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| PROCARE HOME HEALTH SERVICES | 8300 BROADWAY STREET STE F2A<br>MERRILLVILLE, IN 46410 |

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| E 0000<br><br>Bldg. 00 | | E 0000 | | |
| | An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102.<br><br>Facility ID: 003042<br><br>Survey dates: 10/7/20, 10/8/20, 10/9/20, 10/13/20, and 10/14/20<br><br>Active Census: 68<br><br>Discharged Census: 222<br><br>At this Emergency Preparedness survey, ProCare Home Health Services was found to be not in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers. | | | |
| E 0024<br><br>Bldg. 00 | 403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5)<br>Policies/Procedures-Volunteers and Staffing<br>[(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the | | | |

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

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

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| | policies and procedures must address the following:]<br>(6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.<br><br>*[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency.<br><br>*[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.<br>Based on record review and interview, the administrator failed to ensure an emergency preparedness policy was in place where volunteers could be utilized in 1 of 1 administrator. (A)<br><br>The findings include:<br><br>1. Record review evidenced undated policy titled "Emergency Preparedness Management Policy B-400" which was a detailed instruction of the policy, purpose, special instructions, and sample disaster plan. This policy failed to evidence the required policy and procedure for volunteers with varying levels of skill and training. | E 0024 | The Administrator and DON reviewed and revised the Policy titled “Emergency Preparedness Management for reeducation and clarification of responsibilities. The policy now includes a section where volunteers with varying levels of skill and training could be integrated and utilized.<br>The Administrator and DON will review this policy yearly to ensure that it is current.<br>The Administrator and DON will be responsible for monitoring this policy and procedure and assure that this deficiency does not recur | 10/21/2020 |

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| | During an interview on 10/14/2020, at 2:43 PM, employee A, administrator, indicated there would not be a need for the use of volunteers. | | | |
| E 0036<br><br>Bldg. 00 | 403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d)<br>EP Training and Testing<br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, RHC/FHQs at §491.12:]<br>(d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years.<br><br>*[For LTC at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least | | | |

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| | annually.<br><br>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).<br><br>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. | | | |
| | Based on record review and interview, the administrator failed to ensure staff received emergency preparedness training annually for the home health agency. (A)<br><br>The findings include:<br><br>1. An undated agency policy titled "Emergency Preparedness Management Policy B-400" had an area subtitled "Training" which stated "Agency | E 0036 | The Administrator and Director of Nursing (DON) reviewed Emergency Preparedness Policy B-400 area subtitled “Training” for reeducation and clarification of responsibilities. This deficiency was corrected on 10-21-20 with a Tabletop exercise on Tornado disaster. All staff members participated in the exercise which | 10/21/2020 |

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| | staff members will participate in an annual desktop drill to determine the effectiveness and efficiency of the current plan and any forms developed for use in a disaster.... "<br><br>Record review on 10/14/2020, of the agency's emergency preparedness binder evidenced a document titled "Emergency Preparedness Tabletop Exercise" which was presented by employee A, administrator, on 1/10/2018. The emergency preparedness binder failed to evidence a training exercise conducted within the last year as required.<br><br>During an interview on 10/14/2020, at 2:40 PM, employee A acknowledged there had not been an emergency preparedness training exercise in 1 year and 10 months. | | tested the preparedness of the agency to deal with a Tornado disaster.<br>The Administrator and DON will perform two more tabletop exercises six months apart in the next year to determine the effectiveness and efficiency of the current plan and then annually according to policy the year after.<br>The Administrator and DON will be responsible for this correction and ensuring that this deficiency does not recur | |
| G 0000<br><br>Bldg. 00 | This survey was a recertification, re-licensure, federal focused infection control, emergency preparedness and complaint investigation of a home health agency.<br><br>Survey Dates: 10/7/20, 10/8/20, 10/9/20, 10/13/20, and 10/14/20<br><br>IN00289478 - substantiated with related findings<br>IN00255912 - substantiated with related findings<br><br>Facility ID: 003042<br><br>Skilled Unduplicated Census: 224<br><br>Active Census: 68<br><br>Discharged Census: 222 | G 0000 | | |

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| | 2 home visits with clinical record reviews<br><br>1 home visit without clinical record review<br><br>6 clinical record reviews<br><br>These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings. | | | |
| G 0374<br><br>Bldg. 00 | 484.45(b)<br>Accuracy of encoded OASIS data<br>Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment.<br><br>Based on record review and interview, the agency failed to ensure accuracy of OASIS [Outcome and Assessment Information Set] data in 1 of 2 patients with home visits, out of a total of 8 records reviewed. (#2)<br><br>The findings include:<br><br>Record review on 10/13/2020, evidenced an agency policy titled "OASIS DATA COLLECTION", dated 10/25/2005 which stated "PURPOSE Establish guidelines that insures accurate and timely data collection and submission of OASIS data...."<br><br>Clinical record review on 10/13/2020 for patient #2, certification period 9/6/2020 to 11/4/2020, start of care 7/8/2020, evidenced a document titled "OASIS-D1 Recertification" dated 9/5/2020 and signed by the nurse. This document had a section titled "FUNCTIONAL STATUS". This assessment indicated the patient was able to participate in bathing self with assistance or | G 0374 | The Board of Directors met on 11/11/2020 and employed the services of a consulting firm with over 15 years of Home Health experience to provide consulting guidance to the Administrator and Director of Nursing (DON) in order to improve the quality and accuracy of the encoded OASIS.<br>The encoded OASIS data are now accurate reflection of the patient's status at the time of assessment.<br>A consultant has now been hired to review all OASIS and corrections made by clinicians if necessary, to ensure the accuracy of the assessment.<br>The Consultant and the Director of Nursing (DON) and/or clinical designee will review the OASIS data/clinical notes to ensure the accuracy of all assessments weekly.<br>The DON will be responsible to | 11/11/2020 |

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| | supervision, able to get to and from toilet and transfer when assisted, transfer with minimal human assistance or assistive device, and able to walk with supervision or assistance of another person. This document had another section titled "Section GG: Mobility". In this section, the following activities were documented as "Patient Refused": A. Roll left and right. B. Sit to lying. C. Lying to sitting on side of bed. E. Chair/bed-to-chair transfer. F. Toilet transfer. I. Walk 10 feet. The agency failed to provide an accurate OASIS assessment of the patient.<br><br>During an interview on 10/14/2020 at 11:45a.m., the administrator stated "I don't understand why the documentation is like that" and offered nothing further. | | ensure that this deficiency does not recur. | |
| G 0444<br><br>Bldg. 00 | 484.50(c)(9)<br>State toll free HH telephone hotline<br>Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs.<br>Based on observation, record review and interview, the agency failed to ensure patients were advised of the state toll free home health telephone hotline, its contact information, and that its purpose is to receive complaints or questions about local HHAs (home health agencies) in 1 of 2 patients with home health visits, out of a total of 8 clinical records reviewed. (#2)<br><br>The findings include:<br><br>Record review on 10/13/2020, evidenced an agency policy dated 10/10/17, titled "Patient's Bill of Rights", which stated " ... 7. The patient has | G 0444 | The Administrator and the Director of Nursing (DON) in- serviced the clinical staff, Nurses and Therapists, on emphasizing the STATE HOTLINE for complaints or questions during the admission process and continuously while the patient is in care of the agency. All clinical staff has re-informed all their patients of the state Hotline.<br>10% of the patients will be called randomly monthly for the next 3 months then quarterly to ascertain that this deficiency has been | 11/10/2020 |

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| | the right to be advised of the availability of the toll-free home health agency hotline in the State...."<br><br>Observation during a home visit on 10/13/2020 at 9:40 a.m., for patient #2, failed to evidence home health hotline information in the patient's home.<br><br>During an interview on 10/13/2020 at 9:54 a.m., patient #2 indicated she was not aware of a state home health hotline.<br><br>During an interview on 10/14/2020 at 11:55 a.m., employee B indicated all patients should have home health hotline information in their homes.<br><br>17-12-3(b)(2)(C) | | corrected.<br>The Administrator and DON are responsible to ensure compliance and to prevent reoccurrence. | |
| G 0480<br><br>Bldg. 00 | 484.50(e)(1)(i)(A)<br>Treatment or care<br>(i)(A) Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; and<br>Based on record review and interview, the agency failed to ensure patient care was furnished appropriately by the skilled nurse in 1 of 2 patients with a colostomy, in a total sample of 8 patient records reviewed. (#8)<br><br>The findings include:<br><br>1. An agency policy dated 10/10/2017, titled "3.6 Patient's Bill of Rights" stated "... 3. The patient has the right to be advised in advance, of the disciplines that will furnish care, and the frequency of visits proposed to be furnished ... 9. ProCare Home Health Services must investigate any complaint mad [sic] by the patient or the | G 0480 | The Administrator and Director of Nursing (DON) reviewed the Agency policies titled “3.5 Patients’ Rights”, “3.6 Patients’ Bill of Rights” and “3.7 Patient Concerns” for reeducation and clarification of responsibilities.<br>The skilled staff were reeducated to ensure that patient care is given appropriately in accordance with their professional license; patient/caregiver are informed in advance of the personnel and the disciplines that will furnish care as well as the frequency of visits | 11/10/2020 |

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| | patient's family or guardian regarding the treatment or care that is (or fails to be) furnished or regarding the lack of respect for the patient's property by anyone furnishing services on behalf of ProCare Home Health Services. The Director of nursing ... will investigate all complaints and answer all questions ... 13. The patient has the right to be advised, before care is initiated, of the extent to which payment for ProCare's services may be expected from Medicare/Medicaid or other sources, and the extent to which payment may be required from the patient ... 14. The patient has the right to have his or her property treated with respect ... 17. Should the patient be judged incompetent, the patient has the right to have his/her lawful representative exercise these rights.... "<br><br>2. Clinical record review on 10/13/2020, for patient #8, start of care 3/1/2019, principle diagnosis of unspecified of intellectual disabilities, evidenced a document titled "Admission Service Agreement Home Health" which was signed by employee B, director of nursing (DON), and person D (primary caregiver to patient #8) on 3/1/2019. This document had an area subtitled "Liability for payment" which stated "I understand that the services provided to me by this organization will be billed as follows: [box checked to indicate] Medicaid (Project 100% covered after meeting spend down and/or other requirements)."<br><br>Record review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 2/28/2019 - 4/28/2019, signed by the patient's physician. This document indicated the patient was forgetful, had functional limitations when ambulating, and was prone to skin breakdown. An area of this document subtitled "Orders For Discipline and Treatment" | | planned. Skilled staff will perform complete physical assessment each visit and ensure the patient has supplies needed to manage the patient's condition. Skilled staff will follow the plan of care and ensure education was provided to the patient/patient caregiver on management of the patient's condition. Skilled staff must follow the treatment plan and/or care plan as directed by the primary care physician. The Director of nursing will investigate all complaints and answer all questions<br>In addition to the quarterly monthly satisfaction survey done by our contracted CAHPS provider, 10% of the patients will be contacted by phone monthly and then quarterly after three months for client satisfaction. These activities will be monitored quarterly as a component of the quality improvement program.<br>The Administrator and DON will be responsible to reassuring this deficiency does not recur | |

