STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157471	A. BUILDING 00 B. WING	06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HOME HEALTH CRUSADERS INC	3191 WILLOWCREEK ROAD PORTAGE, IN 46368

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 0000 Bldg. 00	This visit was a focused infection control and complaint survey with 1 complaint. The survey visit took place 6/16/2021 to 6/21/2021. Facility ID: IN009404 Complaint: IN00341416 - unsubstantiated - lack of evidence. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.	G 0000		
G 0572 Bldg. 00	484.60(a)(1) Plan of care Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the patient's plan of care was individualized in 1 of 1 patient records reviewed with a home visit (#1). The findings include:	G 0572	The Director of Nursing has in-serviced nursing staff on g tube site care including what site should be cleaned with, if a dressing should be placed, and how frequently site care was to be	06/23/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	Record review on 6/21/2021, evidenced an undated agency policy titled, "Plan of Care", which stated, " ... POLICY STATEMENT ... 4. The plan of care is individualized to each patient an is developed through consultation with the patient / responsible party, they physician and all clinicians involved in the patient's care ... The plan of care shall include ... n. Types of services and specific procedures to be performed...." Clinical record review on 6/18/2021, for patient #1, with start of care 5/8/2021, certification period 5/8/2021 to 7/6/2021, primary diagnosis of Parkinson's disease, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 6/2/2021. The plan of care had a subcategory titled, "Orders for Discipline and Treatment", which stated, " ... SN [skilled nurse] to instruct patient / caregiver on management of Gastrostomy Tube [an artificial external opening into the stomach for nutritional support], including site care, care of equipment....". The plan of care failed to evidence specific instructions for site care, including what site should be cleaned with, if a dressing should be placed, and how frequently site care was to be performed. During an interview on 6/21/2021 at 10:42 a.m., the clinical supervisor indicated site care should include what site should be cleaned with, if a dressing should be placed, and how frequently site care was to be performed. 17-13-1(a)		performed. In-Service was completed on 6/23/21. See document 1. The physician was notified and verbal order received on 6/21/21. See document 2 and 3. The Director of Nursing reviewed all active patient's with g tube to verify proper site care. This will ensure the patient's plan of care was individualized. The Director of Nursing will be responsible for monitoring g tube site care to ensure that this deficiency is corrected and will not recur.	
G 0574	484.60(a)(2)(i-xvi) Plan of care must include the following			

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Bldg. 00	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 or allowed practitioner may choose to include.			
	Based on observation, record review and interview, the agency failed to ensure the individualized plan of care included all services, medications and treatments in 4 of 4 records reviewed.(#1, #2, #3, #4) The findings include: 1. Record review on 6/21/2021, evidenced an	G 0574	The Director of Nursing in-serviced staff on proper documentation of medications including all medications ordered "as needed" should contain an indication for why the medication was taken, all topical medications should include where, on the body, the medication is to be used, and	06/30/2021

