21 ... Client notified ...." The entry on 1/4/2021 failed to evidence the physician was notified. Review of a document dated and signed by RN F and the patient on 1/4/2021 titled "Admission Service Agreement" evidenced the patient consented to home health aide and skilled nursing services. The document also had an unsigned, undated, unauthenticated entry which stated "effective 4/19/2021". The document failed to include the patient's signature for the amendment dated 4/19/2021. Review of a document signed (signature not dated) by RN F, and signed by physician C on 4/15/2021 titled "Home Health Certification and Plan of Care" for certification period 4/19/2021 - 6/18/2021 stated "... HHA ... 1 visit up to ... [2 hours per day, 5 days per week] ....", and evidenced the nurse was ordered (but not limited to) twice daily, 5 days per week to check blood glucose levels, and weekly medication set up. The plan of care was signed by the physician 5 days prior to the completion of the initial comprehensive assessment on 4/19/2021. Review of a document dated and signed by RN F and the patient on 4/19/2021 titled "Comprehensive Adult Nursing Assessment Including SOC [start of care]/ROC [resumption of care] OASIS [outcome and assessment information set] Elements with Plan of	G0514		

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G0514	Continued from page 24 Care Information" stated "... Date of Physician-ordered Start of Care ... 04/19/2021 ... Date of Referral ... 01/04/2021 ...." The record failed to evidence a referral dated 1/4/2021 or a physician's order for start of care dated 4/19/2021. During an interview on 7/27/2021 at 11:11 AM, RN F indicated a comprehensive assessment was done 12/16/2020, the patient was waiting for additional information, then another one was done "on like" 1/4/2021. When asked again to clarify the 1/4/2021 date (consents signed), she stated "... I can't remember what went on that day ....", and indicated she could not find a comprehensive assessment in the chart for 1/4/2021. Additionally during this interview, the administrator indicated the alternate clinical manager saw the patient on 12/16/2020, then stated "... then we did eligibility and put him on hold ...." She also indicated she had no idea what 1/4/2021 was about, agreed there was no nursing visit note for 1/4/2021, the patient was placed "on hold" as of 12/16/2020, the agency used a 4 page assessment note for the initial visit, then within five days, they did the OASIS and comprehensive assessment. The record failed to evidence a physician's order to place services on hold. 17-14-1(a)(1)(A)	G0514		
G0530	Strengths, goals, and care preferences CFR(s): 484.55(c)(2) 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; This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the registered nurse failed to ensure all comprehensive assessments evidenced all patients' strengths, goals, and/or care preferences for 13 of 13 comprehensive assessments reviewed for 7 of 9 records reviewed (#1, 2, 4, 5, 6, 7, 8). Findings include: 1. Review of an undated policy C-145 titled "Comprehensive Client Assessment" stated "... The	G0530		

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G0530	Continued from page 25 Comprehensive Assessment ... must include at a minimum ... The client's strengths, goals, and care preferences ...." 2. Record review for patient #1 was completed on 8/4/2021, start of care date 2/12/2013, for certification period 7/2/2021 - 8/31/2021. Review of a comprehensive assessment to establish the certification period was completed and signed by the clinical manager and patient on 6/28/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced the patient already had personal goals she was working on, no new personal goals were identified, and failed to evidence care preferences was assessed, or strengths were related to the primary reason the patient received home care. Review of a document titled "Home Care Certification and Plan of Care" evidenced the patient received (but not limited to) daily nursing visits for wound care, and stated "... GOAL - Maintain client in optimum health at home ...." The document failed to evidence patient goals she was already working on. During a home visit on 7/28/2021 at 9:00 AM, the patient indicated her goal was to get her wound healed so she could get back up in her chair. 3. Record review for patient #2 was completed on 8/4/2021, start of care date 11/30/2020, certification period 6/1/2021 - 7/31/2021. During an interview on 8/4/2021 at 12:45 PM, the admission comprehensive assessment and recertification comprehensive assessment for certification period 6/1/2021 - 7/31/2021 was requested. Upon survey exit, the documents were not submitted for review. 4. Record review for patient #3 was completed on 8/4/2021, start of care date 6/5/2020, certification period 6/6/2021 - 8/5/2021, evidenced a document titled "Home Health Certification and Plan of Care" which stated "... skilled nursing ... trach [tracheostomy - an incision in the windpipe made to relieve an obstruction to breathing]... Goals ... To remain safe in home ...." The document failed to evidence patient goals. Review of a document dated and signed by RN H and	G0530		

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G0530	Continued from page 26 family on 6/3/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced the patient already had personal goals she was working on, no new personal goals were identified, and failed to evidence strengths/limitations were assessed. 5. Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, for certification period 5/14/2021 - 7/14/2021, evidenced a document titled "Home Health Certification and Plan of Care" which stated "... GOALS ... Maintain client at home in optimum health ...." Review of a document dated and signed by the clinical manager and patient on 5/10/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" failed to evidence patient personal goals were identified. Review of a document dated and signed by the alternate clinical manager on 7/9/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" failed to evidence the patient's strengths, goals, and/or care preferences were assessed or documented. 6. Record review for patient #5 was completed on 8/4/2021, start of care date 8/7/2015, for certification period 7/19/2021 - 9/16/2021, evidenced a document titled "Home Health Certification and Plan of Care" which stated "... Goals ... Maintain client at home in optimum health ...." Review of a document dated and signed by the alternate clinical manager on 7/15/2021 titled "Comprehensive Adult Assessment" failed to evidence the patient's strengths, goals, and/or care preferences were assessed or documented. During an interview on 7/30/2021 at 3:45 PM, the patient indicated the nurse did not review the plan of care with her during recertification visits. 7. Record review for patient #6 was completed on 8/4/2021, start of care date 3/14/2016, for certification period 5/9/2021 - 7/8/2021, evidenced a document titled "Home Health	G0530		

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G0530	Continued from page 27 Certification and Plan of Care" which stated "... GOALS: Client to remain in home ...." Review of a document dated and signed by the clinical manager and patient on 5/5/2021 titled "Comprehensive Adult Assessment" failed to evidence the patient's strengths, goals, and/or care preferences were assessed or documented. Review of an unsigned document dated 6/30/2021 titled "Discharge Assessment Including OASIS Elements for Discharge ...." failed to evidence the patient's strengths, goals, and/or care preferences were assessed or documented. 8. Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, for certification period 4/19/2021 - 6/18/2021. Review of a document dated and signed by RN F and the patient on 4/19/2021 titled "Comprehensive Adult Nursing Assessment Including SOC [start of care]/ROC [resumption of care] OASIS [outcome and assessment information set] Elements with Plan of Care Information" failed to evidence the patient's personal goals. Review of a document dated and signed by RN F on 5/3/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, which failed to evidence the patient's care preferences, personal goals, or strengths/limitations. Review of a document dated and signed by RN F and the patient on 5/13/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, which failed to evidence the patient's care preferences, personal goals, or strengths/limitations. Review of a document dated and signed by RN F and the patient on 5/24/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, which failed to evidence the patient's care preferences, personal goals, or strengths/limitations. Review of a document dated 6/16/2021 and signed by RN F and the patient signatures not dated) titled "Recertification/Follow-Up Assessment Including	G0530		

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G0530	Continued from page 28 OASIS Elements with Plan of Care Information" evidenced the patient had no care preferences, and failed to evidence personal goals, or strengths/limitations. During an interview on 7/27/2021 11:11 AM, RN F indicated this was her first home health job, and she was unaware that all sections of the comprehensive assessments were required to be completed. 9. Record review for patient #8 was completed on 8/4/2021, start of care date 8/11/2019, for certification period 10/5/2020 - 12/4/2020, Which evidenced a document titled "Home Health Certification and Plan of Care" which stated "... Goals ... Remain in home ...." Review of a document dated and signed by RN H and the patient 10/01/2020 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" which evidenced had personal goals he was working on, but failed to evidence what they were, the patient had care preferences, but failed to evidence what they were, and failed to evidence strengths/limitations. Review of a document dated 10/19/2020 and signed by RN H 9/19/2020 (not a typo) titled "[OASIS] ... Discharge from Agency ...." failed to evidence a comprehensive assessment of the patient was completed. During an interview on 8/4/2021 at 3:52 PM, RN H stated "... I did the [discharge] OASIS form ... I was trained we were never required to do a home visit for [discharges] ...."	G0530		
G0534	Patient's needs CFR(s): 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; This ELEMENT is NOT MET as evidenced by: Based on observation and record review, the registered nurse failed to ensure the comprehensive assessment/re-assessment evidenced the patient's rehabilitative and/or discharge planning needs for 11 of 13 comprehensive assessment/re-assessments reviewed for 7 of 7	G0534		

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G0534	Continued from page 29 records reviewed which contained comprehensive assessments. Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-145 titled "Comprehensive Client Assessment" stated "... The Comprehensive Assessment ... must include at a minimum ... medical, nursing, rehabilitative, social, and discharge planning needs ... Discharge planning is initiated ...." 2. Record review for patient #1 was completed on 8/4/2021 at 11:15 AM, start of care date 2/12/2013, for certification period 7/2/2021 – 8/31/2021 evidenced a document dated and signed by the clinical manager 6/28/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information". The document evidenced a section titled “Rehabilitation Potential/Anticipated Discharge for Plan of Care” failed to evidence discharge plans, and stated “... No D/C [discharge] at this time ....” 3. Record review for patient #3 was completed on 8/4/2021, start of care date 6/5/2020, certification period 6/6/2021 – 8/5/2021, evidenced a document dated and signed by RN H 6/3/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information". The document evidenced a section titled “Rehabilitation Potential/Anticipated Discharge for Plan of Care” failed to evidence discharge plans, and stated “... Remain safe in the home ....” 4. Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, for certification period 5/14/2021 – 7/14/2021, evidenced a document dated 7/12/2021 and signed by RN B on 7/9/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information". The document evidenced a section titled “Rehabilitation Potential/Anticipated Discharge for Plan of Care” which failed to evidence any discharge plans. 5. Record review for patient #5 was completed on 8/4/2021, start of care date 8/7/2015, for certification period 7/19/2021 – 9/16/2021,	G0534		

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G0534	Continued from page 30 evidenced a document dated and signed by RN B 7/15/2021 titled “Comprehensive Adult Assessment” (for recertification of services) evidenced a section titled “Discharge Plans”, which also included rehabilitation potential. The entire section was blank. 6. Record review for patient #6 was completed on 8/4/2021, start of care date 3/14/2016, for certification period 5/9/2021 – 7/8/2021, evidenced a document dated and signed by the clinical manager on 5/5/2021 titled “Comprehensive Adult Assessment” evidenced a section titled “Discharge Plans”, which also included rehabilitation potential. The entire section was blank. 7. Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, evidenced a document dated and signed by RN F and the patient on 4/19/2021 titled "Comprehensive Adult Nursing Assessment Including SOC [start of care]/ROC [resumption of care] OASIS [outcome and assessment information set] Elements with Plan of Care Information" failed to evidence any rehabilitation or discharge plans. Review of a document dated and signed by RN F on 5/3/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, failed to evidence any rehabilitation or discharge plans. Review of a document dated and signed by RN F and the patient on 5/13/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, which failed to evidence any rehabilitation or discharge plans. Review of a document dated and signed by RN F and the patient on 5/24/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, which failed to evidence any rehabilitation or discharge plans. Review of a document dated 6/16/2021 and signed by RN F and the patient signatures not dated) titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" which failed to evidence any rehabilitation or discharge plans.	G0534		

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G0534	Continued from page 31 8. Record review for patient #8 was completed on 8/4/2021, start of care date 8/11/2019, for certification period 10/5/2020 – 12/4/2020, Which evidenced a document dated and signed by RN H on 10/1/2020 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced discharge plans were discussed with the patient, but failed to evidence the plan, and failed to evidence rehabilitation potential.	G0534		
G0536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the registered nurse failed to review all medications the patient was currently taking (both prescription and non-prescription), failed to evidence indications for PRN (as needed) medications, failed to evidence a drug regimen review (DRR) was completed, and/or failed to evidence the physician was notified for potential major drug interactions for 7 of 9 records reviewed (#1, 2, 3, 5, 6, 7, 8). Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-700 titled "Medication Profile" stated "... The medication profile shall include all prescription and nonprescription drugs ... reviewed and updated as needed to reflect current medications the client is taking ... The clinician shall promptly report any identified problems to the physician ...." 2. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-701 titled "Medication Set Up Policy" stated "... monitor for actions and side effects ... medications are reviewed at each visit to determine if there are new or changed medications.	G0536		

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G0536	Continued from page 32 This includes over the counter [OTC] medications ... very important ... nurse ensures ... plan of care reflect all OTC medications that are taken even if they are PRN ... educate the [patient] on side effects and drug interactions ....” 3. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-705 titled “Medication Management” stated “... Comprehensive client assessment ... include review of all medications ... (prescribed, ... [OTC] ... herbal remedies, PRN medications ... relevant laboratory values and regularly scheduled lab testing ... Specific instructions for how and when to take the medication ... Indication for the drug ... Parameters for using PRN medications including amount and frequency and any other time limitations ....” 4. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-706 titled “Medication Orders” stated “... PRN Medications must include ... reason for use and any specific time constraints for administration ....” 5. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-145 titled "Comprehensive Client Assessment" stated "... The Comprehensive Assessment ... must include at a minimum ... 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 non-compliance with drug therapy ....” 6. Record review for patient #1 was completed on 8/4/2021 at 11:15 AM, start of care date 2/12/2013, for certification period 7/2/2021 – 8/31/2021. A document dated and signed by the clinical manager 6/28/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced the patient was alert and oriented, medications were reviewed, no medication changes were identified by the nurse, and the patient used a BIPAP (different settings for inspiration and exhalation) machine for the administration of oxygen. Review of a document dated and signed by the	G0536		

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G0536	Continued from page 33 clinical manager on 6/28/2021 titled “Home Health Certification and Plan of Care” for certification period 7/2/2021 – 8/31/2021 evidenced medications included Tylenol 325 mg (milligrams), 2 tabs (tablets) every 4 hours PRN; Keppra 500 mg, 2 tabs twice daily; Baclofen 10mg daily via an implanted pump; Oxygen 1 LPM (liters per minute) at bedtime; Carvedilol 6.25 mg twice daily; Ibuprofen 200 mg, 3 tabs every 6 hours PRN; Baclofen 10 mg (did not indicate tab or capsule), 3 times daily PRN; Cephalexin 500 mg, 3 times daily; and Buspar 5 mg 3 times daily PRN. The plan of care failed to evidence parameters for use of PRN medications. Review of a document dated 7/22/2021 titled “... [hospital G] Center for Wound Healing ... Wound Telehealth Visit” evidenced a section titled “Current meds” which evidenced (but not limited to) the patient took 10 mg of Buspar, (not 5 mg per agency), and evidenced patient reported on 5/19/2021 she was not taking this medication; she took Florine, Melatonin, Myrbetriq, Sertraline, and Dakin’s cream for wound care, (all not included on agency plan of care; and she took Keppra 1 tab twice daily (not 2 tabs twice daily per agency). During a home visit on 7/28/2021 at 9:00 AM, the patient presented as oriented to person, place, and time, and answered questions appropriately. When asked, the patient indicated she was on 2 LPM (not 1 LPM per agency) oxygen with her CPAP (Continuous positive airway pressure, a machine that forces oxygen continuously to the upper respiratory tract of a person). The agency documented use of a BIPAP. She also indicated her neurologist told her to take 10 mg of Baclofen at night, or 5 mg, and indicated she wasn’t sure. When asked what she took for pain, she indicated she took 2 Tylenol extra strength (500 mg tab) whenever needed (not 325 mg per agency). There was no current list of medications in the home to review. The nurse failed to review the patient’s current medications during the visit, and failed to apply darkens cream topically during wound care. During an interview on 8/4/2021 at 11:15 AM, the clinical manager indicated she clarified with family the patient’s sertraline was increased to twice daily, and it wasn’t baclofen, like the patient indicated during the home visit. When asked about the dose of Tylenol, she indicated if she didn’t see the patient take a medication, it	G0536		