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| | stated "Skilled nurse developed patient plan of care with patient/caregiver involvement to be countersigned by physician. SN [skilled nurse] to perform complete physical assessment each visit with emphasis on new colostomy [surgical procedure that brings end of the colon is diverted through the abdominal wall] ... SN to instruct patient/caregiver on management of colostomy including stoma [end of the colon that is diverted through the abdominal wall] care, s/s [signs and symptoms] of complications to report, application of ostomy appliance, emptying pouch, infection control, bathing, skin care, irrigation and dietary management ... "<br><br>Record review evidenced an agency document titled "Skilled Nurse Visit" which was electronically signed by employee M, RN (registered nurse) on 3/5/2019. This document had an area subtitled "Interventions" that stated "Precut colostomy bag [does not fit. Client has some old colostomy bags from the nursing home that I could cut to client's size. Changed colostomy bag at this time ... Measured stoma at this time. Educated client on signs and symptoms of a urinary tract infection ... " Another area subtitled "Visit Narrative" stated "Colostomy bag on. No complications noted. Measurements of stoma and texted D.O.N. [director of nursing] [employee B] them .... "<br><br>Record review evidenced an agency document titled "Skilled Nurse Visit" which was electronically signed by employee M, RN on 3/8/2019. This document had an area subtitled "Interventions" which stated "Client needed [his/her] colostomy bag changed on Thursday. Client's [sibling] (caregiver) [person D] stated to come Friday instead. I called and spoke to [person D] and stated that I was going to be on my way to | | | |

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| | change colostomy bag. Upon arrival, Colostomy bags were not in the box. Client was sitting with a towel under him ... Informed [person D] that [the patient] will have to go to the Emergency room. I did not have the colostomy supplies to change the colostomy bag. [Person D] stated [he/she] was going to take him to the Emergency room to get changed ... Also, the client's [relative] was there and was made aware of this ... I told [the relative] to keep the towel wrapped around the bag to avoid it dripping on the floor ... Informed director of nursing ... [employee B] D. O. N. verbalized understanding ... "<br><br>Record review evidenced an agency document titled "Communication Note" electronically signed by employee A, PT [physical therapist]/administrator. This document was from 3/11/2019, and stated "Returned a phone call regarding [patient #8] ... Friday was a second time that [employee M] left the patient without stoma bag. They had been in contact with each other while the nurse was in the patient's home. And [person D] indicated [he/she] was going to bring a stoma bag from the store. However, the nurse left before [he/she] arrived ... called the nurse back up to five times but the nurse never replied ... [Person D] had to deal with the bags all weekend and there was feces everywhere ... when [he/she] returns, [he/she] would need nursing to come back and fix colostomy bag ... [employee A] reassured [him/her] ... that we will resolve the situation again as a matter of priority.... "<br><br>The skilled nurse failed to ensure the patient had supplies to manage the new colostomy. The skilled nurse failed to follow the plan of care and ensure education was provided to the patient/patient caregiver on management of the colostomy (which would include ensuring | | | |

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| | supplies are stocked), stoma care, application of the ostomy appliance, emptying the pouch and skin care. The skilled nurse failed to provide treatment and/or care to the patient as directed by the primary care physician. The administrator was aware of the lack of the skilled nurse caring for the patient's colostomy as directed on the plan of care and failed to investigate the incident and provide the patient/patient caregiver with a resolution, as evidenced by review of the complaint log.<br><br>During an interview on 10/13/2019, at 2:52 PM, employee B indicated they let the patient know what is covered at the start of care and added there were extra colostomy supplies kept in the office to use as needed.<br><br>During an interview on 10/13/2019, at 3:00 PM, employee A indicated person D is the patient's primary caregiver and would be responsible for maintaining the patients colostomy when the agency is not there due to the patients intellectual disability. | | | |
| G 0484<br><br>Bldg. 00 | 484.50(e)(1)(ii)<br>Document complaint and resolution<br>(ii) Document both the existence of the complaint and the resolution of the complaint; and<br>Based on record review and interview, the agency failed to document both the existence and resolution of a patient complaint in 2 of 3 discharged patients, in a total sample of 8 records reviewed. (#4, #8).<br><br>1. Review of an agency policy dated 10/10/2017, titled "PATIENT'S BILL OF RIGHTS", stated " ... ProCare Home Health Services must investigate any complaint mad [sic] by the patient or the patient's family or guardian regarding treatment or | G 0484 | This deficiency has now been corrected. The complaints documentations were previously maintained in hard and soft format; now there is a single Complaint Log Binder (Log), integrating the Electronic Medical Record (EMR) (soft format) with the physical complaint log binder (hard format). All complaints will be filed in the Complaint Log Binder, | 11/05/2020 |

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| | care that is (or fails to be) furnished ... The Director of nursing ... will investigate all complaints and answer all questions...."<br><br>2. The agency complaint log was received from the clinical manager on 10/7/2020 at 11:30 a.m. The clinical manager indicated the log was complete. Review of agency's complaint log on 10/7/2020 at 11:35 a.m., failed to evidence any entries from patient #4.<br><br>Clinical record review on 10/13/2020, of patient #4's electronic medical record in Axxess failed to evidence any communication notes addressing patient concerns about care.<br><br>During an interview on 10/9/2020 at 3:20 p.m., patient #4 indicated she spoke to the clinical manager "several times" about concerns she had about her care. The patient indicated no resolution was made.<br><br>During an interview on 10/14/2020 at 11:55 a.m., the clinical manager indicated if a patient complains, the clinical manager or administrator will discuss with the patient and any staff members involved to investigate and resolve the complaint. The clinical manager indicated this information is documented in the agency complaint book or in a communication note in the patient's clinical record. The agency failed to document existence and resolution of the patient's complaint.<br><br>3. Clinical record review on 10/13/2020, of patient #8, start of care 3/1/2019, evidenced an agency document titled "Incident/Accident Log" electronically signed by employee A on 3/15/2019. This document indicated the patient, caregiver, | | investigated, and followed up until resolved.<br>The Log will be monitored quarterly for completeness and accuracy as a component of the quality improvement program.<br>The Administrator and DON will be responsible to reassuring this deficiency does not recur | |

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| | and employee was involved and stated "Return a phone call regarding [patient #8]. [Person D] complained bitterly about the nurse. He/She indicated at the start of care that she was not familiar with the condition of the patient. And Friday was a second time he/she left the patient without stoma bag. They had been in contact with each other while the nurse was in the patient's home. And [person D] had indicated he/she was going to bring a stoma bag from the store. However, the nurse left before [person D] arrived at about 6:30 p.m. in the evening ... [Person D] is very upset ... " Review of the agency's complaint log failed to evidence a complaint/incident documented for patient #8.<br><br>An interview on 10/13/2020, at 2:55 PM, employee A indicated complaints should be maintained in the patients clinical record and in the agency complaint log. A copy of the complaint/incident should be added to the clinical record and complaint log as soon as it is completed.<br><br>17-12-3(c )(2) | | | |
| G 0536<br><br>Bldg. 00 | 484.55(c)(5)<br>A review of all current medications<br>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.<br>Based on observation, record review, and interview, the agency failed to ensure a complete current review of medications was performed in 4 of 8 clinical records reviewed. (#2, #5, #6, #7).<br><br>The findings include: | G 0536 | The Administrator and Director of Nursing (DON) reviewed the agency policy titled “4.13 Patient Record Contents” for reeducation and clarification of procedures. The deficiency for failure to list | 11/10/2020 |

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| | 1. Review of an agency policy dated 10/15/2005, titled "PATIENT RECORD CONTENTS", stated "The agency shall maintain a clinical record for each patient ... The record shall contain ... Medication profile including action, allergies, effects, and side effects or prescribed and over-the-counter drugs...."<br><br>2. Clinical record review on 10/13/2020 for patient #2, start of care 7/8/2020 and certification period 9/6/2020 to 11/4/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Recertification of Continuing Need for Care)" dated 9/16/2020 and signed by the physician. This plan of care contained the following medication orders: " ... Gabapentin [a medication used to treat nerve pain] 300 MG (milligrams) oral capsule 1 cap three times daily by mouth ... Memantine [a medication used for Alzheimer's] 10 MG oral tablet 1 tab twice daily by mouth ... Oxybutynin [a medication used to treat overactive bladder]10 MG (milligrams) CR Tablet, 1 tab every night by mouth...."<br><br>Observation during a home visit for patient #2 on 10/13/2020 at 9:30 a.m., evidenced a patient medication list from patient's physician office, dated 9/25/2020. The medication list stated " ... Gabapentin 300 mg capsule ... take one capsule by mouth daily ... Memantine 5 mg tablet ... take one tablet by mouth daily...." This list failed to evidence the medication Oxybutynin.<br><br>The medication list also stated " ... Anusol-HC 2.5% rectal cream [a medication used to treat hemorrhoids] ... Breo Ellipta [a medication used to treat asthma] 100-25 mcg/dose Dsdv inhaler ... ferrous sulfate [an iron supplement] 325 mg ... | | home medications on the plan of care has now been corrected with a listing of all the medications and their routes as ordered by the physician on the plan of care.<br>Also, the Antibiotic medication issue has been resolved with documentation of discontinuation of the medication. The medication list for patient #2 has now been reconciled with the list provided by the physician. The medication list for patient #5 is now reconciled and updated to reflect the discontinuation of the antibiotics.<br>The prescription for the drug Tramadol for patient #6, is now written as a PRN order. In addition, 100% of active clinical records were reviewed for this deficiency and all deficiencies found were corrected. The DON reeducated the skilled nursing and therapy staff on 11-10-2020 on the importance of reviewing all the medications the patient is currently on to ensure that correct dosages, routes, and indications for PRN medications are listed on the Plan of Care.<br>The DON or her clinical designee will now review the plan of care and clinical notes weekly to ensure that the clinical staff has reviewed the patient's medications at each visit and updated any changes made by the physician on the Medication Profile.<br>To prevent this deficiency from reoccurring, 10% of the plan of | |

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| | hydroxyzine [a medication used to treat itching] 10 mg tablet ... take 10 mg by mouth daily...." The agency plan of care failed to evidence these 3 medications.<br><br>During an interview with patient #2 on 10/14/2020 at 10:08 a.m., the patient indicated the home medication list provided by the physician was the correct, current medication list.<br><br>During an interview on 10/14/2020 at 11:45 a.m., employee B indicated the nurse should review all patient medications during each assessment.<br><br>3. Clinical record review on 10/13/2020, of patient #5, start of care 8/4/2020, evidenced an agency document titled "Home Health Certification and Plan of Care" from certification period 10/3/2020 - 12/1/2020, which indicated a primary diagnosis of diverticulitis (inflammation or infection in one or more small pouches in the digestive tract). This document had an area subtitled "Medications" which stated "Lorazepam [sedative] 0.5 MG [milligram] Oral Tablet ... 3 x [times] By mouth (PO) ... Tramadol [pain medication] 50 MG/ML [milliliter] ORAL ... every 6 hour as needed By mouth (PO) ... Piperacillin-Tazobactam [antibiotic] 3 G [gram]-0.375 G Intravenous Solution ... every 8 hours for 28 days intravenous (IV) ... [SIC]"<br><br>During an interview on 10/13/2020, at 11:00 AM, patient #5 indicated they were no longer on antibiotic therapy and it had been over a week since the last dose was administered. | | cares will be monitored quarterly to ensure that the patients home medications are the same as the medication profile list, and the current plan of care.<br>The DON will be responsible to ensure that this deficiency does not recur. | |