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	undated agency policy titled, "Plan of Care", which stated, " ... POLICY STATEMENT 1. Physician orders are obtained prior to the initiation of care and with any changes in the plan of care. 2. Medication reconciliation is completed on each visit and updates to the medication record shall reflect any medication changes ... The plan of care shall include: ... Types of services and specific procedures to be performed...." 2. Record review on 6/21/2021, evidenced an undated agency policy titled, "Physician Orders", which stated, "POLICY All drugs, treatments, procedures, and care provided to patients must be ordered by a physician ... All additions, changes, or deletion of medications obtained by a clinician or other authorized staff member require a verbal order. Orders for medications must include the drug name, dosage, route of administration, frequency, and other directions for use...." 3. Clinical record review on 6/18/2021 for patient #1, with start of care 5/8/2021, certification period 5/8/2021 to 7/6/2021, primary diagnosis of Parkinson's disease, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 6/2/2021. The plan of care had a subcategory titled, "Medications", which stated, "QUETIAPINE [an anti-psychotic medication] ... 1 tablet QD [each day] feeding tube ... SILODOSIN [a medication used to treat problems caused by an enlarged prostate] ... 1 tablet QD feeding tube ... ZINC ... 1 tablet QD feeding tube ... LITHIUM [a mood stabilizer] ... 1 capsule ... feeding tube ... CYCLOBENZAPRINE [a muscle relaxant] ... BID [twice a day] PRN [as needed] for muscle relaxers feeding tube ... LORAZEPAM [an anti-anxiety medication] ... 1		proper route of medication needs to be updated and include both routes if indicated. See document 1. In-service was completed on 6/23/21. The physician was notified and all medications were switched for TF to oral route. A verbal order was received on 6/21/21. The nurse then created a new medication profile, reviewed it with patient and wife, and placed it in the home folder. See document 4 and 5. The Director of Nursing and Alternate Director of Nursing reviewed all current active patient's medication list to verify correct route, all topical medications state a specific site, and as needed medications had an indication for why the medication was taken. All new medication profiles were given to skilled nurse and placed in patient's home folder. Skilled nurse review medication profile with patient and/or caregiver. This was completed by 6/30/21. The Director of Nursing in-serviced nursing staff on care coordination with other services/agencies in the home; which should be included in the plan of care and coordination of care regardless of payor source. See document 1.	

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	tablet Q [every] 6 hrs PRN [as needed] for anxiety feeding tube ... SIMVASTATIN [a cholesterol-lowering medication] ... 1 tablet QD feeding tube ... ACETAMINOPHEN 650 MG [milligram] / 20.3 ML [milliliter] ... 20.3 ml Q [every] 6 hrs PRN [as needed] feeding tube ... ASPIR [sic] 81 1 tablet QD feeding tube ... CARDIZEM [a medication used to treat high blood pressure and chest pain] ... 1 tablet QD feeding tube ... CELEXA [an anti-depressant] ... 1 tablet QD feeding tube...." During a home visit on 6/17/2021 at 10:05 a.m., personal care assistant A, from agency B, was observed handing patient #1 medications, which the patient took by mouth. At 10:37 a.m., employee C, PT [physical therapist], was observed assisting the patient to ambulate up stairs while personal care assistant A provided standby assistance. During an interview on 6/21/2021 at 10:34 a.m., the clinical supervisor indicated the plan of care for patient #1 should indicate the patient's medications could be taken by mouth or by feeding tube. Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 6/2/2021. Review of the plan of care failed to evidence the patient was receiving personal care assistance. During an interview on 6/21/2021 at 10:35 a.m., the clinical supervisor indicated the plan of care should include all services and treatments a patient is receiving. When informed of the findings, the clinical supervisor stated, "[employee C] probably didn't know. It's probably		In-service was completed on 6/23/21. Patient's wife updated agency on private caregiver services on 6/21/21. Director of Nursing, physical therapy, and skilled nurse performed a case conference with private caregiver on 6/21/21. See document 4. The Director of Nursing reviewed all patient's with active physical therapy to include physical therapy in the patient's plan of care. This will ensure the individualized plan of care included all services. The Director of Nursing will be responsible for for monitoring these corrective actions to ensure that is deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for correct documentation of medications including correct route, as needed medications have an indication for why the medication is taken, topical medications state a specific site, and physical therapy is part of the patient's plan of care.	

