STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157608	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOOSIER HOMECARE SERVICES LLC	**614 EAST 53RD STREET , ANDERSON, Indiana, 46013**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 08/09, 08/10, 08/11, 08/12, 08/13, 08/16, and 08/17 of 2021. At this Emergency Preparedness survey, Hoosier Homecare Services LLC., was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal recertification, complaint investigation, and COVID-19 focused infection control survey of a Home Health Agency. Complaint #: 29903; substantiated with findings. Complaint #: 29904; substantiated with findings. Survey Dates: 08/09, 08/10, 08/11, 08/12, 08/13, 08/16, and 08/17 of 2021. A fully extended survey was announced on 08/12/2021 at 2:58 p.m. An Immediate Jeopardy related to §484.60 Care Planning, Coordination of Services, and Quality of Care was identified and announced on 08/13/2021 at 11:50 a.m. Based on the Condition-level deficiencies identified during the 08/17/2021 survey, your home health agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act, on 08/12/2021 at 2:58 p.m. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for two years beginning 08/17/2021 and continuing through 08/16/2023.	G0000		

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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G0000 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 observation, record review, and interview the agency failed to provide all services as outlined in the plan of care and failed to perform complete accurate assessments as ordered in the plan of care for 3 of 17 patients reviewed. (Patient 11, 13, and 16). Findings include: 1. A document titled Patient Rights and Responsibilities was provided by the administrator on 8/9/2021. The document indicated but is not limited to; “Patient Rights: … 5. You have the right to an appropriate assessment … the right to refuse care … the right to receive all services outlined in the Plan of Care …” 2. A policy titled "Care Plan" was provided by the administrator on 8/12/2021 at 10:37 a.m. The document indicated but is not limited to, "Each patient will have a care plan on file that addresses their identified needs ... the care plan shall include ... a list of specific interventions with plans for implementation ... " 3. A policy titled “Pressure Ulcer Dressing Change” was provided by the alternate administrator on 8/10/2021 at 10:00 a.m. The document indicated but was not limited to “Documentation Guidelines 1. Document in the clinical record … c. Location, size of the ulcer. … color and appearance of the wound bed.” 4. A policy titled “Photo Documentation” was provided by the alternate administrator on 08/09/2021 at 1:30 p.m. The policy indicated, but was not limited to, “ ... To document the initial condition of the client’s skin upon admission ... To document clear, accurate status of skin ... To facilitate communication between the treatment team and prescribing physician ... Applies To: Registered Nurses, Licensed Practical/Vocational Nurses, Therapists ... ” 5. The complete clinical record for patient 13, the start of care 5/13/2021, was reviewed on	G0000 G0436		

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G0436	Continued from page 2 8/11/2021. The record evidenced the following: A document titled "Home Health Certification and Plan of Care" indicated but was not limited to, a diagnosis of neuromuscular dysfunction of the bladder, unspecified and paraplegia. The document included the following orders and treatments, " SN (skilled nursing) 1x9 (1 time a week times 9 weeks) ... Patient has or is at risk for having pressure ulcers-risk for infection ... SN to assess skin for breakdown every visit ..." A document titled, "RN-Skilled Nursing Visit" for 5/20/2021 signed by an employee I, Registered Nurse. The document indicated but was not limited to, "Skin ... WNL (within normal limits) ... A document titled, "RN-Skilled Nursing Visit" for 5/24/2021 was signed by employee C, Registered Nurse. The document indicated but was not limited to, "Skin ... Dry ... Warm ... Good/Elastic ... Assessment ... provided [sic] has no open areas or wounds at this time ..." A document titled, "LPN/LVN-Skilled Nursing Visit" for 6/02/2021 was signed by employee D, Licensed Practical Nurse. The document indicated but was not limited to, "Skin ... Dry ... Warm ... Good/Elastic ... Assessment ... " 6. Hospitalization records for patient 13 were received on 8/13/2021. The records indicated but were not limited to an emergency room visit dated 6/1/2021. The clinical impression documented by the medical provider indicated an open wound, 4 cm (centimeters) by 5 cm ulceration with central eschar (dead tissue) on the proximal posterior right thigh. The wound was cultured, and the results indicated evidenced heavy growth of Proteus mirabilis, heavy growth of Pseudomonas aeruginous, and heavy growth of Providencia stuartii. The patient received IV (intravenous) antibiotics and was prescribed oral antibiotics for home. 7. Documentation from the personal services agency providing care for patient 13 received on 8/17/2021 evidenced a document titled "Incident Report" dated 5/27/2021 for patient 13 that indicated, but was not limited to, "I was cleaning him [patient 13] up and noticed a rash on the front right leg and a fluid pocket on the back of his right leg underneath his butt." The family was notified at 7:44 p.m. signed by non-employee A. A	G0436		

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G0436	Continued from page 3 picture of the wound was attached. A second document titled "Activity" evidenced an entry from non-employee B stated the personal care agency was notified of emergency room admission on 6/2/2021 for patient 13 and that patient would receive oral antibiotics. The non-employee also documented non-employee A had reported that the wound had worsened. 8. The complete clinical record for Patient 16, start of care 02/13/2021, was reviewed on 08/10/2021 and evidenced the following: A document dated 02/11/2021, signed by Non-employee C on 02/12/2021, titled F2F (Face 2 Face). The document indicated, but was not limited to, " ... Home Health Services PT (physical therapy), OT (occupational therapy), NSG (nursing), HHA (home health aide) ... " A document dated 02/13/2021, signed by Employee G, titled Physician Order, indicated but was not limited to, "This patient has been admitted to skilled home health services for the following disciplines: PT/OT/SN ... Skilled Nursing warranted due to active surgical wound ... Physical therapy to evaluate and treat at 1x1w (1 time a week for one week), 2x4w (2 times a week for 4 weeks), 1 times per week for 4 weeks … Fall prevention … Assess environment for personal safety hazards … Gait and balance exercises ... ". The clinical record failed to evidence orders for a home health aide, orders for specific interventions, frequency, or duration for skilled nursing, orders for wound care, and orders for occupational therapy. A 2/18/2021 document titled PTA visit indicated during the PTA (physical therapy assistant) visit, the PTA documented the patient declined all intervention except laying supine due to weeping from a liver laceration wound. The PTA stated the patient was supposed to be changing his liver bandage every day but ran out of pads and has been using a towel. The document failed to indicate that they physician was made aware of the status of the patient's living condition, status of the patient's wound, or the need for wound care and supplies. A 02/19/2021 document titled OT (occupational therapist) Evaluation indicated that the patient had no assistance, the patient lived on the 3rd floor and there was clutter and garbage scattered	G0436		

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G0436	Continued from page 4 throughout. There was an insect/rodent infestation present. The patient was sleeping with a mattress on the floor with no sheets. Skilled OT was necessary to address deficits. The document failed to indicate that the physician was made aware of the living conditions of the patient. The clinical record failed to indicate that the physician was made aware that Patient 16 would not be receiving therapy as ordered. 9. The complete clinical record for Patient 11, start of care date 07/01/2021, was reviewed on 08/11/2021 and evidenced the following: A document titled “Home Health Certification and Plan of Care”, for the certification period from 07/01/2021-08/29/2021, indicated but was not limited to, “ ... SN (skilled nurse): 1wk1 (1 time a week for 1 week), 2wk8 (2 times a week for 8 weeks) ... Assessment of patient with Pressure ulcer of the left buttock, stage 2, pressure ulcer of right heel, stage 2, Pressure ulcer of right buttock, stage 2 ... SN to Perform wound care to R (right) and L (left) buttocks ... R heel ... SN to assess skin ... every visit ... “ A document titled “LPN/LVN (licensed practical nurse/licenses vocational nurse) Skilled Nursing Visit” dated 07/07/2021, signed by Employee D, indicated but was not limited to, “ ... dressing to R and L buttocks removed, areas cleansed with NS (normal saline) and patted dry bordered foam applied ... dressing to R heel removed Cleansed with NS, applied NS moistened prisma to wound bed, covered with dry gauze, wrapped in kerlix, secured with tape ... ” The document failed to evidence wound measurements, wound appearance, or condition of the wound bed and surrounding skin. A document titled “LPN/LVN Skilled Nursing Visit” dated 08/03/2021, signed by Employee L, indicated but was not limited to, “ ... Cleansed wound to R and L buttocks with NS, patted dry, applied hydrocolloid dressing to wound bed ... ” The document failed to evidence that wound care was done to the right heel. The document failed to evidence wound measurements, wound appearance, or condition of the wound bed and surrounding skin. 10. During an interview with the administrator and the alternate administrator on 08/12/2021 at 11:23 a.m., when notified that the RN notes provided wound measurements, but the LPN visit notes did not, the alternate administrator stated “When	G0436		

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G0436	Continued from page 5 COVID began, we changed the policy. LPN's don't have to measure wounds." When asked if the alternate administrator considered LPN's skilled nurses, as the plan of care contains orders for a skilled nurse to change wound dressings and assess skin, the alternate administrator stated, "LPN's aren't obligated to measure wounds." An updated wound measurement policy was requested, but not provided by the agency.	G0436		
G0464	Advise the patient of discharge for cause CFR(s): 484.50(d)(5)(i) (i) Advise the patient, representative (if any), the physician(s) or allowed practitioner(s), issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered; This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to notify in advance a discharge for cause was being considered for 2 of 5 closed records. (Patient 13 & Patient 16) Findings include: 1. A policy titled "Patient Rights and Responsibilities" was provided by the administrator on 08/09/2021. The policy indicated, but was not limited to, "7. You have the right to expect the agency to have the proper resources to render safe care ... If the agency is unable to do so, you will be referred elsewhere unless a more suitable provider is not available, in which case ... will be informed of the agency's limitations and lack of suitable alternate arrangements before care is initiated ... 13. You have a right to receive all services outlined in the Plan of Care ... 20. You have the right to be informed of anticipated termination of services ... in writing and verbally before services are to stop and with reasonable time ... Patient Rights Regarding Transfer and Discharge of Services ... 1. The transfer or discharge is necessary for the patient's welfare ... the HHA can no longer meet the patient's needs ... The HHA must arrange a safe and appropriate transfer to other care entities ... The HHA must do the following before	G0464		