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G0536	Continued from page 34 wouldn't be included on the medication list, and the patient was confused. When asked why the comprehensive assessment indicated the patient was oriented, she indicated it was just for that day. When asked about the medications documented on the physician's note as compared to the agency's, she indicated she spoke to the wound clinic, they were wrong, and they corrected theirs. When asked if she had documentation, she stated "No." During this time, she stated "... We have corrected all meds since survey started ...." She also indicated she did not know the machine was a CPAP, not a BIPAP. 7. Record review for patient #2 was completed on 8/4/2021, start of care date 11/30/2020, certification period 6/1/2021 – 7/31/2021, evidenced a document titled "Home Health Certification and Plan of Care" which indicated medications (but not limited to) ferrous sulfate twice daily, Losartan potassium 2.5 mg daily, triamcinolone cream- apply to bilateral feet (did not indicate how often), Tylenol 325 mg every 4 hours as needed (no indication for use), and Norco every 4 hours as needed (no indication for use). During a home visit on 7/28/2021 at 10:15 AM, the following (but not limited to) OTC medications were observed on the patient's shelf: Imodium liquid, Antiacid tabs, Tucks pads, cortisone cream, Systane eye drops, Milk of magnesia, Tylenol ES (500 mg tabs), Glucose tabs, and theraworks pain relief foam. During this time, RN H indicated assisted living facility (ALF) A managed and administered the patient's medications. Also, during this time, the surveyor interviewed the ALF director of nursing, who submitted the patient's current medication profile. During an interview on 7/28/2021 with the ALF's director of nursing, he indicated the medication profile submitted was the patient's correct schedule, and he hadn't had any care coordination/conferences with Trinity Home Care nurses. Review of ALF A document (not part of agency clinical record) titled "Order Summary Report" evidenced (but not limited to) the following medications: ferrous sulfate once daily, Losartan potassium 50 mg daily, triamcinolone cream- apply to bilateral feet daily- Trinity home health care nurses to do (ordered 3/29/2021), Tylenol 325 mg	G0536		

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G0536	Continued from page 35 every 4 hours as needed for pain, Norco every evening as needed for pain, and halobetasol Propionate ointment 5% topically to lower extremities every 12 hours as needed for wounds- Trinity home health care nurses to do (ordered 3/29/2021). Review of a drugs.com web-site reference for drug interactions checker (not part of agency record): https://www.drugs.com/interactions-check.php?drug_list=172-0,243-3197,276-0,1426-14721,1228-0,1082-0,1129-0,1257-0,1146-676,1489-0,1590-0,71-8487,1342-10798,705-360,735-5507,2054-0,1654-1024,2232-0, evidenced a major potential drug interaction between methotrexate and aspirin, and stated "... Major ... [potential drug interaction] ... Highly clinically significant. Avoid combinations; the risk of the interaction outweighs the benefit ...." The record failed to evidence the physician was contacted. During an interview on 8/4/2021 at 12:45 PM, the clinical manager indicated medication reconciliation was not done if medications on the patient's shelf were not accounted for on the clinical record, RN H indicated she could never get a hold of ALF A's director of nursing. 8. Record review for patient #3 was completed on 8/4/2021, start of care date 6/5/2020, certification period 6/6/2021 – 8/5/2021, evidenced a document titled "Home Health Certification and Plan of Care" which evidenced 21 PRN medications without indications for use, 4 medications that were previously discontinued based on reconciliation with the home folder medication profile (ciclopirox, sodium fluoride, levothyroxine, and loratadine) and; 2 medications with conflicting doses based on reconciliation with the home folder medication profile during a home visit on 7/28/2021 at 12:10 PM (trazadone and ibuprofen). The plan of care indicated trazadone 300 mg daily, and ibuprofen 20 mg daily. Oxygen was not listed on the plan of care. Review of a document dated and signed by RN H on 6/3/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced the medication regimen was reviewed with no changes, and no potential drug interactions identified. Review of a drugs.com web-site reference for drug interactions checker (not part of agency record):	G0536		

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G0536	Continued from page 36 https://www.drugs.com/interactions-check.php?drug_list=318-0,665-0,703-0,1066-0,2918-0,2228-0,11-12,110-0,896-1617,1310-0,1457-0,1463-0,1486-0,1937-0,1912-0,1192-705,2057-0,1690-1051 evidenced 2 potential major drug interactions between ibuprofen and naproxen, and trazadone and sertraline. The record failed to evidence the physician was contacted. 9. Record review for patient #5 was completed on 8/4/2021, start of care date 8/7/2015, for certification period 7/19/2021 – 9/16/2021, evidenced a document dated and signed by the alternate clinical manager titled “Comprehensive Adult Assessment” failed to evidence the patient’s medications were reviewed and reconciled. During an interview on 7/30/2021 at 3:45 PM, the patient indicated the nurse did not “go over” her medications during the 7/15/2021 nursing visit. 10. Record review for patient #6 was completed on 8/4/2021, start of care date 3/14/2016, for certification period 5/9/2021 – 7/8/2021, evidenced a document dated and signed by the clinical manager on 5/5/2021 titled “Home Health Certification and Plan of Care” for certification period 5/9/2021 – 7/8/2021, which indicated medications included (but not limited to) ibuprofen, warfarin, aspirin, trazodone, Zofran, cyclobenzaprine, diltiazem, loperamide, lorazepam, hydrocodone (Norco), gabapentin, losartan, invega (paliperidone), and asepapine (Saphris), and evidenced 4 PRN medications without indications for use. Review of a document dated and signed 5/5/2021 by the clinical manager titled “Comprehensive Adult Assessment” evidenced no significant drug interactions were identified during drug regimen review. Review of an unsigned document dated 6/30/2021 titled “Discharge Assessment Including OASIS Elements for Discharge ....” stated “... At the time of, or at any time since ... [the start of care] ... was the patient/caregiver instructed ... to monitor ... and how to report problems ... [answer] ... No ....”, and failed to evidence medications were reconciled or a drug regimen review was completed. Review of a drugs.com web-site reference for drug interactions checker (not part of agency record):	G0536		

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G0536	Continued from page 37 https://www.drugs.com/interactions-check.php?drug_list=1463-0,1476-0,890-14143,276-0,1488-0,2311-0,1349-805,1344-803,363-0,927-494,1147-0,1781-2498,11-12,1146-676,71-8487,1540-0,1066-603,1949-1259,1750-1118,2027-0,3168-13988,353-156,2228-0,1752-1120,1126-657,243-3197,2365-487,758-0,1310-0,1482-14224,1448-13129,1489-0,2840-0 evidenced 13 potential major drug interactions between ibuprofen and naproxen, and trazadone and sertraline. The record failed to evidence the physician was contacted. 11. Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, evidenced a document undated and signed by RN F titled “Home Health Certification and Plan of Care” for certification period 4/19/2021 – 6/18/2021, which evidenced medications included (but not limited to) Bactrim DS (trimethoprim), losartan, omeprazole, and clopidogrel, and evidenced 1 PRN medication without indications for use. Review of a document dated and signed by RN F and the patient on 4/19/2021 titled "Comprehensive Adult Nursing Assessment Including SOC [start of care]/ROC [resumption of care] OASIS [outcome and assessment information set] Elements with Plan of Care Information" failed to evidence a medication regimen reconciliation or review was completed. Review of a document dated and signed by RN F on 5/3/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, which failed to evidence a medication regimen reconciliation or review was completed. Review of a document dated and signed by RN F and the patient on 5/13/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, which failed to evidence a medication regimen reconciliation or review was completed. Review of a document dated and signed by RN F and the patient on 5/24/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, which failed to evidence a medication regimen reconciliation or review was completed. Review of a document dated 6/16/2021 and signed by	G0536		

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G0536	Continued from page 38 RN F and the patient signatures not dated) titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" which failed to evidence a medication regimen reconciliation or review was completed. Review of a drugs.com web-site reference for drug interactions checker (not part of agency record): https://www.drugs.com/interactions-check.php?drug_list=243-0,3505-16377,276-0,705-0,875-0,1147-0,1176-0,1489-0,1750-0,1752-0,2128-3117 evidenced 2 potential major drug interactions between ibuprofen and naproxen, and trazadone and sertraline. The record failed to evidence the physician was contacted. 12. Record review for patient #8 was completed on 8/4/2021, start of care date 8/11/2019, for certification period 10/5/2020 – 12/4/2020, which evidenced a document titled “Home Health Certification and Plan of Care” for certification period 4/19/2021 – 6/18/2021, which evidenced medications included (but not limited to) amiodarone, furosemide, tizanidine, hydrocodone, baclofen, atenolol, and gabapentin; and 2 PRN medications without indications for use. Review of a document dated and signed by RN H on 10/1/2020 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information” evidenced the medication regimen was reviewed, and no potential drug interactions were identified. Review of a drugs.com web-site reference for drug interactions checker (not part of agency record): https://www.drugs.com/interactions-check.php?drug_list=1147-0,318-0,3438-16026,273-0,172-0,167-0,2329-16534,1146-0,1082-0,2205-0,11-0,71-8487 evidenced 9 potential major drug interactions between amiodarone and furosemide, furosemide and tizanidine, hydrocodone and tizanidine, amiodarone and tizanidine, amiodarone and hydrocodone, baclofen and hydrocodone, atenolol, and tizanidine, hydrocodone and gabapentin, and amlodipine and tizanidine. The record failed to evidence the physician was contacted. 13. During an interview on 7/26/2021 at 10:08 AM, the administrator indicated the nurses reviewed meds every 60 days, if there was something major, they consulted the physician, and the drug regimen review was usually done during the admission visit to identify issues.	G0536		

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G0536	Continued from page 39 14. During an interview on 7/27/2021 at 11:11 AM, when asked if orders were needed for all OTC medications, if all medications should be evidenced on the medication profile and plan of care, RN F indicated she thought they should be only if they (nurses) administered them, and the administrator indicated they should be on the plan of care. 15. During an interview on 7/27/2021 at 2:00 PM, when asked if PRN medications should include indications for use, the clinical manager and RN H both stated "... Yes."	G0536		
G0538	Primary caregiver(s), if any CFR(s): 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the registered nurse failed to ensure the comprehensive assessment/re-assessment included all required information regarding the patient's primary caregiver 6 of 7 records reviewed which contained comprehensive assessments (#1, 4, 5, 6, 7, 8). Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-145 titled "Comprehensive Client Assessment" stated "... The Comprehensive Assessment ... must include at a minimum ... client's primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, and their availability and schedules ...." 2. Record review for patient #1 was completed on 8/4/2021 at 11:15 AM, start of care date 2/12/2013, for certification period 7/2/2021 – 8/31/2021. A document dated and signed by the clinical	G0538		

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G0538	Continued from page 40 manager 6/28/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" was reviewed. The document evidenced the patient had support from other community agencies, and the patient's son was the primary caregiver, but failed to evidence the son's name, contact information, availability or schedule. During an interview on 8/4/2021 at 11:15 AM, the clinical manager indicated she did not know the son's availability. 3. Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, for certification period 5/14/2021 – 7/14/2021. A document dated 7/12/2021 and signed by RN B on 7/9/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information". The document evidenced the patient had additional support from disability services & support agency I and failed to evidence if the patient had a primary caregiver, or the schedule of agency I's availability and services. During an interview on 7/26/2021 at 5:12 PM, the patient indicated agency I provided services on Mondays, Tuesdays, Wednesdays, Fridays, and every other Saturday for about 3 hours each visit, and they did errands, took him places he needed to go, and did personal care. During an interview on 8/4/2021 at 1:59 PM, the clinical manager indicated she didn't know agency I's schedule. 4. Record review for patient #5 was completed on 8/4/2021, start of care date 8/7/2015, for certification period 7/19/2021 – 9/16/2021. A document dated and signed by RN B 7/15/2021 titled "Comprehensive Adult Assessment" (for recertification of services) failed to evidence if the patient had a primary caregiver. 5. Record review for patient #6 was completed on 8/4/2021, start of care date 3/14/2016, for certification period 5/9/2021 – 7/8/2021. A document dated and signed by the clinical manager on 5/5/2021 titled "Comprehensive Adult Assessment" evidenced the patient resided at	G0538		

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G0538	Continued from page 41 assisted living facility (ALF) J, what type of services they provided, and failed to evidence if the patient had a primary caregiver. 6. Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, with certification period of 4/19/2021 – 6/18/2021. Review of a document dated and signed by RN F and the patient on 5/13/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, which failed to evidence if the patient had a primary caregiver. 7. Record review for patient #8 was completed on 8/4/2021, start of care date 8/11/2019, for certification period 10/5/2020 – 12/4/2020. Which evidenced a document dated and signed by RN H on 10/1/2020 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced the patient had a caregiver, but failed to evidence name or contact information, and evidenced the patient received services from home health agency K, but failed to evidence the contact information, or what services and schedule they were received.	G0538		
G0540	The patient's representative (if any); CFR(s): 484.55(c)(7) The patient's representative (if any); This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the registered nurse failed to ensure the comprehensive assessment/re-assessment evidenced the patient's representative (if any) for 5 of 7 records reviewed which contained comprehensive assessments (#1, 4, 5, 6, 7). Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-145 titled "Comprehensive Client Assessment" stated "... The Comprehensive Assessment ... must include at a minimum ... the client's representative, if any ...." 2. Record review for patient #1 was completed on	G0540		

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G0540	Continued from page 42 8/4/2021 at 11:15 AM, start of care date 2/12/2013, for certification period 7/2/2021 – 8/31/2021. A document dated and signed by the clinical manager 6/28/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information". The document evidenced a section titled “Representative Contact Information”, which stated (but not limited to) “... Does the patient have a representative? ... [boxes to check yes or no] ....” The section was blank, and failed to evidence if the patient selected a representative. 3. Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, for certification period 5/14/2021 – 7/14/2021. A document dated 7/12/2021 and signed by RN B on 7/9/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information". The document evidenced a section titled “Representative Contact Information”, which stated (but not limited to) “... Does the patient have a representative? ... [boxes to check yes or no] ....” The section was blank, and failed to evidence if the patient selected a representative. 4. Record review for patient #5 was completed on 8/4/2021, start of care date 8/7/2015, for certification period 7/19/2021 – 9/16/2021. A document dated and signed by RN B 7/15/2021 titled “Comprehensive Adult Assessment” (for recertification of services) failed to evidence if the patient selected a representative. 5. Record review for patient #6 was completed on 8/4/2021, start of care date 3/14/2016, for certification period 5/9/2021 – 7/8/2021. A document dated and signed by the clinical manager on 5/5/2021 titled “Comprehensive Adult Assessment” failed to evidence if the patient selected a representative. Review of an unsigned document dated 6/30/2021 titled “Discharge Assessment Including OASIS Elements for Discharge ....”, which failed to evidence if the patient selected a representative.	G0540		

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G0540	Continued from page 43 6. Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, for certification period 4/19/2021 – 6/18/2021. Review of a document dated and signed by RN F and the patient on 5/13/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the assessment was for an ROC, which failed to evidence if the patient selected a representative.	G0540		
G0544	Update of the comprehensive assessment CFR(s): 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the registered nurse failed perform a comprehensive re-assessment when the patient's condition warranted for 1 of 1 record reviewed with a significant change in condition. Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-145 titled "Comprehensive Client Assessment" stated "... Reassessments are conducted based on client needs, physician orders, professional judgement and/or OASIS [outcome and assessment information set] or other regulatory requirement, and for any changes in the plan of care will be sent to the physician ...." 2. Record review for patient #3 was completed on 8/4/2021, start of care date 6/5/2020, certification period 6/6/2021 – 8/5/2021. A document titled "Home Health Certification and Plan of Care" which evidenced primary diagnosis gastrostomy (a tube inserted from the abdomen directly into the stomach for administration of nutrition, medications and fluids), and additional diagnoses of chronic respiratory failure, cerebral	G0544		