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| | During an interview on 10/13/2020, at 2:11 PM, employee B, clinical manager, was asked to clarify the for the medications Lorazepam and Tramadol. Employee B indicated they would have to guess Lorazepam is taken three times a day and Tramadol would be taken if needed for pain. The plan of care failed to evidence complete details of the medications ordered.<br><br>During an interview on 10/13/2020, at 2:16 PM, employee B indicated the patient was on antibiotic therapy due to the primary diagnosis of diverticulitis, but was past the duration of 28 days. The plan of care failed to evidence a current, complete medication list.<br><br>4. Clinical record review on 10/14/2020, of patient #6, start of care 7/1/2020, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/1/2020 - 8/29/2020. This document had an area subtitled "Medications" which stated "Tramadol 50 MG Oral Tablet 1 tab Twice Daily By mouth (PO) ... "<br><br>During an interview on 10/14/2020, employee B was asked to clarify why patient #6 was taking Tramadol twice a day. They indicated the patient did not take Tramadol twice daily, and it should have been written as a PRN (as needed) order.<br><br>5. Clinical record review on 10/14/2020, of patient #7, start of care 5/15/2020, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/15/2020 - 7/13/2020. This document had an area subtitled "Medications" which stated "Ammonium Lactate 12% Topical Cream Mod [moderate] amt [amount] BID [twice daily] to Legs and Feet due to Dry Skin By mouth (PO) ... Ipratropium-Albuterol 0.5 MG-2.5 MG/3 MLINHILATION [SIC] Solution 1 | | | |

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| | vial Q [every] 4 Hours/PRN when awake By mouth (PO) ... Meclizine 12.5 MG Oral Tablet 1 tab TID [three times daily]/PRN By mouth (PO) ...<br><br>During an interview on 10/14/2020, at 10:33 AM, employee B, indicated PO (by mouth) is an incorrect route for Ammonium Lactate 12% topical cream. They also indicated the lack of PRN indications for the medications Meclizine 12.5 MG and Ipratropium-Albuterol 0.5 MG- 2.5 MG/3 ML.<br><br>17-14-1(a)(1)(B) | | | |
| G 0572<br><br>Bldg. 00 | 484.60(a)(1)<br>Plan of care<br>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.<br>Based on record review and interview, the agency failed to ensure patients received the services ordered in the plan of care and the plan of care had been established and signed by the primary care physician in 5 of 8 clinical records reviewed (#1, #2, #3, #7, #8)<br><br>The findings include:<br><br>1. Record review of an undated agency policy titled "CHARTING" stated " ... PROCEDURE Home health care staff and interdisciplinary team | G 0572 | Director of Nursing (DON) reviewed the policy titled “3.9 Medical Supervision/Patient Plan of Care” for reeducation and clarification of procedures. The plan of care for patient #1, certification period 8/11/2020 to 10/9/2020, dated 8/10/2020, has now been signed by the physician. Patient #2 was noted to have refused visits for the period of 9/11/2020, 9/18/2020, 9/25/2020, 10/2/2020, 10/6/2020 | 11/10/2020 |

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| | members document all patient home health care on the day service is rendered...."<br><br>2. Clinical record review on 10/13/2020 for patient #2, start of care 7/8/2020 and certification period 9/6/2020 to 11/4/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Recertification of Continuing Need for Care)" dated 9/16/2020 and signed by physician. This document stated "SN [skilled nurse] Frequency: 1w9 [once a week, for 9 weeks]...."<br><br>Review of patient #2's electronic medical record [Axxess] on 10/13/2020, evidenced a patient calendar of visits. This calendar evidenced skilled nurse visits on 9/11/2020, 9/18/2020, 9/25/2020, 10/2/2020, 10/6/2020, and 10/9/2020 which was evidenced as "Not yet started".<br><br>Clinical record review on 10/13/2020 for patient #2, evidenced a document titled "Patient Vital Signs" printed from patient electronic medical record. This log failed to evidence entries for skilled nurse visits scheduled on 9/11/2020, 9/25/2020, 10/2/2020, 10/6/2020, and 10/9/2020.<br><br>During an interview on 10/14/2020 at 11:55 a.m., the clinical supervisor indicated skilled nurse visits for this patient should be documented weekly. The supervisor stated, "I'd have to look into that. I don't know why they're not in there." and offered no further documentation. The agency failed to evidence they provided the services ordered in the physician signed plan of care.<br><br>3. Clinical record review on 10/13/2020 for patient #3, start of care 7/15/2020, and certification period 9/13/2020 to 11/11/2020, evidenced a document | | and 10/9/2020 stating that she did not need the nurse; the physician has been notified and a signed order has been obtained. For patient #3, the visit notes are completed for the period and are now in the patient's chart. The signed copy of the plan of care for patient #3, for the certification period 9/13/2020 to 11/11/2020 is now in the patient's chart. 10 percent of active patients' charts were reviewed for this deficiency and none was found to be deficient at this time. On 11-10-20, the DON in-serviced the skilled staff on completing their notes at the time of the visit and assessments within 24 hours. The skilled staff were instructed that all orders need to be signed before interventions can be carried out. Also, all patients should be educated on orders listed in the Plans of Cares (POCs) and that patients are instructed on their conditions with a complete assessment of the patient's conditions with all vitals and any testing results such as Diabetic testing performed and documented.<br>The DON or her clinical designee will now review all clinical notes and the POCs weekly to ensure that orders and treatment plans are being followed according to the Plan of Care and all that all POCs have physicians' signatures. To prevent this deficiency from | |

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| | titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE" dated 9/12/2020, not signed by a physician. This plan of care had a subcategory titled "Orders For Discipline and Treatment" which stated " ... Frequency: ... PT [physical therapy] Frequency: 2w4 [twice a week for 4 weeks]...."<br><br>Review of patient #3's electronic medical record [Axxess] on 10/13/2020, evidenced a patient calendar of visits. This calendar evidenced physical therapy visits on 10/2/2020, 10/7/2020 and 10/9/2020 evidenced as "Not yet started".<br><br>During an interview on 10/7/2020 at 9:36 a.m., the administrator indicated 48 hours is allowed for clinicians to turn in documentation following a visit.<br><br>During an interview on 10/14/2020 at 11:30 a.m., the clinical supervisor reviewed the patient's electronic medical record, stated "I would have to look into it", and offered no further documentation. There failed to be evidence the home health agency provided the services ordered in the patient's plan of care.<br><br>Review of patient #3's electronic medical record in Axxess on 10/13/2020 failed to evidence a physician signed plan of care.<br><br>During an interview on 10/14/2020 at 11:30 a.m., the clinical manager indicated she may have the signed plan of care in a "fax folder". On 10/14/2020 at 1:28 p.m., the clinical manager produced a copy of a signed plan of care for patient #3, for certification period 7/15/2020 to 9/12/2020. The agency failed to evidence a signed plan of care for the certification period 9/13/2020 to 11/11/2020. | | reoccurring, 10% of clinical records will be reviewed quarterly for evidence that physician's orders are being followed and Plans of Cares are signed.<br>The DON will be responsible to ensure that this deficiency does not recur. | |

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| | 4. Clinical record review on 10/13/2020 for patient #1, start of care 4/13/2020 and certification period 8/11/2020 to 10/9/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Recertification of Continuing Need for Care)", dated 8/10/2020, not signed by physician.<br><br>Review of patient #1's electronic medical record in Axxess on 10/13/2020 failed to evidence a physician signed plan of care.<br><br>During an interview on 10/14/2020 at 1:30 p.m., the clinical manager indicated a physician signed plan of care should be in the patient's electronic record and offered no further documentation.<br><br>5. Clinical record review on 10/14/2020 for patient #7, start of care 5/15/2019, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/15/2019 - 7/13/2019. This document had an area subtitled "Orders for Discipline and Treatment" which stated "SN to perform complete physical assessment each visit with emphasis on Anemia [condition in which blood doesn't have enough healthy red blood cells] and GI [gastrointestinal] Bleed ... Nursing ... SN to assess cardiovascular [pertaining to the heart] status ... SN to instruct patient on disease process, including who to contact if signs and symptoms persist or worsen as well as dietary measures ... SN to assess genitourinary [pertaining to the genital and urinary organs] status ... SN to instruct patient on disease process, including who to contact if signs and symptoms persist or worsen as well as dietary measures ... SN to instruct patient/caregiver | | | |

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| | regarding self management and prevention of Urinary Tract Infection ... " Record review failed to evidence instruction to the patient/caregiver regarding genitourinary status or urinary tract infections, cardiovascular function, or dietary measures for the entire certification period 5/15/19 - 7/13/19.<br><br>During an interview on 10/14/2020, at 10:37 AM, employee B acknowledged the SN failed to instruct the patient as ordered on the plan of care.<br><br>6. Clinical record review on 10/13/2020, of patient #8, start of care 3/1/2019, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 3/1/2019 - 4/28/2019, and signed by the patient's physician. This document had an area subtitled "Orders for Discipline and Treatment" which stated "SN to assess other co-morbidities including intellectual disability, diabetes ... and other conditions that present themselves during this episode of care ... Patient assessed to be at high risk for emergency department visits and/or hospital readmission. All necessary interventions to address the underlying risk factors are as follows: ... SN to monitor blood sugar levels to assess efficacy of medication and dietary therapy; coordinate care with physician for need to change plan of care ... "<br><br>Record review evidenced agency documents titled "Skilled Nurse Visit" dated 3/5/2019 and 3/8/2019, both electronically signed by employee M, RN. These documents failed to evidence the patient's blood sugar was obtained as ordered on the plan of care.<br><br>During an interview on 10/13/2020, at 3:03 PM, employee B indicated a blood sugar should have | | | |

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| | been obtained at each visit.<br><br>17-13-1(a) | | | |
| G 0574<br><br>Bldg. 00 | 484.60(a)(2)(i-xvi)<br>Plan of care must include the following<br>The individualized plan of care must include the following:<br>(i) All pertinent diagnoses;<br>(ii) The patient's mental, psychosocial, and cognitive status;<br>(iii) The types of services, supplies, and equipment required;<br>(iv) The frequency and duration of visits to be made;<br>(v) Prognosis;<br>(vi) Rehabilitation potential;<br>(vii) Functional limitations;<br>(viii) Activities permitted;<br>(ix) Nutritional requirements;<br>(x) All medications and treatments;<br>(xi) Safety measures to protect against injury;<br>(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.<br>(xiii) Patient and caregiver education and training to facilitate timely discharge;<br>(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;<br>(xv) Information related to any advanced directives; and<br>(xvi) Any additional items the HHA or physician may choose to include.<br>Based on record review and interview, the agency failed to ensure the individualized plan of care included a complete medication list and safety measures to protect against injury in 3 out of 3 | G 0574 | The Administrator and Director of Nursing (DON) reviewed the policy titled “SUPERVISE SKILLED PROFESSIONAL ASSISTANTS” | 11/12/2020 |

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| | patients who were prescribed medications to be taken as needed or were taking blood thinners (#2, #3, #4) from a total sample of 8 patients.<br><br>The findings include:<br><br>1. Review of an agency policy dated 10/15/2005, titled "PATIENT RECORD CONTENTS", stated "The agency shall maintain a clinical record for each patient ... The record shall contain ... Medication profile including action, allergies, effects, and side effects or prescribed and over-the-counter drugs...."<br><br>Review of an agency policy dated 10/15/2005, titled "MEDICAL SUPERVISION/PATIENT PLAN OF CARE", stated " ... The patient plan of care ... Includes the following: ... Patient medication ... Any safety measures to protect against injury...."<br><br>2. Clinical record review on 10/13/2020 for patient #2, start of care 7/8/2020 and certification period 9/6/2020 to 11/4/2020, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Recertification of Continuing Need for Care)" dated and signed by the physician on 9/16/2020. This document had a subcategory titled "Medications" which stated " ... ARTIFICIAL TEARS 0.4% OPHTHALMIC SOLUTION 1 DROP BOTH EYES Three times daily as needed each eye or both eyes (O.U) ... ALBUTEROL [a medication used to treat asthma] 90 MCG/INH [micrograms per inhalation] INHALATION POWDER 2 PUFFS Every 6 hours as needed by mouth ... HYDROCODONE-ACETAMINOPHEN [a pain medication] 5 MG [milligrams]-325 MG ORAL TABLET 1 TAB EVERY 6 HOURS AS NEEDED By mouth (PO) ... ELIQUIS [a blood thinning medication] 2.5 MG ORAL TABLET 1 TAB Twice | | for re-education and clarification of procedures. 10% of active clinical records were reviewed for this deficiency and none was found to be deficient at this time. The agency now has a signed order for the physical therapist assistant to also provide care for patient #2. The physical therapist assistant notes for the period and subsequently have now been cosigned by the physical therapist after case conferencing with the physical therapist assistant regarding patient #2's plan of care and treatment goals. The therapy and skilled nursing staff were in-serviced (11/10/2020) on the importance of maintaining the supervisory relationship to those supervised through in person contact, phone, and electronic medical records (EMR) communications to ensure compliance with supervisory requirements. Supervisory Visits will now be scheduled at the time of the initial assessments in the EMR. Skilled staff will communicate with those supervised to ensure Supervisory Visits and documentations are completed when done.<br>The Director of Nursing (DON) or her clinical designee will now review on a weekly basis all PT and PTA notes in cases where there is PTA to ensure there is supervision with communication and visit notes are cosigned and | |