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	a private pay.". When queried, the clinical supervisor indicated the services provided should be included in the plan of care and coordination of care regardless of payor source. Clinical record review evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 6/2/2021. The plan of care had a subcategory titled, "Medications", which stated, " ... ACETAMINOPHEN 650 MG [milligram] / 20.3 ML [milliliter] ... 20.3 ml Q [every] 6 hrs PRN [as needed] feeding tube (FT) U...." The plan of care failed to evidence an indication for use of the medication. During an interview on 10/21/2021 at 10:26 a.m., the clinical supervisor indicated all medications ordered "as needed" should contain an indication for why the medication was taken. 4. Clinical record review on 6/17/2021 for patient #2, with start of care 9/30/2020, certification period 9/30/2020 to 11/28/2020, primary diagnosis of Paraplegia, incomplete, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 10/19/2020. The plan of care had a subcategory titled, "Medications", which stated, " ... MICONAZOLE 2% TOPICAL OINTMENT 1 application to affected areas - PRN [as needed] (Redness) Topical...." The plan of care failed to evidence how frequently and where, on the body, the medication was to be used. During an interview on 6/21/2021 at 10:47 a.m., the clinical supervisor indicated all medication orders should include how frequently they are taken, and all topical medications should include where, on the body, the medication is to be used. When			

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	informed of the findings, the clinical supervisor indicated the plan of care failed to include all the necessary components of the medication order. 5. Clinical record review on 6/18/2921 for patient #3, with start of care 6/26/2020, certification period 12/23/2020 to 2/20/2021, primary diagnosis of Encounter for attention to gastrostomy [an artificial external opening into the stomach for nutritional support], evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 1/14/2021. Review of the plan of care failed to evidence physical therapy. Clinical record review evidenced an agency document titled, "PT [physical therapy] EVALUATION", dated 1/6/2021, signed by employee D, PT. Clinical record review evidenced a group of documents titled "PT VISIT", each signed by employee D, PT, dated 1/11/2021, 1/13/2021, 1/18/2021, 1/21/2021, and 1/25/2021. Review of the patient's electronic medical record (Axxess) failed to evidence an order to initiate physical therapy. During an interview on 6/21/2021 at 11:05 a.m., the clinical supervisor indicated the a physician's order was required to initiate a physical therapy evaluation and treatment, and the therapy ordered should be included in the plan of care. When informed of the findings, the clinical supervisor produced a copy of a handwritten physician order to initiate physical therapy, signed by physician D, dated 1/5/2021. The agency failed to include physical therapy in the patient's plan of care. Clinical record review on 6/18/2021 for patient #3 evidenced an agency document titled, "HOME			

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	HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 1/14/2021. The plan of care had a subcategory titled, "Medications", which stated, "VOLTAREN 1% TOPICAL GEL 1 application daily - PRN [as needed] to affected areas - pain Topical...." The plan of care failed to evidence where, on the body, the medication was to be used. During an interview on 6/21/2021 at 10:47 a.m., the clinical supervisor indicated all topical medication orders should include where, on the body, the medication is to be used. When informed of the findings, the clinical supervisor indicated the plan of care failed to include all the necessary components of the medication order. 6. Clinical record review on 6/21/2021 for patient #4, with start of care 6/8/2021, certification period 6/8/2021 to 8/6/2021, primary diagnosis of Displaced bimalleolar fracture right lower leg [broken right ankle], evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician. The plan of care had a subcategory titled, "Medications", which stated, " ... COLACE 100 MG [milligram] ORAL CAPSULE 1 capsule BID [twice a day] PRN [as needed] By mouth ... IBUPROFEN 400 MG ORAL TABLET 1 tablet Q [every] 6 hrs PRN [as needed] By mouth ... MIRALAX ORAL POWDER FOR RECONSTITUTION 17 Grms [grams] in 8 oz H2O QD [each day] PRN By mouth...." The plan of care failed to evidence an indication for use of each of these 3 medications. During an interview on 10/21/2021 at 10:26 a.m., the clinical supervisor indicated all medications ordered "as needed" should contain an indication for why the medication was taken. When			

