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	15K082	A. BUILDING _____ B. WING _____	C 03/02/2021

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AT HOME HEALTH CARE AGENCY LLC	12602 GLOBAL DR BLDG 2061 STE D YODER, IN 46798

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G 000	INITIAL COMMENTS This visit was for a Federal Recertification and State Licensure survey, in conjunction with 3 complaints. This was a fully extended survey. The administrator was notified the survey was fully extended on 2/24/21 at 11:40 AM. IN00295490 - Substantiated with findings IN0032158 - Substantiated with findings IN00334922 - Substantiated with findings Survey Dates: February 22, 23, 24, 25, 26, & March 1, 2; 2021 Facility number: 012746 Provider number: 15k082 Unduplicated Census: 81 Based on the Condition-level deficiencies during the March 2, 2021 survey, At Home Health Care Agency, LLC was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 2/24/21. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, At Home Health Care Agency, LLC is precluded from operating or being the site of a home health aide training and/or competency evaluation programs for the two years beginning March 2, 2021 and continuing through March 2, 2023 for being found out of compliance with the Conditions of Participation 42 CFR 484.55 Comprehensive assessment of patients, 484.60 Care Planning, coordination, quality of care, 484.65 Quality assessment and performance improvement (QAPI), 484.70 Infection prevention and control, 484.75 Skilled professional services, 484.80 Home health aide services, and 484.105 Organization and administration of services.	G 000		

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

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G 000	Continued From page 1 These deficiencies reflects State Findings cited in accordance with 410 IAC 17. Refer to the State Form for additional State Findings.	G 000		
G 372	Encoding and transmitting OASIS CFR(s): 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary. This Standard is not met as evidenced by: Based on record review and interview, the agency failed to ensure that OASIS (outcome and assessment information set) submissions were completed in a timely fashion, (prior to COVID-19 the expectation was within 30 days of completing the assessment). Findings include: An agency policy dated 1/2018 and titled "Reporting of OASIS Data," Policy # 120 stated " ...The Agency will report all OASIS data collected according to current federal and/or state requirements ... Agency must encode and have the capability of transmitting OASIS data for each patient within thirty (30) days of completing any required OASIS data set assessment ...." On 2/26/21 at 10:48 AM, OASIS submissions were received from the administrator. The last OASIS submission was completed on 8/5/2020 at 6:27 AM. During an interview on 3/1/21 at 3:09 PM, when	G 372		

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G 372	Continued From page 2 asked who oversees OASIS submissions, the Clinical Manager indicated it would be her responsibility, but that currently, Employee D (Human Resources Manager), oversaw that. During an interview on 3/1/21 at 4:26 PM, when the surveyor notified the administrator and clinical manager of the concern above, the clinical manager in turn asked if there was a chance the submissions were done, and they hadn't printed them out. The surveyor indicated that the agency was responsible for knowing that and provided opportunity for the agency to investigate their own question. During the exit conference on 3/1/21 at 5:30 PM, the agency was asked if there was any additional information to submit for review. No additional information was received at that time. The agency was told that emailed documents would be accepted until 3/2/21. No OASIS submissions were ever emailed.	G 372		
G 374	Accuracy of encoded OASIS data CFR(s): 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. This Standard is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure outcome and assessment information set (OASIS) data accurately reflected the patient's status, without conflicting information, at the time of the assessment for 8 of 10 records reviewed. (Patients #1, 2, 3, 4, 5, 7, 8, 10). Findings include: 1. An agency policy dated 1/2018 and titled	G 374		

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G 374	Continued From page 3 "OASIS-C Outcome and Assessment Information Set," Policy # 17 stated " ... Purpose: to form the basis for outcome measurement ... The home health agency is responsible for monitoring the accuracy of the assessment data and the adequacy of the assessment process ...." 2. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated diagnoses of, but not limited to, Lymphedema (swelling that generally occurs in one of your arms or legs), cellulitis of the right lower limb (a bacterial skin infection), osteoarthritis (wearing down of cartilage occurs gradually and worsens over time), morbid obesity (100 pounds over ideal body weight, a BMI of 40 or more, or 35 or more and experiencing) obesity-related health conditions, such as high blood pressure or diabetes), and idiopathic aseptic necrosis of right femur (a bone condition that results from poor blood supply to an area of bone, causing localized bone death). A recertification comprehensive assessment completed on 2/5/21 indicated on Patient Contacts (485-19) that there was no other caregiver involved in the care of the patient on page 5 of 20. On page 13 of 20, the assessment stated "son" prepared meals. On page 11 of 20, M1610 indicated the patient was incontinent of bladder. On page 12 of 20, the assessment indicated "frequency and urgency." On page 16 of 20, M1840 indicates the patient was "able to get to and from the toilet and transfer independently with or without a device." On the same page, M1850 indicated the patient was "able to bear weight and pivot during the transfer process but unable to transfer self." On the same page,	G 374		

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G 374	Continued From page 4 M1860 indicated patient was "chairfast, unable to ambulate but is able to wheel self independently." On page 9 of 20, "Integumentary Status (Wounds)" section stated the patient had no wounds or open areas. On page 19 of 20, the "Goals" section stated, " ... worsening lymphedema in bilateral lower legs has developed opened sore ...." 3. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated diagnoses of, but not limited to, excoriation disorder (habitually and excessively picking, scratching, gouging or squeezing at otherwise healthy skin), essential primary hypertension (a form of hypertension that by definition has no identifiable secondary cause), and major depressive disorder with psych features (a mental disorder in which a person has depression along with loss of touch with reality). A recertification comprehensive assessment completed on 12/26/2020 indicated "Stage 2" for "most problematic unhealed pressure ulcer/injury that is stageable: excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device", under section M1324 on page 9 of 20. On page 19 of 20, the "Goals" section states, " ...Pt [patient] picks skin on both legs and buttocks which has led to several unstageable wound spots on both legs and buttocks ... Wound spots are numerous, and are at different stages of healing ...." 4. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for the certification period 10/20/2020 to 12/18/2020	G 374		

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G 374	Continued From page 5 that indicated diagnoses of, but not limited to, type two diabetes mellitus with diabetic neuropathic arthropathy (insufficient production of insulin causing high blood sugar with subsequent decreased sensation in the joints), hyperlipidemia (elevated cholesterol blood level), essential primary hypertension (a form of hypertension that by definition has no identifiable secondary cause), and chronic kidney disease (gradual loss of kidney function). During a home visit observation on 2/24/21 at 8:00AM, Home Health Aide M was observed assisting with personal care with patient #3. The patient was observed rising from recliner, ambulating to bathroom, and standing in hallway, waiting on HHA to start personal care, unassisted and independently without difficulty or an assistive device. The HHA was observed providing verbal ques during the visit and provided minimal hands-on care during shower. At all times, the patient was able to transfer and ambulate without any assistance during the visit. A recertification comprehensive assessment was completed on 2/15/2021. The assessment revealed on M1850 the patient was able to transfer from bed to chair, with minimal human assistance or with the use of an assistive device. Under section GG0170, indicated the patient could independently transfer from bed to a chair. 5. The clinical record of patient #4 was reviewed on 2/23/21 and indicated a start of care date of 5/14/2020. The record contained a plan of care for the certification period 5/14/2020 to 7/12/2020 that indicated diagnoses of, but not limited to, Type II diabetes mellitus (insufficient production of insulin causing high blood sugar), obesity (excessive amount of body fat), atrial fibrillation	G 374		

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G 374	Continued From page 6 (irregular heart rhythm), stage 2 pressure ulcer of right buttocks (injury to the skin and its underlying tissue due to prolonged pressure on it), unspecified open wound abdominal wall without penetration of the peritoneal cavity, urinary tract infection (infection in any part of urinary systems), urinary retention (inability to voluntarily empty the bladder completely or partially), chronic obstructive pulmonary disease (a group of progressive lung disorders characterized by increasing breathlessness), chronic pain (pain that last for more than 3 months), hypothyroidism (a condition resulting from decreased production of thyroid hormones), ataxia (loss of coordination of voluntary muscle movements), osteoarthritis (inflammation of one or more joints), major depressive disorder (mental health disorder having episodes of psychological depression), and candidiasis of skin and nail (common fungal infection that affect the skin and nails). A Skilled Nursing Comprehensive Resumption of Care was completed on 7/3/2021. The question M1242 stated "frequency of pain interfering with patient's activity or movement," as "less often than daily" (patient had a diagnosis of chronic pain). "Acceptable level of pain" and "Current severity of pain," was blank. Pain "Location" is listed as "back and hips." 6. The clinical record of patient #5 was reviewed on 2/23/21 and indicated a start of care date of 4/24/2015. The record contained a plan of care for the certification period 4/3/2019 to 6/1/2019 that indicated diagnoses of, but not limited to, type II diabetes mellitus, obesity (excessive amount of body fat), post-traumatic stress disorder (mental health condition that develops following a traumatic event), weakness (loss of muscle strength), intramural leiomyoma of uterus	G 374		

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G 374	Continued From page 7 (non-cancerous tumors in the uterus), chronic post-thoracotomy pain (chronic pain after thoracic surgery), and dysmenorrhea (painful periods, menstrual cramps). A SN (Skilled Nurse) Comprehensive Discharge was completed on 5/16/2019. M1242 indicated that patient never has any pain. Diagnoses of chronic post-thoracotomy pain and dysmenorrhea are noted on patient's care plan. 485-19 stated patient was oriented to "Person, Place, Time, and is Alert." M1740 stated patient has a " ...memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required ...." 7. The clinical record of patient #7 was reviewed on 2/23/21 and indicated a start of care date of 10/20/2020. The record contained a plan of care for the certification period 12/19/2020 to 2/16/2021 that indicated diagnoses of, but not limited to, bipolar disorder (serious mental illness characterized by extreme mood swings), type II diabetes mellitus, schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized speech and behavior), major depressive disorder (mental health disorder having episodes of psychological depression), essential primary hypertension, emphysema (lung disease which results in shortness of breath), chronic obstructive pulmonary disease (a group of progressive lung disorders characterized by increasing breathlessness), and benign prostatic hyperplasia (condition in which the flow of urine is blocked due to the enlargement of prostate gland), and medications, but not limited to, " ... Invega Sustenna ... effective 4/4/2020 ... Every Day Intramuscular ...."	G 374		

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G 374	Continued From page 8 A recertification comprehensive assessment was completed on 2/15/2021 and stated on M1610 that patient " ...requires a urinary catheter ..." and then further stated, " ...retention ...." M2030 stated " ...NA (not applicable) - no injectable medications prescribed ...." 8. The clinical record of patient #8 was reviewed on 2/23/21 and indicated a start of care date of 3/27/2019. The record contained a plan of care for the recertification period 1/15/2021 to 3/15/2021 that indicated diagnoses of, but not limited to, quadriplegia (paralysis of all four limbs), dysphagia (condition in which a person's ability to eat and drink is disrupted), gastronomy tube (tube inserted through the belly that brings nutrition directly to the stomach), colostomy status (colostomy is an opening in the large intestine, or the surgical procedure that creates one), chronic respiratory failure (when the airways that carry air to your lungs become narrow and damaged), and contractures of the left hand and right lower leg (a contracture is a permanent shortening of a muscle or joint). A recertification comprehensive assessment was completed on 1/14/2021 and stated on " ...Cardiac Status ..." that patient had a "pacemaker [inserted 12/1/2016] ...." M1021/M1023 failed to list the pacemaker as a current diagnosis. M1610 stated " ...requires a urinary catheter ..." and then further in the assessment stated the patient had "retention." 9. The clinical record of patient #10 was reviewed on 2/23/21 and indicated a start of care date of 7/9/2020. The record contained a plan of care for the recertification period of 1/5/2021 to 3/5/2021 that indicated diagnoses of, but not limited to, hemiplegia following cerebral infarction affecting	G 374		

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G 374	Continued From page 9 right dominant side (area of necrotic tissue in the brain from a blockage or narrowing in the arteries supplying blood and oxygen to the brain resulting in paralysis of one side of the body), essential primary hypertension (a form of hypertension that by definition has no identifiable secondary cause), major depressive disorder (mental health disorder having episodes of psychological depression), chronic obstructive pulmonary disease (a group of progressive lung disorders characterized by increasing breathlessness), nontraumatic intracranial hemorrhage (bleeding between the brain tissue and skull or within the brain tissue itself), and bacteremia (presence of bacteria in the blood). A recertification comprehensive assessment was completed on 1/4/21. M1610 indicated patient was incontinent on page 11 of 20. On the same page, the assessment stated " ...WNL (within normal limits) ..." under the section titled, " ...Genitourinary Tract for Elimination Status ...." M1620 indicated patient was " ...incontinent of bowel four to six times weekly ..." The section titled, " ...Gastrointestinal Tract ..." states " ...WNL (within normal limits) ...." 10. During an interview on 3/1/21 at 3:09 PM, when asked if the comprehensive assessment should have missing or incorrect information, the Clinical Manager stated, "I would hope not. I mean I can't say that for every one of them, but I would hope not. The computer program should catch it."	G 374		
G 438	Have a confidential clinical record CFR(s): 484.50(c)(6) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.	G 438		

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G 438	Continued From page 10 This Element is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure confidentiality of clinical records. Findings include: An agency policy titled "Timely Submission of Patient Documentation," dated 1/2018, stated, " ...all visit reports ... must be submitted the next scheduled work day ... not exceeding three (3) business days ...." On 2/23/21 at 11:55 AM, a box of documents was observed in a plastic tote with no lid (known to the staff as the tickler file), that contained patient information sitting on the floor that could be seen from the doorway, in Scheduler G's office. Patient names could be visualized from the door. The surveyor also observed a stack of papers scheduler G removed from the top left side drawer of her desk, that was unlocked. That stack of papers was reviewed which contained patient 9's aide visit documentation. Simultaneously, scheduler G was asked if the documents in their office were turned in the day before. She stated, "No, I hold these for two (2) weeks before filing into the 'tickler' file. 17-12-3(b)(2)(E)	G 438		
G 478	Investigate complaints made by patient CFR(s): 484.50(e)(1)(i) (i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics: This Element is not met as evidenced by: Based on record review and interview, the agency	G 478		

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G 478	Continued From page 11 failed to investigate and document complaints for 3 of 3 patient complaints reviewed (#4, 11, 12). Findings include: 1. An agency policy dated 1/2018 and titled "Complaint Resolution," Policy #11 stated " ...All staff members are empowered to take a complaint, document it (using the Complaint Report Form), and report it to the Director of Nursing (Clinical Manager) ... the Director of Nursing (Clinical Manager) will forward the complaint to Compliance Officer ... Compliance Officer will acknowledge receipt of the complaint by contacting the complainant directly (within 24 hours) ... Next, he/she will investigate and if possible, resolve problems revealed by complaints from patient ... the agency is to initiate a complaint investigation with[sic] 7 business days of the agencies receipt of the complaint and document all the components of the investigation ... within 10 days, the agency provides written notification to the patient/family of the results of its' investigation and response ... Compliance Office is responsible for the system of complaint management including actions taken and responses or outcomes ... patient will be informed of follow up action with exception of disciplinary action ... follow up regarding the patient's response to the resolution is documented for further tracking ... from trends, root causes are determined and actions taken to prevent recurrence ... Compliance Office completes report monthly, that summarizes all complaints by type and number ... actions and resolutions of these complaints is presented for review at QAPI Committee meetings ...." 2. An agency complaint reviewed from the complaint log on 7/6/2020 regarding patient #4	G 478		

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G 478	Continued From page 12 indicated " ...Patient's daughter for Patient #4 did mention during a Care Coordination Meeting about the Nurses had given the Patient the wrong insulin ... Patient was discharged 6/26/2020 ... [Employee H], RNCM (registered nurse case manager) resumed patient back to service Friday 7/3 per physician orders after been on hold due to COVID-19 19 Case Positive per CDC protocol ... upon resumption one of the insulins was not picked up from pharmacy yet and RNCM advised and encouraged husband of patient strongly that insulin is needed, Family promised to pick up 2nd insulin ordered from pharmacy ... [Employee H] ended up giving available insulin in the home ... patient has two types of insulin ... one with every meal which the one that was not picked up and the 2nd one is due only morning and nighttime, which was the one that was administered by [Employee H] ... 12 noon visit [Employee I] came for blood sugar check and insulin administration, Husband and Son were not home during this visit, [Employee I] administered the insulin that was available in the refrigerator, which is the old insulin that patient had always gotten before Hospital Admission as the new 2nd insulin had still not been picked up ... thereby administrating the wrong insulin as the ordered insulin has not been picked up yet and still not available in the home for the nurse to administer ...." Employee J (former Clinical Manager) made contact with Employee H (registered nurse case manager) and Employee I (registered nurse) and had a meeting to discuss and educate them on medication errors, effective communication, and handing off report for resumed patients and new admits. Employee J listed the resolution as asking the family to administer insulin by themselves, making the nurses notify the family of their blood sugar reading at every visit, and educating clients on medication administration	G 478		

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G 478	Continued From page 13	G 478		

and the need to pick up medication from pharmacy in a timely manner. The complaint failed to evidence a thorough complaint investigation evidenced by staff interviews or education regarding the areas of concerns per complaint, no other patients with same nurses who cared for them were interviewed to see if systemic problems existed.

3. An agency complaint reviewed from the complaint log on 12/21/2021 regarding patient #11 indicated " ...On 12/18/2020, the Director of Nursing at [Entity F] advised that a Home Health Aide who had worked for patient #11 had been stealing from the patient and had been accused by the family of the patient, of the alleged theft ... no further details were provided ...investigation pursed and revealed that limited information is available ... Employee C [Alternate Clinical Manager] visited [Entity F] and spoke with Director of Nursing ... no additional details were given in person ... possible home health aide is no longer employed ...." The complaint failed to evidence a thorough complaint investigation evidenced by staff interviews or education regarding the areas of concerns per complaint, no other patients with same aides who cared for them were interviewed to see if systemic problems existed.