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G0464	Continued from page 6 it discharges a patient ... a. Advise the patient ... physician(s) issuing orders or the home health plan of care ... that a discharge is being considered; b. Make efforts to resolve the problem(s) presented ... c. Provide the patient ... with contact information for other agencies or providers ... d. Document the problem(s) and efforts made to resolve the problem ..." 2. A document titled "Patient Discharge Process" was provided by the alternate administrator on 8/10/2021 at 10:00 a.m. The document indicated but was not limited to; "Agency staff will provide the patient with a 15-day notification of the impending discharge ... Upon discharge to self-care, the patient will receive verbal/written information regarding community services, medication use, any procedures/treatments to be performed, and follow-up visits for physician care ... To avoid charges of 'abandonment' at the time of discharge agency documentation will include the following: a. Evidence that the decision was not made unilaterally. The patient, family, and the physician participated in the decision to discharge the patient from the agency. b. Evidence that the patient no longer qualifies for home care services. c. If there are unmet needs and the agency is no longer able to meet those needs documentation that appropriate notice was given (verbal and written) and referrals made as indicated." 3. The complete clinical record for patient 13 was reviewed on 8/10/2021 and evidenced the following: A document titled "Home Health Change of Care Notice (HHCCN) indicated that starting on 6/11/2021 the agency would discharge the patient if they did not have a face-to-face visit with a physician within 30 days of admission due to insurance nonpayment. The document stated, "Your doctor's orders for your home care have changed." The HHCCN was signed on admission 5/13/2021 prior to care being delivered and prior to any physician changes having occurred. A document titled "Patient Communication" dated 5/27/2021 signed by employee E, Office Manager, indicated but was not limited to "Spoke with patients mother as well as patient. Patient has not showed up for past 2 md (medical doctor) appts (appointments) that was scheduled. Patient has an appt set up for 6/10/21 and was told to make sure he makes the appointment."	G0464		

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G0464	Continued from page 7 A document titled "Patient Communication" dated 6/10/2021 signed by employee E, Office Manager, indicated, but was not limited to "Md office called to inform that patient missed F2F appt this date. Could not get him rescheduled by 6/11/2021. Called and informed patients mother and patient that services would be stopped effective 6/11/21 due to not showing up for F2F." A document titled "Discharge Summary" dated 6/11/2021 signed by employee F, Registered Nurse. "The document indicated, but was not limited to, "Reason for discharge ... Noncompliant ... Information Provided for Continuing Needs/Specific Discharge Instructions? ..."The RN failed to document who the information was provided to on the discharge assessment. The agency failed to provide a 15-day discharge notice, failed to identify barriers and implement interventions for non-compliance, and failed to notify the physician prior to the discharge date a discharge for cause was being considered for patient 13. 4. The complete clinical record for Patient 16, start of care date 02/13/2021, was reviewed on 08/10/2021 and evidenced the following: A 02/16/2021 document, signed by Employee H, titled Missed Visit Form (PTA Visit) was faxed to Non-employee D on 02/18/2021. The document indicated, but was not limited to, “PTA (physical therapy assistant) has called Pt (patient) 3 days in a row without answer. In person attempt made ... Apartment building door was locked (at 4:30 p.m.) with a sign posted that it is locked daily at 4:00 p.m. ... Further phone and in person attempts to be made this week ... “ A 02/17/2021 document, signed by Employee I, titled Patient Communication. The document indicated, but was not limited to, “SN (skilled nurse) received phone call from pt (patient) emergency contact ... expressed concern that ... unable to reach pt for the last 24-48 hours ... Voiced concern as homecare staff had been unable to reach him via phone or knocking ... SN notified supervisors at this time ... pt slurring ... words … hadn’t eaten and was walking … to get food ... SN informed emergency contact ... would be contacting authorities to do a welfare check ... SN notified 911 at this time ... ” The document	G0464		

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G0464	Continued from page 8 failed to evidence that the physician was made aware of changes in the patient's status or the need for emergency services. A 2/18/2021 document titled PTA Visit, signed by Employee H, indicated during the PTA (physical therapy assistant) visit, the PTA documented the patient declined all intervention except laying supine due to weeping from a liver laceration wound. The PTA documented that the patient did participate in 4 different exercises. The PTA documented that the patient needed food and water; the PTA reached the emergency contact who stated they were unable to provide food for the patient. The PTA stated the patient was supposed to be changing his liver bandage every day but ran out of pads and has been using a towel. The PTA noted that the agency was informed of patient's current situation. The document failed to indicate that the physician was made aware of the status of the patient's living conditions, the patient's wound status, or the need for wound care and wound care supplies. A 02/19/2021 document titled OT (occupational therapist) Evaluation, signed by Employee J, indicated that the patient had no assistance, the patient lived on the 3rd floor and there was clutter and garbage scattered throughout. There was an insect/rodent infestation present. The patient was sleeping with a mattress on the floor with no sheets. The patient had poor judgement and safety awareness. Skilled OT was necessary to address deficits. The document failed to indicate that the physician was made aware of the patient's living conditions. A 02/19/2021 document titled SN (skilled nurse) Evaluation, signed by Employee I, indicated that nurse was visiting the patient for evaluation assessment, vital signs, and wound assessment. The document indicated, but was not limited to, " ... Psychosocial WNL (within normal limits) ... alert and forgetful ... Stated PT was not here this day ... SN had spoke with therapist and pt (patient) while (therapist) was in home ... Denied SN evaluating wound ... had a paper towel over it ... Demonstrated Medication Compliance: Yes ... " A 02/22/2021 document titled Discharge Summary indicated, but was not limited to, "Physician notified of discharge prior to discharge date, per agency policy & timeline ... Pt requires extensive assistance to complete ADL's and	G0464		

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G0464	Continued from page 9 transfers ... Pt advised to go to the ER due to concerns regarding drainage form wound site and elevated temp ... had falls since being home; 2 of which occurred this day ... yellow, thick drainage from puncture site ... no food noted in home; pt stated he had food last Thursday ... Pt determined to not be safe at home and is non-compliant with SN care ... ". A 02/22/2021 document, signed by Employee E, titled Patient communication indicated, but was not limited to, “SN called MD (medical doctor) office to notify of patient noncompliant with care and meds. Advise patient to go to ER.” The clinical record for Patient 16 failed to evidence that the patient and physician were notified in advance, with a 15-day notice, that the patient was being discharged from the agency. The clinical record failed to evidence interventions for noncompliance and the outcome of the interventions and failed to document barriers leading to non-compliance. The patient was discharged with no other agency assuming care, an active rodent infestation, high fever, multiple falls, and infected wound; all having a high potential for an adverse outcome of death. 5. During an interview on 08/09/2021 at 12:15 p.m. with administrator and alternate administrator, when asked how patient noncompliance was addressed, the alternate administrator stated, “It’s a case-by-case situation. We would involve the physician or family if it wasn’t improving. After 3 consecutive missed visits, we would send out a 30-day discharge notice.” 6. During an interview on 8/16/2021 at 3:43 p.m. with the administrator and alternator administrator, when informed there is no documentation of the medical doctor being notified the patient hadn't eaten in days, appeared neglected, and was acutely ill, the administrator stated the physician would receive a copy of the discharge summary when the summary was ready. The alternate administrator stated “ ... I feel like we did everything we could have ... ” 7. During an interview on 8/12/2021, the administrator stated the regulations allow for discharge without notice if they are unsafe and needed extended care and the patient was a danger to himself.	G0464		
G0466	Make efforts to resolve the problem(s)	G0466		

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G0466	Continued from page 10 CFR(s): 484.50(d)(5)(ii) (ii) Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to make efforts to resolve the problem(s) presented by the patient's behavior or situation for 1 of 17 records reviewed. (Patient 16). Findings include: 1. A document titled RN Job Description indicated, but was not limited to, " ... Reports significant changes in client status to physician ... in a timely manner consistent with client needs ... Maintains client records showing ... intervention, and evaluation ... " 2. A policy titled "Care Plans" was provided by the administrator on 8/12/2021 at 10:37 a.m. The document indicated but was not limited to, "Each patient will have a care plan on file that addresses their identified needs and the agency's plan to respond to those needs ... the care plan shall be reviewed, evaluated, and revised ... based upon the patient's health status and/or environment ... Following the initial assessment ... interventions shall correspond to the problems identified ... c. A list of specific interventions with plans for implementation ... " 3. A policy titled "Patient Rights and Responsibilities" was provided by the administrator on 08/09/2021. The policy indicated, but was not limited to, "7. You have the right to expect the agency to have the proper resources to render safe care ... If the agency is unable to do so, you will be referred elsewhere unless a more suitable provider is not available, in which case ... will be informed of the agency's limitations and lack of suitable alternate arrangements before care is initiated ... 13. You have a right to receive all services outlined in the Plan of Care ... 20. You have the right to be informed of anticipated termination of services ... in writing and verbally before services are to stop and with reasonable time ... Patient Rights Regarding: Transfer and Discharge of Services ... 1. The	G0466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157608	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/17/2021

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G0466	Continued from page 11 transfer or discharge is necessary for the patient's welfare ... the HHA can no longer meet the patient's needs ... The HHA must arrange a safe and appropriate transfer to other care entities ... The HHA must do the following before it discharges a patient ... a. Advise the patient ... physician(s) issuing orders or the home health plan of care ... that a discharge is being considered; b. Make efforts to resolve the problem(s) presented ... c. Provide the patient ... with contact information for other agencies or providers ... d. Document the problem(s) and efforts made to resolve the problem ... " 4. The complete clinical record for Patient 16, start of care date 02/13/2021, was reviewed on 08/10/2021 and evidenced the following: A document dated 02/13/2021, signed by Employee G, titled Physician Order, indicated but was not limited to, "This patient has been admitted to skilled home health services for the following disciplines: PT/OT/SN ... Skilled Nursing warranted due to active surgical wound ... Physical therapy to evaluate and treat at 1x1w (1 time a week for one week), 2x4w (2 times a week for 4 weeks), 1 times per week for 4 weeks ... Fall prevention ... Assess environment for personal safety hazards ... Gait and balance exercises ... " The document failed to included orders for a home health aide. The clinical record failed to evidence orders for specific interventions, frequency, or duration for skilled nursing, orders for wound care, and orders for occupational therapy. A 02/17/2021 document, signed by Employee I, titled Patient Communication. The document indicated, but was not limited to, "SN (skilled nurse) received phone call from pt (patient) emergency contact ... expressed concern that ... unable to reach pt for the last 24-48 hours ... Voiced concern as homecare staff had been unable to reach him via phone or knocking ... SN notified supervisors at this time ... pt slurring ... words … hadn't eaten and was walking … to get food ... SN informed emergency contact ... would be contacting authorities to do a welfare check ... SN notified 911 at this time ... " The document failed to evidence that the physician was made aware of changes in the patient's status in a timely manner, or the need for emergency services. The clinical record failed to evidence an outcome after emergency services were summoned.	G0466		