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G0544	Continued from page 44 palsy, and unspecified convulsions. During a home visit on 7/28/2021 at 12:10 PM, licensed practical nurse (LPN) G indicated it appeared the patient experienced an unwitnessed seizure this morning (7/28/2021). LPN G indicated upon her arrival, the patient was lethargic, had altered level of consciousness, and she was flaccid (limp). She indicated she notified physician H (the patient's neurologist) and the RN case manager. When asked who the RN case manager was, she indicated she didn't know. During this time, RN H arrived to the patient's home to observe the surveyor visit, but did not perform any care to or assessment of the patient. During an interview on 8/4/2021 at 1:30 PM, when asked if a comprehensive assessment should have been completed by a registered nurse due to the seizure activity reported, the clinical manager indicated RN H went that day (During the home visit on 7/28/2021). During this time, RN H indicated she did not assess the patient.	G0544		
G0546	Last 5 days of every 60 days unless: CFR(s): 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the registered nurse (RN) failed to ensure comprehensive re-assessments were completed during the last 5 days of every 60 days for 7 of 8 records reviewed with skilled services (#1, 2, 3, 4, 5, 6, 7). Findings include: 1. Review of an undated Briggs Healthcare, Home Care Operational Guidelines policy C-155 titled "Client Reassessment/ Update of Comprehensive Assessment" stated "... The Comprehensive assessment will be updated and revised ... Every	G0546		

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G0546	Continued from page 45 second calendar month beginning with start of care {within last five (5) days of the episode, including day sixty (60)} ... at least every fifty-six to sixty (56-60) days ...." 2. Review of an undated policy C-145 titled "Comprehensive Client Assessment" stated "... ongoing assessments ... will be done at least once in every sixty (60) day period ...." 3. Record review for patient #1 was completed 8/4/2021, start of care date 2/12/2013, evidenced a document titled "Home Health Certification and Plan of Care", which indicated the certification period was from: 07/02/2021 to 08/31/2021 equaled 61 days, not 60. Review of a web-based reference titled "Home Health Certification Period Calculator", https://benefitperiodcalculator.com/home-health-certification-period-calculator/, evidenced the correct certification period based on the patient's start of care date of 2/12/2013 was 6/28/2021 - 8/26/2021. Review of a document dated 6/28/2021 titled "Recertification/Follow-Up Assessment Including OASIS [Outcome and Assessment Information Set] Elements with Plan of Care Information" evidenced the comprehensive re-assessment occurred on the 61st day. During an interview on 8/4/2021 at 11:15 AM, the administrator and director of nursing confirmed the comprehensive re-assessment occurred on the 61st day. 4. Record review for patient #2 was completed on 8/4/2021, start of care date 11/30/2020, evidenced a document dated and signed by RN (registered nurse) H on 6/1/2021 titled "Home Health Certification and Plan of Care", which indicated the certification period was from: 06/01/2021 to 07/31/2021 (equaled 61 days, not 60). Review of a web-based reference titled "Home Health Certification Period Calculator", https://benefitperiodcalculator.com/home-health-certification-period-calculator/, evidenced the correct certification period based on the patient's start of care date of 11/30/2020 was 5/29/2021 - 7/27/2021.	G0546		

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G0546	Continued from page 46 On 8/4/2021 at 12:45 PM, the comprehensive re-assessment completed for certification period 6/1/2021 - 7/31/2021 was requested. Upon survey exit, the document was not submitted for review. 5. Record review for patient #3 was completed on 8/4/2021, start of care date 6/5/2020, evidenced a document titled "Home Health Certification and Plan of Care", which indicated the certification period was from: 06/06/2021 to 08/05/2021 (equaled 61 days, not 60). Review of a web-based reference titled "Home Health Certification Period Calculator", https://benefitperiodcalculator.com/home-health-certification-period-calculator/, evidenced the correct certification period based on the patient's start of care date of 7/29/2021 was 5/31/2021 - 7/29/2021. Review of a document dated 6/3/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced the comprehensive re-assessment was completed on the 64th day of the correct certification period. During an interview on 8/4/2021 at 1:30 PM, the administrator and director of nursing agreed the certification period was incorrect, and the comprehensive re-assessment occurred after the 60th day. 6. Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, evidenced a document titled "Home Health Certification and Plan of Care", which indicated the certification period was from: 05/14/2021 to 7/13/2021 (equaled 61 days, not 60). Review of a web-based reference titled "Home Health Certification Period Calculator", https://benefitperiodcalculator.com/home-health-certification-period-calculator/, evidenced correct certification periods based on the patient's start of care date of 7/29/2021 were 4/6/2021 - 6/4/2021, 6/5/2021 - 8/3/2021, and 8/4/2021 - 10/02/2021. Review of a document dated 5/10/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced the comprehensive re-assessment was completed on the 95th day for the actual	G0546		

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G0546	Continued from page 47 certification period 4/6/2021 - 6/4/2021. Review of a document dated 7/12/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced the comprehensive re-assessment was completed on the 98th day for the actual certification period 6/5/2021 - 8/3/2021. During an interview on 7/27/2021 at 2:00 PM, the director of nursing and RN H agreed the certification dates were incorrect, and agreed the incorrect dates made the comprehensive re-assessments late. During an interview on 8/4/2021 at 1:59 PM, the administrator and director of nursing agreed the certification periods were incorrect, and the comprehensive re-assessments occurred after the 60th day. On 8/4/2021 at 1:59 PM, RN H indicated she completed an additional comprehensive re-assessment today (8/4/2021), it was not submitted for review, and was completed on the 61st day for the correct certification period 8/4/2021 - 10/02/2021. 7. Record review for patient #5 was completed on 8/4/2021, start of care date 8/7/2015, evidenced a document titled "Home Health Certification and Plan of Care", which indicated the certification period was from: 07/19/2021 to 9/16/2021 (equaled 61 days, not 60). Review of a web-based reference titled "Home Health Certification Period Calculator", https://benefitperiodcalculator.com/home-health-certification-period-calculator/, evidenced the correct certification period based on the patient's start of care date of 8/7/2015 was 7/5/2021 - 9/2/2021. Review of a document dated 7/15/2021 titled "Comprehensive Adult Assessment" evidenced the comprehensive re-assessment was completed on the 71st day. During an interview on 8/4/2021 at 3:15 PM, the administrator and director of nursing agreed the certification period was incorrect, and the comprehensive re-assessment occurred after the 60th day.	G0546		

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G0546	Continued from page 48 8. Record review for patient #6 was completed on 8/4/2021, start of care date 3/4/2016, evidenced a document titled "Home Health Certification and Plan of Care", which indicated the certification period was from: 05/9/2021 to 7/8/2021 (equaled 61 days, not 60). Review of a web-based reference titled "Home Health Certification Period Calculator", https://benefitperiodcalculator.com/home-health-certification-period-calculator/, evidenced the correct certification periods based on the patient's start of care date of 3/4/2016 was 4/6/2021 - 6/4/2021, and 6/5/2021 - 8/3/2021. Review of a document dated 5/5/2021 titled "Comprehensive Adult Assessment" evidenced the comprehensive re-assessment was completed on the 90th day. During an interview on 8/4/2021 at 3:30 PM, the administrator and director of nursing agreed the certification period was incorrect, and the comprehensive re-assessment occurred after the 60th day. 9. Record review for patient #7 was completed on 7/27/2021, with an unknown start of care date. A document dated 12/14/2020 was faxed to the agency as a referral. Review of a document dated and signed 12/16/2020 by the alternate director of nursing (RN B) and the patient, titled "Comprehensive Adult Nursing Assessment", evidenced the patient needed home health services, and a comprehensive assessment was completed. A nursing progress note dated and signed by RN F on 4/14/2021 indicated "Writer submitting 485 [plan of care] to be effective 4/19/21. Client [patient] notified ...." Review of a web-based reference titled "Home Health Certification Period Calculator", https://benefitperiodcalculator.com/home-health-certification-period-calculator/, evidenced the correct certification periods based on the patient's start of care date of 4/19/2021 was 4/19/2021 - 6/17/2021. Review of a document titled "Home Health Certification and Plan of Care",	G0546		

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G0546	Continued from page 49 which indicated the certification period was from: 4/19/2021 to 6/18/2021 (equaled 61 days, not 60). Review of a document dated and signed 4/19/2021 by RN F titled "Comprehensive Adult Nursing Assessment ...." evidenced a start of care comprehensive assessment was completed 124 days after the patient's initial comprehensive assessment on 12/16/2020. During an interview on 8/4/2021 at 11:15 AM the administrator indicated all certification periods for all patients were incorrect, they were all 61 days, and it was an EMR (electronic medical record) malfunction. 17-14-1(a)(1)(B)	G0546		
G0550	At discharge CFR(s): 484.55(d)(3) At discharge. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the registered nurse (RN) failed to ensure a comprehensive reassessment was performed and completed at discharge, and/or failed to ensure it included a summary of the patient's progress in meeting the care plan goals for 2 of 2 discharged records reviewed when skilled care was provided (#6, 8). Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-500 titled “Client Discharge Process” stated “ ... The discharge comprehensive assessment and OASIS [outcome assessment and information set] data collection is required for all situations that result in an Agency discharge ....” 2. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-155 titled “Client Reassessment/Update of Comprehensive Assessment” stated “... The comprehensive assessment will be updated and revised ... must be done at least ... discharge ....”	G0550		

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G0550	Continued from page 50 3. Record review for patient #6 was completed on 8/4/2021, start of care date 3/4/2016, discharge date of 6/30/2021. A document dated 6/30/2021, which failed to evidence assessment of the patient's supportive assistance/care preferences summary, assessment of the patient's endocrine system (such as blood sugar levels, blood sugar ranges, diabetic foot exam), vital signs (temperature, heart rate, blood pressure, breaths per minute), psychosocial, mental, cognitive status, patient limitations, education/training and risk factors related to plan of care post-discharge, reason for discharge, or a summary of the patient's progress in meeting the care plan goals. 4. Record review for patient #8 was completed on 8/4/2021, start of care date 8/11/2019, discharge date 10/19/2020. A document dated and signed by RN H on 09/19/2020 [sic] titled "Outcome and Assessment Information Set [OASIS]" failed to evidence a discharge comprehensive assessment was completed. During an interview on 8/4/2021 at 4:24 PM, RN F indicated she did not make a discharge visit or complete a comprehensive assessment for patient #8 and indicated she was told just complete the OASIS items on the discharge assessment. 5. During an interview on 7/27/2021 at 11:11 AM, when asked what the agency's discharge process was, the administrator stated "... Within forty-eight hours, we send a DC [discharge] summary and order to the physician, and a letter to the patient with a copy of the DC summary and a satisfaction survey ...."	G0550		
G0560	Discharge Planning CFR(s): 484.58 Condition of Participation: Discharge planning. This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure it assisted all discharged patients/caregivers in securing other formal assistance (such as another home health care provider) prior to discharge from the agency (G562); and failed to ensure all discharge and/or	G0560		

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G0560	Continued from page 51 transfer summaries were completed, sent to the receiving facility/provider, and/or included all required medical information (G564). This practice had the potential to affect all agency patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR §484.58 Condition of participation: Discharge planning.	G0560		
G0562	Discharge Planning CFR(s): 484.58(a) Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. This STANDARD is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure all discharged patients/caregivers received assistance in finding another home care agency for 1 of 1 discharge records reviewed who required other formal assistance after discharge from the agency (#8). Findings include: Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-500 titled “Client Discharge Process” stated “... Discharge planning is ... To facilitate ... discharge or transfer to another entity when ... this is the best solution for the patient ... To ensure continuity of care ... appropriate referrals are made to agencies/institutions to meet continuing client needs ... Upon discharge to self-care, the client will receive verbal/written information regarding ... follow-up visits for physician care ... If there are unmet needs ... documentation will demonstrate that appropriate	G0562		

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G0562	Continued from page 52 notice was given ... and referrals made as indicated ...." Record review for patient #8 was completed on 8/4/2021, start of care date 8/11/2019. A document dated and signed by RN F on 10/19/2020 titled "Care Summary ... Discharge Summary" stated "... This Summary Area MUST Be Completed In All Cases ... Reason for Admission ... wound care ... Summary of Care (to date) ... wound care [daily] by nurse ... HHA [home health aide] ... 2 visits per day for self-care deficit ... indicate reason and date [of discharge] ... agency decision ... 10/18/2020 ... Condition at Discharge ... [patient] goes to wound clinic [every two weeks] ... Discharge Planning (specify future follow up, referrals, etc.) ... Patient to find new agency for his needs ... Medical information attached ... [blank] ...." The document failed to evidence which wound clinic (with contact information) the patient was seen at, or the agency assisted the patient in securing another home health agency to assume his services for wound and HHA services. Review of a document on agency letterhead dated and signed by RN O on 10/16/2020 stated "... [regarding] Discharge of services ... inability to provide adequate staffing ... Please contact ... [social services organization M] ... for a list [of available agencies] ... available in your area ...." During an interview on 7/27/2021 at 11:11 AM, when asked to describe the agency's discharge process, the administrator indicated within 48 hours, a discharge summary and order was sent to the physician, and a letter was sent to the patient with a copy of the discharge summary and a satisfaction survey.	G0562		
G0564	Discharge or Transfer Summary Content CFR(s): 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.	G0564		

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G0564	Continued from page 53 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure it sent a discharge and/or transfer summary to the receiving facility and/or physician, for 4 of 4 discharged and/or transferred records reviewed (#6, 7, 8, 9). Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-500 titled “Client Discharge Process” stated “... Discharge planning is ... To facilitate ... discharge or transfer to another entity when ... this is the best solution for the patient ... To ensure continuity of care ... documented in writing and includes all written/verbal instruction regarding the client’s ongoing care needs and available resources provided to the client and the family ... appropriate referrals are made to agencies/institutions to meet continuing client needs ... Upon discharge to self-care, the client will receive verbal/written information regarding community services, medication use, any procedures/treatments ... and follow-up visits for physician care ... If there are unmet needs ... documentation will demonstrate that appropriate notice was given ... and referrals made as indicated ....” 2. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-840 titled “Client Transfer” stated “... A Transfer Summary shall be completed by the Registered Nurse ... The original Transfer Summary ... shall be sent to ...v provider or facility ... plan for transfer shall be discussed with the physician and orders obtained ....” 3. Record review for patient #6 was completed on 8/4/2021, start of care date 3/4/2016, discharge date 6/30/2021. A document dated and signed by the clinical manager on 6/30/2021 titled “Care Summary ... Discharge Summary” failed to evidence the name of the patient’s physician, or that the physician was sent a discharge summary or notified of discharge. 4. Record review for patient #7 was completed on 7/27/2021, discharge date of 8/26/2021, and certification period 4/19/2021 – 6/18/2021.	G0564		