4. An agency complaint reviewed from the complaint log on 5/28/2019 regarding patient #12 indicated " ...nephew of Patient #12 called office ... allegations were that [Employee X] has been accepting money from ... [patient] ... she takes him to the bank every month after he receives his monthly check and he gives her $180.00 ... she always tells him how bad she and her family are doing, so [patient] feels sorry for her and was giving her money to help her out ... he also states

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G 478	Continued From page 14 [Employee X] may be stealing his pain medicine too ... he states he saw her standing around ... [patient's] medications ... [Former Employee N] ... went to pharmacy to confirm medications had been picked up ... [Employee I] who does medication set ups for patient, confirmed that no medications were missing ... [Employee X] confirmed, in office, that she never accepted any money from Patient #12 ... Patient #12 was interviewed again and confirmed allegations had been going on for 6 to 8 months ... employee was suspended for 7 days pending results from investigation ... employee was required to go to [walk in clinic] for drug test on the same day and the results were negative ... employee was requested to come into office on 6/5/2019 and 6/7/2019 and did not report to office ... employee was terminated 6/7/2019 via letter ...." The complaint failed to evidence a thorough complaint investigation evidenced by staff or interviews with other patients with same staff who cared for them to see if systemic problems existed. 5. During an interview on 2/22/21 at 10:31 AM, when asked what the process for complaint intake was, the administrator, stated if complaints were received at night, scheduler G took them, the Case Manager would visit with the family and fill out form the next day. When asked if the administrator signed off on all complaints, she stated "I get a copy of all complaints, but I do not sign them, just get a copy of all of them."	G 478		
G 510	Comprehensive Assessment of Patients CFR(s): 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA	G 510		

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G 510	Continued From page 15 must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. This Condition is not met as evidenced by: Based on observation, record review, and interview, the registered nurse (RN) failed to ensure the comprehensive assessment contained the patient's current health status (See Tag G528); failed to evidence the patient's continuing need for home care (See Tag G532); failed to ensure the comprehensive assessment included individualized medical, nursing, rehabilitative, social, and discharge planning needs (See Tag G534); failed to ensure the comprehensive assessment contained a complete review of medications, drug interactions were identified, and the medication list was maintained (See Tag G536); failed to identify availability of caregiver assistance (See Tag G538); failed to ensure comprehensive assessments included up to date information (See Tag G544); and failed to ensure all necessary medical information was sent during a discharge or transfer (See Tag G564). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.55 Comprehensive Assessment.	G 510		
G 528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This Element is not met as evidenced by: Based on record review and interview, the comprehensive assessment failed to contain all information about the current health status for 1 of 10 records reviewed (#3).	G 528		

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G 528	Continued From page 16 Findings include: A policy titled "Medical Record Content," dated, 1/2018, stated, " ...The agency will provide an accurate and current medical record for every patient seen by the agency ..." The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for the certification period 10/20/2020 to 12/18/2020 that indicated diagnoses of, but not limited to, type two diabetes mellitus with diabetic neuropathic arthropathy (insufficient production of insulin causing high blood sugar with subsequent decreased sensation in the joints), hyperlipidemia (elevated cholesterol blood level), essential primary hypertension (a form of hypertension that by definition has no identifiable secondary cause), and chronic kidney disease (gradual loss of kidney function). An untitled document obtained from Entity B (patient's primary care provider), dated 2/3/2021 indicated the patient had a history of a kidney transplant. The comprehensive assessment failed to identify the patient ever had a transplant or what type. During an interview on 3/1/21 at 3:09 PM, when asked if the comprehensive assessment should have missing or incorrect information, Employee B (Clinical Supervisor) stated, "I would hope not. I mean I can't say that for every one of them but I would hope not. The computer program should catch it."	G 528		
G 532	Continuing need for home care CFR(s): 484.55(c)(3) The patient's continuing need for home care;	G 532		

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G 532	Continued From page 17 This Element is not met as evidenced by: Based on observation, record review, and interviewx, the agency failed to ensure the comprehensive assessment contained the patient's continuing need for home care in 2 of 3 home visits observed (#1, 3). Findings include: 1. An agency policy dated 1/2015 and titled "Discharge Planning," Policy #35 stated " ...The agency will assess each patient's discharge planning and/or continuing care needs on an ongoing basis and will involve the physician, the patient and the caregiver if appropriate, in the planning process ...." 2. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated diagnoses of, but not limited to, Lymphedema (swelling that generally occurs in one of your arms or legs), cellulitis of the right lower limb (a bacterial skin infection), osteoarthritis (wearing down of cartilage occurs gradually and worsens over time), morbid obesity (100 pounds over ideal body weight, a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes), and idiopathic aseptic necrosis of right femur (a bone condition that results from poor blood supply to an area of bone, causing localized bone death). Under the section titled "Orders/Interventions for Services & Treatments (Specify Amount/Frequency/Duration)", " ...Lift patient with a two-assist technique ..." is listed. A home visit observation was conducted with	G 532		

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Employee K (Registered Nurse) and Employee L (Registered Nurse) on 2/25/21 at 9:00 AM, with patient #1. The patient was observed to be able to wheel self in her wheelchair. The patient was able to walk approximately 10 feet from wheelchair to her bed with the assistance of a walker. The two nurses were observed helping the patient into bed, while only was one needed to assist, as patient was able to offer assistance.

A recertification comprehensive assessment completed on 2/5/21 indicated on page 16 of 20, M1840 indicated the patient was "able to get to and from the toilet and transfer independently with or without a device." On the same page, M1850 indicated the patient was "able to bear weight and pivot during the transfer process but unable to transfer self." On the same page, M1860 indicated patient was "chairfast, unable to ambulate but is able to wheel self independently." The comprehensive assessment failed to accurately assess the patient's need for two nurses for care, as ordered by the plan of care.

3. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for the certification period 10/20/2020 to 12/18/2020 that indicated diagnoses of, but not limited to, type two diabetes mellitus with diabetic neuropathic arthropathy (insufficient production of insulin causing high blood sugar with subsequent decreased sensation in the joints), hyperlipidemia (elevated cholesterol blood level), essential primary hypertension (a form of hypertension that by definition has no identifiable secondary cause), and chronic kidney disease (gradual loss of kidney function). The plan of care also stated, under "Medications: Dose/Frequency/Route", " ...Lantus [a long-acting insulin used to treat adults

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G 532	Continued From page 19 with type 2 diabetes and adults] effective 2/28/2018 ... 10 units ... bedtime ... Subcutaneous [injection applied under the skin] ...." The plan of care went on to state, under the section titled "Order/Interventions for Services & Treatments," " ...Skilled Nurse Visit Orders to monitor blood glucose levels twice daily ... administer insulin ...." The same document also stated, " ...Home Health Aide frequency is 6 hrs [hours]/day for 7 days/week ... HHA [home health aide] to help with ambulation within pt's [patient's] own residence ... patient is diabetic ... requires help with blood glucose monitoring ...." An untitled document obtained from Entity B (patient's primary care provider), dated 2/3/2021, under a section titled "Current Medication," indicated patient no longer took Lantus and it was not currently ordered. The same document also stated the patient's hemoglobin A1C (a blood test that measures average blood glucose, or blood sugar, level over the past 3 months) was 5.4%, indicating patient is non-diabetic, according to the test range of under 5.7%. A home visit observation was conducted with Employee M (Home Health Aide) on 2/24/21 at 8:00 AM. The patient was observed needing only verbal cues when completing transfers and activities of daily living. During an interview with patient #3, when asked how often a skilled nurse visits and what he/she does while there, the patient indicated they were supposed to come daily to do vitals and blood sugars twice a day. A recertification comprehensive assessment completed on 2/15/2021. The section titled "Functional Limitations (485-18A)," was left blank.	G 532		

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G 532	Continued From page 20 Under the section, "Goals," the assessment states, " ...Client is legally blind and did have history of stroke with left sided weakness ...." M1850 indicates patient was able to transfer from bed to chair, with minimal human assistance or with the use of an assistive device. Letter E, under section GG0170, indicated the patient could independently transfer from bed to a chair. The assessment failed to accurately assess the patient's continuing need for home care. 4. During an interview on 3/1/21 at 3:09 PM, when asked if the comprehensive assessment should reflect the patient's skilled need, Employee B (Clinical manager) indicated that it should. When asked if the plan of care should be revised to reflect the patient's skilled need, Employee B stated, "oh absolutely."	G 532		
G 534	Patient's needs CFR(s): 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; This Element is not met as evidenced by: Based record review and interview, the home health agency failed to ensure they had a comprehensive assessment policy and that agency comprehensive assessments included individualized medical, nursing, rehabilitative, social, and discharge planning needs for 10 of 10 records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10). Findings include: 1. An agency policy dated 1/2015 and titled "Discharge Planning," Policy #35 stated " ...The agency will assess each patient's discharge planning and/or continuing care needs on an ongoing basis and will involve the physician, the patient and the caregiver if appropriate, in the	G 534		

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G 534	Continued From page 21 planning process ...." 2. A policy titled "Medical Record Content," dated, 1/2018, stated, " ...The agency will provide an accurate and current medical record for every patient seen by the agency ..." 3. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated a primary diagnosis of Lymphedema (swelling that generally occurs in one of your arms or legs). The clinical record included a comprehensive recertification assessment, completed on 2/5/2021, by Employee L (Registered Nurse). The comprehensive assessment included a section titled, "Rehab Potential/Discharge Plans," which stated, " ...Discharge ... when patient functions without agency assistance. ..." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharge with rationale. 4. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated a primary diagnosis of excoriation disorder (habitually and excessively picking, scratching, gouging or squeezing at otherwise healthy skin). The clinical record included a comprehensive recertification assessment, completed on 12/26/2020, by Employee L (Registered Nurse). The comprehensive assessment included a section titled, "Rehab Potential/Discharge Plans," which stated, " ...Discharge ... when patient functions without	G 534		

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G 534	Continued From page 22 agency assistance ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharge with rationale. 5. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for the certification period 2/17/2021 to 4/17/2021 that indicated a primary diagnosis of type two diabetes mellitus with diabetic neuropathic arthropathy (insufficient production of insulin that causing high blood sugar with subsequent decreased sensation in the joints). The clinical record included a comprehensive recertification assessment, completed on 2/15/2021, by Employee C (Registered Nurse). The comprehensive assessment included a section titled, "Rehab Potential/Discharge Plans," which stated, " ...Discharge ... when patient functions without agency assistance ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharge with rationale. An untitled document obtained from Entity B (patient's primary care provider), dated 2/3/2021, under a section titled "Current Medication," indicates patient no longer takes Lantus and it is not currently ordered. The same document also states the patient's hemoglobin A1C (a blood test that measures average blood glucose, or blood sugar, level over the past 3 months) was 5.4%, indicating patient is non-diabetic, according to the test range of under 5.7%. The same document went on to indicate, in a section titled, "Surgical History," that the patient had a history of a kidney transplant. The comprehensive assessment failed	G 534		

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G 534	Continued From page 23 to identify nursing or medical needs related to having a history of organ transplant and no longer having a primary diagnosis of type two diabetes. 6. The clinical record of patient #4 was reviewed on 2/23/21 and indicated a start of care date of 5/14/2020. The record contained a plan of care for the certification period 5/14/2020 to 7/12/2020 that indicated a primary diagnosis of type two diabetes mellitus (insufficient production of insulin causing high blood sugar). The clinical record included a comprehensive recertification assessment, completed on 7/3/2020, by Employee H (Registered Nurse). The comprehensive assessment included a section titled, "Rehab Potential/Discharge Plans," which stated, " ...Discharge ... when patient functions without agency assistance ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharge with rationale. 7. The clinical record of patient #5 was reviewed on 2/23/21 and indicated a start of care date of 4/24/2015. The record contained a plan of care for the certification period 4/3/2019 to 6/1/2019 that indicated a primary diagnosis of type two diabetes mellitus (insufficient production of insulin causing high blood sugar). The clinical record included a comprehensive recertification assessment, completed on 4/2/2019, by Employee C (Registered Nurse). The comprehensive assessment included a section titled, "Rehab Potential/Discharge Plans," which stated, " ...Discharge ... when patient functions without agency assistance ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be	G 534		

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G 534	Continued From page 24 discharge with rationale. 8. The clinical record of patient #6 was reviewed on 2/23/21 and indicated a start of care date of 5/31/2019. The record contained a plan of care for the certification period 11/21/2020 to 1/19/2021 that indicated a primary diagnosis of chronic obstructive pulmonary disease (a group of progressive lung disorders characterized by increasing breathlessness). The clinical record included a comprehensive recertification assessment, completed on 11/19/2020, by Employee C (Registered Nurse). The comprehensive assessment included a section titled, "Rehab Potential/Discharge Plans," which stated, " ...Discharge ... when patient functions without agency assistance ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharge with rationale. 9. The clinical record of patient #7 was reviewed on 2/23/21 and indicated a start of care date of 10/20/2020. The record contained a plan of care for the certification period 12/19/2020 to 2/16/2021 that indicated a primary diagnosis of bipolar disorder (serious mental illness characterized by extreme mood swings). The clinical record included a comprehensive recertification assessment, completed on 12/17/2020, by Employee L (Registered Nurse). The comprehensive assessment included a section titled, "Rehab Potential/Discharge Plans," which stated, " ...Discharge ... when patient functions without agency assistance ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharge with rationale.	G 534		

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G 534	Continued From page 25 10. The clinical record of patient #8 was reviewed on 2/3/21 and indicated a start of care date of 3/27/2019. The record contained a plan of care for the recertification period 1/15/2021 to 3/15/2021 that indicated a primary diagnosis of quadriplegia (paralysis of all four limbs). The clinical record included a comprehensive recertification assessment, completed on 1/14/2021, by Employee H (Registered Nurse). The comprehensive assessment included a section titled, "Rehab Potential/Discharge Plans," which stated, " ...Discharge ... when patient functions without agency assistance ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharge with rationale. 11. The clinical record of patient #9 was reviewed on 2/23/21 and indicated a start of care date of 7/6/2017. The record contained a plan of care for the recertification period of 2/15/2021 to 4/15/2021 that indicated a primary diagnosis of unspecified mood disorder (affective disorders are a set of psychiatric diseases). The clinical record included a comprehensive recertification assessment, completed on 2/11/2021, by Employee H (Registered Nurse). The comprehensive assessment included a section titled, "Rehab Potential/Discharge Plans," which stated, " ...Discharge ... when patient functions without agency assistance ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharge with rationale. 12. The clinical record of patient #10 was reviewed on 2/23/21 and indicated a start of care	G 534		

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G 534	Continued From page 26 date of 7/9/2020. The record contained a plan of care for the recertification period of 1/5/2021 to 3/5/2021 that indicated a primary diagnosis of hemiplegia following cerebral infarction affecting right dominant side (area of necrotic tissue in the brain from a blockage or narrowing in the arteries supplying blood and oxygen to the brain resulting in paralysis of one side of the body). The clinical record included a comprehensive recertification assessment, completed on 1/4/2021, by Employee C (Registered Nurse). The comprehensive assessment included a section titled, "Rehab Potential/Discharge Plans," which stated, " ...Discharge ... when patient functions without agency assistance ...." The comprehensive assessment failed to evidence thorough and individualized discharge planning, which included if/when the patient could be discharge with rationale. 13. During an interview on 3/1/21 at 3:09 PM, when asked if the comprehensive assessment should reflect the patient's skilled need, Employee B (Clinical manager) indicated that it should. 17-14-1(a)(1)(B)	G 534		
G 536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This Element is not met as evidenced by: Based on observation, record review, and interview, the registered nurse (RN) failed to ensure the comprehensive assessment contained	G 536		

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G 536	Continued From page 27 a complete review of medications, drug interactions were identified, and the medication list was maintained for 10 of 10 records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10). Findings include: 1. An policy dated 1/2018, titled, "Medication Administration," policy #147, stated, " ...Agency staff will check all patient medicines to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, and contraindicated medication and report any problems to the physician ... patient will be assessed and reassessed on an ongoing basis for medication effectiveness and actual or potential drug related problems ... staff will use information from medication monitoring to assess the medication's continued administration and will communicate medication findings to patient's physician and other appropriate staff ... prior to the administration of any medication by any route, the nurse will verify ... no contraindications ... any unresolved, significant concerns about medications will be discussed by the nurse with the patient's physician and appropriate staff ..." A policy dated 1/2018, titled, "Medication Profile," policy #182, stated, " ...Comprehensive assessment (OASIS) performed at the time of admission includes a review of all medications that the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicative drug therapy and noncompliance with drug therapy ... The nurse will add all new/changed medication(s) to the medication profile ... Discontinued ("D/C") medications will be documented and dated ... The medication profile will be reviewed every	G 536		

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G 536	Continued From page 28 home visit and updated as changes occur ....' 2. A policy dated 1/2018, titled, "Medication Reconciliation," policy #154, stated, " ...The medication list/profile will be updated with each new or changed medication ... The patient's medication list in the home will also be updated ...." A policy titled "Medical Record Content," dated, 1/2018, stated, " ...The agency will provide an accurate and current medical record for every patient seen by the agency ..." 3. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 2/9/21 to 4/9/21 that indicated a primary diagnosis of Lymphedema (swelling that generally occurs in one of your arms or legs). The record failed to evidence it contained a complete review of medications, drug interactions were identified, and the medication list was maintained as evidenced by: The record included a "Patient Medication Sheets [sic]", reviewed and signed by former Employee N (former Clinical manager) on 12/29/2020. The medication list included orders for, but not limited to, "Rivaroxaban [blood thinner for prevention of blood clots] ... Vitamin D3 [supplement] ... Hydrocodone-Acetaminophen [pain medicine] ... Losartan Potassium [taken to treat high blood pressure] ... metformin [taken to treat type 2 diabetes] ... Nystatin [treats fungal infections] ... cyclobenzaprine hydrochloride [muscle relaxant designed to relieve pain and discomfort related to muscle spasms] ... furosemide [treat fluid retention] ... Bupropion hydrochloride XL [antidepressant] ...." No evidence of a drug regimen review was included.	G 536		

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G 536	Continued From page 29 A comprehensive recertification assessment, completed on 2/5/2021, by Employee L (Registered Nurse). No evidence of a drug regimen review was included. On 2/25/21 at 10:00 AM, during a home visit with patient #1, the home folder was observed and found to have a medication list dated 2/24/21, signed by Employee K (Registered Nurse). The medication list in the patient's folder was compared to the most current medication list provided in the clinical record and was found to be inaccurate. The medications taken by the patient, as reported by the patient, proved 2/24/21 list to be inaccurate. The patient stated, "I take the ones in the drawer." Upon observation of the area the patient was referencing, the medications Rivaroxaban, Vitamin D3, Hydrocodone-Acetaminophen, Losartan, Metformin, Bupropion, Bumetanide, Cholecalciferol, and Tizanidine were observed. On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed major interactions with bupropion and hydrocodone, bumetanide and tizanidine, hydrocodone and tizanidine, and losartan and tizanidine. 4. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated a primary diagnosis of excoriation disorder (habitually and excessively picking, scratching, gouging or squeezing at otherwise healthy skin). The record failed to evidence it contained a complete review of medications, drug interactions were identified, and the medication	G 536		