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| | daily P.O ... ASPIRIN [a medication used to help prevent blood clots] 81 MG ORAL TABLET 1 TAB DAILY By mouth (PO)...." The plan of care failed to evidence as needed indications and / or bleeding precautions for the prescribed medications.<br><br>During an interview on 10/14/2020 at 11:55 a.m., the clinical manager indicated the indication for usage of each as needed medication should be documented in the plan of care.<br><br>During an interview on 10/14/2020 at 11:55 a.m., the clinical manager indicated the agency failed to include bleeding precautions in the patient's plan of care.<br><br>3. Clinical record review on 10/13/2020 for patient #4, start of care 1/31/2018 and certification period 1/31/2018 to 3/31/2018, evidenced a document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE" dated 1/31/2018 and signed by physician. This document had a subcategory titled "Medications" which stated " ... IBUPROFEN [an anti-inflammatory medication] 800 MG ORAL TABLET 1 TAB TID [three times a day]/PRN [as needed] By mouth (PO) ... ACETAMINOPHEN-CODEINE [a pain medication] 300 MG-30 MG ORAL TABLET 1 TAB Q [every] 6 HOURS/PRN [as needed] By mouth (PO)...." The plan of care failed to evidence the indication for these as needed medications.<br><br>During an interview on 10/14/2020 at 11:30 a.m., the clinical manager indicated the indication for usage of each as needed medication should be documented in the plan of care.<br><br>4. Clinical record review on 10/13/2020 for patient | | Supervisory Visits are performed, and documentations are completed. 10% of clinical records will be selected and reviewed quarterly as part of the Quality Assessment and Performance Improvement (QAPI) program to ensure there is supervision with communication and visit notes are cosigned, Supervisory Visits are performed, and documentations are completed.<br>The Director of Nursing (DON) will ensure that this deficiency does not recur. | |

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| | #3, start of care 7/15/2020 and certification period 9/13/2020 to 11/11/2020, evidenced a document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Recertification of Continuing Need for Care" dated 9/12/2020 and signed by the nurse. This document had a subcategory titled "Medications" which stated " ... TYLENOL 325 MG ORAL TABLET 1 t dly By mouth (PO)...." The plan of care failed to evidence the indication for this as needed medication.<br><br>During an interview on 10/14/2020 at 11:30 a.m., the clinical supervisor indicated the indication for usage of each as needed medication should be documented in the plan of care.<br><br>17-13-1(a)(1)(D)(ix,x) | | | |
| G 0580<br><br>Bldg. 00 | 484.60(b)(1)<br>Only as ordered by a physician<br>Drugs, services, and treatments are administered only as ordered by a physician.<br>Based on record review and interview, the agency failed to ensure physician orders were in place for all drugs, treatments, and services provided by the home health agency in 6 of 8 patient records reviewed. (#3, 4, 5, 6, 7, 8)<br><br>The findings include:<br><br>1. An agency policy revised on 10/10/2017, titled "4.13 Patient Record Contents" stated "The agency shall maintain a clinical record for each patient, which is initiated at the time of the first visit. The record shall contain pertinent past and current medical, nursing, social, and other therapeutic information. The patients chart shall contain data including but not limited to: ... Specific written orders as prescribed and signed by the attending physician ... " | G 0580 | The Administrator and Director of Nursing (DON) reviewed the Home Health Agency's policy "4.13 Patient Record Contents", "3.17 Physician Telephone Orders", and "Therapy Services" for reeducation and clarification of procedures. In addition, 100% of active clinical records were reviewed for this deficiency and all deficiencies found were corrected. There is now a physician order for patient #3 for a revised plan of care for continuation of physical therapy effective 8/13/2020. There are now orders in the charts for patients #5 and #6 for the initiation of skilled nursing and home health aide | 11/10/2020 |

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| | An agency policy revised on 10/10/2017, titled "3.17 Physician Telephone Orders" stated "Policy ... Physician home health care telephone orders are given only to Home Health Care Registered Nurses ... Procedure ... Physician telephone orders are only received by ProCare Registered Nurses' whom will document the following: Document physician orders on a Physician Telephone Order from specific all designating the order as a telephone order. Transcribe physician telephone order. The Director of Nursing will contact the physician who has not signed and returned orders, and request that the form be signed and returned to ProCare agency.... "<br><br>Review of an agency policy dated 10/19/2006, titled "THERAPY SERVICES", stated "A copy of the verbal order and the Therapy Referral Form will be faxed to the Agency/Therapist providing therapy services. A copy of the Therapy Referral Form will be submitted along with the M.D. order ... After the assessment, the Therapist will ... submit initial assessment to ProCare Home Health within 24-48 hrs. Procare Home Health Services will submit the submitted initial assessment to the physician for signature...."<br><br>2. Clinical record review on 10/13/2020, of patient #5, start of care 8/4/2020, failed to evidence an order from the physician responsible for the medical plan of care for the initiation of skilled nursing services.<br><br>On 10/13/2020, at 2:25 PM, employee A submitted a copy of a faxed document titled "[entity C] Prescriber Orders" which indicated to be an order for TPN (total parenteral nutrition - a method of feeding through intravenous fluids) to entity C. This document failed to evidence all prescribed | | services. The Administrator and Director of Nursing noted that the agency must receive signed physician's orders before patient admission and creation of plan of care. Also, physicians' orders must be in place for all drugs, treatments, and services provided by the home health agency. Telephone orders will now be given to the registered nurse or her clinical designee for transcription and sent to the physician for signature. Specifically, signed orders will be in place for any other services that the patient may require before the services are provided.<br>To prevent this deficiency from reoccurring, all created Plan of Cares will be reviewed weekly by the DON or her designee to ensure physicians' signatures are in place. 10% of the patients' charts will be reviewed quarterly for physicians' signatures and for evidence that the physician's orders are being followed. Administrator and DON will be responsible to ensure that this deficiency does not recur. | |

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| | services, drugs, treatments, and an agency to perform the services.<br><br>3. Clinical record review on 10/14/2020, for patient #6, start of care 8/10/2020, failed to evidence an order from the physician responsible for the medical plan of care for the initiation of skilled nursing and home health aide services.<br><br>4. Clinical record review on 10/14/2020, of patient #7, start of care 5/15/2019, failed to evidence an order from the physician responsible for the medical plan of care for the initiation of skilled nursing, physical therapy, and occupational therapy services.<br><br>On 10/14/2020, at 10:53 AM, employee A submitted a copy of a faxed document titled "[Entity A] General Order" that stated "May d/c [discharge] home with home health. Nurse for medication management, HHA [home health aide], PT/OT to eval [evaluate] and treat ... " which indicated to be a verbal telephone order taken on 5/7/2019 by an licensed practical nurse (LPN) from entity A. This document failed to evidence all prescribed services, drugs, treatments, agency, and a physician's signature.<br><br>5. Clinical record review on 10/13/2020, of patient #8, start of care 3/1/2019, failed to evidence an order from the physician responsible for the medical plan of care for the initiation of skilled nursing and physical therapy services.<br><br>On 10/13/2020, at 3:16 PM, employee A submitted a copy of a faxed document from 2/27/2019, titled "[Entity B] Order Audit Report" that stated "May discharge home with home health and a walker ... " This document failed to evidence all prescribed | | | |

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| | services, drugs, treatments, agency, and a physician's signature. 6. Clinical record review on 10/13/2020 for patient #3 evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 7/15/2020 to 9/12/2020. This plan of care had a subcategory titled "Orders For Discipline and Treatment" which stated " ... Frequency: ... PT [physical therapy] Frequency: 2w6 [twice a week for 6 weeks]...."<br><br>Clinical record review evidenced an agency document titled "PT DISCHARGE" dated 8/13/2020 and signed by physical therapist. This document had a subcategory titled "Reason for Discharge". The box next to "Goals Met" was marked with an "X".<br><br>Review of patient #3's electronic medical record [Axxess] evidenced a patient visit calendar. This calendar indicated physical therapy visits were made on 8/26/2020, 8/28/2020, 9/2/2020, 9/4/2020, and 9/9/2020.<br><br>Clinical record review evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 9/13/2020 to 11/11/2020, not signed by physician. This plan of care had a subcategory titled "Orders For Discipline and Treatment" which stated " ... Frequency: ... PT [physical therapy] Frequency: 2w4 [twice a week for 4 weeks]...."<br><br>Clinical record review evidenced an agency document titled "Physical Therapy Plan of Care with Full Evaluation" dated 9/11/2020, signed by physical therapist, not signed by physician.<br><br>During an interview on 10/14/2020 at 11:30 a.m., | | | |

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| | the administrator stated, "the patient needed to continue", but failed to evidence an assessment or physician order to resume therapy prior to 9/11/2020. The agency failed to evidence a physician signed physical therapy plan of care.<br><br>7. Clinical record review on 10/13/2020 for patient #4, start of care 1/31/2018 and certification period 1/31/2018 to 3/5/2018, evidenced a document titled "Physical Therapy Evaluation Initial Evaluation". This document was dated 2/5/2018 and signed by the physical therapist. This assessment failed to evidence a physician signature.<br><br>During an interview on 10/14/2020 at 1:45 p.m., the administrator indicated the initial assessment should be signed by the physician and offered no further documentation.<br><br>17-13-1(a) | | | |
| G 0596<br><br>Bldg. 00 | 484.60(c)(3)(i)<br>Revisions communicated to patient and MDs<br>(i) Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, and all physicians issuing orders for the HHA plan of care.<br>Based on record review and interview, the agency failed to ensure revisions to the plan of care were communicated to the physician in 1 of 3 patients receiving physical therapy (#3) out of a total sample of 8 patients.<br><br>The findings include:<br><br>Review of an agency policy dated 10/15/2005, titled "MEDICAL SUPERVISION/PATIENT PLAN OF CARE", stated, "Changes in the plan of care are documented through written and signed plans | G 0596 | The Administrator and Director of Nursing (DON) reviewed the policy on Medical Supervision/Patient Plan for reeducation and clarification. The plan of care for the certification period 7/15/20 to 9/12/20 is now signed and in the patient's chart. There is also now a physician order for a revised plan of care for continuation of physical therapy effective 9/11/2020. The plan of care for the certification | 11/10/2020 |