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G0564	Continued from page 54 The record indicated the patient was transferred to an inpatient facility on 5/10/2021, and failed to evidence a transfer summary was completed and sent to the receiving facility, or the physician was notified. Review of a document received 8/6/2021, dated and signed by the clinical manager on 7/27/2021 titled “Care Summary ... Discharge Summary” failed to evidence the name of the patient’s physician, or that the physician was sent a discharge summary or notified of discharge. 5. Record review for patient #8 was completed on 8/4/2021, start of care date 8/11/2019, discharge date of 10/19/2020. A document dated and signed by RN F on 10/19/2020 titled “Care Summary ... Discharge Summary” failed to evidence the name of the patient’s physician, or that the physician was sent a discharge summary or notified of discharge. 6. Record Review for patient #9 was completed on 8/4/2021, start of care date 02/01/2016, discharge date of 3/31/2019, certification period 3/10/2019 – 5/8/2019. A document dated and signed by the agency’s former administrator D on 4/26/2019 titled “Care Summary ... Discharge Summary” stated “... indicate reason and date [of discharge] ... Transfer/Admit to other agency/organization/facility ... (Complete Transfer/Referral section below) ... [date of discharge] 03/31/2019 ... Discharge Planning (specify future follow up, referrals, etc.) ... Patient to find new agency for his needs ... Medical information attached ... [blank] ....” The section titled “Transfer/Referral” was blank, and the record failed to evidence the physician was notified or discharge/transfer summary was sent. 7. During an interview on 7/27/2021 at 11:11 AM, when asked if the agency sent transfer summaries to receiving facilities, the administrator stated “... No, I notify the doctor.” When asked to describe the agency’s discharge process, she indicated agency staff sent a discharge summary and order the physician within 48 hours, and a letter was sent to the patient with a copy of the discharge summary and a satisfaction survey.	G0564		
G0570	Care planning, coordination, quality of care	G0570		

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G0570	Continued from page 55 CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the registered nurse failed to ensure all plans of care were individualized, established by the certifying physician, included patient-specific measurable outcomes and goals, and/or all patients received all services in the plan of care (G572); failed to ensure all patients' plans of care were comprehensive, individualized, and included (but not limited to) a description of the patient's risk for emergency department visits and hospital re-admission, all necessary interventions to address the underlying risk factors, patient-specific interventions and education, measurable outcomes and goals identified by the HHA and the patient, and information related to any advance directives (G574); failed to ensure all patients and/or caregivers received ongoing training, monitored comprehension and response to training (G610); failed to ensure all patients received current medication schedules with instructions written in plain language, without medical abbreviations (G616) and; failed to provide all patients the written name and contact information of the agency's clinical manager (G622). This practice had the potential to affect all agency patients. The cumulative effect of this systemic problem	G0570		

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G0570	Continued from page 56 resulted in the agency being out of compliance with the Condition of Participation 42 CFR §484.70: Care Planning, Coordination of Services, and Quality of Care.	G0570		
G0572	Plan of care CFR(s): 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the registered nurse (RN) failed to ensure all plans of care were individualized, established by the certifying physician, included patient-specific measurable outcomes and goals, and/or all patients received all services in the plan of care, for 8 of 8 skilled records reviewed. Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-580 titled “Plan of Care” (POC) stated “... Home care services are furnished under the supervision and direction of the client’s physician. The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members ... agency staff to develop a plan of care individualized to meet specific identified needs ... designated to attain personal health goals ... assure the plan meets state/federal guidelines, and all applicable ... regulations ....” The policy failed to evidence the plan of care must include patient-specific measurable outcomes and goals. 2. Review of an undated copyright Briggs Healthcare, Operational Guidelines: Home Care	G0572		

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G0572	Continued from page 57 policy C-110 titled “Standards of Practice” stated “... Client care will be provided under the Plan of Care established by the Physician ....” 3. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-635 titled “Physician Orders” stated “... All medications, treatments and services ... must be ordered by a physician ... All medications and treatments, that are part of the client’s plan of care, must be ordered by the physician ....” 4. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines agency policy C-380 titled "Home Care Bill of Rights" failed to evidence the patient’s right to receive all services as ordered on the plan of care. 5. Record review for patient #1 was completed 8/4/2021, start of care date 2/12/2013, evidenced a document titled "Home Health Certification and Plan of Care", for certification period 7/02/2021 - 8/31/2021 with a primary diagnosis of paralysis, complete, and other diagnoses pressure ulcer of left buttock, bowel incontinence, and seizure, and stated “... GOAL ... Maintain client in optimum health at home so long as it is safe and feasible ....” The plan of care failed to evidence patient-specific measurable outcomes and goals based on the patient’s diagnoses, care, and treatments the agency provided. Review of a document dated 6/28/2021 titled "Recertification/Follow-Up Assessment Including OASIS [Outcome and Assessment Information Set] Elements with Plan of Care Information" evidenced primary diagnosis paralysis, complete, and other diagnoses pressure ulcer of left buttock, bowel incontinence, and seizure; wound was cleansed with soap and water, packed with aquacel AG+ (antimicrobial primary dressing for use in wounds that are infected or at risk of infection), and covered with mepilex (foam cover dressing); was a high nutritional risk, bedbound, presence of a size 20 french suprapubic catheter (a tube inserted through a surgically created hole in the lower abdomen directly into the bladder to drain urine), last changed 6/21/2021 at a physician’s office, history of seizures; contractures of both feet, and risk for falling. The document evidenced a section to check yes or no- if a verbal order was obtained, which was blank, and a section titled “Physician Verbal Order” which was blank	G0572		

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G0572	Continued from page 58 and failed to evidence the registered nurse called the physician to report comprehensive assessment findings and obtain an order to recertify home health services. 6. Record review for patient #2 was completed on 8/4/2021, start of care date 11/30/2020, which evidenced a document signed by the certifying physician on 6/11/2021 titled "Home Health Certification and Plan of Care" for certification period 6/01/2021 - 7/31/2021, and contained a primary diagnosis of left leg wound, other pertinent diagnosis included right leg wound, orders for home health aide (HHA) services and daily skilled nursing services for wound care; goals included to remain safe in optimal care in own home, healing of left leg wound, and compliance with wound care appointments. The plan of care failed to patient-specific measurable outcomes and goals based on the patient's diagnoses, care, and treatments the agency provided, and the record failed to evidence the patient received HHA services until 6/28/2021, or the physician was called to report comprehensive assessment findings and obtain an order to recertify home health services. Review of a document "Completed Tasks by Date" for dates 6/1/2021 – 7/31/2021 evidenced home health visits were not started until 6/28/2021, and additional visits occurred on 7/7/2021, 7/9/2021, 7/16/2021, 7/19/2021, 7/21/2021, and 7/26/2021. During an interview during a home visit on 7/28/2021, HHA J and RN H were present, and RN H indicated HHA J started with this patient about a couple of weeks prior. 7. Record review for patient #3 was completed on 8/4/2021, start of care date 6/5/2020, which evidenced a document dated and signed by the certifying physician on 6/7/2021 titled "Home Health Certification and Plan of Care", for certification period 6/06/2021 - 8/05/2021. The plan of care indicated "…Principal Diagnosis ... Gastrostomy [an opening into the stomach from the abdominal wall, made surgically for the introduction of food, medications, and fluids] ... Other Pertinent Diagnosis ... Chronic Respiratory Failure [a condition that slowly develops over time when the lungs can't get enough oxygen into the blood] ... Cerebral Palsy [a disorder that affect a person's ability to move and maintain balance and posture] ... Unspecified	G0572		

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G0572	Continued from page 59 convulsion [seizures] ... Skilled Nursing ... Agency is requesting skilled nursing to provide personal care ... CPT treatment [chest physiotherapy, repetitive compression the chest to help loosen mucus so it can be coughed or suctioned out], trach care [tracheostomy- an incision in the windpipe made to relieve an obstruction to breathing], bolus [a type of feeding where a syringe is used to send formula through the feeding/g- tube] g-tube feedings [a tube inserted directly into the stomach for administration of nutrition, medications, and fluids], g-tube care, monitor oxygenation, positioning every two hours and hoyer lift transfers [mechanical lift for transferring a patient], up to 12.5 hours per day ... 7 days per week for 26 weeks ... Goals/Rehabilitation Potential/Discharge Plans ... No discharge plans at this time. To remain safe in the home ....” The record failed to evidence the patient received skilled nursing services 7 days per week per the ordered plan of care, and the plan of care failed to evidence detailed/specific interventions based on the comprehensive re-assessment and findings during the patient’s home visit, or patient-specific measurable outcomes and goals based on the patient’s diagnoses. During a home visit on 7/28/2021 from 12:10 – 1:25 PM, LPN G was present, and RN H arrived near the end of the surveyor observation. LPN G indicated she saw the patient 11 hours daily, 4 days per week, family cared for the patient all other times, she pre-filled the patient’s pill planner weekly, she crushed and administered all medications, administered nebulizer treatments and suctioning, applied CPT vest twice daily, administrated oxygen 2-3 LPM (liters per minute) at night to maintain oxygen saturation > (greater than) 90%, changed the patient’s 6 c/f (cuffed/fenestrated) trach tube monthly, changed the size 18 fr (french) mic-key button (a type of g-tube) every 3 months, provided total, primary care (all personal care), showered the patient weekly, the patient wore briefs, the patient’s seizures started “about 7 years ago”, diagnosed with sydenham chorea (a neurologic disorder characterized by rapid, irregular, and aimless involuntary movements of the arms and legs, trunk, and facial muscles), history of 2 strokes, and the Levaquin (antibiotic) was a standby/as needed medication.	G0572		

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G0572	Continued from page 60 Review of a document dated 6/3/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced a section titled “Primary Diagnosis & ... Other Diagnosis” which evidenced the patient’s primary diagnosis was gastrostomy, and additional diagnoses included chronic respiratory failure, cerebral palsy, and unspecified convulsions. The document also evidenced the patient was a high risk for skin tears due to immobility and incontinence, she had a trach, she was on intermittent oxygen at 2 LPM (liters per minute), nebulizer treatments were administered as needed, sitting upright improved her breathing, she was not short of breath, but then evidenced she was short of breath when she needed suctioned, she had hypothyroidism (abnormally low activity of the thyroid gland, resulting in retardation of growth and mental development), she was NPO (received nothing by mouth), nutritional intake was jevity 1.5, 237 ml (milliliters) 4 times daily via g-tube, incontinent of bowel and bladder, she was aphasic (inability to speak), had a history of seizures, she used a communication board, she had contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) to both hands, she was a fall risk, safety measures included O2 (oxygen), fall, seizure and aspiration precautions, siderails up, 24 hour supervision, clear pathways, lock wheelchair with transfers, infection control measures; the patient’s only risk factor identified was “currently taking 5 or more medications”, the only goal was to remain safe in the home, the patient participated in music and horse therapy, family ordered supplies, supplies included: hospital bed, hoyer lift, nebulizer, oxygen concentrator, pressure relieving device, and wheelchair. Finally, the document evidenced a section to check yes or no- if a verbal order was obtained, which was blank, and a section titled “Physician Verbal Order” which was blank, and failed to evidence the registered nurse called the physician to report comprehensive assessment findings and obtain an order to recertify home health services. 8. Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, for certification period 5/14/2021 – 7/14/2021, evidenced a document dated and signed by the certifying physician on 5/12/2021 titled "Home Health Certification and Plan of Care" which evidenced primary diagnosis spina bifida (a birth	G0572		

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G0572	Continued from page 61 defect of the spine often causes paralysis of the lower limbs, and sometimes mental handicap), other pertinent diagnoses included left below the knee amputation, AV shunt (arteriovenous shunt, a U-shaped plastic tube inserted between an artery and a vein), scoliosis (curvature of the spine), and lymphedema (lymph fluid buildup in the body's soft tissues, causing swelling); evidenced the patient received HHA 2 visits daily for up to 2 hours each visit, 7 days per week, skilled nursing visits 4 times weekly for application of lower extremity compression wraps, and stated "... Goals ... to maintain client in home in optimum health so long as it is safe and feasible ...." The plan of care failed to evidence detailed/specific interventions based on the comprehensive re-assessment, or patient-specific measurable outcomes and goals based on the patient's diagnoses. Additionally, the record failed to evidence the patient continued to receive the second daily visit by the HHA on or after 7/2/2021. Review of a document dated 5/10/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" evidenced the patient had a colostomy (surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall to divert and drain stool from the body), urinary retention (inability to empty all the urine from the bladder), stage 3 kidney disease (kidney damage), the patient self-catheterized every 4 hours to drain urine via suprapubic (lower abdomen) insertion site, fall risk, and the document evidenced a section to check yes or no- if a verbal order was obtained, which was checked "no", and a section titled "Physician Verbal Order" which was blank. Review of a document dated 7/5/2021 and signed by the clinical manager on 7/9/2021 and by the certifying physician on 7/12/2021 titled "Physician's Order" stated "... discharge second visit [HHA] ...." During an interview on 8/4/2021 at 1:59 PM, the clinical manager indicated she did not call the physician to obtain an order to discontinue the second daily HHA visits (dated 7/5/2021), she just wrote and faxed it. During an interview on 7/26/2021 at 5:43 PM, the	G0572		

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G0572	Continued from page 62 patient indicated he did not consent to, or request the discontinuation of the second daily HHA visit, the agency had a hard time staffing, and they “just cut” the visits. 9. Record review for patient #5 was completed on 8/4/2021, start of care date 8/7/2015, for certification period 7/19/2021 – 9/16/2021, evidenced a document dated and signed by the certifying physician on 7/19/2021 titled "Home Health Certification and Plan of Care", evidenced primary diagnosis quadriplegia C1-C4, complete (paralyzed from the neck down), and other pertinent diagnosis urinary diversion- Indiana pouch (surgically-created urinary diversion used to create a way for the body to store and eliminate urine), the patient received (but not limited to) HHA 1 visit up to 9 hours daily Monday-Friday, 1-2 visits daily (up to 5 hours total) on Saturdays and Sundays, the patient was paralyzed from the neck down, needed assistance with personal care, and stated “... Goals ... to maintain client in home in optimum health so long as it is safe and feasible ....” The plan of care failed to evidence detailed/specific interventions based on the comprehensive re-assessment, or patient-specific measurable outcomes and goals based on the patient’s diagnoses. Review of a document dated 7/15/2021 titled “Comprehensive Adult Assessment” failed to evidence the registered nurse called the physician to report comprehensive assessment findings and obtain an order to recertify home health services, or patient-specific measurable outcomes and goals based on the patient’s diagnoses. During an interview on 7/28/2021 at 6:23 PM, the patient stated “... for the past few months, there’s been like literally no help for days ... out of the past 10 weeks ... 11 no call, no shows ... and no replacement [HHA coverage] ....”, and indicated she needed help to get up, meals, and get back in bed, around June 5th, it was a weekend, she had no coverage for 48 hours, the administrator’s daughter texted her and said she was working on HHA coverage, but the patient never got the HHA services that weekend. Additionally, the patient indicated her personal goal was to know she had a way to get up in the morning, go to bed at night with assist, and not worry.	G0572		