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G 536	Continued From page 30 list was maintained as evidenced by: The record included a "Patient Medication Sheets [sic]", reviewed and signed by former Employee N (former Clinical manager) on 11/11/2020. The medication list included orders for, but not limited to, "Flomax [used to improve urination in men with enlarged prostate] ... Norvasc [treats high blood pressure] ... Vitamin C [supplement] ... Metoprolol Tartrate [treats high blood pressure] ... ammonium lactate [used to treat dry, scaly, itchy skin] ... Eliquis [lower the risk of stroke or a blood clot] ... Prozac [antidepressant] ... Claritin [treats allergy symptoms] ... Singular [treats allergy symptoms] ... Hydroxyzine [treats anxiety, nausea, vomiting, allergies, skin rash, hives, and itching] ... Vitamin B-12 [supplement] ... Ferrous Sulfate [iron deficiency anemia] ...." No evidence of a drug regimen review was included. A comprehensive recertification assessment, completed on 12/26/2020, by Employee L (Registered Nurse). No evidence of a drug regimen review was included. On 2/25/21 at 2:00 PM, during a home visit with patient #2, the home folder was observed and found to have a medication list dated 2/24/21, signed by Employee K (Registered Nurse). The medication list in the patient's folder was compared to the most current medication list provided in the clinical record and was found to be inaccurate. The medications taken by the patient, as reported by the patient, proved 2/24/21 list to be inaccurate as well. The patient stated, "I take the ones they send to me." Upon observation of the area the patient was referencing, Metoprolol, Prozac, Norvasc, Hydroxyzine, Eliquis, Vitamin C, Claritin, and Singular were found.	G 536		

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G 536	Continued From page 31 On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed moderate interactions for Metoprolol and Prozac, Metoprolol and Norvasc, Prozac and Norvasc, Metoprolol and Hydroxyzine, Prozac and Hydroxyzine, Prozac and Eliquis, and Norvasc and Eliquis. 5. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for the certification period 2/17/2021 to 4/17/2021 that indicated a primary diagnosis of type two diabetes mellitus with diabetic neuropathic arthropathy (insufficient production of insulin that causing high blood sugar with subsequent decreased sensation in the joints). The record failed to evidence it contained a complete review of medications, drug interactions were identified, and the medication list was maintained as evidenced by: The same plan of care included medication order for, but not limited to, " ...Memantine [treats dementia associated with Alzheimer's disease] ... Norvasc [treats high blood pressure], Doxazosin [treats high blood pressure] ... Acetaminophen [treats pain] ... Carbatrol [treat seizures, nerve pain, and bipolar disorder] ... Donepezil [treats Alzheimer's Disease] ... Famotidine [treats ulcers, gastroesophageal reflux disease, and excess stomach acid] ... Magnesium [supplement] ... Plavix [blood thinner] ... Janumet [treats diabetes] ... Allegra [treats allergy symptoms] ... Clonidine [treats high blood pressure] ... Lantus [treats diabetes], Aspirin [treats pain and reduces the risk of heart attack] ... Dilantin [treats and prevents seizures] ... Mycophenolate Mofetil [immunosuppressant] ...	G 536		

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G 536	Continued From page 32 Tacrolimus [immunosuppressant] ... Vitamin D [supplement] ... Fluphenazine [treats schizophrenia] ....' The clinical record included a comprehensive recertification assessment, completed on 2/15/2021, by Employee C (Registered Nurse). No evidence of a drug regimen review was included. On 2/24/21 at 8:00 AM, during a home visit with patient #3, the home folder was observed and found to have a medication list dated 2/24/21. The medication list in the patient's folder was compared to the most current medication list provided in the clinical record and was found to be inaccurate. The medications taken by the patient, as reported by the patient, proved 2/24/21 list to be inaccurate as well. The patient indicated he no longer took insulin for over a year now, when asked if he took a sliding scale insulin based on his blood sugar. On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed major interactions for Carbatrol and Norvasc, Dilantin and Norvasc, Carbatrol and Tacrolimus, and Dilantin and Tacrolimus. An untitled document obtained from Entity B (patient's primary care provider), dated 2/3/2021, under a section titled "Current Medication," indicated patient no longer took Lantus and it was not currently ordered. The medication list from Entity B also included medications that are not on the most recent plan of care. 6. The clinical record of patient #4 was reviewed on 2/23/21 and indicated a start of care date of 5/14/2020. The record contained a plan of care	G 536		

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G 536	Continued From page 33 for the certification period 7/13/2020 to 9/10/2020 that indicated a primary diagnosis of type two diabetes mellitus (insufficient production of insulin causing high blood sugar). The record failed to evidence it contained a complete review of medications, drug interactions were identified, and the medication list was maintained as evidenced by: The record included a "Patient Medication Sheets [sic]", reviewed and signed by former Employee N (former Clinical Manager) on 5/22/2020. The medication list included orders for, but not limited to, " ...Lantus [treats diabetes] ... Hydrocodone-acetaminophen [treats pain] ... Hydroxyzine [Hydroxyzine [treats anxiety, nausea, vomiting, allergies, skin rash, hives, and itching] ... Januvia [treats type two diabetes] ... Ketoconazole [treats fungal skin infections] ... Levothyroxine [treats low thyroid] ... Magnesium [supplement] ... Metoprolol [treats high blood pressure] ... Metoclopramide [treats gastroesophageal reflux disease and gastroparesis in patients with diabetes] ... Mupirocin [treat skin infections] ... Myrbetriq [treats overactive bladder] ... Narcan [treats narcotic overdose in an emergency situation] ... Neomycin [treats and prevents infection in minor cuts, scrapes, or burns] ... Omeprazole [treats heartburn, a damaged esophagus, stomach ulcers, and gastroesophageal reflux disease] ... Ondanestron [prevents nausea and vomiting] ... Oxybutynin chloride [treats overactive bladder] ... Pravastatin [treat high cholesterol and triglyceride levels] ... Restore Cleaner & Moisturizer [wound cleaning] ... Torsemide [treats fluid retention] ... Triamcinolone acetonide [treats various skin conditions] ... Vitamin D [supplement] ...." No evidence of a drug regimen review was included.	G 536		

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A document titled, "Discharge Summary," from Entity C [coronary intensive care unit], contains a medication list including order for, but not limited to, " ...Vitamin C [supplement] ... Lantus ... insulin lispro [treats diabetes] ... Zinc gluconate [supplement] ... polyethylene glycol [treats constipation] ... Eliquis [lower the risk of stroke or a blood clot] ... Aspirin [[treats pain and reduces the risk of heart attack] ... Cetirizine hydrochloride [treat hay fever and allergy symptoms, hives, and itching] ... Levothyroxine ... Metoclopramide [treats gastroesophageal reflux disease and gastroparesis in patients with diabetes] ... Paroxetine [treat depression, anxiety disorders, obsessive-compulsive disorder, and premenstrual dysphoric disorder] ... Pravastatin ... Tramadol [treats pain] ... albuterol [prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease] ... Budesonide [treats asthma when inhaled] ... Vitamin D ... Metoprolol ... Mupirocin ... Omeprazole ... Oxybutynin ...." The medications included on the list do not match the plan of care medications ordered after hospitalization.

The clinical record included a comprehensive resumption of care assessment, completed on 7/3/2020, by Employee H (Registered Nurse). No evidence of a drug regimen review was included.

The clinical record included a comprehensive recertification assessment, completed on 7/9/2020, by Employee H (Registered Nurse). No evidence of a drug regimen review was included.

The plan of care for certification period 7/13/2020 to 9/10/2020, contained a medication list including order for, but not limited to, " ...Lantus

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G 536	Continued From page 35 ... Insulin Lispro ... Polygethylene Glycol ... Vitamin C ... Zinc Gluconate ... Eliquis ... Albuterol ... Budesonide ... Cephalexin [treat infections] ... Duloxetine Hydrochloride [treats depression, anxiety, diabetic peripheral neuropathy, fibromyalgia, and chronic muscle or bone pain] ... Fluticasone Propionate [treats hay fever and nasal polyps] ... Fluticasone Salmeterol [prevent and treat wheezing, shortness of breath, coughing, and chest tightness caused by chronic obstructive pulmonary disease] ... Hydrocodone-acetaminophen ... Hydroxyzine ... Januvia ... Ketoconazole ... Levothyroxine ... Magnesium ... Metoprolol ... Metoclopramide ... Mupirocin ... Myrbetriq ... Narcan ... Neomycin ... Omeprazole ... Ondanestron ... Oxybutynin chloride ... Pravastatin ... Restore Cleaner & Moisturizer ... Torsemide ... Triamcinolone Acetonide ... Vitamin D ... Metronidazole [treats various infections] ...." On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed major interactions for Ketoconazole and Triamcinolone, Ketoconazole and Fluticasone, Ketoconazole and Hydrocodone-Acetaminophen, Hydroxyzine and Hydrocodone-Acetaminophen, Neomycin and Torsemide, Ketoconazole and Fluticasone-Salmeterol, Ketoconazole and Budesonide, Ondansetron and Duloxetine, and Ketoconazole and Eliquis. 7. The clinical record of patient #5 was reviewed on 2/23/21 and indicated a start of care date of 4/24/2015. The record contained a plan of care for the certification period 4/3/2019 to 6/1/2019 that indicated a primary diagnosis of type two diabetes mellitus (insufficient production of insulin	G 536		

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causing high blood sugar). The record failed to evidence it contained a complete review of medications, drug interactions were identified, and the medication list was maintained as evidenced by:

The clinical record included a comprehensive recertification assessment, completed on 4/2/2020, by Employee C (Registered Nurse). No evidence of a drug regimen review was included.

The plan of care included orders of medications for, but not limited to, " ...Tretinoin [treats acne and other skin conditions] ... Crestor [treats high cholesterol and triglyceride levels] ... Hydrocodone-Acetaminophen [pain medicine] ... cyclobenzaprine hydrochloride [muscle relaxant designed to relieve pain and discomfort related to muscle spasms] ... Ibuprofen [treats fever and mild to severe pain] ... Vitamin C [supplement] ... Adderall [treats the symptoms of hyperactivity and for impulse control] ... Vitamin D3 [supplement] ... Ferrous Sulfate [iron deficiency anemia] ... Lisinopril [treats high blood pressure] ... Viibryd [treats depression] ...." On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed major interactions between Cyclobenzaprine and Hydrocodone-Acetaminophen, Adderall and Viibryd, and Cyclobenzaprine and Viibryd.

8. The clinical record of patient #6 was reviewed on 2/23/21 and indicated a start of care date of 5/31/2019. The record contained a plan of care for the certification period 11/21/2020 to 1/19/2021 that indicated a primary diagnosis of chronic obstructive pulmonary disease (a group of progressive lung disorders characterized by increasing breathlessness). The record failed to

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G 536	Continued From page 37 evidence it contained a complete review of medications, drug interactions were identified, and the medication list was maintained as evidenced by: The clinical record included a comprehensive recertification assessment, completed on 11/19/2020, by Employee L (Registered Nurse). No evidence of a drug regimen review was included. The plan of care included orders of medications for, but not limited to, " ...Gabapentin [treats nerve pain] ... Amitriptyline [treats nerve pain and depression] ... Atorvastatin [treats high cholesterol and triglycerides] ... Clopidogrel [blood thinner] ...." On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed moderate interactions between Amitriptyline and Gabapentin and Atorvastatin and Clopidogrel. 9. The clinical record of patient #7 was reviewed on 2/23/21 and indicated a start of care date of 10/20/2020. The record contained a plan of care for the certification period 12/19/2020 to 2/16/2021 that indicated a primary diagnosis of bipolar disorder (serious mental illness characterized by extreme mood swings). The record failed to evidence it contained a complete review of medications, drug interactions were identified, and the medication list was maintained as evidenced by: The clinical record included a comprehensive recertification assessment, completed on 12/17/2020, by Employee L (Registered Nurse). No evidence of a drug regimen review was	G 536		

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G 536	Continued From page 38 included. The record included a "Patient Medication Sheets [sic]", reviewed and signed by former Employee N (former Clinical Manager) on 12/30/2020. The medication list included orders for, but not limited to, " ...Acetaminophen [treats pain and fever] ... Albuterol Sulfate [prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease] ... Amlodipine [treat high blood pressure and chest pain] ... Ibuprofen [treats fever and mild to severe pain] ... Invega Sustenna [treats schizophrenia and schizoaffective disorder] ... Lamotrigine [treats seizures and bipolar disorder] ... Lisinopril [treats high blood pressure] ... Loratadine [treats allergy symptoms and hives] ... metformin [taken to treat type 2 diabetes] ... Mirtazapine [treats depression] ... Sucralfate [treats stomach ulcers] ... Vitamin D3 [supplement] ...." No evidence of a drug regimen review was included. The clinical record included a comprehensive recertification assessment, completed on 2/15/2021, by Employee L (Registered Nurse). No evidence of a drug regimen review was included. On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed moderate interactions between Ibuprofen and Norvasc, Ibuprofen and Lisinopril, Ibuprofen and Metformin, Sucralfate and Metformin, Lisinopril and Metformin, Albuterol and Metformin, Amlodipine and Invega Sustenna, Lisinopril and Invega Sustenna, Albuterol and Invega Sustenna, and Metformin and Invega Sustenna.	G 536		

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G 536	Continued From page 39 10. The clinical record of patient #8 was reviewed on 2/3/21 and indicated a start of care date of 3/27/2019. The record contained a plan of care for the recertification period 1/15/2021 to 3/15/2021 that indicated a primary diagnosis of quadriplegia (paralysis of all four limbs). The record failed to evidence it contained a complete review of medications, drug interactions were identified, and the medication list was maintained as evidenced by: The record included a "Patient Medication Sheets [sic]", reviewed and signed by former Employee N (former Clinical Manager) on 12/30/2020. The medication list included orders for, but not limited to, " ...Acetaminophen [treats pain and fever] ... Baclofen [muscle relaxer and treats spasms] ... Glycopyrrolate [reduces saliva] ... Guaifenesin [helps loosen congestion in your chest and throat, making it easier to cough] ... Pseudoephedrine [treats nasal congestion] ... Lyrica [treats fibromyalgia, diabetic nerve pain, spinal cord injury nerve pain, and pain after shingles in adult patient] ... Loratadine [treats allergy symptoms and hives] ... Scopolamine Transdermal Patch [prevents nausea and vomiting after anesthesia, narcotic pain medicines, and surgery] ... Famotidine [treats and prevents ulcers in the stomach and intestine] ... Polyethylene Glycol [laxative] ... Probiotic [supplement] ... Albuterol Sulfate [prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease] ... Colace [stool softener] ... Alprazolam [treats anxiety and panic disorders] ... Oxycodone [pain medicine] ... Flonase [treats allergy symptoms] ... Lidocaine [numbing medication] ... Levetireacetam [treats seizures]	G 536		

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G 536	Continued From page 40 ...." No evidence of a drug regimen review was included. The clinical record included a comprehensive recertification assessment, completed on 1/14/2021, by Employee H (Registered Nurse). No evidence of a drug regimen review was included. 11. On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed moderate reactions between Albuterol and Glycopyrrolate, Levetiracetam and Lyrica, Baclofen and Lyrica, Guaifenesin and Lyrica, Xanax and Lyrica, Albuterol and Polyethlene Glycol, Baclofen and Levetiraetam, Guaifenesin and Levetiracetam, Xanax and Levetriacetam, Scopolamine and Glycoprrolate, Xanax and Guaifenesin, Albuterol and Scopolamine, Dextromethorphan and Baclofen, Xanax and Baclofen, Albuterol and Pseudoephedrine, Famotidine and Albuterol, and Acetaminophen and Lidocaine. 12. The clinical record of patient #9 was reviewed on 2/23/21 and indicated a start of care date of 7/6/2017. The record contained a plan of care for the recertification period of 2/15/2021 to 4/15/2021 that indicated a primary diagnosis of unspecified mood disorder (affective disorders are a set of psychiatric diseases). The record failed to evidence it contained a complete review of medications, drug interactions were identified, and the medication list was maintained as evidenced by: The record included a "Patient Medication Sheets [sic]", reviewed and signed by former Employee N (former Clinical Manager) on 12/31/2020. The medication list included orders for, but not limited	G 536		

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G 536	Continued From page 41 to, " ...Gabapentin [treats nerve pain] ... Colace [stool softener] ... Mirtazapine [treats depression] ... Pantoprazole Sodium [treat gastroesophageal reflux disease and a damaged esophagus] ... Levothyroxine [treats low thyroid] ... Humulin [treats diabetes] ... Albuterol [prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease] ... Aspirin [treats pain and reduces the risk of heart attack] ... Insulin lispro [treats diabetes] ... Atorvastatin [treats high cholesterol and triglycerides] ... Anoro Ellipta [treats chronic obstructive pulmonary disease, including chronic bronchitis, emphysema, or both, for better breathing and to reduce the number of flare-ups] ... Carvedilol [treats high blood pressure and heart failure] ... Famotidine [treats ulcers, gastroesophageal reflux disease, and excess stomach acid] ... Tamsulosin [treats the symptoms of an enlarged prostate] ... Seroquel [treat schizophrenia, bipolar disorder, and depression] ... Divalproex Sodium [treats certain types of seizures (epilepsy)] ... Invega Sustenna [treats schizophrenia and schizoaffective disorder] ... Losartan Potassium Hydrochlorothiazide [treats high blood pressure and water retention] ... Losartan Potassium [taken to treat high blood pressure] ... Ventolin HFA [treat or prevent bronchospasm] ... Guaifenesin [thins mucus] ... Tussin [treats coughs and congestion] ...." No evidence of a drug regimen review was included. A document titled, "Encounter Summary - Progress Note," obtained from Entity D (patient's primary care provider), dated 1/13/2021, under a section titled "Medications," indicates patient had been prescribed "Cefdinir [treat a wide variety of bacterial infections]." There was no update to the	G 536		

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G 536	Continued From page 42 plan of care at this time. The clinical record included a comprehensive recertification assessment, completed on 2/11/2021, by Employee H (Registered Nurse). No evidence of a drug regimen review was included. On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed major interactions between Albuterol and Carvedilol and Carvedilol and Anoro Ellipta. 13. The clinical record of patient #10 was reviewed on 2/23/21 and indicated a start of care date of 7/9/2020. The record contained a plan of care for the recertification period of 1/5/2021 to 3/5/2021 that indicated a primary diagnosis of hemiplegia following cerebral infarction affecting right dominant side (area of necrotic tissue in the brain from a blockage or narrowing in the arteries supplying blood and oxygen to the brain resulting in paralysis of one side of the body). The record failed to evidence it contained a complete review of medications, drug interactions were identified, and the medication list was maintained as evidenced by: A partial (pages 1 - 4, and 6 - 11, of 142) document titled, "Ambulatory Referral to Home Health - Face to Face Encounter," obtained from Entity E (Hospital), dated 7/2/2020, under a section titled "Medications," indicates medication orders for, but not limited to, " ...Clonidine [treats high blood pressure] ... Ferrous Sulfate [treats iron deficiency anemia] ... furosemide [treat fluid retention] ... Hydralazine [treats high blood pressure] ... Isosorbide Dinitrate [treats heart failure, esophageal spasm, and chest pain] ...	G 536		