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| | of modifications or, if the changes are requested orally, are reduced to writing ... and countersigned by the attending physician as soon as possible...."<br><br>Clinical record review on 10/13/2020, for patient #3, evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 7/15/2020 to 9/12/2020. This plan of care had a subcategory titled "Orders For Discipline and Treatment" which stated " ... Frequency: ... PT [physical therapy] Frequency: 2w6 [twice a week for 6 weeks]...."<br><br>Clinical record review evidenced an agency document titled "PT DISCHARGE" dated 8/13/2020 and signed by physical therapist. This document had a subcategory titled "Reason for Discharge". The box next to "Goals Met" was marked with an "X".<br><br>Review of patient #3's electronic medical record in Axxess evidenced a patient visit calendar. This calendar indicated physical therapy visits were made on 8/26/2020, 8/28/2020, 9/2/2020, 9/4/2020, and 9/9/2020.<br><br>Review of patient #3's electronic medical record in Axxess failed to evidence communication with the physician about revising the plan of care.<br><br>Clinical record review evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE" for certification period 9/13/2020 to 11/11/2020, not signed by physician. This plan of care had a subcategory titled "Orders For Discipline and Treatment" which stated " ... Frequency: ... PT [physical therapy] Frequency: 2w4 [twice a week | | period 9/13/2020 to 11/11/2020, has now been signed by the physician and placed in the patient's chart. In addition, 100% of active clinical records of patients receiving Physical Therapy were reviewed for this deficiency and no other deficiency was found at this time. The Administrator and DON in-serviced the staff on 11-10-2020 on the importance of communicating revisions to the plan of care by writing out a physician's order and ensuring that the order is signed and received within 30 days.<br>The DON or her clinical designee will now review weekly, all plans of cares to ensure that all revisions to any plan of care are communicated to the physician and they are signed.<br>10% of clinical records will be selected and reviewed quarterly for evidence that all revisions to any plan of care are communicated to the physician and they are signed.<br>The Administrator and DON will be responsible to ensure that this deficiency does not recur. | |

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| | for 4 weeks]...."<br><br>Clinical record review evidenced an agency document titled "Physical Therapy Plan of Care with Full Evaluation" dated 9/11/2020, signed by physical therapist, not signed by physician.<br><br>During an interview on 10/14/2020 at 11:30 a.m., the administrator stated, "the patient needed to continue", but failed to evidence an assessment or physician order to resume therapy prior to 9/11/2020. The agency failed to ensure communication with the physician regarding revisions to the plan of care.<br><br>17-14-1(a)(1)(G) | | | |
| G 0606<br><br>Bldg. 00 | 484.60(d)(3)<br>Integrate all services<br>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.<br>Based on record review and interview, the agency failed to integrate services to ensure coordination of care provided by all disciplines in 2 of 3 patients receiving physical therapy (#2, #4), out of a total sample of 8 patients.<br><br>The findings include:<br><br>1. Review of an agency policy dated 10/19/2006 titled "SKILLED THERAPY SERVICES", stated " ... All personnel providing services shall maintain communication to assure that their efforts effectively complement one another and support the objectives of the patient's care. The means of communication and the results shall be | G 0606 | The administrator and DON reviewed the policy titled "SKILLED THERAPY SERVICES" for reeducation and clarification of services provided by all health care providers in the patient's home. All field staff were in-serviced by the DON on 11/12/2020 on the importance of all health care providers to familiarize themselves with each other and know which disciplines are on the patient's case with their frequencies and visit schedule for the patient. Staff were reeducated | 11/12/2020 |

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| | documented in the clinical record or minutes of case conferences...."<br><br>2. Clinical record review on 10/13/2020 for patient #4, start of care 7/15/2020 and certification period 9/13/2020 to 11/11/2020 evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Recertification of Continuing Need for Care)" dated 9/12/2020. This document had a subcategory titled "Orders For Discipline and Treatment" which stated " ... Frequency: SN [skilled nurse] Frequency: 1w9 [once a week for 9 weeks] PT [physical therapy] Frequency 2w4 [twice a week for 4 weeks]...."<br><br>Review of the electronic medical record [Axxess] for patient #4 on 10/13/2020, evidenced a patient visit calendar. This calendar indicated skilled nursing and physical therapy visits on 9/16/2020, 9/23/2020, 9/30/2020, and 10/7/2020. Review of electronic visit notes evidenced overlapping of skilled nursing and physical therapy visit times.<br><br>Review of the electronic medical record [Axxess] for patient #4 on 10/13/2020, failed to evidence interdisciplinary communication.<br><br>Review of the electronic medical record evidenced a skilled nurse visit note on 9/16/2020. This note evidenced a pain assessment which indicated "no pain this week."<br><br>Electronic record review evidenced a physical therapy visit note on 9/16/2020. This note evidenced a pain assessment which indicated the patient reported a pain rating of "6".<br><br>Electronic record review evidenced a physical therapy visit note on 9/25/2020. This note | | on documenting the coordination of care and services with each other and outside agencies on the patient's case.<br>The DON or her clinical designee will now review all progress notes weekly to ensure that staff is in compliance with the coordination of care of the patient and documenting the care and communication. Also, during the monthly case conference meetings, coordination of care will be<br>emphasized. 10% of clinical records will be selected and reviewed weekly for documentation of coordination and communication between disciplines<br>The DON will be responsible to ensure that this deficiency does not recur. | |

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| | evidenced a pain assessment which indicated the patient reported a pain rating of "6".<br><br>Electronic record review evidenced a skilled nurse visit note on 9/30/2020. This note evidenced a pain assessment which indicated "no pain this week".<br><br>Electronic record review evidenced a physical therapy visit note on 9/30/2020. This note evidenced a pain assessment which indicated the patient reported a pain rating of "7".<br><br>During an interview on 10/14/2020 at 11:30 a.m., the clinical supervisor indicated there should be interdisciplinary communication notes in the electronic medical record and offered no further documentation.<br><br>During an interview on 10/14/2020 at 11:33 a.m., the administrator stated about scheduling patient visits who receive multiple services, "We try not to do them at the same time." When queried about the findings, the administrator said, "There is a conflict".<br><br>3. Clinical record review on 10/13/2020 for patient #2, start of care 7/8/2020 and certification period 9/6/2020 to 11/4/2020, evidenced an agency document titled "Physical Therapy Plan of Care with Full Evaluation" dated 9/15/2020 and signed by physician. This plan of care failed to evidence the use of a physical therapy assistant.<br><br>Review of the electronic medical record for patient #2 on 10/13/2020, evidenced a patient visit calendar. This calendar indicated physical therapy assistant visits on 9/17/2020, 9/22/2020, 9/24/2020, 9/29/2020, and 10/1/2020 were "pending co-signature". | | | |

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| | During an interview on 10/13/2020 at 10:08 a.m., employee E, PTA [physical therapy assistant] stated about employee I, supervising physical therapist, "He has his own visits in the computer. He's never really talked to me."<br><br>During an interview on 10/14/2020 at 11:30 a.m., the clinical supervisor indicated the supervising physical therapist failed to co-sign the PTA's visits. The clinical supervisor also indicated there should be interdisciplinary communication notes in the electronic medical record in Axxess and offered no further documentation.<br><br>17-12-2(g) | | | |
| G 0608<br><br>Bldg. 00 | 484.60(d)(4)<br>Coordinate care delivery<br>Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.<br>Based on record review and interview, the agency failed to ensure care coordination with other agencies in 1 of 1 shared patients, out of a total sample of 8 records reviewed. (#6)<br><br>The findings include:<br><br>An undated agency policy titled "3.16 Case Conferences" stated "The purpose of case conferences to : ... Determine the adequacy of the plan of treatment and appropriateness of continuation of care ... Assure coordination of services in patient-goal directed activity on the part of each home care staff member ... All professional disciplines participating in the patient's care should have input at his [sic] conference ... Documentation of the conference | G 0608 | The administrator and DON reviewed the policy titled 3.16 Case Conferences for re-education and clarification of responsibilities. Previous coordination of care documentations were found and are now in the patient's chart. Coordination of care and documentation are now being done weekly for the patient. No other patient was found to have this deficiency, since this is the only patient that was being shared with another agency at the present time. All field staff were in-serviced by the DON on 11/12/2020 on the | 11/12/2020 |

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| | shall be the responsibility of the primary nurse or supervisor, or other professional as instructed by the supervisor ... All staff delivering patient care services is encouraged to have at lease weekly contact with their Case manager as needed. Any conference related to an individual patient may be documented as a case conference ... "<br><br>Clinical record review on 10/14/2020, for patient #6, start of care 7/1/2020, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/1/2020 - 8/29/2020. This document had an area subtitled "F2F [face to face] addendum (Admission Narrative)" that stated "Patient also receives care from a non skilled homecare agency for 4 hours daily with homemaker services and for 6 hours every evening with HHA [home health aide] services from a different skilled home care agency ... " Record review failed to evidence documented coordination of care with the other agencies involved in the patient's care.<br><br>During the entrance conference on 10/7/2020, at 9:35 AM, employee B, clinical manager, revealed there was one patient that was shared with another agency. They indicated patient #6 received home health aide services from entity E, and homemaker services from entity F. They also expressed that care coordination with other agencies was conducted by phone and video conference.<br><br>During an interview on 10/14/2020, at 11:08 AM, employee B indicated the clinical record failed to evidence care coordination with other agencies involved in the patient's care. They revealed a ProCare HHA would see the patient during the day, and then a HHA from entity E would see the patient in the evening. They also indicated it was | | imperative that all health care providers to familiarize themselves with other agencies that are on a patient's case and know their care objectives, scheduled frequency of visits and other pertinent information for the patient. Staff were also reeducated on documenting communication and coordination of services with other agencies on each case.<br>The DON or her clinical designee will now review all progress notes weekly to ensure compliance with documentation of coordination of care with other agencies on each case. Also, during the monthly case conference meetings, coordination of care documentation will be emphasized. 10% of clinical records will be selected and reviewed quarterly for to ensure compliance with documentation of coordination of care with other agencies on each case.<br>The administrator and DON will be responsible to ensure that this deficiency does not recur. | |

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| | unknown when entity F came to the patient's home.<br><br>G 0614<br>484.60(e)(1)<br>Visit schedule<br>Bldg. 00<br>Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.<br>Based on observation, record review and interview, the home health agency failed to ensure their patients received a written visit schedule in 4 of 4 patients with home visit or interviews out of 8 total clinical records reviewed (#1,#2,#4, #5).<br><br>The findings include:<br><br>1. Review of an agency policy dated 10/10/2017, titled "PATIENT'S BILL OF RIGHTS", stated " ... 2. ProCare Home Health Services shall maintain documentation showing that it has complied with the requirements of this section. 3. The patient has the right to be advised in advance, of the disciplines that will furnish care, and the frequency of visits proposed to be furnished...."<br><br>2. Observation of a home visit on 10/9/2020 at 11:55 a.m., for patient #1, failed to evidence a written visit schedule in the patient's home.<br><br>During an interview on 10/9/2020 at 12:06 p.m., employee D indicated there was not a written visit schedule in the home of patient #1.<br><br>3. Observation during a home visit on 10/13/2020 at 9:40 a.m., for patient #2, failed to evidence a written visit schedule in the patient's home<br><br>During an interview on 10/13/2020 at 9:54 a.m., employee E indicated there was not a written visit schedule in the home of patient #2. | G 0614 | The administrator and DON reviewed the policy titled "PATIENT'S BILL OF RIGHTS" for reeducation and clarification of responsibilities. The staff were re-educated on the patient's right to be advised in advance of the frequency of visits proposed to be furnished and to have a written visit schedule in the patient's home. All field staffs were in-serviced by the DON on 11/12/2020 on the importance of documenting home visits on schedule in the patient's home care book and ensuring that each patient has an admission book in the home.<br>The DON or her clinical designee will now review all supervisory notes weekly to ensure compliance with visit schedules in the home. The schedule will state when each discipline on the case will be visiting the patient's home. The DON will be responsible to ensure that this deficiency does not recur. | 11/12/2020 |