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G0466	Continued from page 12 A 2/18/2021 document titled PTA Visit indicated that during the PTA (physical therapy assistant) visit, the PTA documented the patient declined all intervention except laying supine due to weeping from a liver laceration wound. The PTA documented the patient needed food and water; the PTA reached the emergency contact who stated they were unable to provide food for the patient. The PTA stated the patient was supposed to be changing his liver bandage every day but ran out of pads and has been using a towel. The document indicated that the PTA notified their supervisor but failed to evidence further interventions or outcomes. A 02/19/2021 document titled OT (occupational therapist) Evaluation indicated that the patient had no assistance, the patient lived on the 3rd floor and there was clutter and garbage scattered throughout. There was an insect/rodent infestation present. The patient was sleeping with a mattress on the floor with no sheets. The OT documented that the patient was educated on ordering food via their smartphone, but patient declined. The document failed to indicate that the physician was made aware of the living conditions of the patient. A 02/19/2021 document titled SN (skilled nurse) Evaluation, signed by Employee I, indicated that nurse was visiting the patient for evaluation assessment, vital signs, and wound assessment. The document indicated, but was not limited to, " ... Psychosocial WNL (within normal limits) ... alert and forgetful ... Stated PT was not here this day ... SN had spoke with therapist and pt (patient) while (therapist) was in home ... Denied SN evaluating wound ... had a paper towel over it ... Demonstrated Medication Compliance: Yes ... Reviewed medications, but the pt has no system to set meds up ... ". A 02/22/2021 document titled Discharge Summary indicated, but was not limited to, "Physician notified of discharge prior to discharge date, per agency policy & timeline ... Pt requires extensive assistance to complete ADL's and transfers ... Pt advised to go to the ER due to concerns regarding drainage form wound site and elevated temp ... had falls since being home; 2 of which occurred this day ... yellow, thick drainage from puncture site ... no food noted in home; pt stated he had food last Thursday ... Pt determined to not be safe at home and is non-compliant with	G0466		

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G0466	Continued from page 13 SN care ... ". A 02/22/2021 document, signed by Employee E, titled Patient communication indicated, but was not limited to, "SN called MD (medical doctor) office to notify of patient noncompliant with care and meds. Advise patient to go to ER." The clinical record failed to evidence that any effort was made by the agency to address the insect/rodent infestation, to set the patient up with a meal delivery system, or to address the lack of wound care. The clinical record failed to evidence that the physician was made aware of the patient's poor living conditions, inability to set up a medication system, or the worsening condition of the patient and the patient's wound. 5. During an interview with the administrator on 08/12/2021 at 11:23 a.m., when asked why the patient was discharged in the state they were, the administrator stated, "The patient was unsafe to be home alone." When asked if the agency had a social worker or ever referred patients to a social worker, the administrator stated, "We would refer the patient to meals on wheels. We take on the role of social worker in that case." 6. During an interview with the administrator and the alternate administrator on 08/16/2021 at 3:00 p.m., when the status of the patient on 02/22/2021 was reiterated, and the administrator and alternate administrator were asked if they thought adult protective services (APS) should have been called, the administrator stated, " ... the police were called on 02/14 ... I mean, what can you do?" When asked again why APS wasn't called, the alternate administrator stated, "The occupational therapist tried to teach the patient to order groceries online, but the patient declined. I feel like we did everything we could."	G0466		
G0468	Provide contact info other services CFR(s): 484.50(d)(5)(iii) (iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to provide contact information for other	G0468		

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G0468	Continued from page 14 agencies or providers who may be able to provide care for 1 of 5 closed records reviewed. (Patient 16) Findings include: 1. A document titled "Patient Discharge Process" was provided by the alternate administrator on 8/10/2021 at 10:00 a.m. The document indicated but was not limited to; " ... Upon discharge to self-care, the patient will receive verbal/written information regarding community services, medication use, any procedures/treatment to be performed, and follow-up visits for physician care ..." 2. A policy titled "Patient Rights and Responsibilities" was provided by the administrator on 08/09/2021. The policy indicated, but was not limited to, "7. You have the right to expect the agency to have the proper resources to render safe care ... If the agency is unable to do so, you will be referred elsewhere unless a more suitable provider is not available, in which case ... will be informed of the agency's limitations and lack of suitable alternate arrangements before care is initiated ... 20. You have the right to be informed of anticipated termination of services ... in writing and verbally before services are to stop and with reasonable time ... Patient Rights Regarding: Transfer and Discharge of Services ... 1. The transfer or discharge is necessary for the patient's welfare ... The HHA must arrange a safe and appropriate transfer to other care entities ... The HHA must do the following before it discharges a patient ... c. Provide the patient ... with contact information for other agencies or providers ... " 3. The complete clinical record for Patient 16, start of care date 02/13/2021, was reviewed on 08/10/2021 and evidenced the following: A 02/22/2021 document titled Discharge Summary indicated, but was not limited to, "Physician notified of discharge prior to discharge date, per agency policy & timeline ... Pt requires extensive assistance to complete ADL's and transfers ... Disoriented, Forgetful ... Poor Home Environment, Impaired Decision Making ... Pt advised to go to the ER due to concerns regarding drainage form wound site and elevated temp ... had falls since being home; 2 of which occurred this day ... yellow, thick drainage from puncture site	G0468		

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G0468	Continued from page 15 ... no food noted in home; pt stated he had food last Thursday ... Pt determined to not be safe at home and is non-compliant with SN care ... Patient remained in the community (without formal assistive services) ... ". The document failed to evidence that the agency arranged for a safe and appropriate transfer to another agency, and that the patient received information regarding community services or contact information for alternate home health agencies. 4. During an interview on 8/12/2021, the administrator stated the regulations allow for discharge without notice if they are unsafe and needed extended care and the patient was a danger to themselves.	G0468		
G0470	Document efforts to resolve problems CFR(s): 484.50(d)(5)(iv) (iv) Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records; This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to document efforts for resolving non-compliance for 2 of 2 patients discharged for non-compliance. (Patient 13 and Patient 16) Findings include: 1. A policy titled "Care Plans" was received on 8/10/2021 at 10:00 a.m. by the alternate administrator. The document indicated, but was not limited to "a Care Plan shall be developed ... interventions shall correspond to the problems identified ... the Care Plan shall include ... a list of specific interventions with plans for implementation ..." 2. A policy titled "Clinical Documentation" was provided by the administrator on 8/12/2021 at 10:37 a.m. by the alternate administrator. The document indicated but was not limited to, "Purpose To ensure that there is an accurate record of the services provided, patient response, and ongoing need for care. To document conformance with the Plan of Care, modifications to the plan, interdisciplinary involvement." 3. The complete clinical record for patient 13,	G0470		

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G0470	Continued from page 16 the start of care 5/13/2021, was reviewed on 8/11/2021. The record evidenced the following: A document titled "Home Health Certification and Plan of Care" indicated but was not limited to, a diagnosis of neuromuscular dysfunction of the bladder, unspecified and paraplegia. The document included the following orders and treatments, " SN (skilled nursing) 1x9 (1 time a week times 9 weeks) ... Patient has or is at risk for having pressure ulcers-risk for infection ... SN to assess skin for breakdown every visit ..." A document titled "Patient Communication" dated 5/20/2021 signed by employee E, Office Manager, indicated, but was not limited to "Spoke with patients mother Teresa and informed her that patient needed set up with his PCP (primary care physician) by 6/11/2021." A document titled "Patient Communication" dated 5/27/2021 signed by employee E, Office Manager, indicated but was not limited to "Spoke with patients mother as well as patient. Patient has not showed up for past 2 md (medical doctor) appts (appointments) that was scheduled. Patient has an appt set up for 6/10/21 and was told to make sure he makes the appointment." A document titled "Patient Communication" dated 6/10/2021 signed by employee E, Office Manager, that indicated, but was not limited to "Md office called to inform that patient missed F2F appt this date. Could not get him rescheduled by 6/11/2021. Called and informed patients mother and patient that services would be stopped effective 6/11/21 due to not showing up for F2F." A document titled "Discharge Summary" dated for 6/11/2021 signed by employee F, Registered Nurse. "The document indicated, but was not limited to, "Reason for discharge ... Noncompliant ... Information Provided for Continuing Needs/Specific Discharge Instructions? ..." 4. During an interview on 8/16/2021 at 2:00 p.m. when asked if the agency had to try to identify barriers to the patient missing their MD appointments such as transportation being a paraplegic or if any alternatives had been offered such as telehealth the administrator stated that if the barriers aren't documented in the communication note then there were no barriers patient was just non-compliant.	G0470		

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G0470	Continued from page 17 5. The complete clinical record for Patient 16, start of care date 02/13/2021, was reviewed on 08/10/2021 and evidenced the following: A 02/17/2021 document, signed by Employee I, titled Patient Communication. The document indicated, but was not limited to, " ... pt slurring ... words … hadn't eaten ... would be contacting authorities to do a welfare check ... SN notified 911 at this time ... " The document failed to evidence that the physician was made aware of changes in the patient's status or the need for emergency services. A 2/18/2021 document titled PTA Visit indicated that during the PTA (physical therapy assistant) visit, the PTA documented the patient declined all intervention except laying supine due to weeping from a liver laceration wound. The PTA documented the patient needed food and water; the PTA reached the emergency contact who stated they were unable to provide food for the patient. The PTA stated the patient was supposed to be changing his liver bandage every day but ran out of pads and has been using a towel. The document failed to evidence that the physician was made aware of the patient's status or that the plan of care may need to be altered. A 02/22/2021 document titled Discharge Summary indicated, but was not limited to, "Physician notified of discharge prior to discharge date, per agency policy & timeline ... Pt requires extensive assistance to complete ADL's and transfers ... Pt advised to go to the ER due to concerns regarding drainage form wound site and elevated temp ... had falls since being home; 2 of which occurred this day ... yellow, thick drainage from puncture site ... no food noted in home; pt stated he had food last Thursday ... Pt determined to not be safe at home and is non-compliant with SN care ... ". A 02/22/2021 document, signed by Employee E, titled Patient communication indicated, but was not limited to, "SN called MD (medical doctor) office to notify of patient noncompliant with care ... advise patient to go to ER." 6. The clinical record failed to evidence efforts made to address any non-compliance from the patient or attempts to inform the physician that the plan of care needed to be altered to meet the	G0470		

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G0470	Continued from page 18 needs of the patient. 7. During an interview on 8/16/2021 at 3:43 p.m. with the administrator and alternator administrator, when asked if the patient's financial situation had been assessed, or if they had made a referral as the patient clearly needed help and had no caregiver, the alternate administrator stated they had previously called adult protective services on other patients and the patient's families would get angry and call them (the agency), so the agency would leave it up to the physician. When informed there's no documentation of the medical doctor being notified the patient hadn't eaten in days, appeared neglected, and was acutely ill, the administrator stated the physician would receive a copy of the discharge summary when the summary was ready. The alternate administrator stated " ... I feel like we did everything we could have ... "	G0470		
G0570	Care planning, coordination, quality of care 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: An Immediate Jeopardy related to §484.60 Care Planning, Coordination of Services, and Quality of Care was identified and announced on 8/13/2021 at 11:50 a.m. The immediate jeopardy was unremoved at survey exit date of 8/17/2021.	G0570		09/01/2021