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G 536	Continued From page 43 polyethylene glycol [treats constipation] ... Prazosin [treats high blood pressure and urinary retention] ... Rivaroxaban [blood thinner] ... Senna [laxative] ... Spironolactone [treats high blood pressure and fluid retention] ...." The clinical record included a comprehensive recertification assessment, completed on 7/9/2020, by Employee L (Registered Nurse). No evidence of a drug regimen review was included. The clinical record failed to evidence a plan of care for the certification dates of 7/9/2020 to 9/6/2020. A document titled, "Face to Face Encounter," obtained from Entity F (Physician's Office specializing in Infectious Disease), dated 7/15/2020, under a section titled "Personal Patient Information Provided by Agency," stated, " ...Pt's most recent hospitalization and discharge from Entity E (Hospital) [6/24/2020 - 7/9/2020] was due to complaints of fever and weakness ... Pt (patient) had an extended stay due to bacteremia and sepsis ... Pt was subsequently discharged with a continuous infusion of antibiotic therapy ... Nafcillin 12 gm in 600 ml to be infused 24 hours at 25 ml/hr via a 7 cm (centimeter) PICC (peripherally inserted central catheter) line in the left brachial arm ..." Under the section titled, "Current Outpatient Medications on File Prior to Visit," contains medication orders for, but not limited to, " ...Aspirin [treats pain and reduces the risk of heart attack] ... Carvedilol [treats high blood pressure and heart failure] ... Ferrous Sulfate [treats iron deficiency anemia] ... Furosemide [treat fluid retention] ... Hydralazine [treats high blood pressure] ... Isosorbide Dinitrate [treats heart failure, esophageal spasm, and chest pain] ... Multivitamin [supplement] ...	G 536		

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G 536	Continued From page 44 Nitroglycerin [treats chest pain] ... Nafcillin [treats bacterial infections] ... Prazosin [treats high blood pressure and urinary retention] ... Topiramate [treats seizures and migraine headaches] ... Clonidine [treats high blood pressure] ... Tramadol [treats pain] ..." The agency failed to submit evidence of a plan of care, nor an updated plan of care for this certification period. The clinical record included a comprehensive recertification assessment, completed on 9/4/2020, by Employee L (Registered Nurse). No evidence of a drug regimen review was included. The record included a "Patient Medication Sheets [sic]", reviewed and signed by former Employee N (former Clinical Manager) on 9/9/2020. The medication list included orders for, but not limited to, " ...Acetaminophen [treats pain] ... Aspirin [treats pain and reduces the risk of heart attack] ... Atorvastatin [treats high cholesterol and triglycerides] ... Vitamin D3 [supplement] ... Ferrous Sulfate [treats iron deficiency anemia] ... Hydralazine [treats high blood pressure] ... Nitroglycerin [treats chest pain] ... Isosorbide Dinitrate [treats heart failure, esophageal spasm, and chest pain] ... Prazosin [treats high blood pressure and urinary retention] ... Rivaroxaban [blood thinner] ... Triamcinolone acetonide [treats various skin conditions] ... Clonidine [treats high blood pressure] ... Spironolactone [treats high blood pressure and fluid retention] ... Topiramate [treats seizures and migraine headaches] ... Carvedilol [treats high blood pressure and heart failure] ... Furosemide [treat fluid retention] ... Levothyroxine [treats low thyroid] ...." No evidence of a drug regimen review was included. The record included a "Patient Medication Sheets [sic]", reviewed and signed by former Employee N	G 536		

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(former Clinical Manager) on 11/13/2020. The medication list included orders for, but not limited to, " ...Acetaminophen [treats pain] ... Aspirin [treats pain and reduces the risk of heart attack] ... Atorvastatin [treats high cholesterol and triglycerides] ... Vitamin D3 [supplement] ... Ferrous Sulfate [treats iron deficiency anemia] ... Hydralazine [treats high blood pressure] ... Nitroglycerin [treats chest pain] ... Isosorbide Dinitrate [treats heart failure, esophageal spasm, and chest pain] ... Prazosin [treats high blood pressure and urinary retention] ... Rivaroxaban [blood thinner] ... Triamcinolone acetonide [treats various skin conditions] ... Clonidine [treats high blood pressure] ... Spironolactone [treats high blood pressure and fluid retention] ... Topiramate [treats seizures and migraine headaches] ... Carvedilol [treats high blood pressure and heart failure] ... Furosemide [treat fluid retention] ... Levothyroxine [treats low thyroid] ...." No evidence of a drug regimen review was included.

The clinical record included a comprehensive recertification assessment, completed on 1/4/2021, by Employee C (Registered Nurse). No evidence of a drug regimen review was included.

On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed major interactions between Aspirin and Rivaroxaban.

14. During an interview on 2/22/21 at 10:31 AM, when asked how a drug regimen review is done, Employee B (Clinical Manager), stated, "I usually go off the medication list from the hospital and verify with the pharmacy. I do my best to verify there are no duplicates."

15. During an interview on 2/23/21 at 5:00 PM,

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G 536	Continued From page 46 when asked if all recent documentation should be in the paper clinical chart, Employee B (Clinical Manager), stated, "I thought they had it all up to date, but I am finding out they don't. It should be." 17-14-1(a)(1)(B)	G 536		
G 538	Primary caregiver(s), if any CFR(s): 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; This Element is not met as evidenced by: Based on record review and interview, the agency failed to have a policy on comprehensive assessments, and the registered nurse (RN) failed to identify availability/schedules of caregiver assistance for 10 of 10 records reviewed with primary caregivers (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10). Findings include: 1. A policy titled "Medical Record Content," dated, 1/2018, stated, " ...The agency will provide an accurate and current medical record for every patient seen by the agency ..." 2. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 2/9/21 to 4/9/21 that indicated a primary diagnosis of Lymphedema (swelling that generally occurs in one of your arms or legs). A comprehensive recertification assessment, completed on 2/5/2021, by Employee L (Registered Nurse), which failed to evidence the primary caregiver's availability and schedule.	G 538		

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G 538	Continued From page 47 3. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated a primary diagnosis of excoriation disorder (habitually and excessively picking, scratching, gouging or squeezing at otherwise healthy skin). A comprehensive recertification assessment, completed on 12/26/2020, by Employee L (Registered Nurse), which failed to evidence the primary caregiver's availability and schedule. 4. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for the certification period 2/17/2021 to 4/17/2021 that indicated a primary diagnosis of type two diabetes mellitus with diabetic neuropathic arthropathy (insufficient production of insulin that causing high blood sugar with subsequent decreased sensation in the joints). The clinical record included a comprehensive recertification assessment, completed on 2/15/2021, by Employee C (Registered Nurse), which failed to evidence the primary caregiver's availability and schedule. 5. The clinical record of patient #4 was reviewed on 2/23/21 and indicated a start of care date of 5/14/2020. The record contained a plan of care for the certification period 7/13/2020 to 9/10/2020 that indicated a primary diagnosis of type two diabetes mellitus (insufficient production of insulin causing high blood sugar). The clinical record included a comprehensive resumption of care assessment, completed on 7/3/2020, by Employee H (Registered Nurse), which failed to evidence the primary caregiver's availability and schedule.	G 538		

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G 538	Continued From page 48 6. The clinical record of patient #5 was reviewed on 2/23/21 and indicated a start of care date of 4/24/2015. The record contained a plan of care for the certification period 4/3/2019 to 6/1/2019 that indicated a primary diagnosis of type two diabetes mellitus (insufficient production of insulin causing high blood sugar). The clinical record included a comprehensive recertification assessment, completed on 4/2/2020, by Employee C (Registered Nurse), which failed to evidence the primary caregiver's availability and schedule. 7. The clinical record of patient #6 was reviewed on 2/23/21 and indicated a start of care date of 5/31/2019. The record contained a plan of care for the certification period 11/21/2020 to 1/19/2021 that indicated a primary diagnosis of chronic obstructive pulmonary disease (a group of progressive lung disorders characterized by increasing breathlessness). The clinical record included a comprehensive recertification assessment, completed on 11/19/2020, by Employee L (Registered Nurse), which failed to evidence the primary caregiver's availability and schedule. 8. The clinical record of patient #7 was reviewed on 2/23/21 and indicated a start of care date of 10/20/2020. The record contained a plan of care for the certification period 12/19/2020 to 2/16/2021 that indicated a primary diagnosis of bipolar disorder (serious mental illness characterized by extreme mood swings). The clinical record included a comprehensive recertification assessment, completed on 12/17/2020, by Employee L (Registered Nurse), which failed to evidence the primary caregiver's availability and schedule.	G 538		

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G 538	Continued From page 49 9. The clinical record of patient #8 was reviewed on 2/3/21 and indicated a start of care date of 3/27/2019. The record contained a plan of care for the recertification period 1/15/2021 to 3/15/2021 that indicated a primary diagnosis of quadriplegia (paralysis of all four limbs). The clinical record included a comprehensive recertification assessment, completed on 1/14/2021, by Employee H (Registered Nurse), which failed to evidence the primary caregiver's availability and schedule. 10. The clinical record of patient #9 was reviewed on 2/23/21 and indicated a start of care date of 7/6/2017. The record contained a plan of care for the recertification period of 2/15/2021 to 4/15/2021 that indicated a primary diagnosis of unspecified mood disorder (affective disorders are a set of psychiatric diseases). The clinical record included a comprehensive recertification assessment, completed on 2/11/2021, by Employee H (Registered Nurse), which failed to evidence the primary caregiver's availability and schedule. 11. The clinical record of patient #10 was reviewed on 2/23/21 and indicated a start of care date of 7/9/2020. The record contained a plan of care for the recertification period of 1/5/2021 to 3/5/2021 that indicated a primary diagnosis of hemiplegia following cerebral infarction affecting right dominant side (area of necrotic tissue in the brain from a blockage or narrowing in the arteries supplying blood and oxygen to the brain resulting in paralysis of one side of the body). The clinical record included a comprehensive recertification assessment, completed on 1/4/2021, by Employee C (Registered Nurse), which failed to evidence the primary caregiver's availability and	G 538		

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G 538	Continued From page 50 schedule. 12. During an interview on 3/1/21 at 3:21 PM, when asked if the comprehensive assessment should contain caregiver availability schedule and willingness to provide care, Employee B (Clinical Manager), stated, "I know it's on our contact list in the patient's home."	G 538		
G 544	Update of the comprehensive assessment CFR(s): 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This Standard is not met as evidenced by: Based on record review, interview, and observation, the agency failed to have a policy on comprehensive assessments and the registered nurse failed to ensure comprehensive assessments were updated for 3 of 3 patients with observed home visits (#1, 2, 3). Findings Include: 1. A policy titled "Medical Record Content," dated, 1/2018, stated, " ...The agency will provide an accurate and current medical record for every patient seen by the agency ..." 2. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated diagnoses of, but not limited to, Lymphedema (swelling that generally occurs in	G 544		

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G 544	Continued From page 51 one of your arms or legs), cellulitis of the right lower limb (a bacterial skin infection), osteoarthritis (wearing down of cartilage occurs gradually and worsens over time), morbid obesity (100 pounds over ideal body weight, a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes), and idiopathic aseptic necrosis of right femur (a bone condition that results from poor blood supply to an area of bone, causing localized bone death). A document titled, "Discharge Summary," dated 1/23/21, from Entity B (Hospital), under the section titled, "Why you were hospitalized," stated, " ...Your primary diagnosis was Kidney Stone ...." The section titled, "Procedures Performed During Hospitalization," states, " ...Uretal Stent Insertion ...." A comprehensive resumption of care assessment was completed on 1/25/2021, by Employee L (Registered Nurse). The assessment indicated the patient was incontinent of bladder and had urgency, but failed to evidence information regarding stent insertion. A recertification comprehensive assessment was completed on 2/5/2021, by Employee L (Registered Nurse). M1610 indicates the patient is incontinent of bladder. On page 12 of 20, the assessment states, " ...frequency, urgency, and Other: Pt [Patient] on bladder meds [medications] for kidney stones for 21 days Pee is amber ...." but failed to evidence information regarding the stent. 3. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for	G 544		

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G 544	Continued From page 52 the certification period 12/27/20 to 2/24/21 that indicated diagnoses of, but not limited to, excoriation disorder (habitually and excessively picking, scratching, gouging or squeezing at otherwise healthy skin), essential primary hypertension (a form of hypertension that by definition has no identifiable secondary cause), and major depressive disorder with psych features (a mental disorder in which a person has depression along with loss of touch with reality). The record fails to make updates to the included assessment information, as evidenced by: A recertification comprehensive assessment completed on 12/26/2020 indicated "Stage 2" for "most problematic unhealed pressure ulcer/injury that is stageable: (excludes pressure ulcer/injury that cannot be staged due to a non-removable dressing/device", under section M1324 on page 9 of 20. On page 19 of 20, the "Goals" section states, " ...Pt [patient] picks skin on both legs and buttocks which has led to several unstageable wound spots on both legs and buttocks ... Wound spots are numerous, and are at different stages of healing ...." A document titled, "Nursing Visit Note," dated 2/13/21, Employee K (Registered Nurse), left the section titled, "Skin," blank. A home visit observation was conducted with Employee K (Registered Nurse) on 2/25/21 at 2:00 PM, with patient #2. The patient was observed to have multiple open areas on bilateral lower legs, left upper arm, back of head, and both buttocks. Employee K did not ask patient #2 to show him his right arm, torso, or back. 4. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of	G 544		

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G 544	Continued From page 53 1/9/2017. The record contained a plan of care for the certification period 10/20/2020 to 12/18/2020 that indicated diagnoses of, but not limited to, type two diabetes mellitus with diabetic neuropathic arthropathy (insufficient production of insulin causing high blood sugar with subsequent decreased sensation in the joints), hyperlipidemia (elevated cholesterol blood level), essential primary hypertension (a form of hypertension that by definition has no identifiable secondary cause), and chronic kidney disease (gradual loss of kidney function). The plan of care also stated the patient was on Lantus insulin and required a nurse for administration. An untitled document obtained from Entity B (patient's primary care provider), dated 2/3/2021, under a section titled "Current Medication," indicates patient no longer takes Lantus and it is not currently ordered. The same document also stated the patient's hemoglobin A1C (a blood test that measures average blood glucose, or blood sugar, level over the past 3 months) was 5.4%, indicating patient was non-diabetic, according to the test range of under 5.7%. During an interview with patient #3, when asked how often a skilled nurse visits and what he/she does while there, the patient indicated they were supposed to come daily to do vitals and blood sugars twice a day and stated they had not been on insulin for over a year. 5. During an interview on 2/22/21 at 10:31 AM, when asked how a change is condition is reported, Employee B (Clinical Manager), stated a "Change in condition is marked by the skilled nursing assessment." 6. During an interview on 3/1/21 at 3:21 PM,	G 544		

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G 544	Continued From page 54 when asked if the comprehensive assessment should be revised when needed, Employee B (Clinical Manager), stated, "Oh, absolutely." 17-14-1(a)(1)(B)	G 544		
G 564	Discharge or Transfer Summary Content CFR(s): 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. This Standard is not met as evidenced by: Based on record review and interview, the agency failed to ensure all necessary medical information was sent during a discharge or transfer in 1 of 2 records reviewed, in a sample of 10 (#4). Findings include: An agency policy dated 1/20/18 titled "Discharge planning," stated " ...Discharge and transfer summaries will be sent to the primary care practitioner and other health care professionals who are responsible for providing care and services to the patient ...." The clinical record of patient #4 was reviewed on 2/23/21 and indicated a start of care date of 5/14/2020. The record contained a plan of care for the certification period 7/13/2020 to 9/10/2020 that indicated a primary diagnosis of type two diabetes mellitus (insufficient production of insulin causing high blood sugar). The record failed to evidence of a transfer summary was completed for the receiving entity.	G 564		

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G 564	Continued From page 55 A document titled, "Case Communication," completed by Employee H, stated, " ...RN (Registered Nurse) called 911, and pt [patient] was taken to the ER [emergency room] around 9 PM ...." During an interview on 3/1/21 at 3:09 PM, when asked if a transfer summary should be sent to the physician with every transfer, Employee B (Clinical Manager), indicated yes.	G 564		
G 570	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: Based on observation, record review and interview, the agency failed to meet the needs of the patient for 1 of 10 records reviewed (#2); failed to ensure the Registered Nurse followed the plan of care (See Tag G572); the agency	G 570		

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G 570	Continued From page 56 failed to ensure accurate and complete information on the plan of care (See Tag G574); failed to ensure the plan of care was revised (See Tag G592); failed to ensure their patients were properly educated according to their patient-specific needs (See Tag G610); failed to ensure all patients were provided with a copy of written instructions outlining visits, including frequency of visits by the home health personnel (See Tag G614); failed to ensure a medication list was provided to the patient (See Tag G616); the agency failed to provide written instructions outlining treatments and therapy that would be administered by agency staff (See Tag G618); and failed to ensure all patients were provided with a copy of written instructions outlining name and contact information of the home health Clinical Manager (See Tag G622). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.60 Care planning, coordination, quality of care. Regarding G570, the findings include: 1. A policy titled "Disease Response and Management (COVID-19)," dated 1/2020, Policy #TBD, stated, " ...All clients will participate in the organization's effort to prevent the spread of COVID-19 or a communicable disease by ... if a client becomes quarantined, or test positive for COVID-19 ... At Home will suspend all personal care services until medical clearance is provided ... if suspending personal care services poses a risk to the client (high acuity requiring total care, skilled nursing tasks or nurse delegated tasks) At home will coordinate with the payer and the client's health care professionals to support the client's ongoing care needs (i.e., home health	G 570		

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G 570	Continued From page 57 agency, inpatient care facility ... For home health operations, face to face services that cannot be suspended due to patient needs (nursing and/or HHA), care will continue to be provided while observing standard infection control principles, including Universal precautions and proper PPE technique ...." 2. A document titled, "Orientation Manual," dated 11/7/2019, stated, " ...Holidays ... New Year's Day ... Memorial Day ... Independence Day ... Labor Day ... Thanksgiving Day ... Christmas Day ...." 3. The agency failed to have a policy on how to assign a "triage code" to their patients. 4. An agency policy revised 2/202, titled "Bed bug policy," Policy #022 stated, Agency staff will assess upon admission, at reassessment, and if the patient's condition changes, the patient's environment for basic home safety. ... Procedure: Agency staff will be educated on handling [sic] beg [sic] bugs or other types of insects of pest infestation, to reduce risk of injuries or threats to life and health, and to encourage the active involvement of patients and their families in their own care ..." 5. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 2/9/21 to 4/9/21 that indicated a primary diagnosis of Lymphedema (swelling that generally occurs in one of your arms or legs) and a skilled nursing frequency of 4 hours per day 7 days per week for wound care and lymphedema pump to lower legs. The agency failed to meet the patient's needs during the holidays, as evidenced by:	G 570		

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G 570	Continued From page 58 The record failed to evidence the agency assigned the patient a triage code upon admission to determine their triage level. A document titled, "Missed Visit Notification Form," dated 12/25/20, states, " ...Holiday no service ...." The document was sent to the patient's primary care provider on 12/25/20. A document titled, "Missed Visit Notification Form," dated 1/1/21, states, " ...Holiday no service ...." The document was sent to the patient's primary care provider on 1/5/21. 6. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated a primary diagnosis of excoriation disorder (habitually and excessively picking, scratching, gouging or squeezing at otherwise healthy skin), a skilled nursing frequency of one time daily, seven days a week, and a home health aide (HHA) frequency of four hours a day, seven days a week. The agency failed to meet the patient's needs during the holidays, as evidenced by: The record failed to evidence the agency assigned the patient a triage code upon admission to determine their triage level. A document titled, "Missed Visit Notification Form," dated 11/26/20, states, " ...Holiday no service ...." The document was sent to the patient's primary care provider on 11/26/20. A document titled, "Missed Visit Notification Form," dated 12/25/20, states, " ...Holiday no	G 570		

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service ...." The document was sent to the patient's primary care provider on 12/25/20.