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	informed of the findings, the clinical supervisor reviewed the plan of care and indicated the plan of care failed to include all the necessary components of the medication order. 17-13-1(a)(1)(B)(D)(ii)(iii)(ix)			
G 0606 Bldg. 00	484.60(d)(3) Integrate all services Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to coordinate care provided by all disciplines in 1 of 1 patient records reviewed with a home visit (#1). The findings include: Record review on 6/21/2021 evidenced an undated agency policy titled, "COORDINATION OF PATIENT SERVICES", which stated, "POLICY All members of the home care team will maintain a liaison to ensure that the patient's care is well-coordinated. PURPOSE To ensure appropriate, quality care is being provided and to maintain continuity of care and maximize patient outcomes ... POLICY STATEMENT ... Case conferences will be conducted after the initial assessments, at a minimum of every 30 days ... and at any other time when a clinician identifies a need ... Conferences will be recorded in the clinical record." During a home visit on 6/17/2021 at 10:05 a.m., personal care assistant A, from agency B, was observed handing patient #1 medications which	G 0606	The Director of Nursing in-serviced nursing staff on care coordination with other services/agencies in the home; which should be included in the plan of care and coordination of care regardless of payor source. All disciplines will assess for other services/agencies in the home to ensure that the patient's care is well coordinated. See document 1. In-service was completed on 6/23/21. Patient's wife updated agency on private caregiver services on 6/21/21. Director of Nursing, physical therapy, and skilled nurse performed a case conference with private caregiver on 6/21/21. See document 4. The Director of Nursing will be responsible for for monitoring these corrective actions to ensure	06/23/2021

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	the patient took by mouth. At 10:37 a.m., employee C, PT [physical therapist], was observed assisting the patient to ambulate up stairs while personal care assistant A provided standby assistance. Clinical record review on 6/18/2021 for patient #1 with start of care 5/8/2021, certification period 5/8/2021 to 7/6/2021, primary diagnosis of Parkinson's disease, evidenced an agency document titled, "HOME HEALTH CERTIFICATION AND PLAN OF CARE", signed by the physician on 6/2/2021. Review of the plan of care failed to evidence the patient was receiving personal care assistance. Review of the patient's electronic medical record (Axxess) failed to evidence the patient was receiving personal care assistance and any communication with agency B. During an interview on 6/21/2021 at 10:35 a.m., the clinical supervisor indicated if a patient is shared with another agency, she would call the other agency, review the plan of care, frequency of visits, services provided, and exchange contact information. The clinical supervisor indicated this communication should be documented in the patient's electronic medical record. When informed of the findings, the clinical supervisor stated, "[employee C] probably didn't know. It's probably a private pay.". When queried, the clinical supervisor indicated the services provided should be included in the plan of care and coordination of care regardless of payor source. 17-12-2 (h)		that is deficiency is corrected and will not recur.	

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G 0716 Bldg. 00	484.75(b)(6) Preparing clinical notes Preparing clinical notes; Based on observation, record review and interview, the home health agency failed to ensure the skilled nurse prepared the clinical notes accurately in 1 of 1 discharged records reviewed receiving home health aide services (#2). The findings include: Record review on 6/21/2021, evidenced an undated agency document titled, "CLINICAL RECORDS", which stated, "POLICY Each patient shall have a clinical record, identifiable for home health services ... in accordance with accepted professional and patient privacy standards ... PURPOSE To ensure that a complete and accurate record of patient care is maintained...." Record review on 6/21/2021, evidenced an undated agency document titled, "DOCUMENTATION OF PATIENT SERVICES", which stated, "POLICY Documentation shall be written on patient care, patient-related communications, verbal orders, supervision, and any other information related to the patient's home health services ... PURPOSE To establish a standard for clinical documentation ... POLICY STATEMENT ... Notes shall be written on the day of service and incorporated into the clinical record at least every 14 days...." Record review on 6/21/2021, evidenced an undated agency document titled, "SKILLED NURSING SERVICES", which stated, " ... PURPOSE To ensure that patients receive competent nursing care according to their individual needs ... POLICY STATEMENT The Registered Nurse will: ... Supervise Home Health	G 0716	The Director of Nursing in-serviced nursing staff on documentation of HHA supervisory visits. See Document 1. In serviced was completed on 6/23/21. Skilled nurse admits it was an error. The Director of Nursing reviewed all active patient charts who have home health aide services to ensure proper documentation of HHA supervisory visits. This will ensure the skilled nurse prepared the clinical notes accurately. The Director of Nursing will be responsible for for monitoring these corrective actions to ensure that is deficiency is corrected and will not recur. 10% of all clinical records will be audited quarterly for proper documentation of HHA supervisory visits.	06/23/2021