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G0572	Continued from page 63 10. Record review for patient #6 was completed on 8/4/2021, start of care date 3/14/2016, , evidenced a document signed by the certifying physician on 5/24/2021 titled " "Home Health Certification and Plan of Care" for certification period 5/9/2021 – 7/8/2021, evidenced primary diagnosis COPD (chronic obstructive lung disease), other pertinent diagnoses included epilepsy (a disorder in which brain activity becomes abnormal, causing seizures or periods of unusual behavior, sensations, and sometimes loss of awareness), bipolar disorder (a brain disorder that causes changes in a person's mood, energy, and ability to function), and schizophrenia (a serious mental disorder in which people interpret reality abnormally), received HHA services 3 days per week for up to 2 hours each visit, for assistance with personal and incidental care, and the goal was to remain in home as long as safe and feasible. The plan of care failed to evidence detailed/specific interventions or patient-specific measurable outcomes and goals based on the comprehensive re-assessment. Review of a document dated 5/5/2021 titled “Comprehensive Adult Assessment” evidenced the patient didn’t follow a diabetic diet, she was a moderate nutritional risk, she resided at an assisted living facility (ALF), ALF reported patient has occasionally returned drunk from outings, refused to use her oxygen, had a glucometer to check blood sugars (due to diabetes), high fall risk, and stated “... GOALS ... Demonstrate compliance with medication by 7/8/21 ... Stabilization of cardiovascular pulmonary [heart/lung] condition by 7/8/2021 ... Demonstrates following medical regime by 7/8/2021 ... Verbalizes pain controlled at acceptable level by 7/8/2021 ....”, and failed to evidence the registered nurse called the physician to report comprehensive assessment findings and obtain an order to recertify home health services. Review of an unsigned document dated 6/30/2021 titled “Discharge Assessment Including OASIS Elements for Discharge ....” evidenced the patient had impaired decision making which caused failure to perform usual personal care, she required assistance to shower, and failed to evidence the patient was made aware or consented to the discharge, plans to address her needs were discussed, reason for discharge, the patient’s signature or date, or the registered nurse called	G0572		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G0572	Continued from page 64 the physician to report comprehensive assessment findings and obtain an order to discharge home health services. Review of a document received on 8/4/2021 dated and signed by the clinical manager 6/30/2021, an unsigned by the certifying physician stated "... Discharge services due to patient met her goals ...." During an interview on 8/4/2021 at 3:30 PM, the clinical manager indicated RN F completed the document dated 6/30/2021 titled "Discharge Assessment Including OASIS Elements for Discharge", and she didn't know if an actual visit was made. When asked why the patient had a HHA visit the same day as the discharge, if she was independent and no longer needed HHA services, she indicated she didn't know. When asked why the patient was discharged if she still needed HHA services, she indicated she didn't know. 11. Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, for certification period 4/19/2021 - 6/18/2021. The record evidenced the original physician's order for home care was dated 12/14/2020, an initial comprehensive nursing assessment was completed on 12/16/2020, and patient consents for treatment forms were signed on 1/4/2021 (with no associated nursing visit or assessment present in the record for 1/4/2021). After 12/16/2020, the record failed to evidence any nursing services were provided until 4/19/2021, at which time a comprehensive assessment was completed. The record failed to evidence the physician was contacted at any time between 12/16/2020 and 4/14/2021 to notify of the delay in start of care, no services were rendered, or to request a different start of care date. Review of a document dated and signed by the alternate clinical manager 12/14/2020 and physician C (patient's certifying physician) on 12/15/2020 titled "Physician's Order", which stated "... Assessment for Home Health Aide with Supervisory Nurse ...." The fax cover sheet document included with this physician's order, also dated and signed 12/14/2020 by the alternate clinical manager titled "Fax Transmittal Form" stated "... Patient requesting SN [skilled nurse] services for weekly med set [medication pill planner set up] and hha [sic- home health aide] services daily to assist [with] IADLs [those activities that allow an individual to live	G0572		

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G0572	Continued from page 65 independently in a community] ADLs [personal care tasks] and personal care ...." Review of a document dated and signed 12/16/2020 by the alternate clinical manager and the patient, titled "Comprehensive Adult Nursing Assessment", evidenced a comprehensive assessment was completed and the patient needed home health aide (HHA) and nursing services. The document failed to evidence the registered nurse called the physician to report comprehensive assessment findings and obtain an order to certify home health services. Review of a document titled "Nursing Progress Notes for Home Health Care" evidenced an entry dated and signed by RN F 1/4/2021 which stated "... Provider pending Insurance Authorization, Family able to supplement care ... Client willing to wait approval ....", and an entry dated and signed by RN F on 4/14/2021 which stated "... Writer submitting [plan of care] to be effective 4/19/21 ... Client notified ...." The entry on 1/4/2021 failed to evidence the registered nurse called the physician to report services were on hold since December 16, 2020, or obtain an order to certify home health services on 4/19/2021. Review of a document dated 4/19/2021 titled "Comprehensive Adult Nursing Assessment Including SOC/ROC OASIS Elements with Plan of Care Information" evidenced the patient had multiple TIAs (mini-strokes) daily, which caused confusion and forgetfulness, constant, extreme pain, had multiple hospitalizations due to gastroenteritis and pain, primary diagnosis gastroenteritis, other pertinent diagnoses included diabetes, polyneuropathy, and peripheral artery disease (limited blood flow to the extremities), multiple risks for hospitalization, lost 9 pounds in 1 month, he lived alone and had little to no assistance from friends/family, frequently fell due to pain, was a high nutritional risk, weight loss was due to nausea, vomiting, diarrhea, was depressed nearly every day, was short of breath with minimal exertion, he had hypoglycemia (low blood sugar); bleeding, seizure, and fall precautions, the patient had knowledge deficits for glucometer use, nutritional management, medication administration, pain management, and use of medical devices. The document failed to evidence the registered nurse called the physician to report comprehensive assessment findings and obtain an order to certify home health services.	G0572		

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G0572	Continued from page 66 Review of a document signed (undated) by RN F, and signed by physician C on 4/15/2021 titled "Home Health Certification and Plan of Care" for certification period 4/19/2021 - 6/18/2021 stated "... HHA ... 1 visit up to ... [2 hours per day, 5 days per week] ....", and evidenced the nurse was ordered (but not limited to) twice daily, 5 days per week to check blood glucose levels, and weekly medication set up, was signed by the physician 5 days prior to the completion of the initial comprehensive assessment on 4/19/2021, and goals included for the patient to comply with medication regimen this certification period, and to remain free from infection. Review of a document dated and signed by RN F on 7/2/2021 and physician C on 7/6/2021 titled "Notice of Interruption of Services" stated "... Reason for Interruption ... unable to staff HHA from 4/19/21 – 6/21/21 ...." During an interview on 7/27/2021 at 11:11 AM, RN F indicated a comprehensive assessment was done 12/16/2020, the patient was waiting for additional information, then another one was done "on like" 1/4/2021. When asked again to clarify the 1/4/2021 date (consents signed), she stated "... I can't remember what went on that day ....", and indicated she could not find a comprehensive assessment in the chart for 1/4/2021. Additionally during this interview, the administrator indicated the alternate clinical manager saw the patient on 12/16/2020, then stated "... then we did eligibility and put him on hold ...." She also indicated she had no idea what 1/4/2021 was about, agreed there was no nursing visit note for 1/4/2021, the patient was placed "on hold" as of 12/16/2020, the agency used a 4-page assessment note for the initial visit, then within five days, they did the OASIS and comprehensive assessment. The record failed to evidence a physician's order to place services on hold. 12. Record review for patient #8 was completed on 8/4/2021, start of care date 8/11/2019, for certification period 10/5/2020 – 12/4/2020, Which evidenced a document dated 10/01/2020 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information", which evidenced the patient had a pressure injury (open wound due to unrelieved pressure) to his coccyx (tailbone), with muscle exposed, it was washed with soap and water, Dakin's (a diluted bleach solution) was applied, covered with wet	G0572		

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G0572	Continued from page 67 gauze, and a dressing by the nurse, was a moderate nutritional risk, bowel and urinary incontinence, used an external condom catheter at times to drain urine, used briefs and incontinence pads, and used MiraLAX (laxative) for constipation. The document failed to evidence the registered nurse called the physician to report comprehensive assessment findings and obtain an order to recertify home health services. Review of a document signed and dated 10/01/2020 by RN H, and signed by the certifying physician on 10/7/2020 titled "Home Health Certification and Plan of Care" for certification period 10/5/2020 – 12/4/2020 evidenced primary diagnosis quadriplegia, and other pertinent diagnoses of coccyx wound and atrial fibrillation (irregular heart rhythm), one goal to remain in the home as long as safe and feasible, and failed to evidence current wound care orders, or measurable outcomes and goals based on the patient's diagnoses. 13. During an interview on 7/29/2021 at 11:59 AM, the administrator indicated the clinical manager and RN H were auditing all plans of care and would make corrections as indicated. 14. During an interview on 8/4/2021 at 11:15 AM, when asked if registered nurses call the physicians to obtain orders such as (but not limited to) admission orders, verbal orders, or to review and approve the plans of care, the administrator, clinical manager, and RN H, all indicated they did not verbally contact physicians, they just wrote orders and faxed them to the physicians for signatures, and they didn't know they had to actually call the physicians to obtain orders. 17-13-1(a)	G0572		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and	G0574		

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G0574	Continued from page 68 equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the registered nurse failed to ensure all patients' plans of care included a description of the patient's risk for emergency department visits and hospital re-admission, all necessary interventions to address the underlying risk factors, patient-specific interventions and education, and information related to any advance directives for 8 of 8 skilled records reviewed. Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-580 titled "Plan of Care" (POC) stated	G0574		

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G0574	Continued from page 69 "... The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members ... agency staff to develop a plan of care individualized to meet specific identified needs ... designated to attain personal health goals ... assure the plan meets state/federal guidelines, and all applicable ... regulations ... shall be completed in full to include ... All pertinent diagnosis(es) ... Mental status ... Type, frequency, and duration of all visits/services ... Prognosis ... Rehabilitation potential ... Functional limitations and precautions ... Activities permitted or restrictions ... Specific dietary or nutritional requirements or restrictions ... Medications, treatments, and procedures ... Medical supplies and equipment required ... Any safety measures to protect against injury ... Instructions to client/caregiver, as applicable ... Treatment goals ... Instructions for timely discharge or referral ... Discharge plans ... Other appropriate items ... All of the above items must always be addressed on the Plan of Care ... The Plan of Care ... will be developed following the initial assessment ...." The policy failed to evidence the plan of care must also include a description of the patient's risk for emergency department visits and hospital re-admission, all necessary interventions to address the underlying risk factors, patient-specific interventions and education, measurable outcomes and goals identified by the HHA and the patient, and information related to any advanced directives. 2. Record review for patient #1 was completed 8/4/2021, start of care date 2/12/2013, evidenced a document titled "Home Health Certification and Plan of Care", for certification period 7/02/2021 - 8/31/2021, evidenced primary diagnosis paralysis, complete, and other diagnoses pressure ulcer of left buttock, bowel incontinence, and seizure. The plan of care failed to evidence 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-specific interventions and education, or information related to any advance directives. Review of a document dated 6/28/2021 titled "Recertification/Follow-Up Assessment Including OASIS [Outcome and Assessment Information Set] Elements with Plan of Care Information" evidenced primary diagnosis paralysis, complete, and other	G0574		

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G0574	Continued from page 70 diagnoses pressure ulcer of left buttock, bowel incontinence, and seizure; a sacral (lower back) wound was cleansed with soap and water, packed with aquacel AG+ (antimicrobial primary dressing for use in wounds that are infected or at risk of infection), and covered with mepilex (foam cover dressing); was a high nutritional risk, bedbound, presence of a size 20 french suprapubic catheter (a tube inserted through a surgically created hole in the lower abdomen directly into the bladder to drain urine), last changed 6/21/2021 at a physician's office, history of seizures; contractures of both feet, risk for falling, and used a BiPap machine (forces oxygen into and out of the lungs). During a home visit on 7/28/2021 at 9:00 AM, when asked, the patient indicated she used a CPAP (continuous forcing of air into the lungs) machine at night with 2 LPM (liters per minute) of oxygen, she thought family cleaned the CPAP machine weekly, she took 2 extra strength (500 mg/milligrams) Tylenol when needed for pain, her personal goal was to get her wound healed so she could get out of bed, and her urologist changed her suprapubic catheter (a tube inserted into a surgically created opening from the abdomen to the bladder to drain urine) monthly. During an interview on 8/4/2021 at 11:15 AM, the clinical manager agreed the following should have been on the plan of care: CPAP settings and cleaning schedule, high nutritional risk interventions, suprapubic catheter size, when changed, and who was responsible, interventions to prevent falls, and agreed some information from the comprehensive reassessment did not flow over to the plan of care. 3. Record review for patient #2 was completed on 8/4/2021, start of care date 11/30/2020, evidenced a document signed by the certifying physician on 6/11/2021 titled "Home Health Certification and Plan of Care" for certification period 6/01/2021 - 7/31/2021, evidenced (but not limited to) a primary diagnosis of left leg wound, other pertinent diagnosis included right leg wound, orders for home health aide (HHA) services and daily skilled nursing services for wound care; goals included to remain safe in optimal care in own home, healing of left leg wound, and compliance with wound care appointments. The plan of care failed to evidence a description of the patient's risk for emergency department visits and	G0574		

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G0574	Continued from page 71 hospital re-admission, and all necessary interventions to address the underlying risk factors, patient-specific interventions and education, measurable outcomes and goals identified by the agency and the patient, or information related to any advance directives. 4. Record review for patient #3 was completed on 8/4/2021, start of care date 6/5/2020, evidenced a document titled "Home Health Certification and Plan of Care", for certification period 6/06/2021 - 8/05/2021, which stated “... Principal Diagnosis ... Gastrostomy [an opening into the stomach from the abdominal wall, made surgically for the introduction of food, medications, and fluids] ... Other Pertinent Diagnosis ... Chronic Respiratory Failure [a condition that slowly develops over time when the lungs can’t get enough oxygen into the blood] ... Cerebral Palsy [a disorder that affect a person's ability to move and maintain balance and posture] ... Unspecified convulsion [seizures] ... Skilled Nursing ... Agency is requesting skilled nursing to provide personal care ... CPT treatment [chest physiotherapy, repetitive compression the chest to help loosen mucus so it can be coughed or suctioned out], trach care [tracheostomy- an incision in the windpipe made to relieve an obstruction to breathing], bolus [a type of feeding where a syringe is used to send formula through the feeding/g- tube] g-tube feedings [a tube inserted directly into the stomach for administration of nutrition, medications, and fluids], g-tube care, monitor oxygenation, positioning every two hours and hoyer lift transfers [mechanical lift for transferring a patient], up to 12.5 hours per day ... 7 days per week for 26 weeks ... Goals/Rehabilitation Potential/Discharge Plans ... No discharge plans at this time. To remain safe in the home ....” The plan of care failed to evidence (but not limited to) additional pertinent diagnoses of sydenham chorea (a neurologic disorder characterized by rapid, irregular, and aimless involuntary movements of the arms and legs, trunk, and facial muscles), hypothyroidism (abnormally low activity of the thyroid gland, resulting in retardation of growth and mental development), personal history of 2 strokes, the patient was aphasic (inability to speak) and used a communication board, required 24 hour care and specialized transportation, the patient participated in music and horse therapy, all	G0574		

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G0574	Continued from page 72 supplies such as (but not limited to) trach tube with size, mic-key (a type of gastrostomy/g-tube) tube size, any advance directives, parameters for use of oxygen, parameters for administration of nebulizers, parameters and method of suctioning (oral, tracheal), vital sign parameters and when to contact the physician, water flush for g-tube, last seizure activity, aspiration precautions (food or fluids enter into airway), other physicians involved with the patient's care and treatment, the patient's risks for emergency department (ED) and/or hospital admission and interventions to address the risks, specific/detailed nursing interventions provided by the agency, patient/family education, patient or agency measurable outcomes and goals, patient progress to goals, rehabilitation potential, advance directives, or discharge plans. During a home visit on 7/28/2021 from 12:10 – 1:25 PM, LPN G was present, and RN H arrived near the end of the surveyor observation. LPN G indicated she saw the patient 11 hours daily, 4 days per week, family cared for the patient when she was not there, she pre-filled the patient's pill planner weekly, she crushed and administered all medications, administered nebulizer treatments and suctioning, applied CPT vest twice daily, administrated oxygen 2-3 LPM (liters per minute) at night to maintain oxygen saturation > (greater than) 90%, changed the patient's 6 c/f (cuffed/fenestrated) trach tube monthly, changed the size 18 fr (french) mic-key button every 3 months, provided total, primary care (all personal care), showered the patient weekly, the patient wore briefs, the patient's seizures started "about 7 years ago", diagnosed with sydenham chorea, history of 2 strokes, and the Levaquin (antibiotic) was a standby/as needed medication. During this time, the patient's home folder/binder was reviewed, which evidenced (but not limited to) a handwritten document titled "Quick Reference" with the patient's name and date of birth, which evidenced (but not limited to) names and contact information for the patient's pulmonologist (lung doctor), neurologist, dentist, g-tube surgeon, optometrist, and dietician; last flu vaccine was received 10/12/2020, last pneumonia vaccine was received 10/12/2020, and was given every 6 years; seizure activity 2/18/2020, 3/20/2021 and 7/28/2021; parameters to notify the pulmonologist if out of range: vital sign ranges- systolic blood pressure (top number) 80-140, diastolic (bottom	G0574		