A document titled, "Missed Visit Notification Form," dated 1/1/21, states, " ...Holiday no service ...." The document was sent to the patient's primary care provider on 1/5/21.

7. During an interview on 2/23/21 at 5:00 PM, when asked if the agency cares for known COVID-19 positive patient, Employee A (Administrator) stated, "No, I don't believe we do." The clinical manager (CM) stated they would probably start calling other agencies to see if someone else could take care of the patients. The CM stated the last time it occurred the patient was sent to a SNF (Skilled Nursing Facility) that took care of COVID-19 positive patients. The CM stated the owners are "absolutely terrified of it [COVID-19]." The CM stated the agency had older employees and were not sure if they wanted the liability. When asked why the agency did not take care of COVID-19 positive patients, the administrator stated, "The individual goes into quarantine and inoculation. We wait 10 - 14 days to go back in the house." The administrator stated the African American population was scared of COVID and most of the employees are African American. Then stated "we don't want to put staff at risk of spreading it. We go right back in after 10 - 14 days."

8. During an interview on 3/1/21 at 3:09 PM, when asked if the agency had a bed bug policy, the Administrator stated, "Yes, we won't go back in the house until they have something saying a vendor [someone who is able to treat] has been in there." Then she stated if it's a "needful" person, then they suit up." When asked who determined who was a "needful person,"

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G 570	Continued From page 60 Employee A stated, " Most patient know they have bed bugs but if they're must-sees we will try to compromise. We might lessen the time in there." She stated staff will put on their shoe booties and suits to go in. Furthermore, the administrator stated normally people know they have bed bugs. Then when the aide gets bitten, the agency will instruct patients to go get it fixed. When asked how the agency ensured the patient's needs were met during the hold time, The administrator stated, "We put them on hold." When asked who took care of patients who were on hold, Employee A stated, "The primary caregiver will take care of them." We've had to discharge people who had chronic problems." When asked how the agency determined who must be saw, the clinical manager stated, "we document their level" upon admission. She stated a one is a must cover and no one else can cover, two is a family member can cover, three is a changing schedule type. The determination of the patient number is on a handwritten form that the nurse completed called a "Triage Code Form". 17-13-1(a)	G 570		
G 572	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 refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.	G 572		

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G 572	Continued From page 61 This Standard is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the Registered Nurse followed the plan of care for 2 of 2 skilled nurse home visits (#1, 2), and failed to have a plan of care policy. Findings include: 1. A policy titled "Medical Record Content," dated, 1/2018, stated, " ...The agency will provide an accurate and current medical record for every patient seen by the agency ..." 2. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated diagnoses of, but not limited to, Lymphedema (swelling that generally occurs in one of your arms or legs), cellulitis of the right lower limb (a bacterial skin infection), osteoarthritis (wearing down of cartilage occurs gradually and worsens over time), morbid obesity (100 pounds over ideal body weight, a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes), and idiopathic aseptic necrosis of right femur (a bone condition that results from poor blood supply to an area of bone, causing localized bone death). The plan of care also contained orders for skilled nursing 4 hours per day 7 days per week for wound care and lymphedema pump to lower legs and to teach/educate the patient regarding signs of infection. A home visit observation was conducted with Employee K (Registered Nurse) and Employee L (Registered Nurse) on 2/25/21 at 10:00 AM.	G 572		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 572	Continued From page 62 Employee K and Employee L failed to complete teaching regarding signs of infection. 3. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated diagnoses of, but not limited to, excoriation disorder (habitually and excessively picking, scratching, gouging or squeezing at otherwise healthy skin), essential primary hypertension (a form of hypertension that by definition has no identifiable secondary cause), and major depressive disorder with psych features (a mental disorder in which a person has depression along with loss of touch with reality). The plan of care contained orders for the nurse daily to complete a full head to toe assessment, apply tubigrip stockings to bilateral lower legs, assess safety of home and patient awareness, and perform medication reconciliation, instruct the patient on fall prevention. A home observation was conducted with Employee K (Registered Nurse) on 2/25/21 at 2:00 PM. Employee K failed to complete a full head to toe assessment, apply tubigrip stocking to bilateral lower legs, assess safety of home and patient awareness, and perform medication reconciliation, instruct the patient on fall prevention. 4. During an interview on 3/1/21 at 3:09 PM, when asked if patients should receive education from the nursing staff, Employee A (Administrator) and Employee B (Clinical Manager), stated "yes." 17-13-1(a)	G 572		
G 574	Plan of care must include the following	G 574		

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G 574	Continued From page 63 CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This Element is not met as evidenced by: Based on observation and record review the agency failed to evidence all medication, durable medical equipment (DME), diagnoses, and safety measures were listed on the plan of care for 3 of 3 patients with home visit observations (#1, 2, 3), and the agency failed to have a plan of care policy in place.	G 574		

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G 574	Continued From page 64 Findings include: 1. A policy titled "Medical Record Content," dated, 1/2018, stated, " ...Each medical record will contain ... a statement of any change in the patient's condition ... updated orders as obtained ...." 2. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated diagnoses of, but not limited to, Lymphedema (swelling that generally occurs in one of your arms or legs), cellulitis of the right lower limb (a bacterial skin infection), osteoarthritis (wearing down of cartilage occurs gradually and worsens over time), morbid obesity (100 pounds over ideal body weight, a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes), and idiopathic aseptic necrosis of right femur (a bone condition that results from poor blood supply to an area of bone, causing localized bone death). The plan of care failed to durable medical equipment (lymphedema machine). On 2/25/21 at 10:00 AM, during a home visit with patient #1, the patient was observed using a lymphedema machine. 3. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated a primary diagnosis of excoriation disorder (habitually and excessively picking, scratching, gouging or squeezing at otherwise healthy skin).	G 574		

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G 574	Continued From page 65 The record included a "Patient Medication Sheets [sic]", reviewed and signed by former Employee N (former Clinical manager) on 11/11/2020. The medication list included orders for, but not limited to, "Flomax [used to improve urination in men with enlarged prostate] ... Norvasc [treats high blood pressure] ... Vitamin C [supplement] ... Metoprolol Tartrate [treats high blood pressure] ... ammonium lactate [used to treat dry, scaly, itchy skin] ... Eliquis [lower the risk of stroke or a blood clot] ... Prozac [antidepressant] ... Claritin [treats allergy symptoms] ... Singular [treats allergy symptoms] ... Hydroxyzine [treats anxiety, nausea, vomiting, allergies, skin rash, hives, and itching] ... Vitamin B-12 [supplement] ... Ferrous Sulfate [iron deficiency anemia] ...." The plan of care evidenced medications Flomax, ammonium lactate, Hydroxyzine, Vitamin B-12 which failed to be observed and identified in the home. On 2/25/21 at 2:00 PM, during a home visit with patient #2, the home folder was observed and found to have a medication list dated 2/24/21, signed by Employee K (Registered Nurse). The medication list in the patient's folder was compared to the most current medication list provided in the clinical record and was found to be inaccurate. The medications taken by the patient, as reported by the patient, proved 2/24/21 list to be inaccurate as well. The patient stated, "I take the ones they send to me." Upon observation of the area the patient was referencing, Metoprolol, Prozac, Norvasc, Hydroxyzine, Eliquis, Vitamin C, Claritin, and Singular were found. 4. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for	G 574		

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G 574	Continued From page 66 the certification period 10/20/2020 to 12/18/2020 that indicated diagnoses of, but not limited to, type two diabetes mellitus with diabetic neuropathic arthropathy (insufficient production of insulin that causing high blood sugar with subsequent decreased sensation in the joints), hyperlipidemia (elevated cholesterol blood level), essential primary hypertension (a form of hypertension that by definition has no identifiable secondary cause), and chronic kidney disease (gradual loss of kidney function). The plan of care failed to evidence accurate pertinent diagnoses. An untitled document obtained from Entity B (patient's primary care provider), dated 2/3/2021, under a section "Surgical History," indicated the patient had a kidney transplant. The diagnosis, safety measures, or interventions related to the previous kidney transplant failed to be evidenced on the plan of care. 17-13-1(a)(1)(C) 17-13-1(a)(1)(D)(ii) 17-13-1(a)(1)(D)(ix)	G 574		
G 592	Revised plan of care CFR(s): 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. This Element is not met as evidenced by: Based on record review and interview, the agency failed to ensure the plan of care was revised for 1 of 2 records reviewed of hospitalized patients (#1), and the agency failed to have a plan of care policy.	G 592		

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G 592	Continued From page 67 Findings include: The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated diagnoses of, but not limited to, Lymphedema (swelling that generally occurs in one of your arms or legs), cellulitis of the right lower limb (a bacterial skin infection), osteoarthritis (wearing down of cartilage occurs gradually and worsens over time), morbid obesity (100 pounds over ideal body weight, a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes), and idiopathic aseptic necrosis of right femur (a bone condition that results from poor blood supply to an area of bone, causing localized bone death). The plan of care failed to evidence a new diagnosis post hospitalization. A document from Entity E (Hospital), dated 1/23/21 shows a hospitalization due to Kidney stones with subsequent stent placement. During an interview on 3/1/21 at 3:09 PM, the administrator and clinical manager were asked if plans of care should be revised if applicable. The clinical manager stated "Oh, absolutely."	G 592		
G 610	Patients receive education and training CFR(s): 484.60(d)(5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely	G 610		

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G 610	Continued From page 68 discharge. This Element is not met as evidenced by: Based on record review and interview, the agency failed to ensure their patients were properly educated according to their patient-specific needs for 2 of 2 skilled nurse observations (#1, 2). Findings include: 1. A policy titled "Education (Patient/Family/Caregiver)," dated 1/2018, stated, " ...Staff will provide ongoing assessment and analysis of data/information related to patient/caregiver needs, learning preferences, and abilities that include cultural and religious practices, emotional barriers, desire and motivation to learn, physical/cognitive limitations, and language barriers ...." 2. A policy titled "Patient Education," dated 1/2018, stated, " ...Agency will provide initial and ongoing education to meet each individual patient's needs ...." 3. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated orders for teaching related to, but not limited to, infection control standards. A home observation was conducted with Employee K (Registered Nurse) and Employee L (Registered Nurse), on 2/25/21 at 10:00 AM, with patient #1. Employees K and L failed to complete teaching regarding infection control. 4. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for	G 610		

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G 610	Continued From page 69 the certification period 12/27/20 to 2/24/21 that indicated orders for teaching related to, but not limited to, use of assistive devices. A home observation was conducted with Employee K (Registered Nurse), on 2/25/21 at 2:00 PM, with patient #2. Employee K failed to complete teaching regarding use of assistive devices. 5. During an interview on 3/1/21 at 3:09 PM, when asked if the patients should receive education from the nursing staff, Employee B (Clinical Manager) and Employee A (Administrator), stated yes.	G 610		
G 614	Visit schedule CFR(s): 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. This Element is not met as evidenced by: Based on observation and interview, the agency failed to ensure all patients were provided with a copy of written instructions outlining visits, including frequency of visits by the home health personnel for 3 of 3 home visits observed (#1, 2, 3). Findings include: 1. A home observation was conducted with Employee K (Registered Nurse) and Employee L (Registered Nurse), on 2/25/21 at 10:00 AM, with patient #1 (start of care 8/13/20). The patient's home health folder was observed, and it failed to evidence a schedule of visits provided by the agency. 2. A home observation was conducted with	G 614		

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G 614	Continued From page 70 Employee K (Registered Nurse), on 2/25/21 at 2:00 PM, with patient #2 (start of care 5/7/2019). The patient's home health folder was observed, and it failed to evidence a schedule of visits provided by the agency. 3. A home visit observation was conducted with Employee M (Home Health Aide), on 2/24/21 at 8:00 AM, with patient #3 (start of care1/9/2017). The patient's home health folder was observed, and it failed to evidence a schedule of visits provided by the agency. 4. During an interview on 3/1/21 at 3:09 PM, when asked if the patients receive a visit schedule, Employee B (Clinical Manager) stated, "Yes, we mail them." When asked when the agency mails the patient schedule to the patient, Employee B stated, "Once a month preferably. They should've already been out."	G 614		
G 616	Patient medication schedule/instructions CFR(s): 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. This Element is not met as evidenced by: Based on observation and interview, the agency failed to ensure a medication list was provided to the patient for 3 of 3 home visits observed (#1, 2, 3). Findings include: 1. A home observation was conducted with Employee K (Registered Nurse) and Employee L (Registered Nurse), on 2/25/21 at 10:00 AM, with patient #1 (start of care 8/13/20). The patient's	G 616		

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G 616	Continued From page 71 home health folder was observed, and it failed to evidence an accurate and updated medication list provided by the agency. 2. A home observation was conducted with Employee K (Registered Nurse), on 2/25/21 at 2:00 PM, with patient #2 (start of care 5/7/2019). The patient's home health folder was observed, and it failed to evidence an accurate and updated medication list provided by the agency. 3. A home visit observation was conducted with Employee M (Home Health Aide), on 2/24/21 at 8:00 AM, with patient #3 (start of care1/9/2017). The patient's home health folder was observed, and it failed to evidence an accurate and updated medication list provided by the agency. 4. During an interview on 3/9/21 at 3:09 PM, when asked if the medication list was part of the comprehensive assessment, Employee B indicated, yes and that there was a separate list in the patient home. When asked if medication instructions should be complete directions, Employee B indicated it should be done, but that she didn't know if the route of the medication should be included on the list.	G 616		
G 618	Treatments and therapy services CFR(s): 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. This Element is not met as evidenced by: Based on observation, record review, and interview, the agency failed to provide written instructions outlining treatments and therapy that would be administered by agency staff to the patient for 3 of 3 home visits observed (#1, 2, 3).	G 618		

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G 618	Continued From page 72 Findings include: 1. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated orders for skilled nurse (SN) services for wound care, observing weight loss management, medication compliance, and home health aide (HHA) services. A home observation was conducted with Employee K (Registered Nurse) and Employee L (Registered Nurse), on 2/25/21 at 10:00 AM, with patient #1 (start of care 8/13/20). The patient's home health folder was observed, and it failed to evidence instructions outlining treatments and therapy that would be administered by staff. 2. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated orders for skilled nurse (SN) wound care and home health aide (HHA) services. A home observation was conducted with Employee K (Registered Nurse), on 2/25/21 at 2:00 PM, with patient #2 (start of care 5/7/2019). The patient's home health folder was observed, and it failed to evidence instructions outlining treatments and therapy that would be administered by staff. 3. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for the certification period 10/20/2020 to 12/18/2020 that indicated orders for skilled nurse (SN) blood glucose monitoring, medication reminders, and	G 618		

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G 618	Continued From page 73 home health aide (HHA) services. A home visit observation was conducted with Employee M (Home Health Aide), on 2/24/21 at 8:00 AM, with patient #3 (start of care 1/9/2017). The patient's home health folder was observed, and it failed to evidence instructions outlining treatments and therapy that would be administered by staff. 4. During an interview on 3/9/2021 at 3:09 PM, when asked how nurses in the field know the current orders for their patients, Employee B (Clinical Manager), stated, "Well, there should be a signed 485 [plan of care] in the home already. The case managers will update the folders." When asked how the home health aides know there is a change to the aide care plan, Employee B stated, "That falls back to the case managers."	G 618		
G 622	Name/contact information of clinical manager CFR(s): 484.60(e)(5) Name and contact information of the HHA clinical manager. This Element is not met as evidenced by: Based on observation the agency failed to ensure all patients were provided with a copy of written instructions outlining name and contact information of the home health Clinical Manager for 3 of 3 home visit observations (#1, 2, 3). Findings include: 1. During a home visit at patient #1's home on 2/25/21 at 10:00 AM, the patient and caregivers were asked if they knew who the Clinical Manager was, only the caregivers knew who the Clinical Manager was. When asked who the Alternate Clinical Manager was, only the caregivers knew who the Alternate Clinical	G 622		

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G 622	Continued From page 74 Manager was. The home folder was observed and found to have no information on who the Clinical Manager and Alternate Clinical Manager is. 2. During a home visit at patient #2's home on 2/25/21 at 2:00 PM, the patient and caregiver were asked if they knew who the Clinical Manager was, only the caregiver knew who the Clinical Manager was. When asked who the Alternate Clinical Manager was, only the caregivers knew who the Alternate Clinical Manager was. The home folder was observed and found to have no information on who the Clinical Manager and Alternate Clinical Manager is. 3. A home visit observation was conducted with Employee M (Home Health Aide), on 2/24/21 at 8:00 AM, with patient #3 (start of care 1/9/2017). The patient's home health folder was observed and found to have no information on who the Clinical Manager and Alternate Clinical Manager is.	G 622		
G 640	Quality assessment/performance improvement CFR(s): 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and	G 640		