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	Aides according to agency policy...." Clinical record review on 6/17/2021 for patient #2, with start of care 9/30/2020, certification period 9/30/2020 to 11/28/2020, primary diagnosis of Paraplegia, incomplete, evidenced a group of agency documents titled, "COMMUNICATION NOTE". A note dated 10/02/2020, signed by the clinical supervisor, stated, "[physician C] notified of missed HHA [home health aide] visit...." A note dated 10/08/2020, signed by employee F, stated, "[physician C] notified of missed HHA visit...." Review of the patient's electronic medical record (Axxess) evidenced the first HHA visit was made on 10/16/2020. Clinical record review evidenced a group of agency documents titled, "HHA Supervisory Visit". Review of these documents evidenced HHA supervisory visit notes dated 10/8/2020 and 10/15/2020. No HHA visits had yet been made. During an interview on 6/21/2021 at 10:48 a.m., the clinical manager indicated the nurse should make supervisory visits at least every 2 weeks when a patient was receiving HHA services to evaluate the HHA. When informed of the findings, the clinical manager stated, "That was an error". 17-14-1(a)(1)(E)			
G 0798 Bldg. 00	484.80(g)(1) Home health aide assignments and duties Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written			

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	patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the agency failed to ensure the registered nurse provided a clear plan of care for the home health aide to follow in 1 of 1 active patient records reviewed receiving home health aide services (#4). The findings include: Record review on 6/22/2021, evidenced an undated agency policy titled, "HOME HEALTH AIDE SERVICES", which stated, " ... POLICY STATEMENT ... Home Health Aide services may include: ... Maintaining a safe environment for the patient ... Documentation of findings and interventions according to agency policy ... The HHA shall provide patient services and direct care by following the care plan exactly as written by the registered nurse and may not make any changes to the plan of care. Any deviations from the plan of care must be reported to the case manager...." Record review on 6/21/2021, evidenced an undated agency document titled, "SKILLED NURSING SERVICES", which stated, " ... PURPOSE To ensure that patients receive competent nursing care according to their individual needs ... POLICY STATEMENT The Registered Nurse will: ... Supervise Home Health Aides according to agency policy...." Clinical record review on 6/18/2021 for patient #4, with start of care 6/8/2021, certification period 6/8/2021 to 8/6/2021, primary diagnosis of Displaced bimalleolar fracture right lower leg	G 0798	The Director of Nursing in-serviced nursing staff on providing a clear plan of care for the home health aide to follow. In-service was completed on 6/23/21. See document 1. The physician was notified and verbal order received on 6/21/21 to change HHA care plan to include making bed. Patient and caregiver was updated on plan of care by skilled nurse. See document 6, 7, and 8. The Director of Nursing reviewed all active patient's with home health aide services to verify a clear plan of care. The Director of Nursing will be responsible for for monitoring these corrective actions to ensure that is deficiency is corrected and will not recur.	06/25/2021