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G0570	Continued from page 19 The immediate jeopardy began on 2/13/2021 when the agency accepted a patient (patient 16) with a referral signed by a physician for skilled nursing, physical therapy, occupational therapy, and home health aide services. The patient had a diagnosis of major laceration of the liver, fracture of the lumbar vertebra, multiple fractures of the ribs, and fusion of the spine/lumbosacral region. The agency's physical therapist performed an initial assessment on the patient. The comprehensive assessment indicated the patient had abnormal weight loss, weakness, and severe protein-calorie malnutrition. The patient was at high nutritional risk and had an inadequate diet. The patient lived alone in poor, unstable living conditions. The patient had a mattress on the floor due to a bug infestation. The agency failed to follow its own policy when identifying an insect infestation. The clinical record failed to evidence professional treatment was sought. On 02/22/2021 the patient was discharged from the agency without a 15-day notice. During the discharge visit, the patient was noted to be found down in the hallway by an unknown male who stated the patient had fallen twice. The patient was noted to have a temp of 102.2, thick yellow drainage coming from puncture wound, had not eaten since the prior Thursday (this was the following Monday). The home was still infested with bugs. The patient was advised to go the the ER (emergency room), but declined. The agency left the patient in poor condition with no receiving agency or caregiver and with a high potential for death. A second patient (Patient 13) was admitted on 5/13/2021. Patient 13 was a paraplegic with a history of right glute/hip wounds. The comprehensive assessment indicated the patient had no active wounds or open areas. On 5/13/2021 the physical therapy evaluation indicated the patient had a history of right glute/hip wounds. Skilled nursing visit notes for 5/20/2021 and 5/24/2021 indicated the patient had no open wounds. On 6/1/21 the patient went to the emergency room. The documentation from the emergency room note signed by the medical provider indicated the patient had a 4cm by 5cm ulceration with central eschar on the proximal posterior right thigh. The wound culture evidenced heavy growth of Proteus mirabilis, heavy growth of Pseudomonas aeruginoa, and heavy growth of Providencia stuartii. The patient received IV (intravenous) antibiotics and was prescribed oral antibiotics for home. A skilled nurse visit note	G0570		

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G0570	Continued from page 20 dated 6/2/2021 indicated the patient had no medication changes, a skin assessment was performed, and the patient had no wounds. On 6/11/2021 the patient was discharged for non-compliance and not having a face-to-face. The clinical record evidenced a face-to-face on 4/27/2021. On 6/22/2021 the patient returned to the emergency room and was admitted for multiple right lower extremity wounds and the wound to the right hip had increased in size to golf ball size. The patient was admitted for sepsis related to an unknown organism. The right heel had purulent drainage and a foul smell. Complainant stated patient was found with maggots in the wound and taken to the emergency room on this date and there is a high likelihood the patient will be losing his right foot. The agency failures resulted in 2 of 2 patients discharged without notice suffering adverse outcomes. (Patient 13 and 16) Based on observation, record review, and interview, the agency failed to follow their own policies and procedures to prevent adverse outcomes for 2 of 2 patients who were not assessed appropriately and were discharged without notice and without referring to another agency (See G0570); failed to ensure that patients received the home health services that were written in the Plan of Care for 2 of 17 records reviewed (See G0572); failed to address changes in the patient's discharge plan and document the communication in the clinical record for 2 of 5 discharged clinical records reviewed (See G0598); failed to integrate all orders in the plan of care and failed to assure coordination of care for all services required for 2 of 5 discharged patients reviewed (See G0604); and failed to coordinate care for 2 of 2 patients discharged for noncompliance (See G0608). The cumulative effect of this systemic problem resulted in the agency being out of compliance with 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Findings include: 1. A policy titled "Care Plans" was provided by the administrator on 8/12/2021 at 10:37 a.m. The document indicated but was not limited to, "Each patient will have a care plan on file that	G0570		

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G0570	Continued from page 21 addresses their identified needs and the agency's plan to respond to those needs ... the care plan shall be reviewed, evaluated, and revised ... based upon the patient's health status and/or environment ..." 2. A policy titled "Clinical Documentation" was provided the alternate administrator on 8/10/2021 at 10:00 am. The document indicated but was not limited to, "Telephone or other communication with patients, physicians, families, or other members of the health care team will be documented in clinical progress notes or other interagency communication form." 3. A policy titled "Standard Infection Control Procedures for Home Care" was provided by the administrator on 8/12/2021 at 10:37 a.m. The document indicated but was not limited to, "In the event of insect or rodent infestation noted by agency staff, the agency will be immediately notified, and the agency staff will begin making arrangements with the patient/family to seek professional treatment for the infestation ..." 4. A policy titled "Patient Discharge Process" was provided by Employee B on 08/10/2021 at 10:00 a.m. The document indicated, but was not limited to, "4 ... Agency staff will provide the patient with a 15 day notification of the impending discharge ... 8. Upon discharge to self-care, the patient will receive verbal/written information regarding community services, medication use, any procedures/treatments to be performed and follow-up visits for physician care. 9. To avoid charges of "abandonment" at the time of discharge agency documentation will include the following: a. Evidence that the decision was not made unilaterally. The patient, family, and physician participated in the decision to discharge patient from the agency. b. Evidence that the patient no longer qualifies for home care services. c. If there are unmet needs and the agency is no longer able to meet those needs, documentation will demonstrate that appropriate notice was given (verbal and written) and referrals made as indicated ... ". 5. The complete clinical record for Patient 16 was reviewed on 08/10/2021. The clinical record indicated, but was not limited to, the following: A document titled Physician's Telephone Order dated 02/12/2021 included orders to "Obtain home	G0570		

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G0570	Continued from page 22 health to eval [evaluate] and treat. PT[physical therapy], OT [occupational therapy], NSG [nursing], HHA [home health aide]". A document titled Home Health Certification and Plan of Care for the certification period of 02/13/2021-02/22/2021. The document indicated, but was not limited to, "Mental Status: Oriented, agitated ... SN (skilled nurse): eval and tx (treat), PT: 1X1 (1 time a week for 1 week), 2X4 (2 times a week for 4 weeks), 1X4 (1 time a week for 4 weeks), OT: eval and treat ... Goals and Outcomes: The patient will be free from falls ... free from injury ... skin integrity will remain intact ... " The document failed to evidence any HHA orders. The clinical record failed to evidence documentation of notifying the physician the patient would not be receiving therapy services. A 02/13/2021 document titled OASIS-D1 Start of Care indicated, but was not limited to, "Inpatient Facility Diagnosis: a. fracture of lumbar vertebra b. major laceration of liver ... c. multiple fractures ... fusion of spine, lumbosacral region ... Other diagnosis ... protein-calorie malnutrition ... problems related to living alone ... Risk for Hospitalization ... 1-History of falls (2 or more falls- or any fall with an injury- in the past 12 months 2-Unintentional weight loss of a total of 10 pounds or more ... " A 2/18/2021 document titled PTA visit indicated during the PTA (physical therapy assistant) visit, the PTA documented the patient declined all intervention except laying supine due to weeping from a liver laceration wound. The PTA documented the patient needed food and water; the PTA reached the emergency contact who stated they were unable to provide food for the patient. The PTA stated the patient was supposed to be changing his liver bandage every day but ran out of pads and has been using a towel. A 2/19/2021 document titled SN Evaluation indicated that when the SN performed their initial evaluation, the SN stated the patient was forgetful. The patient stated that PT was not present on 2/19/2021 although the SN knew PT had visited that day. SN stated the patient had leftover Chinese food and stated the patient had no system to set up medications; the patient stated he wasn't interested in a system to set up medications.	G0570		

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G0570	Continued from page 23 A 02/19/2021 document titled OT (occupational therapist) Evaluation indicated that the patient had no assistance, the patient lived on the 3rd floor and there was clutter and garbage scattered throughout. There was an insect/rodent infestation present. The patient was sleeping with a mattress on the floor with no sheets. Skilled OT was necessary to address deficits. A 02/22/2021 document titled Discharge Summary indicated, but was not limited to, "Physician notified of discharge prior to discharge date, per agency policy & timeline ... Pt [atient] requires extensive assistance to complete ADL's [activities of daily living] and transfers ... Emergency contact is a friend that lives in apt [apartment] complex; but not the same building. Pt uses walker, but continues to experience falls ... apartment in poor condition with bed bugs noted in chair at DC [discharge] visit ... Pt advised to go to the ER [emergency room] due to concerns regarding drainage from wound site and elevated temp [temperature] ... had falls since being home; 2 of which occurred this day ... yellow, thick drainage from puncture site ... Continued to work with therapy to work towards goals ... No food noted in home; pt stated he had food last Thursday ... Pt determined to not be safe at home and is noncompliant with SN care ... ". The patient was not discharged with appropriate notice. A 02/22/2021 document signed by Employee I titled OASIS-D1 Discharge indicated, but was not limited to, " ... Temp 102.2 ... Intensity of pain 4 ... Nutrition: Meals Prepared Appropriately, Diet Adequate ... Neurological: Disoriented, Forgetful ... Psychosocial: Poor Home Environment, Impaired Decision Making ... failure to perform usual ADL's ... inability to appropriately stop activities, jeopardizes safety through actions ... Emergent Care: at the time of or at any time since ... SOC ... assessment as the patient utilized a hospital emergency department? 0-No ... Response to Skilled Intervention: Verbalized Understanding 50% ... ". The SN found the patient in the hallway being escorted by an unknown male who informed the SN the patient had fallen twice, and he (the unknown male) had found the patient on the floor. The SN documented they advised the patient to go to the emergency room and that patient was not safe at home. A 02/22/2021 document titled Communication note signed by the SN states "SN called MD (medical	G0570		

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G0570	Continued from page 24 doctor) office to notify patient non-compliant with care and meds. Advised patient to go to the ER." The agency failed to evidence documentation that the MD was notified of the patient's living conditions, falls, temperature, wound, rodent infestation, and recent falls. A 02/22/2021 physician order request for signature, that was not faxed until 2/23/2021, indicated the patient was seen for "SN for the the following interventions, assessment, V.S. (vital signs), oxygen saturation, and education. The outcome of this intervention led to pt (patient) dc (discharge) due to noncompliance." The patient was discharged with no other agency assuming care, an active rodent infestation, high fever, multiple falls, and potentially infected wound, all having a high potential for an adverse outcome of death. The agency failed to document interventions for noncompliance and the outcome of the interventions and failed to document barriers leading to non-compliance. 6. During an interview on 8/12/2021, the administrator stated the regulations allow for discharge without notice if they are unsafe and needed extended care and the patient was a danger to himself. 7. During an interview on 8/16/2021 at 3:43 p.m. with the administrator and alternator administrator, when asked if the patient's financial situation had been assessed, or if they had made a referral as the patient needed help and had no caregiver, the alternate administrator stated they had previously called adult protective services on other patients and the patient's families would get angry and call them (the agency) so the agency would leave it up to the physician. When informed there's no documentation of the medical doctor being notified the patient hadn't eaten in days, appeared neglected, and was acutely ill, the administrator stated the physician would receive a copy of the discharge summary when the summary was ready. 8. The complete clinical record for patient 13, start of care 5/13/2021, was reviewed on 8/11/2021. The record evidenced the following: A document titled "Home Health Certification and Plan of Care" indicated but was not limited to, a diagnosis of neuromuscular dysfunction of the	G0570		