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G 640	Continued From page 75 re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. This Condition is not met as evidenced by: Based on record review and interview, the agency failed to ensure a thorough quality assessment and performance improvement (QAPI) plan was developed, implemented, evaluated, and approved by the governing body. These practices impacted all patients. The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.65 Quality Assessment/performance improvement. Findings include: 1. A policy titled "Quality Assessment and Performance Improvement (QAPI) Plan and Program," dated 1/2018, stated, " ...The Agency will establish an ongoing, Agency-wide, data-driven program of quality assessment and performance improvement and maintain documentary evidence of its program ... the governing body is ultimately responsible for QAPI and implementation of the QAPI plan ...." 2. The administrator brought a binder titled "QAPI [Quality Assessment Performance Improvement] And Governing Body," in for review on 3/1/21 at 4:27 PM. There was no observable data within the binder. The QAPI binder failed to evidence any chart audits, tracking of falls, incidents, or any other performance data. 3. The agency failed to ensure their quality	G 640		

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G 640	Continued From page 76 assessment performance improvement (QAPI) program measured, analyzed, and tracked adverse events, falls, or any other performance data especially related to infection control with regards to the public health emergency and failed to show measurable improvement in those areas. 4. The agency failed to utilize quality indicators and failed to ensure the frequency and detail of the data collection was approved by the governing body. 5. The agency failed to utilize performance improvement projects. 6. During an interview on 3/1/21 at 3:09 PM, the administrator stated all 3 owners (1 being the administrator), the agency medical director, human resource director, a community psychologist, and one other non-clinical person made up the QAPI team which usually met two times per year, but because of the agency office moving and the pandemic they would have phone conversations if needed.	G 640		
G 680	Infection prevention and control CFR(s): 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. This Condition is not met as evidenced by: Based on observation, record review, and interview, the agency failed to ensure all staff followed infection control policies (See G682); failed to maintain a coordinated agency-wide program for surveillance, identification, prevention, control, and investigation of infections	G 680		

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G 680	Continued From page 77 and communicable diseases (See G684); failed to ensure all staff received infection control education in relation to daily self-monitoring for COVID-19, and failed to ensure all staff received and implemented infection control education related to performing pre-visit screening of the patient for COVID-19 symptoms (See G686). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.70 Infection Prevention and Control.	G 680		
G 682	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 record review and interview, the agency failed to ensure all staff followed infection control policies and standard precautions for 2 of 3 home visits observed (#1, 2). Findings include: 1. An article from the CDC dated 8/17/20, titled "Handwashing: Clean Hands Save Lives," stated "...Washing your hands is easy, and it's one of the most effective ways to prevent the spread of germs. Clean hands can stop germs from spreading from one person to another and throughout an entire community ... Scrub your hands for at least 20 seconds ...." 2. United States of America, Centers for Disease Control. (2019). Wash Your Hands. Retrieved from	G 682		

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G 682	Continued From page 78 https://www.cdc.gov/features/handwashing/index.html "How to Use Hand Sanitizer: Apply the gel product to the palm of one hand (read the label to learn the correct amount). Rub your hands together. Rub the gel over all the surfaces of your hands and fingers until your hands are dry. This should take around 20 seconds ...." 3. During a home visit observation on 2/25/2021 at 10:00 PM, with patient #1 (start of care 8/13/2020), Employee K (Registered Nurse) was observed not following proper bag technique and had set his bag on the patient's chair without putting a barrier down first. Employee K was also observed donning clean gloves without proper hand hygiene two (2) times during the remainder of personal care, and did not perform hand hygiene after removing gloves after personal care was completed. 4. During a home visit observation on 2/25/2021 at 2:00 PM, with patient #2 (start of care 5/7/2019), Employee K Employee K (Registered Nurse) was observed not following proper bag technique and had set his bag on the patient's chair without putting a barrier down first. Employee K also did not follow proper wound care technique, by using the same washcloth to clean multiple wounds. 17-12-1(m)	G 682		
G 684	Infection control CFR(s): 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's	G 684		

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G 684	Continued From page 79 quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This Standard is not met as evidenced by: Based on record review, the agency failed to maintain a coordinated agency-wide program for surveillance, identification, prevention, control, and investigation of infections and communicable diseases, as part of their Quality Assessment and Performance Improvement (QAPI) program. Findings include: An agency policy titled, "Infection Control Surveillance System: Prioritized Risks Defined," dated 1/2018, stated, "The Agency will implement an infection control surveillance system for patients and staff ... the definition of infections is based on the most common infections prevalent to Agency's services that are high-volume, frequent infectious complications and have a high potential for prevention by staff and/or have an increased risk for negative patient outcomes ... written reports of infections will occur through documentation on the applicable log ...at least quarterly, the director of nursing and infection control and QAPI [quality assessment performance improvement] will review and assess the infection control logs ... data will be aggregated and analyzed on the Infection Control Quarterly Data Aggregation and Analysis: Patients and Employees Form ... Problems and/or undesirable trends infections will be identified,	G 684		

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G 684	Continued From page 80 including potential significant agency acquired and/or community acquired infections. ... QAPI committees will identify common factors that could have led to the transmission of the infection[s] ... committees will make recommendations for and implement improvement activities ...." The administrator brought a binder titled "QAPI [Quality Assessment Performance Improvement]," in for review on 3/1/21 at 4:27 PM. There was no observable data within the binder. The QAPI binder failed to evidence any chart audits, tracking of falls, incidents, OASIS reports, any other quality indicators, identified areas of improvement, or any performance improvement projects.	G 684		
G 686	Infection control education CFR(s): 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). This Standard is not met as evidenced by: Based on record review and interview, the home health agency failed to ensure all staff and patients received infection control education in relation to daily self-monitoring for COVID-19 and failed to ensure all staff received and implemented infection control education related to performing pre-visit screening of the patient for COVID-19 symptoms for 6 of 6 employee records reviewed (B, G, I, K, M, O) and 10 of 10 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8, 9, 10). Findings include: 1. A policy titled "Disease Response and Management [COVID-19]," dated 1/2021, stated, "all agency staff will participate ... by conducting	G 686		

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G 686	Continued From page 81 self-assessments for signs and symptoms of COVID-19 ... each day, prior to meeting with our staff, all clients will do a self-assessment for signs and symptoms of COVID-19 ... agency staff should log temperature of the client, daily, onto the Client Assessment form for COVID-19 ... fever of 100.4 or above ... cough ... shortness of breath ...." 2. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated a primary diagnosis of Lymphedema (swelling that generally occurs in one of your arms or legs). The record failed to evidence teaching of infection control in relation to COVID-19. 3. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated a primary diagnosis of excoriation disorder (habitually and excessively picking, scratching, gouging, or squeezing at otherwise healthy skin). The record failed to evidence teaching of infection control in relation to COVID-19. 4. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for the certification period 2/17/2021 to 4/17/2021 that indicated a primary diagnosis of type two diabetes mellitus with diabetic neuropathic arthropathy (insufficient production of insulin that causing high blood sugar with subsequent decreased sensation in the joints). The record failed to evidence teaching of infection control in	G 686		

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G 686	Continued From page 82 relation to COVID-19. 5. The clinical record of patient #4 was reviewed on 2/23/21 and indicated a start of care date of 5/14/2020. The record contained a plan of care for the certification period 5/14/2020 to 7/12/2020 that indicated a primary diagnosis of type two diabetes mellitus (insufficient production of insulin causing high blood sugar). The record failed to evidence teaching of infection control in relation to COVID-19. 6. The clinical record of patient #5 was reviewed on 2/23/21 and indicated a start of care date of 4/24/2015. The record contained a plan of care for the certification period 4/3/2019 to 6/1/2019 that indicated a primary diagnosis of type two diabetes mellitus (insufficient production of insulin causing high blood sugar). The record failed to evidence teaching of infection control in relation to COVID-19. The record failed to evidence teaching of infection control in relation to COVID-19. 7. The clinical record of patient #6 was reviewed on 2/23/21 and indicated a start of care date of 5/31/2019. The record contained a plan of care for the certification period 11/21/2020 to 1/19/2021 that indicated a primary diagnosis of chronic obstructive pulmonary disease (a group of progressive lung disorders characterized by increasing breathlessness). The record failed to evidence teaching of infection control in relation to COVID-19. 8. The clinical record of patient #7 was reviewed on 2/23/21 and indicated a start of care date of 10/20/2020. The record contained a plan of care for the certification period 12/19/2020 to 2/16/2021 that indicated a primary diagnosis of	G 686		

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G 686	Continued From page 83 bipolar disorder (serious mental illness characterized by extreme mood swings). The record failed to evidence teaching of infection control in relation to COVID-19. 9. The clinical record of patient #8 was reviewed on 2/3/21 and indicated a start of care date of 3/27/2019. The record contained a plan of care for the recertification period 1/15/2021 to 3/15/2021 that indicated a primary diagnosis of quadriplegia (paralysis of all four limbs). The clinical record included a comprehensive recertification assessment, completed on 1/14/2021, by Employee H (Registered Nurse). The record failed to evidence teaching of infection control in relation to COVID-19. 10. The clinical record of patient #9 was reviewed on 2/23/21 and indicated a start of care date of 7/6/2017. The record contained a plan of care for the recertification period of 2/15/2021 to 4/15/2021 that indicated a primary diagnosis of unspecified mood disorder (affective disorders are a set of psychiatric diseases). The record failed to evidence teaching of infection control in relation to COVID-19. 11. The clinical record of patient #10 was reviewed on 2/23/21 and indicated a start of care date of 7/9/2020. The record contained a plan of care for the recertification period of 1/5/2021 to 3/5/2021 that indicated a primary diagnosis of hemiplegia following cerebral infarction affecting right dominant side (area of necrotic tissue in the brain from a blockage or narrowing in the arteries supplying blood and oxygen to the brain resulting in paralysis of one side of the body). The record failed to evidence teaching of infection control in relation to COVID-19.	G 686		

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G 686	Continued From page 84 12. The employee files of Employee B (Clinical Manager), hire date not provided, Employee G (Scheduler, Co-owner, and Governing Body Member), hire date not provided, Employee I (Registered Nurse), hire date not provided, Employee K (Registered Nurse), hire date not provided, Employee M (Home Health Aide), hire date not provided, Employee O (Registered Nurse), hire date not provided, were reviewed and failed to evidence proof of employee COVID-19 self-screening tools being used. The records also failed to evidence teaching of infection control in relation to COVID-19. 13. During an interview on 2/25/21 at 9:20 AM, when asked if they've received any COVID-19 training, Employee L (Registered Nurse), stated, "Yes. Handwashing and standard precautions." 14. During an interview on 2/25/21 at 10:00 AM, when asked if they've had any teaching on COVID-19, patient #1 stated, "No." When asked if all staff screen them for COVID-19 symptoms before visiting them, patient #1 stated, "No." 15. During an interview on 2/25/21 at 2:00 PM, when asked if they've had any teaching on COVID-19, patient #2 stated, "No." 16. During an interview on 3/1/2021 at 3:09 PM, when asked if the agency has a COVID-19 policy, Employee A (administrator) stated, "It's in the Governing Body book." 17. During an interview on 3/1/21 at 3:09 PM, when asked if staff and patients should receive COVID-19 training, Employee B (Clinical Manager) stated, "Yes, they've gone over it very thoroughly. We have a questionnaire with the client each time they're in there."	G 686		

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G 700	Continued From page 85	G 700		
G 700	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. This Condition is not met as evidenced by: Based on observation, record review, and interview, the Registered Nurse (RN) failed to conduct a complete physical assessment during home visits (See Tag G706); the skilled nurse (SN) failed to follow the plan of care (POC) (See Tag G710); the SN failed to provide education to patients and/or their caregivers as ordered per the plan of care (See Tag G714); the skilled nurse (SN) failed to communicate with the doctor related to their plan of care (See Tag G718); the agency failed to include all skilled professionals as part of their quality assessment and performance improvement (QAPI) program (See Tag G720); the agency failed to ensure an RN was responsible for home health agency in-services (See Tag G722); the agency failed to ensure nursing services provided from the Licensed Practical Nurse (LPN) were under the supervision of a n RN (See Tag G726). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.75 Skilled Professional Services.	G 700		

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G 706	Continued From page 86	G 706		
G 706	Interdisciplinary assessment of the patient CFR(s): 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; This Element is not met as evidenced by: Based on observation, record review, and interview, the Registered Nurse (RN) failed to conduct a complete physical assessment for 2 of 2 skilled nurse visit observations (#1, 2), in a total of 3 home visit observations. Findings include: 1. Constantine, Salmon, & Maryniak (January 16, 2012). "Overview of Nursing Health Assessment." Retrieved 3/25/21 from RN.com. " ...Ascultate the anterior and posterior chest: Have patient breath slightly deeper than normal through their mouth. Ascultate from C-7 to approximately T-8, in a left to right comparative sequence. You should auscultate between every rib ... Identify any adventitious breath sounds ...." 2. During a home visit observation with patient #1 was conducted on 2/25/21 at 10:00 AM, with Employee K (Registered Nurse). The RN failed to auscultate the patient's lung sounds on the anterior and posterior areas of the chest. 3. During a home visit observation with patient #1 was conducted on 2/25/21 at 10:00 AM, with Employee K (Registered Nurse). The RN failed to auscultate the patient's lung sounds on the anterior and posterior areas of the chest. 4. During an interview on 3/1/21 at 3:09 PM, when asked if nursing assessments should be completed from head to toe, Employee B (Clinical Manager), stated, "Yes."	G 706		

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G 706	Continued From page 87 17-12-2(g)	G 706		
G 710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care; This Element is not met as evidenced by: Based on observation, record review, and interview, the skilled nurse (SN) failed to follow the plan of care (POC) for 2 of 2 skilled nurse observations (#1, 2). Findings include: 1. An agency policy dated 1/2018, titled, "Medication Reconciliation," policy #154, stated, " ...The medication list/profile will be updated with each new or changed medication ... The patient's medication list in the home will also be updated ...." 2. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated orders for SN to monitor medication compliance. On 2/25/21 at 10:00 AM, during a home visit with patient #1, the home folder was observed and found to have a medication list dated 2/24/21, signed by Employee K (Registered Nurse). The medication list in the patient's folder was compared to the most current medication list provided in the clinical record and was found to be inaccurate. The medications taken by the patient, as reported by the patient, revealed the 2/24/21 list to be inaccurate as well. The patient stated, "I take the ones in the drawer." Upon	G 710		

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G 710	Continued From page 88	G 710		

observation of the area the patient was referencing, the writer found Rivaroxaban, Vitamin D3, Hydrocodone-Acetaminophen, Losartan, Metformin, Bupropion, Bumetanide, Cholecalciferol, and Tizanidine. The skilled nurse failed to monitor medication compliance by assessing accuracy of medications taken by the patient or assessing if the patient had been taking medication as prescribed.

3. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated orders for SN to set up medications and monitor for compliance.

On 2/25/21 at 2:00 PM, during a home visit with patient #2, the home folder was observed and found to have a medication list dated 2/24/21, signed by Employee K (Registered Nurse). The medication list in the patient's folder was compared to the most current medication list provided in the clinical record and was found to be inaccurate. The medications taken by the patient, as reported by the patient, revealed the 2/24/21 list to be inaccurate as well. The patient stated, "I take the ones they send to me." Upon inspection of the area the patient was referencing, the writer observed Metoprolol, Prozac, Norvasc, Hydroxyzine, Eliquis, Vitamin C, Claritin, and Singular. The skilled nurse failed to monitor medication compliance by assessing accuracy of medications taken by the patient or assessing if the patient had been taking medication as prescribed.

4. During an interview on 2/22/21 at 10:31 AM, when asked how a drug regimen review is done, Employee B (Clinical Manager), stated, "I usually

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G 710	Continued From page 89 go off the medication list from the hospital and verify with the pharmacy. I do my best to verify there are no duplicates."	G 710		
G 714	Patient and caregiver education CFR(s): 484.75(b)(5) Patient and caregiver education; This Element is not met as evidenced by: Based on observation and record review, the skilled nurse (SN) failed to provide education to patients and/or their caregivers as ordered per the plan of care for 2 of 2 skilled nursing observations (#1, 2). Findings include: 1. A policy titled "Education (Patient/Family/Caregiver)," dated 1/2018, stated, " ...Staff will provide ongoing assessment and analysis of data/information related to patient/caregiver needs, learning preferences, and abilities that include cultural and religious practices, emotional barriers, desire and motivation to learn, physical/cognitive limitations, and language barriers ...." 2. A policy titled "Patient Education," dated 1/2018, stated, " ...Agency will provide initial and ongoing education to meet each individual patient's needs ...." 3. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated orders for teaching related to, but not limited to, infection control standards. A home observation was conducted with Employee K (Registered Nurse) and Employee L	G 714		

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G 714	Continued From page 90 (Registered Nurse), on 2/25/21 at 10:00 AM, with patient #1. Employees K and L failed to complete teaching regarding infection control. 4. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated orders for teaching related to, but not limited to, use of assistive devices. A home observation was conducted with Employee K (Registered Nurse), on 2/25/21 at 2:00 PM, with patient #2. Employee K failed to complete teaching regarding use of assistive devices. 5. During an interview on 3/1/21 at 3:09 PM, when asked if the patients should receive education from the nursing staff, Employee B (Clinical Manager) and Employee A (Administrator), indicated "yes."	G 714		
G 718	Communication with physicians CFR(s): 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; This Element is not met as evidenced by: Based on observation, record review, and interview, the skilled nurse (SN) failed to communicate with the doctor related to patient's plan of care for 2 of 2 skilled nurse observations (#1, 2). Findings include: 1. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of	G 718		

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G 718	Continued From page 91 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21. On 2/25/21 at 10:00 AM, during a home visit with patient #1, the home folder was observed and found to have a medication list dated 2/24/21, signed by Employee K (Registered Nurse). The medication list in the patient's folder was compared to the most current medication list provided in the clinical record and was found to be inaccurate. The medications taken by the patient, as reported by the patient, proved 2/24/21 list to be inaccurate as well. The patient stated, "I take the ones in the drawer." Upon inspection of the area the patient was referencing, the writer found Rivaroxaban, Vitamin D3, Hydrocodone-Acetaminophen, Losartan, Metformin, Bupropion, Bumetanide, Cholecalciferol, and Tizanidine. The skilled nurse failed to communicate the inconsistencies of the medication list with the doctor and seek clarification. 2. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21. A home visit observation was conducted with Employee K (Registered Nurse) on 2/25/21 at 2:00 PM, with patient #2. The patient was observed to have multiple open areas on bilateral lower legs, left upper arm, back of head, and both buttocks. The assessment evidenced different areas of concern for the skin. Employee K did not ask patient #2 to show him his right arm, torso, or back. The home folder was observed and found to have a medication list dated 2/24/21, signed by Employee K (Registered Nurse). The medication list in the patient's folder was compared to the	G 718		