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	[broken right ankle], evidenced an agency document titled, "HHA Care Plan", dated 6/8/2021, signed by employee E, RN. This care plan had a subcategory titled, "Plan Details". In this section, the task, "Make Bed" was indicated as "N/A". The tasks "Change Linen" and "Light Housekeeping" were indicated as "QV" [every visit]. During a interview on 6/21/2021 at 11:13 a.m., the clinical manager indicated tasks marked as "QV" were to be done by the HHA at each visit, and tasks marked as "N/A", the HHA was not to do. When informed of the findings, the clinical manager stated, "How do you change linen without making the bed? That [the HHA care plan] doesn't even make sense." 17-13-2(a)			
G 0800 Bldg. 00	484.80(g)(2) Services provided by HH aide A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview, the home health aide failed to provide services as indicated in the aide care plan in 2 of 2 records reviewed receiving home health aide services (#2, #4). The findings include: 1. Record review on 6/22/2021, evidenced an undated agency policy titled, "HOME HEALTH	G 0800	The Director of Nursing in-serviced nursing staff on safety precautions indicated in the HHA care plan. Each HHA visit note must indicate the safety precautions that were listed on care plan. See Document 1. In-service completed on 6/23/21.	06/24/2021

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	AIDE SERVICES", which stated, " ... POLICY STATEMENT ... Home Health Aide services may include: ... Maintaining a safe environment for the patient ... Documentation of findings and interventions according to agency policy ... The HHA [home health aide] shall provide patient services and direct care by following the care plan exactly as written by the registered nurse and may not make any changes to the plan of care. Any deviations from the plan of care must be reported to the case manager...." 2. Record review on 6/21/2021, evidenced an undated agency document titled, "SKILLED NURSING SERVICES", which stated, " ... PURPOSE To ensure that patients receive competent nursing care according to their individual needs ... POLICY STATEMENT The Registered Nurse will: ... Supervise Home Health Aides according to agency policy...." 3. Clinical record review on 6/17/2021 for patient #2, with start of care 9/30/2020, certification period 9/30/2020 to 11/28/2020, primary diagnosis of Paraplegia, incomplete, evidenced an agency document titled, "HHA Care Plan", dated 9/30/2020, signed by employee G, RN [registered nurse]. This care plan had a subcategory titled, "Safety Precautions", in which each of the following items were indicated: Keep Pathway Clear, Standard Precautions / Infection Control, Emergency Plan Developed, Keep Side Rails Up, Proper Positioning During Meals, Sharps Safety, Support During Transfer / Ambulation, Fall Precautions, Safety in ADL's [activities of daily living], Slow Position Change, and Use of Assistive Devices. Clinical record review evidenced a group of agency documents titled, "HHA Visit", dated		The Director of Nursing had a one to one conference with aide on 06/24/21. The Director of Nursing educated aide on safety precautions found on the care plan that will need to be addressed in each HHA visit note. The software Axxess does not allow that to be charted therefore the aide must manually type all safety precautions. Administrator and Director of Nursing updated policy E-12 on 6/24/21. See document 9. The Director of Nursing will be responsible for for monitoring these corrective actions to ensure that is deficiency is corrected and will not recur.	

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	10/16/2020, 10/23/2020, 10/30/2020, and 11/6/2020, each signed by employee H, HHA. Each of these visit notes failed to evidence any safety precautions indicated in the HHA care plan. During an interview on 6/21/2021 at 10:48 a.m., the clinical supervisor indicated the HHA should provide care as directed in the HHA care plan. The clinical manager indicated safety precautions should be addressed and documented at each visit by all disciplines. When informed of the findings, the clinical supervisor indicated the HHA documentation failed to evidence safety precautions. 4. Clinical record review on 6/18/2021 for patient #4, with start of care 6/8/2021, certification period 6/8/2021 to 8/6/2021, primary diagnosis of Displaced bimalleolar fracture right lower leg [broken right ankle], evidenced an agency document titled, "HHA Care Plan", dated 6/8/2021, signed by employee E, RN. This care plan had a subcategory titled, "Safety Precautions", in which each of the following items were indicated: Keep Pathway Clear, Standard Precautions / Infection Control, Emergency Plan Developed, Proper Positioning During Meals, Support During Transfer / Ambulation, Fall Precautions, Safety in ADL's [activities of daily living], Slow Position Change, and Use of Assistive Devices. Clinical record review evidenced an agency document titled, "HHA Visit", dated 6/16/2021, signed by employee H, HHA. This visit note failed to evidence any safety precautions indicated in the HHA care plan. During an interview on 6/21/2021 at 10:48 a.m., the clinical supervisor indicated the HHA should provide care as directed in the HHA care plan.			