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G0574	Continued from page 73 number) 50-90, pulse (heart beats per minute) 60-100, temperature 96.0-100.0 F, breaths per minute 12-20, oxygen saturation (O2 sat) 90-100%; may apply oxygen for O2 sat	G0574		
G0610	Patients receive education and training CFR(s): 484.60(d)(5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the registered nurse failed to ensure all patients and/or caregivers received ongoing training, monitored comprehension and response to training for 5 of 5 records reviewed with skilled nursing services. Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-200 titled “Skilled Professional Services” stated “... Providing ... Client and caregiver education ....” 2. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-400 titled “Client/Caregiver Education” stated “... All clients and caregivers will receive verbal and written instructions as appropriate and as required by regulation ....” 3. Record review for patient #1 was completed 8/4/2021, start of care date 2/12/2013, evidenced a document titled "Home Health Certification and Plan of Care", for recertification period 7/02/2021 - 8/31/2021, which evidenced (but not limited to) the patient received skilled nursing services for wound care, the patient used oxygen, and had a suprapubic catheter (a tube inserted into a surgically created opening in the lower abdomen directly into the bladder for urine drainage), and failed to evidence any skilled nursing interventions such as instruction on infection control, seizure precautions, oxygen	G0610		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0610	Continued from page 74 safety, or prevention of new or worsening skin breakdown. Review of a document titled “Care Note Report” evidenced 12 skilled nursing visit entries were made. The section for each of the 12 visits titled “Skilled Intervention/Teaching/[patient/caregiver] Response” failed to evidence any teaching was provided to the patient/caregiver. During an interview on 8/4/2021 at 11:15 AM, the clinical manager indicated there should have been interventions provided. 4. Record review for patient #2 was completed on 8/4/2021, start of care date 11/30/2020, evidenced a document signed by the certifying physician on 6/11/2021 titled "Home Health Certification and Plan of Care" for recertification period 6/01/2021 - 7/31/2021, which evidenced (but not limited to) the patient received skilled nursing services for wound care, she was diabetic, took multiple medications, safety measures included fall and universal (infection control) precautions, and failed to evidence any skilled nursing interventions such as instruction on infection control or fall precautions, diabetes disease management teaching, or prevention of new or worsening skin breakdown. Review of a document titled “Care Note Report” evidenced 23 skilled nursing visit entries were made. The section for each of the 23 visits titled “Skilled Intervention/Teaching/[patient/caregiver] Response” failed to evidence any teaching was provided to the patient/caregiver. During a home visit on 7/28/2021 at 10:15 AM, RN H performed wound care, placed an updated plan of care in the patient’s home folder, failed to review the document with the patient or family member who was also present, and failed to provide any other teaching during the visit. During this time, RN H indicated for wound care patients, they (nurses) just took vitals and did wound care, and nothing else, unless something prompted them to. 5. Record review for patient #3 was completed on 8/4/2021, start of care date 6/5/2020, evidenced a document titled "Home Health Certification and Plan of Care", for certification period 6/06/2021 - 8/05/2021, which stated “... Principal Diagnosis ... Gastrostomy [an opening into the stomach from the abdominal wall, made surgically for the	G0610		

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G0610	Continued from page 75 introduction of food, medications, and fluids] ... Other Pertinent Diagnosis ... Chronic Respiratory Failure [a condition that slowly develops over time when the lungs can't get enough oxygen into the blood] ... Cerebral Palsy [a disorder that affect a person's ability to move and maintain balance and posture] ... Unspecified convulsion [seizures] ... Skilled Nursing ... Agency is requesting skilled nursing to provide personal care ... CPT treatment [chest physiotherapy, repetitive compression the chest to help loosen mucus so it can be coughed or suctioned out], trach care [tracheostomy- an incision in the windpipe made to relieve an obstruction to breathing], bolus [a type of feeding where a syringe is used to send formula through the feeding/g- tube] g-tube feedings [a tube inserted directly into the stomach for administration of nutrition, medications, and fluids], g-tube care, monitor oxygenation, positioning every two hours and hoyer lift transfers [mechanical lift for transferring a patient] ....", and failed to evidence any skilled nursing interventions such as instruction on infection control, g-tube care, aspiration precautions, emergency procedures, or when to contact the agency or physician. Review of a document titled "Care Note Report" evidenced 26 skilled nursing entries were made. The section for each of the 26 visits titled "Skilled Intervention/Teaching/[patient/caregiver] Response" failed to evidence any teaching or reinforcement of previous teaching was provided to the patient/caregiver. 6. Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, for recertification period 5/14/2021 – 7/14/2021, evidenced a document dated and signed by the certifying physician on 5/12/2021 titled "Home Health Certification and Plan of Care" which evidenced primary diagnosis spina bifida (a birth defect of the spine often causes paralysis of the lower limbs, and sometimes mental handicap), other pertinent diagnoses included left below the knee amputation, AV shunt (arteriovenous shunt, a U-shaped plastic tube inserted between an artery and a vein), scoliosis (curvature of the spine), and lymphedema (lymph fluid buildup in the body's soft tissues, causing swelling); evidenced the patient received HHA 2 visits daily for up to 2 hours each visit, 7 days per week, skilled nursing visits 4 times weekly for application of lower extremity compression	G0610		

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G0610	Continued from page 76 wraps, and failed to evidence any skilled nursing interventions such as instruction on infection control or fall precautions, or methods to reduce swelling. Review of a document titled “Care Note Report” evidenced 35 skilled nursing entries were made. The section for each of the 35 visits titled “Skilled Intervention/Teaching/[patient/caregiver] Response” failed to evidence any teaching was provided to the patient. 7. Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, for certification period 4/19/2021 - 6/18/2021. Review of a document signed (undated) by RN F, and signed by physician C on 4/15/2021 titled "Home Health Certification and Plan of Care" for certification period 4/19/2021 - 6/18/2021 evidenced the nurse was ordered (but not limited to) twice daily, 5 days per week to check blood glucose levels, weekly medication set up, bi-weekly diabetic foot check, fall and stroke precautions, and failed to evidence any skilled nursing interventions such as instruction on infection control, stoke or fall precautions, diabetic disease management teaching, or prevention of skin breakdown. 17-14-1(a)(1)(G)	G0610		
G0616	Patient medication schedule/instructions CFR(s): 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure all patients received current medication schedules for 1 of 3 home visits observed. Findings include: Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-360 titled “Coordination of Client Services” stated	G0616		

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G0616	Continued from page 77 "... client needs are continually assessed, addressed in the Plan of Care ... client ... will participate ... Information provided to clients must be verbally and in writing ...." Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-700 titled "Medication Profile" stated "... The original Medication Profile shall be filed in the clinical record. A copy shall be retained by the Registered Nurse or staff member or placed in the client's home chart when extended hours of service are being provided ... have a copy in ... client's home if the agency is setting up or managing the medication administration ...." The policy failed to evidence the agency must provide all patients a current medication schedules with instructions written in plain language, without medical abbreviations. During a home visit on 7/28/2021 at 9:00 AM with patient #1, start of care date 2/12/2013, the patient indicated she didn't know where her home folder was, home health aide (HHA) I indicated she thought it was in the closet, and the clinical manager indicated she knew the patient had a home folder at some point, but she could not locate it. A current medication schedule was not observed in the home. During an interview on 07/28/2021 at 3:00 PM, the administrator agreed the plan of care, schedule, and list of current meds, all in layman's terms, should be in the patients' homes, and they mailed schedules monthly.	G0616		
G0622	Name/contact information of clinical manager CFR(s): 484.60(e)(5) Name and contact information of the HHA clinical manager. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to provide all patients the written name and contact information of the agency's clinical manager for 3 of 3 home visits observed. Findings include: 1. Review of the agency's master admission	G0622		

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G0622	Continued from page 78 packet/home folder received on 7/26/2021 evidenced (but not limited to) a 25-page document dated 8/17/2020 titled "Trinity Home Health Care INC ... Welcome!" failed to evidence the name and contact information of the agency's clinical manager. 3. During a home visit on 7/28/2021 at 9:00 AM with patient #1, start of care date 2/12/2013, the patient indicated she didn't know where her home folder was, home health aide (HHA) I indicated she thought it was in the closet, and the clinical manager indicated she knew the patient had a home folder at some point, but she could not locate it. 3. During a home visit on 7/28/2021 at 10:15 AM with patient #2, start of care date 11/30/2020, the home folder evidenced a document dated 5/2/2018 titled "Trinity Home Health Care INC ... Welcome!", which failed to evidence name and contact information of the agency's clinical manager. 4. During a home visit on 7/28/2021 at 12:10 PM with patient #3, start of care date 6/5/2020, the home folder evidenced a document dated 5/2/2018 titled "Trinity Home Health Care INC ... Welcome!", which failed to evidence name and contact information of the agency's clinical manager. 5. During an interview on 7/27/2021 at 11:15 AM, the master copy of the patient's home folder was reviewed with the administrator, who indicated there was no evidence of name and contact information of the agency's clinical manager.	G0622		
G0700	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in ?409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in ?409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care.	G0700		

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G0700	Continued from page 79 This CONDITION is NOT MET as evidenced by: Based on record review and interview, the registered nurse failed to ensure all patients/caregivers participated in the development and evaluation of the plan of care (G708); and failed to ensure all licensed practical nurses (LPNs) were assessed and demonstrated clinical skills competency prior to being assigned to a patient with complex medical needs (G726). This practice had the potential to affect all agency patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR §484.75: Skilled Professional Services.	G0700		
G0708	Development and evaluation of plan of care CFR(s): 484.75(b)(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the registered nurse failed to ensure all patients/caregivers participated in the development and evaluation of the plan of care for 4 of 9 records reviewed (#1, 4, 5, 7). Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-580 titled “Plan of Care” stated “... The Plan of Care is based on a comprehensive assessment and information provided by the client/family ... will be consistently reviewed ....” 2. Record review for patient #1 was completed on 8/4/2021, start of care date 2/12/2013, for certification period 7/2/2021 - 8/31/2021. Review of a comprehensive assessment to establish the plan of care was completed and signed by the clinical manager and patient on 6/28/2021 titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" failed to evidence the patient’s personal goal.	G0708		

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G0708	Continued from page 80 Review of a document titled "Home Care Certification and Plan of Care" stated "... GOAL – Maintain client in optimum health at home so long as it is safe and feasible ...." The document failed to include the patient's personal goal, or interventions to attain it. During a home visit on 7/28/2021 at 9:00 AM, the patient indicated her goal was to get her wound healed so she could get back up in her chair. 3. Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, for certification period 5/14/2021 - 7/14/2021, evidenced a document dated 7/5/2021 titled "Physician's Order" evidenced the agency discontinued the patient's daily afternoon visit for assistance with personal care. The record failed to evidence the patient was involved with, or approved the change to the plan of care. During an interview on 7/26/2021 at 5:43 PM, the patient indicated his afternoon visits were abruptly cut, he was not involved with the decision, the agency never told him why the visits were cut, and when asked if he was involved with the review of the plan of care during recertification visits, he indicated the nurses never told him if a visit was for recertification. During an interview on 8/4/2021 at 1:59 PM, when asked who determined there was no need for afternoon visits for the patient, RN H indicated it was determined during a case conference, the administrator indicated she offered to restart the evening aide visits, the patient did not accept it, and was upset it took this long to address it. During this time, the record failed to evidence a case conference, the document was requested, and upon survey exit, nothing further was submitted for review. 4. Record review for patient #5 was completed on 8/4/2021, start of care date 8/7/2015 evidenced a document dated and signed by the alternate clinical manager on 7/15/2021 titled "Comprehensive Adult Assessment" was completed to establish the plan of care for certification period 7/19/2021 – 9/16/2021. During an interview on 7/30/2021 at 3:45 PM, the patient indicated the alternate clinical manager did perform a nursing visit during the week ending 7/17/2021. When asked, she indicated the nurse did	G0708		

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G0708	Continued from page 81 not review her medications or the plan of care, and she just took her vital signs. 5. Record review for patient #7 was completed on 7/27/2021, start of care date 4/19/2021, for certification period 4/19/2021 - 6/18/2021, with a comprehensive assessment completed on 4/19/2021. Review of a document titled "Nursing Progress Notes for Home Health Care" evidenced an entry dated and signed by RN F on 4/14/2021 which stated "... Writer submitting [plan of care] to be effective 4/19/21 ...." The plan of care was created prior to the nurse performing a home visit and performing a comprehensive assessment. 17-14-1(a)(1)(C)	G0708		
G0726	Nursing services supervised by RN CFR(s): 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of ?484.115(k). This ELEMENT is NOT MET as evidenced by: Based record review and interview, the registered nurse failed to ensure all licensed practical nurses (LPNs) were assessed and demonstrated clinical skills competency prior to being assigned to a patient with complex medical needs for 1 of 1 LPN employee record reviewed. Findings include: Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-315 titled “Supervision of Staff” stated “... Supervisory visits may be performed ... the first time specialized care is being initiated ....” Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-320 titled “[LPN] Supervision” stated “... Agency shall provide ... [LPN] ... services under the direction and supervision of a Registered Nurse [RN] ... To assess competency in the clinical skill ... LPNs will not routinely provide visits to clients with complex medical needs ....” Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy D-220	G0726		

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G0726	Continued from page 82 titled “Competency Evaluation of Home Care Staff” stated “... The assessment will verify ... staff knowledge and skill appropriate to assigned responsibilities ... will address ... High risk procedures ... will be completed by individuals who have the knowledge and skills to assess performance and ability ... All new employees will be assessed for competency based on the expected requirements for the position ....” Employee record review for LPN G was completed on 7/29/2021 at 3:15 PM, date of hire 5/21/2020, and first patient contact 5/28/2020. The alternate administrator/HR (human resource contact) agreed LPN G provided regular, extended hours of care to a patient with complex medical needs, e.g., tracheostomy care (provision of care to an incision in the windpipe made to relieve an obstruction to breathing), gastrostomy care (care to an opening into the stomach from the abdominal wall, made surgically for the introduction of food, fluids, and administration of medications), and agreed the employee file failed to evidence documentation that a registered nurse assessed and determined LPN G was competent to provide tracheostomy or gastrostomy care to the patient prior to provision of care/treatment of the patient. 17-14-1(a)(1)(J)	G0726		
G0750	Home health aide services CFR(s): 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the administrator failed to ensure all home health aides (HHAs) completed a home health training program that included classroom and supervised practical training which totaled at least 75 hours, and were currently listed in good standing on the Indiana Department of Health (IDOH) HHA registry prior to providing care to agency patients (G754); failed to ensure its home health aide training program included classroom	G0750		

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G0750	Continued from page 83 and supervised practical training which totaled at least 75 hours (G760); failed to ensure the agency's HHAs were assigned to each patient by a registered nurse, with a written home health aide care plan prepared by a registered nurse. (G798); failed to ensure the HHA provided only services consistent with the HHA's training/competency, and/or provided only services included on the plan of care (G800) and; failed to ensure the duties performed by HHAs included only those evidenced in agency policies (G802). This practice had the potential to affect all agency patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation §42 CFR 484.80 Condition of Participation: Home Health Aide Services.	G0750		
G0754	A qualified HH aide successfully completed: CFR(s): 484.80(a)(1)(i-iv) A qualified home health aide is a person who has successfully completed: (i) A training and competency evaluation program as specified in paragraphs (b) and (c) respectively of this section; or (ii) A competency evaluation program that meets the requirements of paragraph (c) of this section; or (iii) A nurse aide training and competency evaluation program approved by the state as meeting the requirements of ?483.151 through ?483.154 of this chapter, and is currently listed in good standing on the state nurse aide registry; or (iv) The requirements of a state licensure program that meets the provisions of paragraphs (b) and (c) of this section. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the administrator failed to ensure all home health aides (HHAs) completed a home health training program that included classroom and supervised practical training which totaled at least 75 hours, and were currently listed in good standing on the Indiana Department of Health	G0754		