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| | 4. During an interview on 10/9/2020 at 3:20 p.m., patient #4 indicated the agency failed to provide a written visit schedule.<br><br>5. During an interview on 10/14/2020 at 11:55 a.m., the DON [Director of Nursing] indicated each patient should be given an agency book and calendar of visits. When informed home visits did not evidence calendar of visits, the DON remained silent and offered nothing further.<br><br>6. A home observation was conducted on 10/13/2020 at 10:34 AM at the residence of patient #5. During the observation, the home admission book was filed away in the drawer of a small tote and was reviewed. The home admission book failed to include a patient schedule. The patients clinical record was reviewed and evidenced the ordered frequencies on the plan of care stated the skilled nurse would come once a week, for 9 weeks for the period 10/3/2020 - 12/1/2020.<br><br>During an interview on 10/13/2020, at 11:02 AM, patient #5 indicated that employee G, SN [skilled nurse], would call the day before a visit to inform the patient of what time the nurse will come. | | | |
| G 0616<br><br>Bldg. 00 | 484.60(e)(2)<br>Patient medication schedule/instructions<br>Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and | | | |

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| | personnel acting on behalf of the HHA.<br>Based on observation and interview, the agency failed to ensure patients were provided a current written patient medication list in 3 of 3 clinical records reviewed with home visits (#1, #2, #5), out of a total of 8 clinical records reviewed.<br><br>The findings include:<br><br>1. Observation of a home visit on 10/9/2020 at 11:55 a.m., for patient #1, failed to evidence written patient medication list in the patient's home.<br><br>During an interview on 10/9/2020 at 12:06 p.m., employee D indicated she had never seen a written patient medication list in the home of patient #1.<br><br>2. Observation of a home visit on 10/13/2020 at 9:40 a.m., for patient #2, failed to evidence written patient medication list from the home health agency in the patient's home.<br><br>During an interview on 10/13/2020 at 9:54 a.m., employee E indicated he had not seen a written patient medication list from the home health agency in the home of patient #2.<br><br>During an interview on 10/13/2020 at 9:56 a.m., patient #2 indicated she did not have a written list of her medications from the home health agency.<br><br>During an interview on 10/14/2020 at 11:45, employee A and employee B indicated the agency failed to ensure all patients were provided with written medication lists in their homes.<br><br>3. A home observation was conducted on | G 0616 | All patients have now been provided with their current written medication list/profile.<br>The DON and designee to now ensure that each patient has a copy of the medication profile in the home admission book. The case manager will ensure that the medication profile is up to date at every visit and at recertification.<br>To prevent this deficiency for reoccurring 10% of the active patient census will be monitored quarterly to ensure that medication profiles are up to date.<br>The DON will be responsible to ensure that this deficiency does not recur. | 11/10/2020 |

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| | 10/13/2020 at 10:34 AM at the residence of patient #5. During the observation, the home admission book was filed away in a drawer of a tote and was reviewed. The home admission book failed to include a medication profile. The patients clinical record was reviewed and evidenced the most current medication profile was dated for the period 10/3/2020 - 12/1/2020. | | | |
| G 0620<br><br>Bldg. 00 | 484.60(e)(4)<br>Other pertinent instructions<br>Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs.<br>Based on record review and interview, the agency failed to ensure pertinent safety instructions were included in the patients care in 2 of 3 discharged records, in a total sample of 8 patient records reviewed. (#7, 8)<br><br>The findings include:<br><br>1. An agency policy, revised on 11/21/2017, titled "3.9 Medical Supervision/Patient Plan of Care" stated "The patient plan of care: 1. Is developed by a physician in consultation with ProCare Home Health staff and interdisciplinary team members. Includes the following: ... Patient medication ... Patient special diet ... Any safety measures to protect against patient injury ... Any other appropriate items ... "<br><br>2. Clinical record review on 10/14/2020, for patient #7, start of care 5/15/2019, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 5/15/2019 - 7/13/2019. This document had an area subtitled "Nutritional Requirements" that stated " Calorie ADA Diet (1800 cal [calorie]), Fluid Restriction ... " Another | G 0620 | All patients have now been provided with their current written medication list/profile.<br>The DON and designee to now ensure that each patient has a copy of the medication profile in the home admission book. The case manager will ensure that the medication profile is up to date at every visit and at recertification.<br>To prevent this deficiency for reoccurring 10% of the active patient census will be monitored quarterly to ensure that medication profiles are up to date.<br>The DON will be responsible to ensure that this deficiency does not recur. | 11/10/2020 |

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| | area was subtitled "Safety" which stated "24 Hour Supervision, Diabetic; Do Not Cut Nails, Fall Precautions, Keep Pathways Clear, O2 [oxygen] Precautions, Presence of Animals (DOG), Safety in ADLs [activities of daily living], Sharps Safety, Standard Precautions/Infection Control, Use of Assistive Device ... " Another area on this document was subtitled "Medications" which stated " Eliquis [blood thinning medication] 2.5 MG [milligram] Oral Tablet 1 t [tablet] dly [daily] By mouth ... " Record review failed to evidence bleeding precautions were initiated and maintained while the patient was taking a blood thinning medication.<br><br>3. Clinical record review on 10/13/2020, for patient #8, start of care 3/1/2019, evidenced a document titled "Home Health Certification and Plan of Care" for certification period 3/1/2019 - 4/28/2019. This document had an area subtitled "Safety" which stated "Diabetic; Do Not Cut Nails, Emergency/Disaster Plan Development, Fall Precautions, Safety in ADLs [activities of daily living], Prone to Skin Breakdown Precaution, Support During Transfer and Ambulation, Use of Assistive Device ... " Another area on this document was subtitled "Medications" which stated "Coumadin [blood thinning medication] 2 MG [milligram] Oral Tablet 1 tablet every evening By mouth ... " Record review failed to evidence bleeding precautions were initiated and maintained while the patient was taking a blood thinning medication.<br><br>During an interview on 10/13/2020, at 3:03 PM, employee B, clinical supervisor, indicated that bleeding precautions should be taken when a patient is on anticoagulant (blood thinning) medication, such as a special diet, monitor the patient for bumps and bruises, and restrict the use | | | |

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| | of razors to help counteract bleeding related injuries. | | | |
| G 0642<br><br>Bldg. 00 | 484.65(a)(1),(2)<br>Program scope<br>Standard: Program scope.<br>(1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care.<br><br>(2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations.<br>Based on record review and interview, the administrator failed to ensure a Quality Assessment and Performance Improvement (QAPI) program was implemented to show measurable data as required for a home health agency.<br><br>The findings include:<br><br>An agency policy approved on 11/5/2001, titled "7.3 Quality Improvement Program" stated "Objectives: To maintain and improve the highest quality patient care and to reduce or eliminate risks and hazards within the patient's environment by: ... identifying opportunities to improve patient care , using ongoing collection and/or screening and evaluating information about outcomes of health care and customer satisfaction ... tracing identified problems to ensure improvement or resolution developing and implementing effective quality improvement mechanisms such as | G 0642 | The Administrator and the DON reviewed titled 7.3 “Quality Improvement Program” for reeducation and clarification of responsibilities. The Board of Directors met on 11/11/2020 and employed the services of a consulting firm with over 15 years of Home Health experience to provide consulting guidance to the Administrator and Director of Nursing (DON) in order to improve compliance with State and Federal rules and improve and ensure the quality of services provided by the agency. The issues stated with this deficiency including the Quality Assessment and Performance Improvement (QAPI) program is now up to date, the meeting minutes for the first two | 11/11/2020 |

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| | monitoring and evaluation committees, incident reporting and trending, and patient/physician questionnaires ... documenting the findings, conclusions, recommendations, actions taken, and results of actions taken using defined statistical process.... "<br><br>An agency policy approved on 11/5/2001, titled "7.5 Quality Assessment and Improvement" stated "Policy and Procedure ... Responsibilities: The President and/or the Administrator will assume the responsibility for effectively tracking and Follow up of all patient complaints or feedback ... Purpose: To monitor data from patient satisfaction surveys to identify areas of improvement ... Methodology: The home health Director of Nursing or Administrative assistant or Designated person shall contact the selected patients via telephone, complete the data collection sheets, and make recommendations for corrective Action on identified problem areas, and submit to the Quality Assurance Committee on a quarterly basis and annual basis a summary of data collected ... [sic]"<br><br>Record review on 10/14/2020, of the agency's QAPI binder evidenced a document titled "Quality Assessment & Performance Improvement (QAPI)" which had an area subtitled "Problem Statement" that stated "Pain rating not being documented appropriately ... " This document stated "Goal: To ensure that 90% of patients with pain will have pain ratings documented with every visit by 07/27/2020 ... " and also, outlined root causes, barriers, and team members which included members from each discipline provided.<br><br>Record review failed to evidence the measurable outcome for the focus of the pain rating assessments that was to be completed by | | quarters are now included in the QAPI binder, the incident report and complaint log binder are now up to date.<br>QAPI will be done quarterly focusing on areas where there is a potential for comprise to patient's safety also in domains where patients' outcomes can be significantly enhanced.<br>The Administrator and the DON will be responsible to ensure that this deficiency does not recur. | |

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| | 7/27/2020. Record review of the agency's QAPI binder failed to evidence documentation of other problem areas of focus, with measurable outcomes and/or results. Record review failed to evidence meeting minutes prior to July 2020.<br><br>During an interview on 10/14/2020, at 2:07 PM, employee B, clinical supervisor, indicated another problem area they were focused on was timeliness of the initial comprehensive assessment. They also expressed QAPI meetings are held quarterly (every 3 months), and the last meeting was held on 7/15/2020.<br><br>At the exit conference on 10/14/2020, at 3:33 PM, employee A, administrator indicated there was no other information or documentation to be submitted for review. | | | |
| G 0682<br><br>Bldg. 00 | 484.70(a)<br>Infection Prevention<br>Standard: Infection Prevention.<br>The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.<br>Based on observation, the skilled nurse failed to ensure hand hygiene was performed at the appropriate times to help prevent the spread of infection in 1 of 3 patient home visits. (patient #5) (employee G)<br><br>The findings include:<br><br>Review of an agency policy dated 10/31/2017, titled "8.4 Infection Control/ Maintenance" stated "Policy ... ProCare Home Health care staff members implement infection control and maintenance procedures for environment and equipment as appropriate ... Purpose ... To | G 0682 | The DON reviewed the policy titled 8.4 “INFECTION CONTROL/MAINTENANCE OF ENVIRONMENT AND EQUIPMENT” for reeducation and clarification of procedures. The DON and field staffs watched a video training on 10/18/2020 on infection control /maintenance of environment and equipment. The field staff was in-serviced on following the procedures on infection control. Sanitizing hands after gloves were removed during | 10/20/2020 |