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	The clinical manager indicated safety precautions should be addressed and documented at each visit by all disciplines. When informed of the findings, the clinical supervisor indicated the HHA documentation failed to evidence safety precautions.			
G 1024 Bldg. 00	484.110(b) Authentication Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure all clinical record entries were legible, clear, complete, and appropriately authenticated in 1 of 1 discharged records reviewed receiving home health aide services (#2) The findings include: Record review on 6/21/2021, evidenced an undated agency document titled, "CLINICAL RECORDS", which stated, "POLICY Each patient shall have a clinical record, identifiable for home health services ... in accordance with accepted professional and patient privacy standards ... PURPOSE To ensure that a complete and accurate record of patient care is maintained...." Record review on 6/21/2021, evidenced an undated agency document titled, "DOCUMENTATION OF PATIENT SERVICES", which stated, "POLICY Documentation shall be written on patient care, patient-related communications, verbal orders, supervision, and	G 1024	The Director of Nursing in-serviced nursing staff on proper wound care documentation including granulation VS epithelialization. See document 1. In-service completed on 6/23/21. The Director of Nursing reviewed active patient's charts with wound care and discovered one skilled nurse was charting 100% granulation. One on one conference was completed with that skilled nurse to ensure proper documentation of wound care. The Director of Nursing will be responsible for for monitoring these corrective actions to ensure that is deficiency is corrected and will not recur.	06/23/2021

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	any other information related to the patient's home health services ... PURPOSE To establish a standard for clinical documentation ... POLICY STATEMENT ... Notes shall be written on the day of service and incorporated into the clinical record at least every 14 days...." Clinical record review on 6/17/2021 for patient #2, with start of care 9/30/2020, certification period 9/30/2020 to 11/28/2020, primary diagnosis of Paraplegia, incomplete, evidenced a group of agency documents titled, "COMMUNICATION NOTE". A note dated 10/02/2020, signed by the clinical supervisor, stated, "[physician C] notified of missed HHA [home health aide] visit...." A note dated 10/08/2020, signed by employee F, stated, "[physician C] notified of missed HHA visit...." Review of the patient's electronic medical record (Axxess) evidenced the first HHA visit was made on 10/16/2020. Clinical record review evidenced a group of agency documents titled, "HHA Supervisory Visit". Review of these documents evidenced HHA supervisory visit notes dated 10/8/2020 and 10/15/2020. No HHA visits had yet been made. During an interview on 6/21/2021 at 10:48 a.m., the clinical manager indicated the nurse should make supervisory visits at least every 2 weeks when a patient is receiving HHA services to evaluate the HHA. When informed of the findings, the clinical manager stated, "That was an error". Clinical record review for patient #2 evidenced a group of agency documents titled, "SKILLED NURSE VISIT" dated 10/8/2020, 10/15/2020, 10/22/2020, 10/29/2020, 11/5/2020, 11/12/2020, and			

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	11/19/2020, each signed by employee G, RN. Each of the visit notes had a subcategory titled, "Wound Care Flowsheet", which stated, "Wound 1 Location: buttock / groin area ... Wound Bed Granulation [a red, bumpy tissue that forms in the bed of a healing wound]: 100...." Each of the visit notes had a subcategory titled, "Treatment Performed", which stated, "no red skin observed to buttock / groin area - medication applied per spouse preventively. No open areas observed...." On 6/21/2021 at 10:52 a.m., when informed of the findings, the clinical manager indicated she believed employee G was indicating the wound was healed. When informed granulation is found in a wound that was healing, not a wound that has completely healed, the clinical supervisor stated, "OK". 17-15-1(a)(7)			