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G0754	Continued from page 84 (IDOH) HHA registry prior to providing care to agency patients for 5 of 6 HHA employee files reviewed (E, J, L, M, N). Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-220 titled "Home Health Aide Services" stated "... Only aides who meet required standards will provide direct care ...." 2. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy D-180 titled “Personnel Records” stated “... personnel record for an employee will include ... License and certifications ....” 3. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy D-220 titled “Competency Evaluation of Home Care Staff” stated “... [HHA] must demonstrate evidence of ... Successful completion of a training program totaling at least seventy-five (75) hours ....” 4. Review of the Indiana.Gov web-based professional licensure search and verify site: https://mylicense.in.gov/everification/Details.aspx?result=93c26386-3d45-4ac8-b0ed-6a0526acb4b3 on 7/29/2021 failed to evidence search results for HHAs J, L, M, or N. On 8/4/2021 the search evidenced HHA E was issued a HHA license on 8/3/2021. 5. During a home visit on 7/28/2021 at 10:15 AM with patient #2, HHA J was present, and indicated she was the aide assigned to the patient, she has not worked as a HHA prior to this job in the past 30 years, she spent about 3 days in the classroom training and testing at Trinity Home Health Care, the clinical manager observed her performance during a visit last week, she couldn't remember the exact date, and no one observed her during her first patient contact. Employee record review for HHA J was completed on 7/29/2021, with date of hire (DOH) 6/18/2021, and first patient contact (FPC) 6/24/2021. The record failed to evidence the agency verified the aide was listed in good standing on the IDOH HHA registry prior to providing care to agency patients.	G0754		

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G0754	Continued from page 85 6. Employee record review for HHA L was completed on 7/29/2021, with date of hire (DOH) 6/28/2021, and first patient contact (FPC) 7/8/2021. The record failed to evidence the agency verified the aide was listed in good standing on the IDOH HHA registry prior to providing care to agency patients. 7. Employee record review for HHA M was completed on 7/29/2021, with date of hire (DOH) 6/23/2021, and first patient contact (FPC) 7/8/2021. The record failed to evidence the agency verified the aide was listed in good standing on the IDOH HHA registry prior to providing care to agency patients. 8. Employee record review for HHA N was completed on 7/29/2021, with date of hire (DOH) 6/8/2021, and first patient contact (FPC) 6/16/2021. The record failed to evidence the agency verified the aide was listed in good standing on the IDOH HHA registry prior to providing care to agency patients. 9. Employee record review for HHA E was completed on 8/4/2021, with date of hire (DOH) 1//6/2020, and first patient contact (FPC) unknown. The record failed to evidence the agency verified the aide was listed in good standing on the IDOH HHA registry prior to providing care to agency patients. 10. During an interview on 7/29/2021 at 12:00 PM, the alternate administrator/ human resource (HR) indicated HHA J was not on the IDOH HHA registry, RN O oversaw the HHA training program and had all the new HHA paperwork for aides trained at this agency, and HHAs were never put into the field until they completed a competency test. When asked if there were other aides working without being listed on the IDOH registry, she stated "... Yes ... two others I think ...." 11. During an interview on 7/29/2021 at 3:15 PM, the alternate administrator/ HR indicated there were a total of 4 HHAs working without HHA certification (not listed in the IDOH registry), and stated "... This is a problem ... I never know who needs to be put on the [IDOH] registry ...." 12. During an interview on 8/4/2021 at 1:59 PM, patient #4's clinical record was reviewed, which evidenced HHA E provided care to the patient on 6/22/2021. During this time, the administrator	G0754		

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G0754	Continued from page 86 confirmed HHA E was not listed on the IDOH HHA registry on 6/22/2021. 13. During an interview on 8/4/2021 at 4:24 PM, the administrator indicated she didn't think the HHA training program had to be 75 hours, new hires enrolled in the HHA training program were in the building for about 3 days, then a nurse took them out to observe care on the first patient contact, and indicated it was hard enough to get them (new hires) to come in for 3 days to train, let alone 75 hours. Also, she indicated the home health aides didn't have to be on the IDOH registry, they just had to be competency tested by a nurse, and indicated again the agency training program didn't have to meet the 75-hour requirement. During this time, the alternate administrator confirmed the agency offered a HHA training program, and RN O was in charge of the program. 17-14-1(l)(1)(A)	G0754		
G0760	Classroom and supervised practical training CFR(s): 484.80(b)(1) Home health aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing services to an individual under the direct supervision of a registered nurse, or a licensed practical nurse who is under the supervision of a registered nurse. Classroom and supervised practical training must total at least 75 hours. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure its home health aide training program included classroom and supervised practical training which totaled at least 75 hours. Findings include: Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy D-220 titled "Competency Evaluation of Home Care Staff" stated "... [HHA] must demonstrate evidence of ... Successful completion of a training program totaling at least seventy-five (75) hours ...." Review of the agency's pre-survey information	G0760		

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G0760	Continued from page 87 evidenced the agency's business hours were from 9:00 AM – 4:00 PM (7 hours daily), Monday through Friday. Employee record review for HHA J was completed on 7/29/2021, with date of hire (DOH) 6/18/2021, and first patient contact (FPC) 6/24/2021. During a home visit on 7/28/2021 at 10:15 AM with patient #2, HHA J was present, and indicated she was the aide assigned to the patient, she has not worked as a HHA prior to this job in the past 30 years, she spent about 3 days (21 hours) in the classroom training and testing at the agency, the clinical manager observed her performance during a visit last week, she couldn't remember the exact date, and no one observed her during her first patient contact (6/24/2021). During an interview on 8/4/2021 at 4:24 PM, the administrator indicated she didn't think the HHA training program had to be 75 hours, new hires enrolled in the HHA training program were in the building for about 3 days, then a nurse took them out to observe care on the first patient contact, and indicated it was hard enough to get them (new hires) to come in for 3 days to train, let alone 75 hours. Also, she indicated the home health aides didn't have to be on the IDOH registry, they just had to be competency tested by a nurse, and indicated again the agency training program didn't have to meet the 75-hour requirement. During this time, the alternate administrator indicated they (agency) spent a lot of time developing their aide training program.	G0760		
G0798	Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the clinical	G0798		

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G0798	Continued from page 88 manager failed to ensure the agency's home health aides (HHAs) were assigned to each patient by a registered nurse, with a written home health aide care plan prepared by a registered nurse. Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-780 titled "Home Health Aide: Assignment" stated "... the designated Registered Nurse ... will assign and orient the aide to the care plan ...." 2. During an interview on 7/26/2021 at 9:30 AM, the clinical manager indicated office staff/HHA E's (not a registered nurse) job was the front desk and scheduling. When asked how many aides the agency employed, she indicated to ask office staff/HHA E, who handled all the aides and scheduling, and she (clinical manager) handled nursing. 17-13-2(a) 17-14-1(m)	G0798		
G0800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the clinical manager failed to ensure the home health aide (HHA) provided only services consistent with the HHA's training/competency, and/or provided only services included on the plan of care for 6 of 6 records reviewed with services provided by an HHA (#1, 2, 4, 5, 6, 8).	G0800		

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G0800	Continued from page 89 Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy D-220 titled “Competency Evaluation of Home Care Staff” stated “... [HHA] will not be permitted to provide ... [HHA] ... services until evidence of adequate training and/or competency has been determined ....” 2. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-780 titled “Home Health Aide: Assignment” stated “... Purpose ... To provide direction and supervision of care provided by Home Health Aides ... To assure the quality of services ... Any change in the assignment must be approved by the professional [registered nurse/RN] managing the client’s care ....” 3. Record review for patient #1 was completed 8/4/2021, start of care date 2/12/2013, certification period 7/02/2021 - 8/31/2021 evidenced a document signed by the certifying physician on 6/30/2021 titled “Home Health Certification and Plan of Care”, which stated “... Nutritional [requirements] ... Regular ... HHA ... for ADLs [activities such as eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet] ... ROM [range of motion] ... Skilled Nursing ... wash wound(s) ... cover with ... dressing ....” The document failed to evidence the patient had a suprapubic catheter (a tube extending from the lower abdomen into the bladder for urine drainage), a 1000 ml (milliliter) per day fluid restriction, or the aide was tasked to perform reinforcement of any wound dressings, or catheter care. Review of a document signed by the clinical manager on 6/28/2021 titled “Care Plan for [patient #1]” evidenced (but not limited to) the patient had a suprapubic catheter, a 1000 ml per day fluid restriction, and the aide was tasked to perform (but not limited to) ROM exercises on the patient’s legs, inspect and reinforce dressing, and perform catheter care. The document failed to evidence specific catheter care such as cleaning around the catheter insertion site (and frequency), frequency of emptying the bag, or infection prevention measures such as (but not limited to) placement of tubing/drainage bag below level of bladder, and failed to evidence the	G0800		

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G0800	Continued from page 90 location or procedure of the dressing to be inspected/reinforced. Review of a document titled “Completed Tasks by Date” evidenced a HHA visit entry dated and electronically authenticated by HHA K on 7/26/2021 at 8:19 PM evidenced catheter care, ROM exercises, and inspection and reinforcement of dressing was performed. The document failed to evidence specific catheter care that was performed, how/what dressing was reinforced, or how many repetitions of ROM exercises were performed on the patient. In addition multiple tasks were completed by the aides, but not marked as required or delegated by an RN. During an interview on 8/4/2021 at 11:03 AM, the clinical manager indicated the patient didn’t have a fluid restriction, she didn’t know why it was listed on the care plan, and she reviewed the aide care plans every certification period. 4. Record review for patient #2 was completed on 8/4/2021, start of care date 11/30/2020, certification period 6/1/2021 – 7/31/2021, evidenced a document titled "Home Health Certification and Plan of Care" evidenced the patient had orders for home health aide and daily skilled nursing services for wound care. The plan of care failed to evidence frequency, duration, or any interventions for the HHA to perform. Review of a document signed and dated 6/1/2021 by RN H titled “Care Plan for [patient #2]” failed to evidence any tasks delegated to the HHA. Review of a document signed and dated 7/30/2021 by RN H titled “Care Plan for [patient #2]” evidenced personal care tasks for the HHA, but was not developed until after aide visits already occurred. Review of a document “Completed Tasks by Date” for dates 6/1/2021 – 7/31/2021 evidenced home health visits were made on 6/28/2021, 7/7/2021, 7/9/2021, 7/16/2021, 7/19/2021, 7/21/2021, 7/26/2021, all without a plan of care for frequency, duration or delegated tasks to be performed. In addition multiple tasks were completed by the aides, but not marked as required or delegated by an RN. During a home visit on 7/28/2021, HHA J and RN H were present, and RN H indicated HHA J started with this patient about a couple of weeks ago.	G0800		

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G0800	Continued from page 91 During this time, RN J placed a copy of the patient's current plan of care and care plan in the patient's home folder, and failed to review it with HHA J. During an interview on 7/29/2021 at 12:00 PM, the alternate administrator indicated HHA J was not listed on the Indiana Department of Health (IDOH) HHA registry. 5. Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, evidenced a document titled "Home Health Certification and Plan of Care", certification period 5/14/2021 - 7/13/2021 which evidenced (but not limited to) colostomy (opening of a portion of the colon through the abdominal wall to its skin surface for bowel elimination) supplies, orders for HHA to provide personal care and ADLs, and nursing for application of compression wraps. The plan of care failed to evidence orders for colostomy care. Review of a document for date range 5/14/2021-7/13/2021 titled "Completed Tasks by Date" evidenced (but not limited to) multiple HHA visits were made by HHA R, who documented she performed ostomy (colostomy) care, a visit was made by HHA S on 5/15/2021 which evidenced she "ran errands" for the patient, a HHA visit was made by office staff/HHA E on 6/22/2021, and there were boxes checked "other" (tasks completed) on the visit notes, which failed to specify what "other" task was completed. In addition multiple tasks were completed by the aides, but not marked as required or delegated by an RN. 6. Record review for patient #5 was completed on 8/4/2021, start of care date 8/7/2015, certification period 7/19/2021 - 9/16/2021, evidenced a document titled "Home Health Certification and Plan of Care", which evidenced the patient received HHA services for personal care, ADLs, IADLs (instrumental activities of daily living- such as shopping, preparing meals, doing laundry, or housework), and ROM exercises. The document also evidenced the patient required straight catheter supplies (supplies used to drain urine from the bladder), but failed to evidence how/who performed the straight catheterizations, the site of insertion, or any other related orders/delegation of tasks. Review of a document for date range 7/19/2021 -	G0800		

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G0800	Continued from page 92 9/16/2021 titled “Completed Tasks by Date” evidenced (but not limited to) ostomy care, and “other” (3 times each visit), were required tasks during HHA visits, HHAs charted they completed ostomy care, and checked the boxes “Other” as completed, but failed to evidence what specific task(s) were done. In addition multiple tasks were completed by the aides, but not marked as required or delegated by an RN. During an interview on 7/30/2021 at 3: 45 PM, the patient indicated she had a hole by her belly button that she used to self cath, and indicated office staff/HHA E took care of her, but it had been “a while” ago. 7. Record review for patient #6 was completed on 8/4/2021, start of care date 3/14/2016, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 5/9/2021 – 7/8/2021, which evidenced the patient received HHA services for personal care, ADLs, and IADLs. Review of a document for date range 5/9/2021 – 7/8/2021 titled “Completed Tasks by Date” evidenced (but not limited to) “other” (not specified tasks) were required tasks during HHA visits, HHAs charted they completed “Other” tasks, but failed to evidence what specific task(s) were done. In addition multiple tasks were completed by the aides, but not marked as required or delegated by an RN. 8. Record review for patient #8 was completed on 8/4/2021, start of care date 8/11/2019, evidenced a document titled “Home Health Certification and Plan of Care” for certification period 10/5/2020 – 12/4/2020, which evidenced the patient received HHA services for ADLs and IADLs, and skilled nursing for wound care. The document failed to evidence the RN delegated ROM exercises to be provided by the HHA. Review of a document for date range 10/5/2020 – 12/4/2020 titled “Completed Tasks by Date” evidenced (but not limited to) “other” (not specified tasks), inspect/reinforce dressing, and ROM exercises were required tasks during HHA visits, HHAs charted they inspected/reinforced dressing, performed ROM exercises, and completed “Other” tasks, but failed to evidence what specific task(s) were done, to what part(s) of the body and how many repetitions ROM exercises were performed, what dressing was inspected/reinforced,	G0800		

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G0800	Continued from page 93 the location, or the specific detail of how the dressing was reinforced. In addition, multiple tasks were completed by the aides, but not marked as required or delegated by an RN. During an interview on 8/4/2021 at 3:52 PM, the administrator indicated the patient requested the aides to perform a lot of ROM exercises with him, and the aides did perform the exercises. 9. During an interview on 8/4/2021 at 11:15 AM, the clinical manager agreed aides performed tasks not delegated on the aide care plans during their visits. 10. During an interview on 8/4/2021 at 1:59 PM, the alternate administrator indicated HHA R did not have a competency evaluation for colostomy care, the administrator agreed that office staff/HHA E was not listed on the IDOH HHA registry on 6/22/2021 (when she made a home visit), and indicated errands shouldn't be on aide care plans. During this time, when asked what specific task(s) the "other" boxes the aides checked on their visit notes were, the administrator, alternate administrator, clinical manager, and RN H all indicated they didn't know. When asked if the record evidenced what "other" task(s) the aide provided/performed, RN H stated "No." Also during this time, the administrator indicated the agency was in the process of getting new EHR (electronic health record) software, and hopefully it would fix the problems they had.	G0800		
G0802	Duties of a HH aide CFR(s): 484.80(g)(3) The duties of a home health aide include: (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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the duties performed by home	G0802		