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| | control spread of infections ... To protect individuals from transmission of communicable/ infectious disease ... Procedure ... Patient infection control procedures include, but are not limited to the following: Frequent hand washing by home health care staff members before and after provision of direct patient care according to ProCare Home Health agency policy and procedure. Appropriate patient wound and skin dressing techniques according to ProCare's agency policy and procedure ... ProCare Home Health staff members infection control procedures include, but are not limited to the following frequent hand washing by home health care staff members: Before and after provision of direct patient care ... After handling soiled or contaminated materials ... "<br><br>Review of an agency policy dated 10/31/2017, titled "6.9 Universal Precautions For All Health Care Workers" stated "3. Gloves - such as vinyl or latex medical gloves, must be worn when cleaning reusable equipment when have direct contact with blood, body fluids, mucous membranes or non-intact skin when handling items soiled with blood or when handling equipment contaminated with blood or body fluids. This includes, but is not limited to the following: ... Dressing changes ... Gloves should be changed after each patient contact. When gloves are removed, thorough hand washing is required. Gloves do not take the place of hand washing ... "<br><br>On 10/13/2020, from 10:34 AM to 11:20 AM, a home visit was conducted at the residence of patient #5, to observe a skilled nurse (SN) visit. Upon arrival, the patient answered the door and then sat at the kitchen table. Employee G, SN, placed a barrier on the kitchen table and placed bag on top of the barrier. The SN sanitized hands | | PICC line dressing change was reiterated and emphasized. A random home visit was made on 10/20/2020 on a nursing field staff and compliance was assured.<br>The DON will now perform random home visits as needed to assure compliance.<br>The DON will be responsible to ensure that this deficiency does not recur. | |

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| | with ABHR (alcohol based hand rub), applied gloves, and removed items from bag and placed on top of the barrier, to measure the patients vital signs including a blood pressure cuff, thermometer, pulse oximeter, stethoscope, and sanitizing wipes. The SN measured the patients temperature, blood pressure, pulse oximetry, heart rate. The SN then began to auscultate the patient's lungs, hearts, and stomach tones. The SN wiped down thermometer, blood pressure cuff, pulse oximeter, and stethoscope, then applied ABHR before the items were placed back into the bag. At 10:43 AM, employee G went into patient #5's bedroom where the patient had laid across the bed. The SN placed a barrier under the patient's right arm, where the PICC (peripherally inserted central catheter) line was. Employee G opened a sterile central line dressing kit, removed a mask, assisted the patient in wearing it and then removed the old dressing from the patient's right arm. At 10:47 AM, the SN removed the soiled gloves and applies a new pair of sterile groves. The SN emptied supplies from the dressing kit onto the sterile field. Employee G removed the skin preparation solution from the sterile field and began to clean the patient's right arm around the site with the applicator provided in the kit. At 10:50 AM, the SN removed the dirty gloves and then donned new sterile gloves. Employee G waited until the skin preparation solution was dry before the occlusive biopatch dressing, stat lock (stabilization device for tubing), and transparent tegaderm dressing was applied. The SN labeled the date and time of dressing change on the PICC site. Employee G rolled all soiled items up in the barrier and placed in the garbage can and then sanitized hands with ABHR. The SN failed to demonstrate infection prevention and control by not sanitizing their hands after the gloves were removed during the PICC line dressing change. | | | |

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| G 0706<br><br>Bldg. 00 | 484.75(b)(1)<br>Interdisciplinary assessment of the patient<br>Ongoing interdisciplinary assessment of the patient;<br>Based on record review and interview, the agency failed to ensure ongoing interdisciplinary assessment of the patient in 1 of 2 patients interviewed (#4), out of a total of 8 clinical records reviewed.<br><br>The findings include:<br><br>Review of an agency policy dated 10/15/2005, titled "ADMISSION POLICY" stated, "Admission criteria are standards by which a patient can be judged for the admission ... Patients needing skilled care must be under the care of a physician...."<br><br>Clinical record review on 10/13/2020 for patient #4, start of care 1/31/2018 and certification period 1/31/2018 to 3/5/2018, evidenced a document titled "PHYSICIAN FACE TO FACE ENCOUNTER" dated 2/13/2018 and signed by the physician. This document failed to evidence a patient assessment. This document failed to evidence any physician documentation of patient information.<br><br>During an interview on 10/9/2020 at 3:20 p.m., patient #4 indicated she was never seen by the physician.<br><br>During an interview on 10/14/2020 at 1:45 p.m., the clinical supervisor indicated the physician's assessment should be documented on the face to face encounter form and offered no further documentation.<br><br>17-12-2(g) | G 0706 | The Director of Nursing (DON) reviewed the policy titled "ADMISSION POLICY" for re-education and clarification of procedures. This deficiency has been corrected. The current Physician face to face (F2F) encounter has the patient assessment. The Director of Nursing (DON) will now ensure that a signed F2F encounter is received prior to admission or within 30 days of the admission. The Director of Nursing (DON) and her clinical designee will now review all F2F encounters/orders on weekly basis to assure compliance with the policy. The Director of Nursing (DON) will be responsible to ensure that this deficiency does not recur. | 11/10/2020 |

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| G 0710<br><br>Bldg. 00 | 484.75(b)(3)<br>Provide services in the plan of care<br>Providing services that are ordered by the physician as indicated in the plan of care;<br>Based on record review and interview, the agency failed to ensure the physical therapist followed the PT (physical therapy) Plan of Care as ordered by the physician in 2 of 5 clinical records reviewed for patients receiving PT services, in a total sample of 8 records. (#7, 8)<br><br>The findings include:<br><br>1. An agency policy, reviewed on 10/10/2017, titled "4.13 Patient Record Contents" stated "The agency shall maintain a clinical record for each patient, which is initiated at the same time of the first visit. The record shall contain pertinent past and current medical, nursing, social, and other therapeutic information. The patient's chart shall contain data including but not limited to: ... An individualized plan of care for all disciplines providing services ... "<br><br>An agency policy, revised on 10/19/2006, titled "9.3 Skilled Therapy Services" stated "Therapy assistant services shall be provided as follows: Services are furnished by a qualified physical therapist assistant or qualified occupational therapist assistant may be furnished under the supervision of a qualified physical or occupational therapist.... "<br><br>An agency policy, revised on 10/19/2006, titled "9.4 Therapy Services" stated "After the assessment, the Therapist will ... Contact the Case Manager/DON [director of nursing] to communicate the findings and plan ... ProCare Home Health Services will submit the submitted | G 0710 | The Administrator reviewed Policy titled 4.13 “PATIENT RECORD CONTENTS” for re-education and clarification of procedures. The therapy staff was in-serviced on the importance of maintaining communication via phone and the EMR about Plan of Care set forth in Initial Evaluation and/or Reassessments in order to meet the requirements of the Physician’s Order.<br>The PT and PTA will now maintain communication via the EMR about appropriate treatments as per PT’s Plan of Care set forth in Initial Evaluation and/or Reassessments in order to meet the requirements of the Physician’s Order.<br>The Director of Nursing (DON) or her clinical designee will now review on a weekly basis all PT and PTA notes in cases where there is PTA to ensure there is communication of the appropriate treatments as per PT’s Plan of Care set forth in Initial Evaluation and/or Reassessments and are in congruence with the Physician’s Order to assure compliance with the policy.<br>The Director of Nursing (DON) will ensure that this deficiency does not recur. | 11/10/2020 |

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| | initial assessment to the physician for signature ... "<br><br>2. Clinical record review on 10/14/2020, for patient #7, start of care 5/15/2019, evidenced an agency document titled "PT Plan of Care" for episode period 5/15/2019 - 7/13/2019, and signed by the physician. This document had an area subtitled "Treatment Plan" which specifically indicated to perform the following: therapeutic exercise, balance training, functional mobility training, bed mobility training, gait training, teach safe and effective use of adaptive/assist device, transfer training, neuromuscular re-education, and to teach safe stair climbing skills. The plan of care was electronically signed by employee K, PT, on 5/15/2019.<br><br>Record review evidenced an agency document titled "Home Health Certificate and Plan of Care" for certification period, 5/15/2019 - 7/13/2019, which was signed by the patient's physician. This document had an area subtitled "Orders for Disciplines and Treatment" that stated "Physical Therapy to assess functional status, home environment to eliminate structural barriers and improve safety and functional independence. PT to assess rehabilitation potential and determine need for gait training, safety precautions, pain management, strengthening/conditioning exercise, balance/ coordination and transfers. PT to establish a home exercise program and plan of care as approved by physician ... "<br><br>Record review evidenced agency documents titled "PT Visit" signed by employee K. Record review failed to evidence treatments including but not limited to, bed mobility training, teach safe and | | | |

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| | effective use of adaptive/assist device, transfer training, and teach safe stair climbing skills as ordered on the PT plan of care on the following dates:<br>5/17/2019, 5/21/2019, 5/23/2019, 5/28/2019, 5/30/2019, 6/4/2019, 6/6/2019, 6/11/2019, and 6/13/2019.<br><br>Record review failed to evidence the following treatments were performed on the previously stated dates, as ordered on the PT plan of care: Bed mobility training, teach safe and effective use of adaptive/assist device, transfer training, and teach safe stair climbing skills.<br><br>3. Clinical record review on 10/13/2020, for patient #8, start of care 3/1/2019, which evidenced an agency document titled "PT Plan of Care" for episode period 3/1/2019 - 4/26/2019, and signed by the physician. This document had an area subtitled "Treatment Plan" which specifically indicated to perform the following: therapeutic exercise, balance training, functional mobility training, teach fall prevention/safety, gait training, teach safe and effective use of adaptive/assist device, establish/upgrade home exercise program, postural control training, and teach energy conservation techniques. The plan of care was electronically signed by employee A, PT, on 3/26/2019.<br><br>Record review evidenced an agency document titled "Home Health Certificate and Plan of Care" for certification period, 3/1/2019 - 4/26/2019, which was signed by the patient's physician. This document had an area subtitled "Orders for Disciplines and Treatment" that stated "Physical Therapy to assess functional status, home environment to eliminate structural barriers and improve safety and functional independence. PT | | | |

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| | to assess rehabilitation potential and determine need for gait training, safety precautions, pain management, strengthening/conditioning exercise, balance/ coordination and transfers. PT to establish a home exercise program and plan of care as approved by physician ... "<br><br>Record review evidenced agency documents titled "PT Visit" signed by employee L, PTA [physical therapy assistant] and co-signed by employee A. These documents failed to evidence the patient had postural control training as ordered on the PT plan of care for the following dates: 3/7/2019, 3/12/2019, and 3/26/2019.<br><br>Record review evidenced agency documents titled "PT Visit" signed by employee L and co-signed by employee A. These documents failed to evidence the patient was taught safe and effective use of adaptive/assist device as ordered on the PT plan of care for the following dates: 3/7/2019, 3/8/2019, 3/12/2019, 3/26/2019, 3/28/2019, 3/29/2019, 4/3/2019, 4/9/2019, 4/12/2019, 4/16/2019, 4/25/2019, and 4/26/2019.<br><br>Record review evidenced agency documents titled "PT Visit" signed by employee L and co-signed by employee A. These documents failed to evidence the patient had functional mobility training as ordered on the plan of care on 4/3/2019 and 4/11/2019.<br><br>Record review evidenced agency documents titled "PT Visit" signed by employee L and co-signed by employee A. These documents failed to evidence the patient was taught energy conservation techniques as ordered on the plan of care on 4/16/2019.<br><br>During an interview on 10/13/2020, at 3:38 PM, | | | |