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G0570	Continued from page 25 bladder, unspecified and paraplegia. The document included the following orders and treatments, " SN 1x9 (1 time a week times 9 weeks) ... Patient has or is at risk for having pressure ulcers-risk for infection ... SN to assess skin for breakdown every visit ..." A document titled, "RN [registered nurse] -Skilled Nursing Visit" for 5/20/2021 signed by employee I, Registered Nurse. The document indicated but was not limited to, "Skin ... WNL (within normal limits) ... A document titled "Patient Communication" dated 5/20/2021 signed by employee E, Office Manager, indicated, but was not limited to "Spoke with patients mother and informed her that patient needed set up with his PCP (primary care physician) by 6/11/2021." A document titled, "RN-Skilled Nursing Visit" for 5/24/2021 signed by employee C, Registered Nurse. The document indicated but was not limited to, "Skin ... Dry ... Warm ... Good/Elastic ... Assessment ... provided [sic] has no open areas or wounds at this time ..." A document titled "Patient Communication" dated 5/27/2021 signed by employee E, Office Manager, indicated but was not limited to "Spoke with patients mother as well as patient. Patient has not shown up for the past 2 MD (medical doctor) appts (appointments) that was scheduled. Patient has an appt set up for 6/10/21 and was told to make sure he makes the appointment." A document titled "Patient Communication" dated 6/10/2021 signed by employee E, Office Manager, that indicated, but was not limited to "Md [medical doctor] office called to inform that patient missed F2F [face to face] appt this date. Could not get him rescheduled by 6/11/2021. Called and informed patients, mother, and patient, that services would be stopped effective 6/11/21 due to not showing up for F2F." A document titled, "LPN/LVN-Skilled Nursing Visit" for 6/02/2021 signed by employee D, Licensed Practical Nurse. The document indicated but was not limited to, "Skin ... Dry ... Warm ... Good/Elastic ... Assessment ... " A document titled "Discharge Summary" dated for 6/11/2021 signed by employee F, Registered Nurse.	G0570		

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G0570	Continued from page 26 "The document indicated, but was not limited to, "Reason for discharge ... Noncompliant ... Information Provided for Continuing Needs/Specific Discharge Instructions? ..."The RN failed to document who the information was provided to on the discharge assessment. A document titled "F2F (face to face) Encounter" dated 4/27/2021. The document indicated but is not limited to, "Date of In-Person Visit: 04/27/2021" signed by Non-Employee G, Nurse Practitioner. 9. Hospitalization records for patient 13 were received on 8/13/2021 for patient 13. The records indicated but were not limited to an emergency room visit dated 6/1/2021. The clinical impression documented by the medical provider indicated an open wound, 4cm by 5cm ulceration with central eschar on the proximal posterior right thigh. The wound was cultured, and the results indicated evidenced heavy growth of Proteus mirabilis, heavy growth of Pseudomonas aeruginous, and heavy growth of Providencia stuartii. The patient received IV antibiotics and was prescribed oral antibiotics for home. 10. During an interview on 8/16/2021 the administrator stated the LPN (licensed practice nurse) who performed the visit on 6/2/2021, the day after the hospital admission, would have documented an ER visit had she known and that maybe she rolled the patient to one side, therefore, missing the wound. The administrator stated the patient also had a responsibility to report the visit and the agency can't take full responsibility when they didn't know. The patient was discharged with no wound care services or other receiving agencies. 11. Documentation from the personal services agency providing care for patient 13 received on 8/17/2021 evidenced a document titled "Incident Report" dated 5/27/2021 for patient 13 that indicated, but was not limited to, "I was cleaning him [patient 13] up and noticed a rash on the front right leg and a fluid pocket on the back of his right leg underneath his butt." The family was notified at 7:44 p.m. signed by non-employee A. A picture of the wound was attached. A second document titled "Activity" evidenced an entry from non-employee B stated the personal care agency was notified of emergency room admission on 6/2/2021 for patient 13 and that patient would receive oral antibiotics. The non-employee also documented	G0570		

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G0570	Continued from page 27 non-employee A had reported that the wound had worsened. 12. Hospitalization records for patient 13 received on 8/13/2021 indicated the patient returned to the emergency room on 6/22/2021. The patient was admitted for "multiple right lower extremity wounds and the wound to the right hip had increased in size to golf ball size ... The right heel had purulent drainage and a foul smell." The patient was diagnosed with sepsis-related to an unknown organism. The right heel had purulent drainage and a foul smell. 13. During an interview on 8/11/2021 with the patient's caregiver, the caregiver stated patient 13 was found to have maggots in his wound on the right hip area and was potentially losing his right foot from wounds and infection found on the heel.	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 record review and interview, the agency failed to ensure that patient's received the home health services that were written in the Plan of Care for 2 of 17 records reviewed. (Patient 13 and 16) Findings include: 1. A policy titled "Care Plans" was provided by the administrator on 8/12/2021 at 10:37 a.m. The document indicated but was not limited to, "Each patient will have a care plan on file that addresses their identified needs and the agency's	G0572		

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G0572	Continued from page 28 plan to respond to those needs ... the care plan shall be reviewed, evaluated, and revised ... based upon the patient's health status and/or environment ... Following the initial assessment ... interventions shall correspond to the problems identified ... c. A list of specific interventions with plans for implementation ... " 2. A policy titled “Patient Rights and Responsibilities” was provided by the administrator on 08/09/2021. The policy indicated, but was not limited to, “7. You have the right to expect the agency to have the proper resources to render safe care ...13. You have a right to receive all services outlined in the Plan of Care ... ” 3. The complete clinical record for Patient 16 was reviewed on 08/10/2021. The clinical record indicated, but was not limited to, the following: A document titled Home Health Certification and Plan of Care for the certification period of 02/13/2021-02/22/2021. The document indicated, but was not limited to, " ... SN (skilled nurse): eval and tx (treat), PT: 1X1 (1 time a week for 1 week), 2X4 (2 times a week for 4 weeks), 1X4 (1 time a week for 4 weeks), OT: eval and treat ... Goals and Outcomes: The patient will be free from falls ... free from injury ... skin integrity will remain intact ... " The document failed to include orders for a home health aide, specific orders for wound care, frequency, and duration of visits for skilled nursing, and orders for OT. A 2/19/2021 document titled SN Evaluation indicated that when the SN performed their initial evaluation, the SN stated the patient was forgetful. The patient stated that PT was not present on 2/19/2021 although the SN knew PT had visited that day. SN stated the patient had leftover Chinese food and stated the patient had no system to set up medications; the patient stated he wasn't interested in a system to set up medications. The document failed to evidence any efforts to address the needs of the patient to ensure that the patient was receiving the medications ordered and had access to an adequate food supply. A 02/19/2021 document titled OT (occupational therapist) Evaluation indicated that the patient had no assistance, the patient lived on the 3rd floor and there was clutter and garbage scattered	G0572		

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G0572	Continued from page 29 throughout. There was an insect/rodent infestation present. The patient was sleeping with a mattress on the floor with no sheets. Skilled OT was necessary to address deficits. The document failed to indicate that the physician was made aware of the living conditions of the patient. The clinical record failed to evidence that the patient would not be receiving therapy services as ordered in the Plan of Care. A 02/22/2021 document titled Discharge Summary indicated, but was not limited to, "Physician notified of discharge prior to discharge date, per agency policy & timeline ... Pt [patient] requires extensive assistance to complete ADL's [activities of daily living] and transfers ... Emergency contact is a friend that lives in apt [apartment] complex; but not the same building. Pt uses walker, but continues to experience falls ... apartment in poor condition with bed bugs noted in chair at DC [discharge] visit ... Pt advised to go to the ER [emergency room] due to concerns regarding drainage from wound site and elevated temp [temperature] ... had falls since being home; 2 of which occurred this day ... yellow, thick drainage from puncture site ... Continued to work with therapy to work towards goals ... No food noted in home; pt stated he had food last Thursday ... Pt determined to not be safe at home and is noncompliant with SN care ... ". A 02/22/2021 document titled Communication note signed by the SN states "SN called MD (medical doctor) office to notify patient non-compliant with care and meds. Advised patient to go to the ER." 4. The agency failed to document interventions for noncompliance and the outcome of the interventions and failed to document barriers leading to non-compliance. The patient was discharged with no other agency assuming care, an active rodent infestation, high fever, multiple falls, and infected wound; all having a high potential for an adverse outcome of death. 5. The complete clinical record for patient 13, the start of care 5/13/2021, was reviewed on 8/11/2021. The record evidenced the following: A document titled "Home Health Certification and Plan of Care" indicated but was not limited to, a diagnosis of neuromuscular dysfunction of the bladder, unspecified and paraplegia. The document	G0572		

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G0572	Continued from page 30 included the following orders and treatments, " SN (skilled nursing) 1x9 (1 time a week times 9 weeks) ... Patient has or is at risk for having pressure ulcers-risk for infection ... SN to assess skin for breakdown every visit ... A document titled, "RN-Skilled Nursing Visit" for 5/20/2021 signed by employee I, Registered Nurse. The document indicated but was not limited to, "Skin ... WNL (within normal limits) ... A document titled "Patient Communication" dated 5/20/2021 signed by employee E, Office Manager, indicated, but was not limited to "Spoke with patients mother Teresa and informed her that patient needed set up with his PCP (primary care physician) by 6/11/2021." A document titled, "RN-Skilled Nursing Visit" for 5/24/2021 signed by employee C, Registered Nurse. The document indicated but was not limited to, "Skin ... Dry ... Warm ... Good/Elastic ... Assessment ... provided [sic] has no open areas or wounds at this time ..." A document titled "Patient Communication" dated 5/27/2021 signed by employee E, Office Manager, indicated but was not limited to "Spoke with patients mother as well as patient. Patient has not shown up for the past 2 MD (medical doctor) appts (appointments) that was scheduled. Patient has an appt set up for 6/10/21 and was told to make sure he makes the appointment." A document titled "Patient Communication" dated 6/10/2021 signed by employee E, Office Manager, indicated but was not limited to "Md office called to inform that patient missed F2F appt this date. Could not get him rescheduled by 6/11/2021. Called and informed patients, mother, and patient, that services would be stopped effective 6/11/21 due to not showing up for F2F." A document titled, "LPN/LVN-Skilled Nursing Visit" for 6/02/2021 signed by employee D, Licensed Practical Nurse. The document indicated but was not limited to, "Skin ... Dry ... Warm ... Good/Elastic ... Assessment ... " A document titled "Discharge Summary" dated for 6/11/2021 signed by employee F, Registered Nurse. "The document indicated, but was not limited to, "Reason for discharge ... Noncompliant ... Information Provided for Continuing Needs/Specific	G0572		