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G 718	Continued From page 92 most current medication list provided in the clinical record and was found to be inaccurate. The medications taken by the patient, as reported by the patient, proved 2/24/21 list to be inaccurate as well. The patient stated, "I take the ones they send to me." Upon inspection of the area the patient was referencing, the writer found Metoprolol, Prozac, Norvasc, Hydroxyzine, Eliquis, Vitamin C, Claritin, and Singular. On 2/25/21, all medications from the patient's list were checked on drugs.com for interactions. The interaction check showed moderate interactions for Metoprolol and Prozac, Metoprolol and Norvasc, Prozac and Norvasc, Metoprolol and Hydroxyzine, Prozac and Hydroxyzine, Prozac and Eliquis, and Norvasc and Eliquis. The SN failed to report medication and assessment findings from the home visit to the doctor. 3. During an interview on 2/22/21 at 10:31 AM, when asked how a drug regimen review is done, Employee B (Clinical Manager), stated, "I usually go off the medication list from the hospital and verify with the pharmacy. I do my best to verify there are no duplicates." 17-14-1(a)(1)(G)	G 718		
G 720	Participate in the HHA's QAPI program; CFR(s): 484.75(b)(8) Participation in the HHA's QAPI program; and This Element is not met as evidenced by: Based on record review and interview, the agency failed to include all skilled professionals as part of their quality assessment and performance improvement (QAPI) program. Findings include: A policy titled "Quality Assessment and	G 720		

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G 720	Continued From page 93 Performance Improvement (QAPI) Plan and Program," dated 1/2018, stated, " ...The Agency will establish an ongoing, Agency-wide, data-driven program of quality assessment and performance improvement and maintain documentary evidence of its program ... the governing body is ultimately responsible for QAPI and implementation of the QAPI plan ...." The administrator brought a binder titled "QAPI," in for review on 3/1/21 at 4:27 PM. There was no observable data within the binder, nor a list of QAPI members to show that all skilled professionals were part of the QAPI program. During an interview on 3/1/21 at 3:09 PM, the administrator stated all 3 owners (1 being the administrator), the agency medical director, human resource director, a community psychologist, and one other non-clinical person made up the QAPI team.	G 720		
G 722	Participate in HHA-sponsored in-service CFR(s): 484.75(b)(9) Participation in HHA-sponsored in-service training. This Element is not met as evidenced by: Based on record review and interview, the agency failed to ensure a skilled nurse (SN) was responsible for home health agency in-services. Findings include: A policy titled, "Inservice Education," dated 1/2018, stated, " ...Inservice training [for HHAs (home health aides)] must be performed by an RN ... HHAs are required to receive at least 12 hours of inservice training during each 12-month period ... The Agency maintains documentation that demonstrates that each HHA has met the requirements ... All inservice and education	G 722		

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G 722	Continued From page 94 programs will be documented ...." The evidence of HHA in-services was requested to be submitted on 3/1/21 at 3:09, and on 3/1/21 at 4:36 PM the agency had failed to submit them. During an interview on 3/1/21 at 3:09 PM, when asked who was responsible for organization and oversight of the in-services, Employee B stated, "That would be [name of human resource director]" When asked where the HHA in-services were kept, Employee B stated, "I don't know," and the administrator stated, "[Employee E, administrative assistant] should have a record of all attendees in her office."	G 722		
G 726	Nursing services supervised by RN CFR(s): 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). This Element is not met as evidenced by: Based on record review and interview, the agency failed to ensure nursing services by the Licensed Practical Nurse (LPN) were provided under the supervision of a Registered Nurse (RN). Findings include: 1. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a Nurse Visit Notes, dated 1/2/2021 and 1/3/2021, completed by Employee I (LPN). The record failed to evidence a Licensed Practical Nurse supervisory visit completed by a Registered Nurse. 2. The clinical record of patient #4 was reviewed on 2/23/21 and indicated a start of care date of 5/14/2020. The record contained Nurse Visit	G 726		

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G 726	Continued From page 95 Notes, dated 6/15/2020, 6/16/2020, 6/17/2020, 6/18/2020, 7/3/2020, 7/4/2020, 7/5/2020, 7/6/20210, 7/7/2020, 7/8/2020, 7/9/2020, 7/10/2020, 7/13/2020, 7/14/2020, 7/15/2020, 7/16/2020, 7/17/2020, 7/20/2020, completed by Employee I (LPN). The record failed to evidence a Licensed Practical Nurse supervisory visit completed by Registered Nurse. 3. The clinical record of patient #9 was reviewed on 2/23/21 and indicated a start of care date of 7/6/2017. The record contained a Nurse Visit Notes, dated 8/24/2020, 8/25/2020, 8/26/2020, 8/27/2020, 8/28/2020, 8/29/2020, 8/30/2020, 8/31/2020, 9/1/2020, 9/2/2020, 9/3/2020, 9/4/2020, 9/6/2020, 9/7/2020, 9/8/2020, 9/9/2020, 9/10/2020, 9/11/2020, 9/14/2020, 9/15/2020, 9/16/2020, 9/17/2020, 9/18/2020, 9/19/2020, 9/20/2020, 9/21/2020, 9/22/2020, 9/23/2020, 9/24/2020, 9/25/2020, 9/26/2020, 9/29/2020, 9/30/2020, 10/1/2020, 10/2/2020, 10/10/2020, 10/11/2020, 10/12/2020, 10/13/2020, 10/14/2020, 10/15/2020, 10/18/2020, 10/19/2020, 10/20/2020, 10/21/2020, 10/22/2020, 10/23/2020, 10/24/2020, 10/25/2020, 10/26/2020, 10/27/2020, 10/28/2020, 10/29/2020, 10/30/2020, 11/2/2020, 11/3/2020, 11/4/2020, 11/5/2020, 11/6/2020, 11/7/2020, 11/8/2020, 11/9/2020, 11/10/2020, 11/11/2020, 11/12/2020, 11/13/2020, 11/17/2020, 11/16/2020, 11/18/2020, 11/19/2020, 11/20/2020, 11/21/2020, 11/22/2020, 11/17/2020, 11/23/2020, 11/25/2020, 11/26/2020, 11/27/2020, 11/30/2020, 12/1/2020, 12/2/2020, 12/3/2020, 12/4/2020, 12/5/2020, 12/6/2020, 12/7/2020, 12/8/2020, 12/9/2020, 12/10/2020, 12/11/2020, 12/14/2020, 12/15/2020, 12/16/2020, 12/17/2020, 12/18/2020, 12/19/2020, 12/20/2020, 12/21/2020, 12/22/2020, 12/23/2020, 12/24/2020, 12/25/2020, 12/28/2020, 12/29/2020, 12/30/2020, 12/31/2020, 1/1/2021, 1/2/2021, 1/3/2021, 1/4/2021, 1/5/2021, 1/6/2021, 1/7/2021,	G 726		

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G 726	Continued From page 96 1/8/2021, 1/11/2021, 1/12/2021, 1/13/2021, 1/14/2021, 1/15/2021, 1/16/2021, 1/17/2021, 1/18/2021, 1/19/2021, 1/20/2021, 1/21/2021, 1/22/2021, 1/25/2021, 1/26/2021, 1/27/2021, 1/28/2021, 1/29/2021, 1/30/2021, 1/31/2021, 2/1/2021, 2/2/2021, 2/3/2021, 2/4/2021, and 2/5/2021 which were completed by LPN's. The record failed to evidence a LPN supervisory visit completed by a Registered Nurse. 4. During an interview on 2/22/21 at 10:16 AM, the clinical manager stated home health aide (HHA) and LPN supervisory visits were completed by the RN every 30 days. 17-14-1(a)(1)(J)	G 726		
G 750	Home health aide services CFR(s): 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. This Condition is not met as evidenced by: Based on record review and interview the agency failed to ensure all home health aides (HHA) successfully completed an entire competency program by verifying skills on a patient or pseudo-patient (See Tag G768); all HHA's received at least 12 hours of in-service training yearly (See Tag G774); failed to ensure HHA care plans contained patient-specific tasks to be performed by the HHA (See Tag G798); and HHA's provided services that were ordered by the physician and were included in the plan of care (See Tag G800). The cumulative effect of this systemic problem	G 750		

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G 750	Continued From page 97 resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.80 Home health aide services.	G 750		
G 768	Competency evaluation CFR(s): 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. This Standard is not met as evidenced by: Based on record review the agency failed to ensure all home health aides (HHA) successfully completed an entire competency program by verifying skills on a patient or pseudo-patient for 2 of 9 HHA employee records reviewed (Employees I, M).	G 768		

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G 768	Continued From page 98 Findings include: 1. A policy titled, "Home Health Aide Services and Training Program," dated 1/2018, stated, " ...Home Health Aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing services to an individual under the direct supervision of a registered nurse or a licensed practical nurse who is under the supervision of a registered nurse ... class room and supervised practical training must total at least 75 hours ... a minimum of 16 hours of classroom training must precede the supervised practical training of the 75 hours ... the Agency must maintain documentation that demonstrates the requirements of this requirement have been met ... An individual may furnish home health services only on behalf of the Agency only after the individual has successfully completed a competency evaluation program ...." 2. The employee file of Employee I (Home Health Aide) was reviewed on 2/25/21 and indicated a start date of 10/31/2019. The record evidenced a document titled "Home Health Aide Competency Checklist," dated 12/18/2019, and signed by Employee C (Alternate Clinical Manager) and Employee I. The record had blank spots on the competency checklist for demonstrates ability to accurately document tasks, care or observations, documentation in clinical record is accurate and effective, temperature, pulse, respirations, blood pressure, standard precautions, understands methods to decrease risk for infections, knowledge of information that must be reported to supervisor, basic cleaning methods, cleaning equipment, is	G 768		

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G 768	Continued From page 99 familiar with individual patient emergency preparedness plan, bed bath, sponge bath, tub bath, sink shampoo, tub shampoo, bed shampoo, nail care, skin care, oral hygiene and gum care, denture care, oral care on unconscious, offering bedpan/placement, urinal, catheter care, perineal care, proper use of gait belt, transfer from chair to toilet/bedside commode, assist ambulating with a cane, assist with wheelchair to/from, assist ambulating with crutch, assist with mechanical lift, knowledge of normal dietary requirements, knowledge of special diets, knowledge of importance of changing positions frequently, assisting with medications, using a safety razor, using an electric razor, elastic/compression stocking application, use of hoyer lift, if patient has Telehealth unit in place, and reminds them to do checks. The record failed to evidence the appropriate competencies had been completed when the employee was hired. 3. The employee file of Employee M (Home Health Aide) was reviewed on 2/25/21 and indicated a start date of 9/6/2012. The record evidenced a document titled "Home Health Aide Competency Checklist," dated 12/8/2020, and signed by Employee C (Alternate Clinical Manager) and Employee M. The record failed to evidence the appropriate competencies had been completed when the employee was hired.	G 768		
G 774	12 hours inservice every 12 months CFR(s): 484.80(d) Standard: In-service training. A home health aide must receive at least l2 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient.	G 774		

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G 774	Continued From page 100 This Standard is not met as evidenced by: Based on record review and interview, the agency failed to ensure all Home Health Aides (HHAs) received at least 12 hours of in-service training yearly, which affected all agency HHA's. Findings include: A policy titled, "Inservice Education," dated 1/2018, stated, " ...Inservice training [for HHAs (home health aides)] must be performed by an RN ... HHAs are required to receive at least 12 hours of Inservice training during each 12 month period ... The Agency maintains documentation that demonstrates that each HHA has met the requirements ... All Inservice and education programs will be documented ...." The evidence of HHA in-services was requested to be submitted on 3/1/21 at 3:09. During an interview on 3/1/21 at 3:09 PM, when asked how home health aide (HHA) in-services were completed, Employee B (Clinical manager) stated, "In person actually. They're due this month. They're done quarterly." When asked if there was an Inservice book, Employee B stated, "I don't know." When asked who was responsible for organization and oversight of the in-services, Employee B stated, "That would be [name of human resource director]." When asked where the HHA in-services were kept, the administrator stated, "[Employee E, administrative assistant] should have a record of all attendees in her office." During the exit conference on 3/1/21 at 5:30 PM, the agency was asked if there was any additional information to submit for review. No additional information was received at that time. The	G 774		

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G 774	Continued From page 101 agency was told that emailed documents would be accepted until 3/2/21. No in-service documentation was ever emailed.	G 774		
G 798	Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This Standard is not met as evidenced by: Based on record review and interview, the registered nurse (RN) failed to ensure that home health aide (HHA) care plans contained patient-specific tasks to be performed by the home health aide for 9 of 9 patients reviewed who received HHA services (#1, 2, 3, 4, 5, 6, 7, 9, 10). Findings include: 1. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period of 2/9/2021 to 4/9/2021, which indicated orders for the Home Health Aide (HHA) to assist with ADL/IDLs (activities of daily living/instrumental activities of daily living), light housekeeping, meal prep, medication reminders, and to report any issues or abnormal findings to the supervising nurse immediately, for two (2) hours a day, five (5) days a week. The aide care plan, dated 2/5/2021, indicated special equipment, bleeding precautions, to take	G 798		

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G 798	Continued From page 102 the patient's temperature daily, and meal preparation, but failed to provide parameters of when to notify the supervising nurse, failed to list what the special equipment was, failed to specify specific timeframes for care to be provided (e.g., daily, every visit), failed to list the type of diet the patient is ordered, and failed to identify what information to notify the supervising nurse with. 2. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 which indicated orders for the HHA to assist with ADL/IDLs, light housekeeping, meal prep, medication reminders, appointment escorting and reminders, to report any issues or abnormal findings to supervising nurse immediately, and to assist the patient to keep a clean, safe, and conducive environment, for four (4) hours a day, seven (7) days a week. The aide care plan, dated 12/26/2020, indicated special equipment, bleeding precautions, to take the patient's temperature daily, and meal preparation, but failed to provide parameters of when to notify the supervising nurse, failed to list what the special equipment was, failed to specify specific timeframes for care to be provided (e.g., daily, every visit), failed to list the type of diet the patient is ordered, and failed to identify what information to notify the supervising nurse with. 3. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for the certification period 2/17/2021 to 4/17/2021, which indicated orders for the HHA to assist with ambulation within patient's own residence, assist with ADL/IDLs, light housekeeping, shower,	G 798		

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G 798	Continued From page 103	G 798		

medication reminders, examine patient feet for any wound, assist with blood glucose monitoring, and to report any issues or abnormal findings to supervising nurse immediately, for six (6) hours a day in three (3) hour increments, for seven (7) days a week.

The aide care plan, dated 2/15/2021, indicated to watch for signs and symptoms of hypoglycemia, and to check temperature every visit. The aide care plan failed to provide parameters of when to notify the supervising nurse, failed to specify specific timeframes for care (e.g., daily, every visit), and failed to specify parameters and signs or symptoms of hypoglycemia (low blood sugar).

4. The clinical record of patient #4 was reviewed on 2/23/21 and indicated a start of care date of 5/14/2020. The record contained a plan of care for the certification period 5/14/2020 to 7/12/2020, indicating the Home Health Aide (HHA) was to assist with ADLs such as bathing, grooming, toileting, dressing, frequent turns, change bed pads as necessary, light housekeeping, meal prep, grocery shopping, feeding, report any issues or abnormal findings to supervising nurse immediately, keep walkways free of debris, and encourage patient to make healthy food choices, for six (6) hours a day, seven (7) days a week.

The aide care plan, dated 7/9/2020, indicated orders for watching for signs and symptoms of hypoglycemia, and to check temperature. The care plan failed to provide parameters to notify the care manager with, failed to specify specific timeframes for care, failed to specify parameters and signs or symptoms of hypoglycemia (low blood sugar), and to specify what healthy food choices are.

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G 798	Continued From page 104 5. The clinical record of patient #5 was reviewed on 2/23/21 and indicated a start of care date of 4/24/2015. The record contained a plan of care for the certification period 4/3/2019 to 6/1/2019, indicating the Home Health Aide (HHA) was to assist with ADL/IDLs, light housekeeping, meal prep, medication reminders, and to report any issues or abnormal findings to supervising nurse immediately, for four (4) hours a day, seven (7) days a week. The aide care plan, dated 4/4/19, indicated orders for watching for signs and symptoms of hypoglycemia and hyperglycemia. The care plan failed to provide parameters to notify the care manager with, failed to list an accurate diet, failed to specify specific timeframes for care, and failed to specify to assist with meal preparation. 6. The clinical record of patient #6 was reviewed on 2/23/21 and indicated a start of care date of 5/31/2019. The record contained a plan of care for the certification period 11/21/2020 to 1/19/2021, indicating the Home Health Aide was to assist with ADL/IDLs, light housekeeping, meal prep, medication reminders, and to report any issues or abnormal findings to the supervising nurse immediately, for four (4) hours a day, seven (7) days a week. The record failed to evidence an aide care plan updated after 7/23/2020. 7. The clinical record of patient #7 was reviewed on 2/23/21 and indicated a start of care date of 10/20/2020. The record contained a plan of care for the certification period 12/19/2020 to 2/16/2021, indicating the Home Health Aide was to assist with ADL/IDLs, light housekeeping, meal prep, medication reminders, perineal care,	G 798		

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hygiene care, empty foley bag as needed, reorient the patient, and to report any issues or abnormal findings to the supervising nurse immediately, for three (3) hours a day, seven (7) days a week.

The aide care plan, dated 12/17/2020, indicated orders for taking the patient's temperature every visit, but failed to list special equipment, failed to specify specific timeframes for care, failed to specify parameters and signs or symptoms of hypoglycemia (low blood sugar) or to look for signs and symptoms of hypoglycemia, failed to check off that the patient had a urinary catheter, and failed to provide parameters to notify the care manager with.

8. The clinical record of patient #9 was reviewed on 2/23/21 and indicated a start of care date of 7/6/2017. The record contained a plan of care for the recertification period of 2/15/2021 to 4/15/2021, indicating the Home Health Aide was to assist with ADL/IDLs, light housekeeping, meal prep, medication reminders, report any issues or abnormal findings to the supervising nurse immediately, keep walkways free of debris, encourage patient to make healthy food choices, and to encourage patient to wear foot protection at all times, for six (6) hours a day, seven (7) days a week, provided in 3 hour increments two times a day.