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G0802	Continued from page 94 health aides (HHAs) included only those evidenced in agency policies for 1 of 6 records reviewed with services provided by an HHA (#4). Findings include: Review of an undated job description titled "Position: Home Health Aide" stated "... [HHA] ... performs services for clients as necessary to maintain their personal comfort ....", and failed to evidence HHA duties included "running errands". Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-220 titled "Home Health Aide Services" failed to evidence HHA duties included "running errands". Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-751 titled "Home Health Aide Care Plan" stated "... The Home Health Aide tasks must be related to the physical care needs of the client ....", and failed to evidence duties included "running errands". Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-800 titled "Home Health Aide: Documentation" stated "... The designated Registered Nurse [RN] ... is responsible for reviewing the ... [HHAs] ... charting before it is placed in the chart ...." Record review for patient #4 was completed on 7/27/2021 and again on 8/4/2021, start of care date 4/17/2019, evidenced a document titled "Home Health Certification and Plan of Care", certification period 5/14/2021 - 7/13/2021 which evidenced (but not limited to) orders for HHA to provide personal care and ADLs (activities such as eating, dressing, getting into or out of a bed or chair, taking a bath or shower, and using the toilet), and failed to evidence orders "running errands". Review of a document for date range 5/14/2021-7/13/2021 titled "Completed Tasks by Date" evidenced (but not limited to) a visit was made by HHA S on 5/15/2021 which evidenced she "ran errands" for the patient. During an interview on 8/4/2021 at 1:59 PM, the administrator indicated errands shouldn't be on aide care plans, and stated "... We don't do that ...."	G0802		

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G0802	Continued from page 95 17-14-1(h)(14)	G0802		
G0940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This CONDITION is NOT MET as evidenced by: Based on observation, record review and interview, the administrator failed to be responsible for the day-to-day operation of the agency (G948); failed to ensure the agency employed qualified personnel, and failed to ensure the agency developed personnel job descriptions and policies that met federal and state regulatory standards (G952); failed to ensure the clinical manager ensured the agency's home health aides (HHAs) were assigned to each patient by a registered nurse (G960); and failed to ensure the registered nurse (RN) provided a complete physical assessment to determine the patient's needs (G984). This practice had the potential to affect all agency patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR §484.105: Organization and administration of services.	G0940		
G0948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA;	G0948		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0948	Continued from page 96 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the administrator failed to be responsible for the day-to-day operation of the agency. Findings include: Review of an undated copyright Briggs Healthcare, Operational Guidelines: Home Care policy B-100 titled “Governing Body” stated “... Appoint a qualified Administrator ... Delegate to that individual the ... responsibility for the day to day operations of the agency ....” The administrator failed to ensure: All patients received the administrator's name to receive complaints (See tag G414). All patients received an OASIS (Outcome and Assessment Information Set) privacy notice found on the CMS (Centers for Medicare and Medicaid Services) website to all patients for whom the OASIS data was collected (See tag G416). All patients received the agency's policies for transfer and discharge (G422); failed to ensure it accommodated and respected the patient's (and/or family's) preferences in his or her own home while agency staff was present (G428); failed to ensure all patients participated in, were informed about, and/or consented to any changes in the home care services/treatment provided (G434); failed to ensure all patients received all services as ordered on the plan of care (G436); failed to provide all patients information on their right to be notified prior to the next home health visit, of any changes in the charges for services they received (G440); and failed to ensure it provided all patients with the names, addresses, and telephone numbers of the Agency on Aging/Aging and Disability Resource Center, Center for Independent Living, and Quality Improvement Organization (G446). The administrator failed to ensure the registered nurse completed a patient assessment was completed within 48 hours of referral (G514); failed to ensure all comprehensive assessments evidenced all patients' strengths, goals, and/or care preferences (G530); failed to ensure the comprehensive assessment/re-assessment evidenced	G0948		

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G0948	Continued from page 97 the patient's rehabilitative and/or discharge planning needs (G534); failed to ensure the registered nurse reviewed all medications the patient was currently taking (both prescription and non-prescription), failed to evidence indications for PRN (as needed) medications, failed to evidence a drug regimen review (DRR) was completed, and/or failed to evidence the physician was notified for potential major drug interactions (G536); failed to ensure the comprehensive assessment/re-assessment included all required information regarding the patient's primary caregiver (G538); failed to ensure the comprehensive assessment/re-assessment evidenced the patient's representative (G540); failed to ensure the registered nurse performed a comprehensive re-assessment when the patient's condition warranted (G544); failed to ensure comprehensive re-assessments were completed during the last 5 days of every 60 days beginning with the start-of-care date (G546); failed to ensure a comprehensive assessment was performed and completed at discharge, and failed to ensure it included a summary of the patient's progress in meeting the care plan goals (G550). The administrator failed to ensure the agency assisted all discharged patients/caregivers in securing other formal assistance (such as another home health care provider) prior to discharge from the agency (G562); and failed to ensure all discharge and/or transfer summaries were completed, sent to the receiving facility/provider, and/or included all required medical information (G564). The administrator failed to ensure the registered nurse developed all plans of care that were individualized, established by the certifying physician, included patient-specific measurable outcomes and goals, and/or all patients received all services in the plan of care (G572); failed to ensure all patients' plans of care were comprehensive, individualized, and included (but not limited to) a description of the patient's risk for emergency department visits and hospital re-admission, all necessary interventions to address the underlying risk factors, patient-specific interventions and education, measurable outcomes and goals identified by the HHA and the patient, and information related to any advance directives (G574); failed to ensure all patients and/or caregivers received ongoing training, monitored comprehension and response to	G0948		

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G0948	Continued from page 98 training (G610); failed to ensure all patients received current medication schedules with instructions written in plain language, without medical abbreviations (G616) and; failed to provide all patients the written name and contact information of the agency's clinical manager (G622). The administrator failed to ensure all home health aides (HHAs) completed a home health training program that included classroom and supervised practical training which totaled at least 75 hours, and were currently listed in good standing on the Indiana Department of Health (IDOH) HHA registry prior to providing care to agency patients (G754); failed to ensure its home health aide training program included classroom and supervised practical training which totaled at least 75 hours (G760); failed to ensure the agency's HHAs were assigned to each patient by a registered nurse, with a written home health aide care plan prepared by a registered nurse. (G798); failed to ensure the HHA provided only services consistent with the HHA's training/competency, and/or provided only services included on the plan of care (G800) and; failed to ensure the duties performed by HHAs included only those evidenced in agency policies (G802). The administrator failed to ensure the clinical manager ensured the agency's home health aides (HHAs) were assigned to each patient by a registered nurse (G960); and failed to ensure the registered nurse (RN) provided a complete physical assessment to determine the patient's needs (G984). During an interview on 8/4/2021 at 4:24 PM, the administrator agreed the agency's admission packets/home folders were incorrect, staff was making new admission packets with the correct administrator's name, and stated "... Someone must have just made copies of old stuff ...." 17-12-1(b)(3) 17-12-1(c)(1)	G0948		
G0952	Ensure that HHA employs qualified personnel CFR(s): 484.105(b)(1)(iv) (iv) Ensure that the HHA employs qualified personnel, including assuring the development of	G0952		

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G0952	Continued from page 99 personnel qualifications and policies. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the administrator failed to ensure the agency employed qualified personnel for 6 of 13 personnel records reviewed (G, J, L, M, N), and failed to ensure the agency developed personnel job descriptions and policies that met federal and state regulatory standards. Findings include: 1. Review of an undated agency job description titled “Position: Home Health Aide” evidenced a section titled “Qualifications”, which stated “... Successful completion of a formal certification training program and/or a written skills test and competency evaluation ... Assists in the administration of medications ....” The document failed to evidence (but not limited to) the home health training program included classroom and supervised practical training, which totaled at least 75 hours, and currently listed in good standing on the Indiana Department of Health (IDOH) Home Health Aide (HHA) registry prior to providing care to agency patients and failed to evidence Indiana regulatory guidelines on home health aide medication assistance. 2. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy D-220 titled “Competency Evaluation of Home Care Staff” stated “... The assessment will verify ... staff knowledge and skill appropriate to assigned responsibilities ... will address ... High risk procedures ... will be completed by individuals who have the knowledge and skills to assess performance and ability ... All new employees will be assessed for competency based on the expected requirements for the position ....” 3. During an interview on 7/29/2021 at 3:15 PM, LPN G’s personnel record was reviewed, date of hire 5/21/2020, and first patient contact 5/28/2020. The alternate administrator/HR (human resource contact) agreed LPN G provided regular, extended hours of care to a patient with complex medical needs, e.g., tracheostomy care (provision of care to an incision in the windpipe made to relieve an obstruction to breathing), gastrostomy care, and agreed the employee file failed to evidence documentation that a registered nurse	G0952		

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G0952	Continued from page 100 assessed and determined LPN G was competent to provide tracheostomy or gastrostomy care to the patient prior to provision of care/treatment of the patient. Also, during this time, HHA's J, L, M, and N's personnel records were reviewed, and the alternate administrator agreed none of the records evidenced the HHAs were currently listed in good standing on the IDOH HHA registry prior to providing care to agency patients. 4. During an interview on 8/4/2021 at 1:59 PM, the administrator indicated office staff/HHA E was not listed in good standing on the IDOH HHA registry prior to providing care to agency patients. 5. During an interview on 8/4/2021 at 4:24 PM, the administrator indicated home health aides (HHA) didn't have to be on the IDOH HHA registry, they just needed to have completed a competency assessment by a nurse. 17-12-1(d)(3)	G0952		
G0960	Make patient and personnel assignments, CFR(s): 484.105(c)(1) Making patient and personnel assignments, This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the clinical manager failed to ensure the agency's home health aides (HHAs) were assigned to each patient by a registered nurse. Findings include: 1. Review of an undated copyright Briggs Healthcare, Home Care Operational Guidelines policy C-780 titled "Home Health Aide: Assignment" stated "... the designated Registered Nurse ... will assign and orient the aide to the care plan ...." 2. During an interview on 7/26/2021 at 9:30 AM, the clinical manager indicated office staff/HHA E's (not a registered nurse) job was the front desk and scheduling. When asked how many aides the agency employed, she indicated to ask office staff/HHA E, who handled all the aides and scheduling, and she (clinical manager) handled	G0960		

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G0960	Continued from page 101 nursing. 17-14-1(a)(1)(K)	G0960		
G0984	In accordance with current clinical practice CFR(s): 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure the registered nurse (RN) provided a complete physical assessment to determine the patient's needs for 3 of 3 (#1, 2, 3) home visits observed with an RN, and 2 additional patient interviews (#4, 5). Findings include: 1. Review of the Journal of Family Practice web-based reference: https://diabetesed.net/wp-content/uploads/2017/05/3-minute-foot-exam.pdf stated "... › Screen for lower extremity complications at every visit for all patients with a suspected or confirmed diagnosis of diabetes ... Strong evidence suggests that consistent provision of foot-care services and preventive care can reduce amputations among patients with diabetes ... Are the dorsalis pedis [foot] ... palpable [able to be felt] ...." 2. Record review for patient #1 was completed 8/4/2021, start of care date 2/12/2013, evidenced a document titled "Home Health Certification and Plan of Care", for certification period 7/02/2021 - 8/31/2021, evidenced primary diagnosis paralysis, complete, and other diagnoses pressure ulcer [a wound caused by prolonged pressure] of left buttock, bowel incontinence, and seizure, and the patient received skilled nursing for wound care. Review of a document dated and signed by the clinical manager 6/28/2021 titled "Recertification/Follow-Up Assessment Including OASIS [Outcome and Assessment Information Set] Elements with Plan of Care Information" evidenced a section for the nurse to assess the patient's risk for skin breakdown, which was blank, and the document failed to evidence the clinical manager	G0984		

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G0984	Continued from page 102 assessed the patient's pressure sore risk on 6/28/2021 during her comprehensive reassessment. Review of a document last signed by the clinical manager on 4/28/2021 by the clinical manager titled "Braden Scale- For predicting Pressure Sore Risk" failed to evidence the clinical manager assessed the patient's pressure sore risk on 6/28/2021 during her comprehensive reassessment. During an interview on 8/4/2021 at 11:15 AM, the clinical manager indicated she did not complete a head-to-toe skin assessment on the patient during the home visit with the surveyor. 4. Record review for patient #2 was completed on 8/4/2021, start of care date 11/30/2020, evidenced a document signed by the certifying physician on 6/11/2021 titled "Home Health Certification and Plan of Care" for certification period 6/01/2021 - 7/31/2021, evidenced (but not limited to) a primary diagnosis of left leg wound, other pertinent diagnosis included right leg wound, and the patient received skilled nursing for wound care. During a home visit on 7/28/2021 at 10:15 AM, RN H indicated the patient had peripheral vascular disease (PVD- compromised circulation of the lower extremities which can cause wounds) and diabetes (which increases the risk of developing lower extremity wounds). The surveyor observed the patient had (but not limited to) swelling of her feet, and cotton gauze in between her toes on both feet. RN H assessed the patient's vital signs (temperature, heart rate, breaths per minute, oxygen saturation, and blood pressure), performed wound care, failed to assess the patient's lung, heart, or bowel sounds, and failed to assess for pedal pulses on either foot. During an interview on 7/28/2021 at 11:45 AM, RN H admitted she did not assess the patient's lung, heart, or bowel sounds, failed to assess for pedal pulses, and stated "... when we do wound care [visits], we just do vital signs ...." and indicated nurses didn't do any other assessments unless something prompted it. During an interview on 8/4/2021 at 12:45 PM, the clinical manager indicated RN H should have removed the dressings on the toes, assessed the toes, and assessed pedal pulses.	G0984		

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G0984	Continued from page 103 5. Record review for patient #3 was completed on 8/4/2021, start of care date 6/5/2020, certification period 6/6/2021 – 8/5/2021, evidenced a document titled "Home Health Certification and Plan of Care" which evidenced (but not limited to) the patient had an unspecified seizure disorder. During a home visit on 7/28/2021 from 12:10 to 1:25 PM, LPN G was present, and indicated family reported the patient had an unwitnessed seizure this morning (7/28/2021), upon LPN G's arrival, the patient was lethargic, had a change in level of consciousness, and was limp, she notified the physician and the agency's RN case manager. RN H, who arrived near the end of the surveyor observation, failed to perform an assessment of the patient. During an interview on 8/4/2021 at 1:30 PM, when asked if an RN should have assessed the patient for the seizure activity reported, the clinical manager indicated RN H did go to the patient's home on 7/28/2021. During this time, RN H admitted she did not assess the patient on 7/28/2021. 6. During an interview on 7/27/2021 at 11:11 AM, RN F indicated she believed diabetic foot assessments were performed on diabetic patients once per certification period and indicated the performance of diabetic foot assessments every nursing visit would be a good plan to have in place. 7. During an interview on 7/26/2021 at 5:43 PM, patient #4 indicated during nursing visits, agency nurses did not check his skin head to toe, front to back, did not listen to his lungs or bowel sounds, he had a colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall to drain stool), the nurses never assessed it, and the nursing visits only lasted about 10 minutes. 8. During an interview on 7/30/2021 at 3:45 PM, patient #5 indicated during nursing visits, agency nurses took her vitals, and that was about it, they didn't review medications, listen to lung or bowel sounds, and did not perform a head-to-toe assessment.	G0984		