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G0572	Continued from page 31 Discharge Instructions? ..."The RN failed to document who the information was provided to on the discharge assessment. A document titled "F2F (face to face) Encounter" dated 4/27/2021. The document indicated but is not limited to, "Date of In-Person Visit: 04/27/2021" signed by Non-Employee G, Nurse Practitioner. 6. Hospitalization records for patient 13 were received on 8/13/2021 for patient 13. The records indicated but were not limited to an emergency room visit dated 6/1/2021. The clinical impression documented by the medical provider indicated an open wound, 4cm by 5cm ulceration with central eschar on the proximal posterior right thigh. The wound was cultured, and the results indicated evidenced heavy growth of Proteus mirabilis, heavy growth of Pseudomonas aeruginous, and heavy growth of Providencia stuartii. The patient received IV antibiotics and was prescribed oral antibiotics for home. 7. During an interview on 8/16/2021 the administrator stated the LPN (licensed practice nurse) who performed the visit on 6/2/202,1 the day after the hospital admission, would have documented an ER visit had she known and that maybe she rolled the patient to one side, therefore, missing the wound. The administrator stated the patient also had a responsibility to report the visit and the agency can't take full responsibility when they didn't know. The patient was discharged with no wound care services or other receiving agencies. 8. Documentation from the personal services agency providing care for patient 13 received on 8/17/2021 evidenced a document titled "Incident Report" dated 5/27/2021 for patient 13 that indicated, but was not limited to, "I was cleaning him [patient 13] up and noticed a rash on the front right leg and a fluid pocket on the back of his right leg underneath his butt." The family was notified at 7:44 p.m. signed by non-employee A. A picture of the wound was attached. A second document titled "Activity" evidenced an entry from non-employee B stated the personal care agency was notified of emergency room admission on 6/2/2021 for patient 13 and that patient would receive oral antibiotics. The non-employee also documented non-employee A had reported that the wound had worsened.	G0572		

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HOOSIER HOMECARE SERVICES LLC	614 EAST 53RD STREET , ANDERSON, Indiana, 46013

(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
G0572	Continued from page 32 9. Hospitalization records for patient 13 received on 8/13/2021 indicated the patient returned to the emergency room on 6/22/2021. The patient was admitted for "multiple right lower extremity wounds and the wound to the right hip had increased in size to golf ball size ... The right heel had purulent drainage and a foul smell." The patient was diagnosed with sepsis-related to an unknown organism. The right heel had purulent drainage and a foul smell. 10. During an interview on 8/11/2021 with the patient's caregiver, the caregiver stated patient 13 was found to have maggots in his wound on the right hip area and was potentially losing his right foot from wounds and infection found on the heel.	G0572		
G0598	Discharge plans communication CFR(s): 484.60(c)(3)(ii) (ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioner's issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any). This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to address changes in the patient's discharge plan and document the communication in the clinical record for 2 of 5 discharged clinical records reviewed. (Patient 13 and Patient 16) Findings include: 1. A document titled "Patient Discharge Process" was provided by the alternate administrator on 8/10/2021 at 10:00 a.m. The document indicated but was not limited to; "Agency staff will provide the patient with a 15-day notification of the impending discharge ... Upon discharge to self-care, the patient will receive verbal/written information regarding community services, medication use, any procedures/treatments to be performed, and follow-up visits for physician care ... To avoid charges of 'abandonment' at the time	G0598		

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G0598	Continued from page 33 of discharge agency documentation will include the following: a. Evidence that the decision was not made unilaterally. The patient, family, and the physician participated in the decision to discharge the patient from the agency. b. Evidence that the patient no longer qualifies for home care services. c. If there are unmet needs and the agency is no longer able to meet those needs documentation that appropriate notice was given (verbal and written) and referrals made as indicated." 2. A document titled "Care Plans" was provided by the administrator on 8/10/2021 at 10:37 a.m. The document indicated but was not limited to; "The Care Plan shall be reviewed, evaluated, and revised ... based upon the patient's health status and/or environment, ongoing patient assessments, caregiver support systems, and the effectiveness of the interventions in achieving progress toward goals." 3. The Center for Medicaid and Medicare State Operations Medicare Benefit Policy Manual Chapter 7 indicates but is not limited to; "As part of the certification of patient eligibility for the Medicare home health benefit, a face-to-face encounter with the patient must be performed by the certifying physician or allowed practitioner himself or herself, a physician or allowed practitioner that cared for the patient in the acute or post-acute care facility (with privileges who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health) or an allowed non-physician practitioner (NPP). Timeframe Requirements ... The encounter must occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care." 4. The complete clinical record for patient 13 was reviewed on 8/10/2021 and evidenced the following: A document titled F2F (face-to-face) Encounter signed by non-employee G, nurse practitioner. The document included "Date of In-Person Visit: 04/27/2021" signed on 4/27/2021. A document titled "Home Health Change of Care Notice (HHCCN) indicated that starting on 6/11/2021 the agency would discharge the patient if they did not have a face-to-face visit with a physician within 30 days of admission due to	G0598		

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G0598	Continued from page 34 insurance nonpayment. The document stated, "Your doctor's orders for your home care have changed." The HHCCN was signed on admission 5/13/2021 prior to care being delivered and prior to any physician changes having occurred. A document titled "Patient Communication" dated 5/27/2021 signed by employee E, Office Manager, indicated but was not limited to "Spoke with patients mother as well as patient. Patient has not showed up for past 2 md (medical doctor) appts (appointments) that was scheduled. Patient has an appt set up for 6/10/21 and was told to make sure he makes the appointment." A document titled "Patient Communication" dated 6/10/2021 signed by employee E, Office Manager, that indicated, but was not limited to "Md office called to inform that patient missed F2F appt this date. Could not get him rescheduled by 6/11/2021. Called and informed patients mother and patient that services would be stopped effective 6/11/21 due to not showing up for F2F." A document titled "Discharge Summary" dated 6/11/2021 signed by employee F, Registered Nurse. "The document indicated, but was not limited to, "Reason for discharge ... Noncompliant ... Information Provided for Continuing Needs/Specific Discharge Instructions? ..."The RN failed to document who the information was provided to on the discharge assessment. 5. The clinical record failed to evidence documentation related to reasoning patient 13 missed MD appointments, interventions implemented to remove any barriers to attending appointments and the outcome of those interventions, failed to evidence documentation evidencing patient and family was informed when missing the visits that services would be discontinued, failed to evidence a 15-day discharge notice, and failed to evidence a safe and appropriate transfer to another agency that provided skilled nursing, or any follow-up care set up for the patient. 6. During an interview on 8/12/2021 at 11:31 a.m., the alternate administrator stated the face-to-face was not received until after the patient was discharged when the office manager went to the nursing home to obtain the document so that they would be paid for the care provided. 7. During an interview on 8/16/2021 with the	G0598		

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G0598	Continued from page 35 administrator when asked why they waited until after the patient was discharged to obtain the face-to-face the administrator stated they wanted the patient to see a doctor to update medications. 8. The complete clinical record for Patient 16, start of care 02/13/2021, was reviewed on 08/10/2021 and evidenced the following: A document dated 02/11/2021, signed by Non-employee C on 02/12/2021, titled F2F (Face 2 Face). The document indicated, but was not limited to, " … has two medications that require a prescription, Klonopin (used to treat seizures, panic disorder and anxiety) and Oxycodone (used to treat moderate to severe pain) … Home Health Services PT (physical therapy), OT (occupational therapy), NSG (nursing), HHA (home health aide) ... medically necessary due to potential re-hospitalization, debility (weakness), lumbar fractures/ S/P (status/post) Lumbar spine fusion L1-4, Gait abnormality. Severe protein calorie malnutrition ... Plan Note .... Laceration of liver ... Neuropathy (dysfunction of one or more peripheral nerves, causing numbness or weakness), anxiety disorder, acute posthemorrhagic anemia ... Abnormal weight loss ... ". A document titled Home Health Certification and Plan of Care for the certification period of 02/13/2021-02/22/2021. The document indicated, but was not limited to, "Mental Status: Oriented, agitated ... SN: eval and tx, PT: 1X1 (1 time a week for 1 week), 2X4 (2 times a week for 4weeks), 1X4 (1 time a week for 4 weeks), OT: eval and treat ... Goals and Outcomes: The patient will be free from falls ... free from injury ... skin integrity will remain intact ... " The document failed to evidence any home health aide orders. The clinical record failed to evidence orders for specific interventions, frequency, or duration for skilled nursing, orders for wound care, and orders for occupational therapy. The clinical record failed to evidence documentation of notifying the physician the patient would not be receiving therapy services. A 02/17/2021 document, signed by Employee I, titled Patient Communication. The document indicated, but was not limited to, " ... pt slurring ... words … hadn't eaten and was walking … to get food ... SN ... would be contacting authorities to do a welfare check ... "	G0598		

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G0598	Continued from page 36 A 2/18/2021 document titled PTA visit indicated during the PTA (physical therapy assistant) visit, the PTA documented the patient declined all intervention except laying supine due to weeping from a liver laceration wound. The PTA documented the patient needed food and water; the PTA reached the emergency contact who stated they were unable to provide food for the patient. The PTA stated the patient was supposed to be changing his liver bandage every day but ran out of pads and has been using a towel. The document failed to indicate that they physician was made aware of the status of the patient's wound, or the need for wound care and wound care supplies. A 02/19/2021 document titled OT (occupational therapist) Evaluation indicated that the patient had no assistance, the patient lived on the 3rd floor and there was clutter and garbage scattered throughout. There was an insect/rodent infestation present. The patient was sleeping with a mattress on the floor with no sheets. Skilled OT was necessary to address deficits. A 2/19/2021 document titled SN Evaluation indicated that when the SN performed their initial evaluation, the SN stated the patient was forgetful. The patient stated that PT was not present on 2/19/2021 although the SN knew PT had visited that day. SN stated the patient had leftover Chinese food and stated the patient had no system to set up medications; the patient stated he wasn't interested in a system to set up medications. The document failed to indicate that the physician was made aware that the patient was not receiving the prescription medications Klonopin (used to treat seizures, panic disorder and anxiety) and Oxycodone (used to treat moderate to severe pain) as prescribed. A 02/22/2021 document titled Discharge Summary indicated, but was not limited to, "Physician notified of discharge prior to discharge date, per agency policy & timeline ... Pt requires extensive assistance to complete ADL's and transfers ... Emergency contact is a friend that lives in apt complex; but not the same building. Pt uses walker, but continues to experience falls ... apartment in poor condition with bed bugs noted in chair at DC visit ... Pt advised to go to the ER due to concerns regarding drainage form wound site and elevated temp ... had falls since being home; 2 of which occurred this day ... yellow, thick drainage from puncture site ...	G0598		

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G0598	Continued from page 37 Continued to work with therapy to work towards goals ... No food noted in home; pt stated he had food last Thursday ... Pt determined to not be safe at home and is non-compliant with SN care ... ". The patient was not discharged with appropriate notice. A 02/22/2021 document, signed by Employee E, titled Patient communication indicated, but was not limited to, “SN called MD (medical doctor) office to notify of patient noncompliant with care and meds. Advise patient to go to ER.” The document failed to indicate that the patient was being discharged from the agency. A 02/22/2021 document, signed by Employee E, titled Physician Order indicated, but was not limited to, “This patient may be discharged ... The reason for the discharge is pt is noncompliant ... was seen for the discipline of SN for the following interventions Assessment, vs (vital signs), oxygen saturation, education. The outcome of this intervention has led to pt DC (discharge) ... ” The document was faxed to Non-employee D on 02/23/2021, a day after the patient was discharged from the agency. The document was signed and returned to the agency on 02/24/2021, two days after the patient was discharged from the agency. 9. During an interview on 8/12/2021, the administrator stated the regulations allow for discharge without notice if they are unsafe and needed extended care and the patient was a danger to themselves. 10. During an interview on 8/16/2021 at 3:43 p.m. with the administrator and alternator administrator, when asked if the patient's financial situation had been assessed, or if they had made a referral as the patient clearly needed help and had no caregiver the alternate administrator stated they had previously called adult protective services on other patients and the patient's families would get angry and call them (the agency) so the agency would leave it up to the physician. When informed there's no documentation of the medical doctor being notified the patient hadn't eaten in days, appeared neglected, and was acutely ill, the administrator stated the physician would receive a copy of the discharge summary when the summary was ready.	G0598		
G0604	Integrate all orders	G0604		