The aide care plan, dated 2/11/2021, indicated orders for the patient's temperature to be taken every visit, but failed to list special equipment, failed to specify specific timeframes for care, failed to specify parameters and signs or symptoms of hypoglycemia (low blood sugar), and failed to list meal preparation.

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G 798	Continued From page 106 9. The clinical record of patient #10 was reviewed on 2/23/21 and indicated a start of care date of 7/9/2020. The record contained a plan of care for the recertification period of 1/5/2021 to 3/5/2021, indicating the Home Health Aide (HHA) was to assist with ADL/IDLs, light housekeeping, meal prep, medication reminders, report any issues or abnormal findings to the supervising nurse immediately, daily bath, hygienic practices, toilet transfers, ambulation assists, wheelchair transfers, grooming, skin care, and to provide constant supervision. The record failed to evidence an aide care plan updated after 11/17/2020. 10. During an interview on 3/9/2021 at 3:09 PM, when asked how nurses in the field knew the current orders for their patients, Employee B (Clinical Manager), stated, "Well, there should be a signed 485 [plan of care] in the home already." When asked how the home health aides knew there was a change to the aide care plan, Employee B stated, "That falls back to the case managers." 17-14-1(m)	G 798		
G 800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This Element is not met as evidenced by: Based on record review, the agency failed to ensure home health aides provided services that were ordered by the physician and were included	G 800		

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G 800	Continued From page 107 in the plan of care, for 7 of 9 records reviewed, that had Home Health Aide services (#1, 2, 3, 4, 6, 7, 9). Findings include: 1. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period of 2/9/2021 to 4/9/2021, which indicated the Home Health Aide (HHA) frequency of two (2) hours a day, five (5) days a week. During the week of 12/21/2020 (week 3), visits were conducted as follows: 2, two-hour visits (12/24/2020, 12/26/2020). During the week of 12/28/2020 (week 4), visits were conducted as follows: 3, two-hour visits (12/29/2020, 12/30/2020, 12/31/2020). During the week of 1/4/2021 (week 5), visits were conducted as follows: 3, two-hour visits (1/8/2021, 1/9/2021, 1/10/2021). During the week of 1/11/2021 (week 6), visits were conducted as follows: 1, two-hour visit (1/11/2021). During the week of 1/25/2021 (week 8), visits were conducted as follows: 4, two-hour visits (1/26/2021, 1/27/2021, 1/28/2021, 1/29/2021). 2. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21, indicating the Home Health Aide (HHA) frequency of four (4) hours a day, seven (7) days a week.	G 800		

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G 800	Continued From page 108 During the week of 1/4/2021 (week 3), visits were conducted as follows: 5, four-hour visits (1/4/2021, 1/5/2021, 1/6/2021, 1/7/2021, 1/8/2021). During the week of 1/11/2021 (week 4), visits were conducted as follows: 6, four-hour visits (1/11/2021, 1/13/2021, 1/14/2021, 1/15/2021, 1/16/2021, 1/17/2021). During the week of 1/18/2021 (week 5), visits were conducted as follows: 6, four-hour visits (1/18/2021, 1/19/2021, 1/20/2021, 1/21/2021, 1/22/2021, 1/23/2021). During the week of 2/1/2021 (week 7), visits were conducted as follows: 5, four-hour visits (2/1/2021, 2/2/2021, 2/3/2021, 2/4/2021, 2/5/2021). 3. The clinical record of patient #3 was reviewed on 2/23/21 and indicated a start of care date of 1/9/2017. The record contained a plan of care for the certification period 10/20/2020 to 12/18/2020, indicating a Home Health Aide frequency of six (6) hours a day, seven (7) days a week, in three (3) hour increments. During the week of 12/21/2020 (week 2), visits were conducted as follows: 2, six-hour visits (12/21/2020, 12/22/2020), 1, seven-hour visit (12/26/2020), and 1, six and a half hour visit (12/27/2020). During the week of 1/18/2021 (week 6), visits were conducted as follows: 6, six-hour visits (1/18/2021, 1/19/2021, 1/20/2021, 1/21/2021, 1/23/2021, 1/24/2021).	G 800		

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G 800	Continued From page 109 During the week of 1/25/2021 (week 7), visits were conducted as follows: 6, six-hour visits (1/25/2021, 1/26/2021, 1/27/2021, 1/28/2021, 1/30/2021, 1/31/2021). During the week of 2/1/2021 (week 8), visits were conducted as follows: 6, six hours visits (2/1/2021, 2/2/2021, 2/3/2021, 2/4/2021, 2/5/2021, 2/6/2021). 4. The clinical record of patient #4 was reviewed on 2/23/21 and indicated a start of care date of 5/14/2020. The record contained a plan of care for the certification period 5/14/2020 to 7/12/2020, indicating the Home Health Aide (HHA) frequency of six (6) hours a day, seven (7) days a week. The record failed to evidence home health aide visits during the certification period reviewed. 5. The clinical record of patient #6 was reviewed on 2/23/21 and indicated a start of care date of 5/31/2019. The record contained a plan of care for the certification period 9/22/2020 to 11/20/2021, indicating the Home Health Aide frequency of four (4) hours a day, seven (7) days a week. During the week of 9/22/2020 (week 1), visits were conducted as follows: 2, four-hour visits (9/26/2020, 9/27/2020). 6. The clinical record of patient #7 was reviewed on 2/23/21 and indicated a start of care date of 10/20/2020. The record contained a plan of care for the certification period 12/19/2020 to 2/16/2021, indicating home health aide frequency of three (3) hours a day, seven (7) days a week. During the week of 10/20/2020 (week 1), no	G 800		

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G 800	Continued From page 110 home health aide visits are documented. During the week of 10/26/2020 (week 2), visits were conducted as follows: 2, three-hour visits (10/28/2020, 10/31/2020). 7. The clinical record of patient #9 was reviewed on 2/23/21 and indicated a start of care date of 7/6/2017. The record contained a plan of care for the recertification period of 2/15/2021 to 4/15/2021, indicating a home health aide frequency of six (6) hours a day, seven (7) days a week. During the week of 12/20/2020 (week 2), visits were conducted as follows: 3, three-hour visits (12/20/2020, 12/25/2020, 12/26/2020). During the week 1/10/2021 (week 5), visits were conducted as follows: 6, three-hour visits (1/10/2021, 1/11/2021, 1/12/2021, 1/13/2021, 1/14/2021, 1/15/2021). During the week of 1/17/2021 (week 6), visits were conducted as follows: 4, two and a half hour visits (1/17/2021, 1/18/2021, 1/19/2021, 1/20/2021), and 3, three-hour visits (1/21/2021, 1/22/2021, 1/23/2021). During the week 1/24/2021 (week 7), visits were conducted as follows: 6, three-hour visits (1/24/2021, 1/25/2021, 1/26/2021, 1/27/2021, 1/28/2021, 1/29/2021).	G 800		
G 940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest	G 940		

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G 940	Continued From page 111 practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This Condition is not met as evidenced by: Based on record review and interview, the governing body failed to manage the operation of the agency by reviewing/creating budgets, operational plans, quality assessment and performance improvement program, adoption of policies and revisions, bylaws, and the capital expenditure plan (See Tag G942); the administrator failed to be responsible for the day to day functions of the agency (See Tag G948); the clinical manager failed to assure patient needs were continuously assessed (See Tag G966); and the clinical manager failed to assure the patient plans of care were updated (See Tag G968). The cumulative effect of this systemic problem resulted in the agency being out of compliance with the Condition of Participation 42 CFR 484.105 Organization and administration of services.	G 940		
G 942	Governing body CFR(s): 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all	G 942		

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G 942	Continued From page 112 home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. This Standard is not met as evidenced by: Based on record review, the governing body failed to manage the operation of the agency by reviewing/creating budgets, operational plans, quality assessment and performance improvement (QAPI) program, adoption of policies and revisions, bylaws, and the capital expenditure plan. Findings include: A policy titled, "Governing Body," dated 1/2018, states, " ...The Governing Body will have bylaws [or equivalent] which will be reviewed and revised annually as needed ... all Governing Body members must fulfill their responsibilities ... The Governing Body is responsible for assuring: that an ongoing program for Quality Assessment/Performance Improvement and patient safety is defined, implemented and maintained ... that the Agency-wide quality assessment and performance improvement efforts to address priorities for improved quality of care and patient safety and that all improvement actions are evaluated for effectiveness ... the Governing Body is comprised of individuals with relevant expertise, business knowledge ... the Governing Body meets semi-annually [every 6 months] to review the operations of the Agency and documents all meetings by minutes ... Meeting documents will be filed and retained for a minimum of five [5] years ... the Administrator reserved the right to call for a meeting of the Governing Body whenever such a time is needed ... Additional activities of the Governing Body include: Decision making ... establishing or	G 942		

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G 942	Continued From page 113 approving written policies and procedures governing operations ... oversight of the management and fiscal operations of the Agency ... review of the organization's budget and operational plans ... provision of services ... annual review of policies and procedures ...." The administrator submitted a binder titled "QAPI And Governing Body," for review on 3/1/21 at 4:27 PM. There was no observable data within the binder. The binder failed to evidence approval of QAPI data, review/approval of policies, bylaws, operational plans, budgets, or capital expenditure plans.	G 942		
G 948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This Element is not met as evidenced by: Based on record review and interview, the administrator failed to be responsible for the day-to-day functions of the agency. Findings include: A policy titled "Administrator: Defined," dated 1/2018, stated " ...The Administrator is responsible for the Agency's functions and all day-to-day operations of the Agency ... The Administrator of the Agency has the following responsibilities: Planning, organizing, directing, and evaluating operations to ensure the provision of adequate and appropriate care and services ...." During an interview on 2/23/21 at 10:52 AM, when asked why Employee D (Human Resources) was the only person who had a key that accessed all patient medical records in filing	G 948		

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G 948	Continued From page 114	G 948		

cabinets, the Clinical Manager stated, "He is a control freak."

During an interview on 2/23/21 at 5:00 PM, when asked if staff could care for their own family members while employed by their agency, the administrator stated, "We've stopped letting staff care for their family." When questioned about patient #8 (a current patient), who is cared for by their family member (an employed nurse by the agency) the administrator stated, "I forgot about him."

During an interview on 2/24/21 at 12:05 PM, when asked if the agency used an electronic medical record (EMR), the administrator stated, "No." When the surveyor told the administrator that Employee C (Alternate Clinical manager) stated that the agency used electronic medical record (EMR) A, (to complete plans of care and comprehensive assessments), the administrator had to confer with Employee D (Human Resources) to verify that an EMR was in fact in place and utilized by agency staff. At that time, the administrator asked employee D if the agency could allow the surveyor to gain access to the EMR. Employee D responded, "I can't make that decision." Employee A called the additional two owners of the agency for permission to grant surveyor access to EMR.

During an interview on 2/24/21 at 12:20 PM, when asked if paper charts were complete, the administrator stated, "Yes."

During an interview on 2/24/21 at 3:21 PM, when asked who created the chart thinning process for patient charts (after discovering patient charts were not complete), Employee D stated, "I did, well, the administrator did."

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G 948	Continued From page 115 An undated document titled "Governing Body 2020-2021," received 2/22/21 at 1:33 PM from the administrator indicated employee W was a member of the governing body. During an interview on 3/1/21 at 3:09 PM, when asked if Employee W was a part of the Governing Body, the administrator stated "no." During an interview on 3/1/21 at 3:09 PM, when asked where documentation of the home health aide in-services was kept, the administrator indicated Employee E (Office Staff) had them. Employee E was asked for in-service documentation, and the agency failed to submit them for review.	G 948		
G 966	Assure patient needs are continually assessed CFR(s): 484.105(c)(4) Assuring that patient needs are continually assessed, and This Element is not met as evidenced by: Based on record review and interview, the clinical manager failed to assure patient needs were continuously assessed for 2 of 10 records reviewed (#1, 2). Findings include: 1. A policy titled "Disease Response and Management (COVID-19)," dated 1/2020, Policy #TBD, stated, " ...All clients will participate in the organization's effort to prevent the spread of COVID-19 or a communicable disease by ... if a client becomes quarantined, or test positive for COVID-19 ... At Home will suspend all personal care services until medical clearance is provided ... if suspending personal care services poses a risk to the client (high acuity requiring total care, skilled nursing tasks or nurse delegated tasks) At	G 966		

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G 966	Continued From page 116 home will coordinate with the payer and the client's health care professionals to support the client's ongoing care needs (i.e., home health agency, inpatient care facility ... For home health operations, face to face services that cannot be suspended due to patient needs (nursing and/or HHA), care will continue to be provided while observing standard infection control principles, including Universal precautions and proper PPE technique ...." 2. A document titled, "Orientation Manual," dated 11/7/2019, stated, " ...Holidays ... New Year's Day ... Memorial Day ... Independence Day ... Labor Day ... Thanksgiving Day ... Christmas Day ...." 3. The agency lacked a policy providing instructions on how to assign a "triage code" to their patients. 4. An agency policy revised 2/202, titled "Bed bug policy," Policy #022 stated, Agency staff will assess upon admission, at reassessment, and if the patient's condition changes, the patient's environment for basic home safety. ... Procedure: Agency staff will be educated on handling [sic] beg [sic] bugs or other types of insects of pest infestation, to reduce risk of injuries or threats to life and health, and to encourage the active involvement of patients and their families in their own care ..." 5. The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 2/9/21 to 4/9/21 that indicated a primary diagnosis of Lymphedema (swelling that generally occurs in one of your arms or legs) and a skilled nursing frequency of 4	G 966		

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G 966	Continued From page 117 hours per day 7 days per week for wound care and lymphedema pump to lower legs. The agency failed to meet the patient's needs during the holidays, as evidenced by: The record failed to evidence the agency assigned the patient a triage code upon admission to determine their triage level. A document titled, "Missed Visit Notification Form," dated 12/25/20, states, " ...Holiday no service ...." The document was sent to the patient's primary care provider on 12/25/20. A document titled, "Missed Visit Notification Form," dated 1/1/21, states, " ...Holiday no service ...." The document was sent to the patient's primary care provider on 1/5/21. 6. The clinical record of patient #2 was reviewed on 2/22/21 and indicated a start of care date of 5/7/2019. The record contained a plan of care for the certification period 12/27/20 to 2/24/21 that indicated a primary diagnosis of excoriation disorder (habitually and excessively picking, scratching, gouging or squeezing at otherwise healthy skin), a skilled nursing frequency of one time daily, seven days a week, and a home health aide (HHA) frequency of four hours a day, seven days a week. The agency failed to meet the patient's needs during the holidays, as evidenced by: The record failed to evidence the agency assigned the patient a triage code upon admission to determine their triage level. A document titled, "Missed Visit Notification Form," dated 11/26/20, states, " ...Holiday no service ...." The document was sent to the	G 966		

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G 966	Continued From page 118 patient's primary care provider on 11/26/20. A document titled, "Missed Visit Notification Form," dated 12/25/20, states, " ...Holiday no service ...." The document was sent to the patient's primary care provider on 12/25/20. A document titled, "Missed Visit Notification Form," dated 1/1/21, states, " ...Holiday no service ...." The document was sent to the patient's primary care provider on 1/5/21. 7. During an interview on 2/23/21 at 5:00 PM, when asked if the agency cares for known COVID-19 positive patient, Employee A (Administrator) stated, "No, I don't believe we do." The clinical manager (CM) stated they would probably start calling other agencies to see if someone else could take care of the patients. The CM stated the last time it occurred the patient was sent to a SNF (Skilled Nursing Facility) that took care of COVID-19 positive patients. The CM stated the owners are "absolutely terrified of it [COVID-19]." The CM stated the agency had older employees and were not sure if they wanted the liability. When asked why the agency did not take care of COVID-19 positive patients, the administrator stated, "The individual goes into quarantine and inoculation. We wait 10 - 14 days to go back in the house." The administrator stated the African American population was scared of COVID and most of the employees are African American. Then stated "we don't want to put staff at risk of spreading it. We go right back in after 10 - 14 days." 8. During an interview on 3/1/21 at 3:09 PM, when asked if the agency had a bed bug policy, the Administrator stated, "Yes, we won't go back in the house until they have something saying a	G 966		

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G 966	Continued From page 119 vendor [someone who is able to treat] has been in there." Then she stated if it's a "needful" person, then they suit up." When asked who determined who was a "needful person," Employee A stated, " Most patient know they have bed bugs but if they're must-sees we will try to compromise. We might lessen the time in there." She stated staff will put on their shoe booties and suits to go in. Furthermore, the administrator stated normally people know they have bed bugs. Then when the aide gets bitten, the agency will instruct patients to go get it fixed. When asked how the agency ensured the patient's needs were met during the hold time, The administrator stated, "We put them on hold." When asked who took care of patients who were on hold, Employee A stated, "The primary caregiver will take care of them." We've had to discharge people who had chronic problems." When asked how the agency determined who must be saw, the clinical manager stated, "we document their level" upon admission. She stated a one is a must cover and no one else can cover, two is a family member can cover, three is a changing schedule type. The determination of the patient number is on a handwritten form that the nurse completed called a "Triage Code Form".	G 966		
G 968	Assure implementation of plan of care CFR(s): 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. This Element is not met as evidenced by: Based on record review and interview, the clinical manager failed to ensure the patient's plans of care were updated for 1 of 2 patients with hospitalizations (#1). Findings include:	G 968		

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G 968	Continued From page 120 The clinical record of patient #1 was reviewed on 2/25/21 and indicated a start of care date of 8/13/2020. The record contained a plan of care for the certification period 12/11/20 to 2/6/21 that indicated diagnoses of, but not limited to, Lymphedema (swelling that generally occurs in one of your arms or legs), cellulitis of the right lower limb (a bacterial skin infection), osteoarthritis (wearing down of cartilage occurs gradually and worsens over time), morbid obesity (100 pounds over ideal body weight, a BMI of 40 or more, or 35 or more and experiencing obesity-related health conditions, such as high blood pressure or diabetes), and idiopathic aseptic necrosis of right femur (a bone condition that results from poor blood supply to an area of bone, causing localized bone death). The plan of care failed to evidence new diagnosis(es) post hospitalization. A document from Entity E (Hospital), dated 1/23/21 evidenced a hospitalization due to Kidney stones with subsequent stent placement. During an interview on 2/23/21 at 5:00 PM, when asked if all recent documentation should be in the clinical chart, Employee B (Clinical Manager), stated, "I thought they had it all up to date, but I am finding out they don't. It should be." During an interview on 3/1/21 at 3:09 PM, the administrator and clinical manager were asked if plans of care should be revised if applicable. The clinical manager stated "Oh, absolutely."	G 968		