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G0604	Continued from page 38 CFR(s): 484.60(d)(2) Integrate orders from all physicians or allowed practitioners involved in the plan of care to assure the coordination of all services and interventions provided to the patient. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to integrate all orders in the plan of care and failed to assure coordination of care for all services required for 2 of 5 discharged patients reviewed. (Patient 13 and Patient 16). Findings include: 1. A policy titled "Care Plan" was provided by the administrator on 8/12/2021 at 10:37 a.m. The document indicated but is not limited to, "Each patient will have a care plan on file that addresses their identified needs ... the care plan shall include ... a list of specific interventions with plans for implementation ... " 2. A policy titled "Clinical Documentation" was provided by the alternate administrator on 8/10/2021 at 10:00 am. The document indicated but was not limited to, "Telephone or other communication with patients, physicians, families, or other members of the health care team will be documented in clinical progress notes or other interagency communication forms." 3. A policy titled "Standard Infection Control Procedures for Home Care" was provided by the administrator on 8/12/2021 at 10:37 a.m. The document indicated but was not limited to, "In the event of insect or rodent infestation noted by agency staff, the agency will be immediately notified, and the agency staff will begin making arrangements with the patient/family to seek professional treatment for the infestation ..." 4. The complete clinical record for patient 13, start of care 5/13/2021, was reviewed on 8/11/2021. The record evidenced the following: A document titled "Home Health Certification and Plan of Care" indicated but was not limited to, a diagnosis of neuromuscular dysfunction of the bladder, unspecified and paraplegia. The document included the following orders and treatments, " SN	G0604		

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G0604	Continued from page 39 (skilled nursing) 1x9 (1 time a week times 9 weeks) ... Patient has or is at risk for having pressure ulcers-risk for infection ... SN to assess skin for breakdown every visit ..." A document titled, "RN-Skilled Nursing Visit" for 5/20/2021 signed by employee I, Registered Nurse. The document indicated but was not limited to, "Skin ... WNL (within normal limits) ... A document titled, "RN-Skilled Nursing Visit" for 5/24/2021 signed by employee C, Registered Nurse. The document indicated but was not limited to, "Skin ... Dry ... Warm ... Good/Elastic ... Assessment ... provided [sic] has no open areas or wounds at this time ..." A document titled, "LPN/LVN-Skilled Nursing Visit" for 6/02/2021 signed by employee D, Licensed Practical Nurse. The document indicated but was not limited to, "Skin ... Dry ... Warm ... Good/Elastic ... Assessment ... Medication Changes … No " 5. The hospital record for patient 13 was provided by entity B on 8/10/2021. The document indicated but was not limited to, an emergency room visit on 6/2/2021 related to an open wound. The patient was discharged with a follow-up order for wound care with the local wound and ostomy clinic and prescriptions for 2 new antibiotics. 6. Documentation from the personal services agency providing care for patient 13 received on 8/17/2021 evidenced a document titled "Incident Report" dated 5/27/2021 for patient 13 that indicated, but was not limited to, "I was cleaning him [patient 13] up and noticed a rash on the front right leg and a fluid pocket on the back of his right leg underneath his butt." The family was notified at 7:44 p.m. signed by non-employee A. A picture of the wound was attached. A second document titled "Activity" evidenced an entry from non-employee B stated the personal care agency was notified of emergency room admission on 6/2/2021 for patient 13 and that patient would receive oral antibiotics. The non-employee also documented non-employee A had reported that the wound had worsened. 7. The home health agency failed to coordinate care with patient 13's personal service agency and patient 13's caregiver resulting in the agency not being aware of the wound identified on 5/27/2021,	G0604		

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G0604	Continued from page 40 hospital admission on 6/2/2021, and new antibiotics and wound care orders prescribed on 6/2/2021. 8. The complete clinical record for Patient 16, start of care 02/13/2021, was reviewed on 08/10/2021 and evidenced the following: A document dated 02/11/2021, signed by Non-employee C on 02/12/2021, titled F2F (Face 2 Face). The document indicated, but was not limited to, " ... Home Health Services PT (physical therapy), OT (occupational therapy), NSG (nursing), HHA (home health aide) ... " A document dated 02/13/2021, signed by Employee G, titled Physician Order, indicated but was not limited to, "This patient has been admitted to skilled home health services for the following disciplines: PT (physical therapy)/OT (occupational therapy)/SN (skilled nursing) ... Skilled Nursing warranted due to active surgical wound … Fall prevention … Assess environment for personal safety hazards … Gait and balance exercises ... " The document failed to include orders for a home health aide, specific orders for wound care, frequency, and duration of visits for skilled nursing, and orders for OT. A 02/17/2021 document, signed by Employee I, titled Patient Communication. The document indicated, but was not limited to, " ... pt slurring ... words … hadn't eaten ... would be contacting authorities to do a welfare check ... SN notified 911 at this time ... " The document failed to evidence that the physician was made aware of changes in the patient's status, need for emergency services, or that the plan of care may need to be altered. A 2/18/2021 document titled PTA Visit indicated that during the PTA (physical therapy assistant) visit, the patient declined all intervention except laying supine due to weeping from a liver laceration wound, and the need for food and water. The PTA stated the patient was supposed to be changing his liver bandage every day but ran out of pads and has been using a towel. The document failed to evidence that the physician was made aware of the patient's status or that the plan of care may need to be altered. A 02/22/2021 document, signed by Employee E, titled Patient communication indicated, but was	G0604		

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G0604	Continued from page 41 not limited to, “SN called MD (medical doctor) office to notify of patient noncompliant with care ... advise patient to go to ER.” The document failed to evidence that the physician was made aware of the patients poor living conditions or the safety of the patient and why the patient was advised to go to the emergency room. 9. The home health agency failed to provide home health aide services, or adequate wound care services resulting in a decline in the patient's condition due to an infection. The clinical record failed to evidence that the physician was made aware of the patient's living conditions or decline in condition. 10. During an interview on 8/16/2021 at 3:43 p.m. with the administrator and alternator administrator, when informed there's no documentation of the physician being notified the patient hadn't eaten in days, appeared neglected, and was acutely ill, the administrator stated the physician would receive a copy of the discharge summary when the summary was ready.	G0604		
G0608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to coordinate care for 2 of 2 patients discharged for noncompliance. (Patient 13 and Patient 16) Findings include: 1. POLICY 2. The complete clinical record for patient 13, the start of care 5/13/2021, was reviewed on 8/11/2021. The record evidenced the following: A document titled "Patient Communication" dated 5/20/2021 signed by employee E, Office Manager,	G0608		

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G0608	Continued from page 42 indicated, but was not limited to "Spoke with patients mother Teresa and informed her that patient needed set up with his PCP (primary care physician) by 6/11/2021." A document titled "Patient Communication" dated 5/27/2021 signed by employee E, Office Manager, indicated but was not limited to "Spoke with patients mother as well as patient. Patient has not shown up for the past 2 MD (medical doctor) appts (appointments) that was scheduled. Patient has an appt set up for 6/10/21 and was told to make sure he makes the appointment." A document titled "Patient Communication" dated 6/10/2021 signed by employee E, Office Manager, indicated, but was not limited to "Md office called to inform that patient missed F2F appt this date. Could not get him rescheduled by 6/11/2021. Called and informed patients, mother, and patient, that services would be stopped effective 6/11/21 due to not showing up for F2F." A document titled, "LPN/LVN-Skilled Nursing Visit" for 6/02/2021 was signed by employee D, Licensed Practical Nurse. The document indicated but was not limited to, "Skin ... Dry ... Warm ... Good/Elastic ... Assessment ... " A document titled "Discharge Summary" dated 6/11/2021 signed by employee F, Registered Nurse. "The document indicated, but was not limited to, "Reason for discharge ... Noncompliant ... Information Provided for Continuing Needs/Specific Discharge Instructions? ..."The RN failed to document who the information was provided to on the discharge assessment. A document titled "F2F (face to face) Encounter" dated 4/27/2021. The document indicated but is not limited to, "Date of In-Person Visit: 04/27/2021" signed by Non-Employee A, Nurse Practitioner. 3. Hospitalization records for patient 13 were received on 8/13/2021 for patient 13. The records indicated but were not limited to an emergency room visit dated 6/1/2021. The clinical impression documented by the medical provider indicated an	G0608		

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G0608	Continued from page 43 open wound, 4cm by 5cm ulceration with central eschar on the proximal posterior right thigh. The wound was cultured, and the results indicated evidenced heavy growth of Proteus mirabilis, heavy growth of Pseudomonas aeruginous, and heavy growth of Providencia stuartii. The patient received IV antibiotics and was prescribed oral antibiotics for home. 4. During an interview on 8/16/2021 the administrator stated the LPN (licensed practice nurse) who performed the visit on 6/2/202,1 the day after the hospital admission, would have documented an ER visit had she known and that maybe she rolled the patient to one side, therefore, missing the wound. The administrator stated the patient also had a responsibility to report the visit and the agency can't take full responsibility when they didn't know. The patient was discharged with no wound care services or other receiving agencies. 5. Documentation from the personal services agency providing care for patient 13 received on 8/17/2021 evidenced a document titled "Incident Report" dated 5/27/2021 for patient 13 that indicated, but was not limited to, "I was cleaning him [patient 13] up and noticed a rash on the front right leg and a fluid pocket on the back of his right leg underneath his butt." The family was notified at 7:44 p.m. signed by non-employee A. A picture of the wound was attached. A second document titled "Activity" evidenced an entry from non-employee B stated the personal care agency was notified of emergency room admission on 6/2/2021 for patient 13 and that patient would receive oral antibiotics. The non-employee also documented non-employee A had reported that the wound had worsened. 6. Hospitalization records for patient 13 received on 8/13/2021 indicated the patient returned to the emergency room on 6/22/2021. The patient was admitted for "multiple right lower extremity wounds and the wound to the right hip had increased in size to golf ball size ... The right heel had purulent drainage and a foul smell." The patient was diagnosed with sepsis related to an unknown organism. The right heel had purulent drainage and a foul smell.	G0608		

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G0608	Continued from page 44 7. During an interview on 8/11/2021 with the patient's caregiver, the caregiver stated patient 13 was found to have maggots on his wound on the right hip area and was potentially losing his right foot from wounds and infection found on the heel. 8. The agency failed to coordinate care between the Hospital, the Personal Care Services Agency, and the patient's caregiver. 9. During the entrance conference on 8/9/2021 at 12:15 p.m. the administrator stated the agency coordinates care with other agencies every 60 days. 10. During an interview on 8/16/2021 at 3:04 p.m. the administrator stated the patient shouldn't get a hall pass, the patient didn't tell the agency he had a wound or a visit to the emergency room and so he shouldn't be just given a pass and we can't just blame it on him being bipolar. 11. The complete clinical record for Patient 16, start of care 02/13/2021, was reviewed on 08/10/2021 and evidenced the following: A document dated 02/13/2021, signed by Employee G, titled Physician Order, indicated but was not limited to, "This patient has been admitted to skilled home health services for the following disciplines: PT (physical therapy)/OT (occupational therapy)/SN (skilled nursing) ... Skilled Nursing warranted due to active surgical wound … Fall prevention … Assess environment for personal safety hazards … Gait and balance exercises ... " The document failed to include orders for a home health aide, specific orders for wound care, frequency, and duration of visits for skilled nursing, and orders for OT. A 02/17/2021 document, signed by Employee I, titled Patient Communication. The document indicated, but was not limited to, "SN (skilled nurse) received phone call from pt (patient) emergency contact ... expressed concern that ... unable to reach pt for the last 24-48 hours ... SN notified supervisors at this time ... pt slurring ... words … hadn't eaten and was walking … to get	G0608		

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G0608	Continued from page 45 food ... SN informed emergency contact ... would be contacting authorities to do a welfare check ... SN notified 911 at this time ... " The document failed to evidence that the physician was made aware of changes in the patient's status and the need for emergency services. The clinical record failed to evidence that any follow up from the agency after emergency services were summoned. A 2/18/2021 document titled PTA Visit indicated that during the PTA (physical therapy assistant) visit, the PTA documented the patient declined all intervention except laying supine due to weeping from a liver laceration wound. The PTA documented the patient needed food and water; the PTA reached the emergency contact who stated they were unable to provide food for the patient. The PTA stated the patient was supposed to be changing his liver bandage every day but ran out of pads and has been using a towel. The document failed to evidence that the physician was made aware of the patient's status or the need for wound care and supplies. A 02/19/2021 document titled OT (occupational therapist) Evaluation, signed by Employee H, indicated that the patient had no assistance, the patient lived on the 3rd floor and there was clutter and garbage scattered throughout. There was an insect/rodent infestation present. The patient was sleeping with a mattress on the floor with no sheets. The document failed to indicate that the physician was made aware of the patient's living conditions. A 02/22/2021 document, signed by Employee E, titled Patient communication indicated, but was not limited to, "SN called MD (medical doctor) office to notify of patient noncompliant with care and meds. Advise patient to go to ER." The document failed to indicate that the patient was being discharged from the agency. A 02/22/2021 document, signed by Employee E, titled Physician Order indicated, but was not limited to, "This patient may be discharged ... The reason for the discharge is pt is noncompliant ... was seen for the discipline of SN for the following interventions Assessment, vs (vital signs), oxygen saturation, education. The outcome of this intervention has led to pt DC (discharge) ... " The document was faxed to Non-employee D on 02/23/2021. The document was signed and returned to the agency on 02/24/2021, two days after the patient was discharged from the agency.	G0608		

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G0608	Continued from page 46 The clinical record failed to evidence that the agency adequately coordinated care with the physician regarding orders, changes in the patient's condition, patient needs, and patient safety. The clinical record failed to evidence that the agency attempted to coordinate care with other businesses such as an exterminator or meal delivery business. 12. During an interview on 8/16/2021 at 3:43 p.m. with the administrator and alternator administrator, when informed there's no documentation of the physician being notified the patient hadn't eaten in days, appeared neglected, and was acutely ill, the administrator stated the physician would receive a copy of the discharge summary when the summary was ready.	G0608		
G0682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure staff was following acceptable standards of practice by actively documenting the absence of illness or signs/symptoms of COVID-19 and failing to screen all patients for COVID-19 prior to performing home visits for 1 of 1 agency reviewed. Findings include: 1. A 3/23/2020 CMS Infection Control Covid-19 questionnaire tool indicated, but was not limited to, "Is the facility screening all staff at the beginning of their shift for fever and signs/symptoms of illness? Is the facility actively taking their temperature and documenting the absence of illness (or signs/symptoms of COVID-19 as more information becomes available)?" Ref: QSO 20-20-All 2. A 12/20/2020 CMS Memorandum Ref: QSO-21-08-NLTC indicated but was not limited; "Education,	G0682		

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G0682	Continued from page 47 Monitoring, and Screening of Staff. Does the facility have a screening process for all staff to complete prior to or at the beginning of their shift that reviews for exposure to others with known or suspected COVID-19, signs/symptoms of illness, and includes whether fever is present (screened upon arrival or self-reported absence of fever)? Is there evidence the provider has educated staff on SARS-CoV?" 3. During an interview with the administrator and the alternate administrator on 08/09/2021 at 11:11 a.m., a document titled “COVID-19 Focused Infection Control Survey Tool: Acute and Continuing Care” was used. The interview indicated, but was not limited to, “Does the facility have a screening process ... No ... How is staff monitored for compliance? Peer-to-peer reporting, trusting our staff, and staff education ... The facility has established/implemented a surveillance plan, based on facility assessment, for identifying, tracking, monitoring, and/or reporting fever, respiratory illness, or other signs/symptoms of COVID-19? No ... ” 4. During a home visit on 08/12/2021 at 9:00 a.m., Employee J failed to screen the patient for COVID-19 symptoms upon arrival to the patient’s home. When asked if the employees were required to conduct any type of self-screening, Employee J stated they were not required to self-screen or track symptoms or lack of symptoms. 5. During an interview with the administrator on 08/12/2021 at 11:23 a.m., when asked if employees had been required to track COVID-19 symptoms, or lack of symptoms, at any point since the start of the pandemic, the administrator stated the employees were not required to do any symptom tracking. 6. During an interview with the alternate administrator on 08/16/2021 at 3:25 p.m., the alternate administrator stated the employees were not required to track their symptoms, or lack of symptoms, and should be calling the patients ahead of time to screen the patients for COVID-19 symptom; they agency stopped tracking symptoms when the mask mandate was lifted.	G0682		
G1024	Authentication CFR(s): 484.110(b)	G1024		

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G1024	Continued from page 48 Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This STANDARD is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure all clinical documents were properly authenticated for 1 of 5 closed records reviewed. (Patient 13). A policy titled "Clinical Documentation" was provided by the alternate administrator on 8/10/2021 at 10:00 am. The document indicated but was not limited to, “A separate note shall be completed for each visit/shift and signed and dated … telephone or other communication with patients, physicians, families, or other members of the health care team will be documented …” A job description titled “Registered Nurses” was provided by the alternate administrator on 8/10/2021 at 10:00 a.m. The document indicated but was not limited to “Essential Functions/Areas of Accountability … documents legibly and according to Agency documentation guidelines and standards.” The complete clinical record for patient 13, the start of care 5/13/2021, was reviewed on 8/11/2021. The record evidenced the following: A document titled "Home Health Change of Care Notice (HHCCN) indicated that starting on 6/11/2021 the agency would discharge the patient if they did not have a face-to-face visit with a physician within 30 days of admission due to insurance nonpayment. The document stated, "Your doctor's orders for your home care have changed." The HHCCN was signed on admission 5/13/2021 prior to care being delivered and prior to the doctor changing the patient’s orders and prior to the agency having any verbal or signed orders from the physician. A document titled “Hoosier Homecare Services:	G1024		

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G1024	Continued from page 49 Notice of Medicare Non-coverage" for patient 13 indicated "The effective date coverage of your home health services services will end:" The agency failed to enter a date identifying when services when end. The document signature is illegible and fails to evidence a date the document was signed. During an interview on 8/12/2021 at 11:31 a.m., the alternate administrator stated the undated/illegible document titled Notice of Medicare Non-coverage was the 15-day notice given to patient 13.	G1024		
G1060	Licensed Practical (Vocational) Nurse CFR(s): 484.115(e) Standard: Licensed practical (vocational) nurse. A person who has completed a practical (vocational) nursing program, is licensed in the state where practicing, and who furnishes services under the supervision of a qualified registered nurse. This STANDARD is NOT MET as evidenced by: Based on record review and interview the Licensed Practical Nurse failed to provide an accurate skin assessment for 1 of 2 closed records with wounds reviewed. (Patient 13). Findings include: A job description titled "Licensed Practical Nurse" was provided by the alternate administrator on 8/10/2021 at 10:00 a.m. The document indicated but was not limited to "Provides professional nursing care as defined in the nurse practice act … follows the care plan established by the registered nurse … recognizes and reports changes in client condition … participates in the coordination of home care services." The complete clinical record for patient 13, the start of care 5/13/2021, was reviewed on 8/11/2021 and evidenced the following: A document titled "Home Health Certification and Plan of Care" indicated but was not limited to, a	G1060		

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G1060	Continued from page 50 diagnosis of neuromuscular dysfunction of the bladder, unspecified and paraplegia. The document included the following orders and treatments, " SN (skilled nursing) 1x9 (1 time a week times 9 weeks) ... Patient has or is at risk for having pressure ulcers-risk for infection ... SN to assess skin for breakdown every visit ..." A document titled, "LPN/LVN-Skilled Nursing Visit" for 6/02/2021 was signed by employee D, Licensed Practical Nurse. The document indicated but was not limited to, "Skin ... Dry ... Warm ... Good/Elastic ... Assessment ... " Documentation from the personal services agency providing care for patient 13 received on 8/17/2021 evidenced a document titled "Incident Report" dated 5/27/2021 for patient 13 that indicated, but was not limited to, "I was cleaning him [patient 13] up and noticed a rash on the front right leg and a fluid pocket on the back of his right leg underneath his butt." The family was notified at 7:44 p.m. signed by non-employee A. A picture of the wound was attached. A second document titled "Activity" evidenced an entry from non-employee B stated the personal care agency was notified of emergency room admission on 6/2/2021 for patient 13 and that patient would receive oral antibiotics. The non-employee also documented non-employee A had reported that the wound had worsened. Hospitalization records for patient 13 received on 8/13/2021 indicated the patient returned to the emergency room on 6/22/2021. The patient was admitted for "multiple right lower extremity wounds and the wound to the right hip had increased in size to golf ball size ... The right heel had purulent drainage and a foul smell." The patient was diagnosed with sepsis related to an unknown organism. The right heel had purulent drainage and a foul smell. During an interview on 8/16/2021, the administrator stated the LPN (licensed practice nurse) who performed the visit on 6/2/2021 the day after the hospital admission, would have documented an ER visit had she known and that maybe she rolled the patient to one side, therefore, missing the wound. The administrator stated the patient also had a responsibility to	G1060		

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G1060	Continued from page 51 report the visit and the agency can't take full responsibility when they didn't know. The patient was discharged with no wound care services or other receiving agencies. The administrator stated, "I'm not arguing about the wound the nurse obviously missed it but the patient has some responsibility."	G1060		