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| | employee A indicated the PT plan of care was revised every 30 days.<br><br>During an interview on 10/13/2020, at 3:49 PM, employee A stated "Therapy is more holistic." They indicated it is not tradition in PT to perform each treatment as ordered on the plan of care at every visit. | | | |
| G 0724<br><br>Bldg. 00 | 484.75(c)<br>Supervise skilled professional assistants<br>Standard: Supervision of skilled professional assistants.<br>Based on record review and interview, the agency failed to ensure a skilled professional assistant was being supervised by a skilled professional in 1 of 3 patients receiving physical therapy services (#2), out of a total sample of 8 clinical records reviewed.<br><br>The findings include:<br><br>Review of an agency document dated 10/19/2006, titled "THERAPY SERVICES" stated, "A case conference for each patient receiving PT [physical therapy], OT [occupational therapy], and ST [speech therapy] services will be conducted at least every thirty (60) days. The assigned Case Manager and HHA [home health aide] (if applicable) will be in attendance...."<br><br>Review of an agency policy dated 10/19/2006, titled "SKILLED THERAPY SERVICES", stated " ... All personnel providing services shall maintain communication to assure that their efforts effectively complement one another and support the objectives of the patient's care. The means of communication and the results shall be documented in the clinical record or minutes of case conferences...." | G 0724 | The Administrator and Director of Nursing (DON) reviewed the policy titled “SUPERVISE SKILLED PROFESSIONAL ASSISTANTS” for re-education and clarification of procedures. The agency now has a signed order for the physical therapist assistant to also provide care for patient #2. The physical therapist assistant notes for the period and subsequently have now been cosigned by the physical therapist after case conferencing with the physical therapist assistant regarding patient #2’s plan of care and treatment goals. In addition, 100% of active clinical records of patients receiving Physical Therapy were reviewed for this deficiency and no other deficiency was found at this time. The therapy and skilled nursing staff were in-serviced (11/10/2020) on the importance of maintaining the supervisory relationship to those supervised through in person contact, phone, and | 11/10/2020 |

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| | Record review on 10/13/2020, evidenced an undated agency policy titled "CASE CONFERENCES" which stated, "All staff delivering patient care services is encouraged to have at least weekly contact with their Case manager and as needed...."<br><br>Clinical record review on 10/13/2020, for patient #2, start of care 7/8/2020 and certification period 9/6/2020 to 11/4/2020 evidenced an agency document titled "Physical Therapy Plan of Care with Full Evaluation" dated 9/15/2020 and signed by physician. This plan of care failed to evidence the use of a physical therapy assistant.<br><br>Review of the electronic medical record [Axxess] for patient #2 on 10/13/2020, evidenced a patient visit calendar. This calendar indicated physical therapy assistant visits on 9/17/2020, 9/22/2020, 9/24/2020, 9/29/2020, and 10/1/2020 were "pending co-signature".<br><br>During an interview on 10/13/2020 at 10:08 a.m., employee E, PTA [physical therapy assistant] stated about employee I, supervising physical therapist, "He has his own visits in the computer. He's never really talked to me."<br><br>During an interview on 10/14/2020 at 11:30 a.m., the clinical manager indicated the supervising physical therapist failed to co-sign the PTA's visits. The agency failed to evidence documentation of any physical therapy assistant supervision. | | electronic medical records (EMR) communications to ensure compliance with supervisory requirements. Supervisory Visits will now be scheduled at the time of the initial assessments in the EMR. Skilled staff will communicate with those supervised to ensure Supervisory Visits and documentations are completed when done.<br>The Director of Nursing (DON) or her clinical designee will now review on a weekly basis all PT and PTA notes in cases where there is PTA to ensure there is supervision with communication and visit notes are cosigned and Supervisory Visits are performed, and documentations are completed. 10% of clinical records will be selected and reviewed quarterly as part of the Quality Assessment and Performance Improvement (QAPI) program to ensure there is supervision with communication and visit notes are cosigned, Supervisory Visits are performed, and documentations are completed.<br>The Director of Nursing (DON) will ensure that this deficiency does not recur. | |
| G 0728<br><br>Bldg. 00 | 484.75(c)(2)<br>Rehab services supervised by PT, OT<br>Rehabilitative therapy services are provided under the supervision of an occupational | | | |

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| | therapist or physical therapist that meets the requirements of §484.115(f) or (h), respectively.<br>Based on record review and interview, the agency failed to ensure the physical therapist (PT) supervised the physical therapist assistant (PTA) in _ of _ patients receiving PT services, out of a total sample of 8 records reviewed. (#8)<br><br>The findings include:<br><br>An agency policy revised on 10/19/2006, titled "9.3 Skilled Therapy Services" stated "Therapy assistant services shall be provided as follows: Services furnished by a qualified physical therapist assistant or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist.... "<br><br>Clinical record review on 10/13/2020, of patient #8, start of care 3/1/2019, evidenced a document titled "PT Plan of Care" for certification period 3/1/2019 - 4/28/2019, and signed by employee A, PT/administrator. This document had an area subtitled "Treatment Plan" which stated "PT Frequency & Duration ... 2w1, 3w6 [two times a week for one week, three times a week for 6 weeks... " followed by other treatments to be performed by PT services.<br><br>Record review evidenced documents titled "PT Visit" which was signed by employee L, PTA, for the following dates: 3/7/2019, 3/8/2019, 3/12/2019, 3/26/2019, 3/28/2019, 3/29/2019, 4/2/2019, 4/3/2019, 4/9/2019, 4/11/2019, 4/12/2019, 4/16/2019, 4/18/2019, 4/19, 2019, 4/25/2019, and 4/26/2019.<br><br>Record review failed to evidence a supervisory visit of the PTA was performed by a physical | G 0728 | The Administrator reviewed policy titled “4.13 PATIENT RECORD CONTENTS” for re-education and clarification of procedures. The therapy staff was in-serviced on the importance of maintaining the supervisory relationship through phone and EMR communications in order to be compliant with the supervisory requirements. PT Supervisory Visits will now be scheduled at the point of the Initial Evaluation by the PT in the EMR, this will also be visible to the PTA’s. The PTA’s will communicate with the PT’s to ensure Supervisory Visits are completed in a timely manner.<br>The Director of Nursing (DON) or her clinical designee will now review on a weekly basis all PT and PTA notes in cases where there is PTA to ensure there is communication and to ensure Supervisory Visits are completed in a timely manner.<br>The Director of Nursing (DON) will ensure that this deficiency does not recur. | 11/10/2020 |

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| | therapist.<br><br>During an interview on 10/13/2019, at 3:38 PM, employee A indicated the PTA's were not supervised like the home health aides. A PTA would make their own decision or assessment while they worked with the patient to achieve the primary functional goal. | | | |
| G 0798<br><br>Bldg. 00 | 484.80(g)(1)<br>Home health aide assignments and duties<br>Standard: Home health aide assignments and duties.<br>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).<br>Based on record review and interview, the agency failed to ensure the home health aide (HHA) care plan was followed in 1 of 3 patients with HHA services, in a total sample of 8 records reviewed. (#6)<br><br>The findings include:<br><br>An agency policy, effective date 10/15/2005, titled "3.18 Visit Protocol For Home Health Aides" stated "ProCare Home Health Aides implement correct agency visit protocol when making a home health care visit to a patient ... Purpose ... To ensure correct ProCare Home Health Aide implementation of home health care patient visit protocol ... Procedure ... The ProCare Home Health Aide makes scheduled home health care visits to patients The Aide: ... Receives verbal and written instructions for patient care from the | G 0798 | The Administrator and Director of Nursing (DON) reviewed the policy titled “3.18 Visit Protocol for Home Health Aides” for re-education and clarification of procedures. The Director of Nursing (DON) has completed the performance review of all home health aides in the agency. All performance reviews are now current. The DON in-serviced the clinical staff and home health aides on 10/21/2020 on the importance of following the tasks laid out in the plan of care and the home health aide care plan.<br>An audit tool has been developed by the Administrator and Director of Nursing (DON) to track home | 10/21/2020 |

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| | Registered Nurse - case manager ... Implements assigned ProCare Home Health Aide Tasks ... "<br><br>Clinical record review on 10/14/2020, of patient #6, start of care 7/1/2020, evidenced an agency document titled "HHA Care Plan" for period 8/10/2020 - 10/8/2020. This document had an area subtitled "Plan Details" which indicated tasks that were to be completed, that included, but was not limited to weigh the patient weekly and shave the patient every visit. Record review failed to evidence a weight documented in the patients clinical record.<br><br>Record review evidenced an agency document titled "HHA Visit" electronically signed by employee J, HHA, on 8/13/2020. This document had an area subtitled "Tasks" where the HHA indicated if the task was completed, refused, or N/A (not applicable). Under personal care tasks, shave was marked as N/A, although it had been assigned as a task to complete each visit.<br><br>Record review evidenced an agency document titled "HHA Visit" electronically signed by employee J, on 8/18/2020. This document had an area subtitled "Tasks" where the HHA indicated if the task was completed, refused, or N/A. Under personal care tasks, shave was marked as N/A, although it had been as an assigned task to complete each visit.<br><br>During an interview on 10/14/2020, at 11:05 AM, employee B indicated the patient is bedbound and can not be weighed in bed. The added task was a typo on the HHA care plan. Also, they clarified the shave task should have indicated refused instead of N/A. | | health aides' performances and to flag and correct home health aides' failure to follow plan of care set by Case Managers. 10% of clinical records will be selected and reviewed quarterly for evidence that tasks on plan of care and home health aides' care plan are followed and documented accordingly.<br>The Administrator and Director of Nursing (DON) will be responsible for ensuring that this deficiency does not recur. | |

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| G 0808<br><br>Bldg. 00 | 484.80(h)(1)(i)<br>Onsite supervisory visit every 14 days<br>If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit.<br>Based on record review and interview, the agency failed to supervise the home health aide (HHA) every 14 days in 2 of 3 patients with HHA services, in a total sample of 8 patient records reviewed. (#2, 6)<br><br>The findings include:<br><br>1. An agency policy last reviewed on 10/10/2017, titled "3.13 Home Health Aide Supervisory Visits" stated "Policy ... A ProCare Home Health Registered Nurse or Physical Therapist, makes a supervisory visit to the patient residence at last [SIC] every two weeks ... Procedure ... A ProCare Home Health Registered Nurse makes a Home Health Aide supervisory visit to the patient residence at least every two weeks, either when the Home Health Aide is present to observe and assist or when the Home Health Aide is absent, to assess relationships and determine whether goals are being met ... "<br><br>An agency policy with an effective date of 11/5/2001, titled "9.2 Home Health Aide Services" stated "The Agency shall provide home health aide services by appropriately qualified home | G 0808 | The Administrator and Director of Nursing (DON) has reviewed the policy titled “3.13 Home Health Aide Supervisory Visits” for re-education and clarification of procedures. The Home Health Aide supervisory visit for patient #6 has been recalculated, so it is now being done within the 14-days’ time frame according to policy and regulation. All home health aide supervisory visits are now being monitored and performed accordingly. The skilled nurse supervisory visit that was scheduled on 10/6/2020 for patient #2 was done and has now been documented. 10 percent of active patients’ charts were reviewed for this deficiency and none was found to be deficient at this time. The Administrator and Director of Nursing (DON) in-serviced the clinical staff and home health aides on 10/21/2020 on the importance performing supervisory | 10/21/2020 |

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| | health aides in accordance with a physician's order and under the direction and supervision of a registered nurse or therapist. The home health aide shall be supervised every 14 days by the nurse or appropriate therapist ... "<br><br>2. Clinical record review on 10/14/2020, of patient #6, start of care 8/10/2020, evidenced a Home Health Aide supervisory visit was completed on 9/20/2020. The next HHA supervisory visit was documented on 10/8/2020, which was 18 days after the previous visit.<br><br>During an interview on 10/14/2020, at 11:11 AM, employee B, Clinical Manager, acknowledged the supervisory visit from 10/8/2020, was past the 14 day time frame.<br><br>3. Clinical record review on 10/13/2020 for patient #2 with start of care 7/8/2020 and certification period 9/6/2020 to 11/4/2020 evidenced an agency document titled "HOME HEALTH CERTIFICATION AND PLAN OF CARE (Recertification of Continuing Need for Care)" dated 9/16/2020 and signed by physician. This plan of care stated " ... HHA [home health aide] Frequency: 5w8 [5 times a week for 8 weeks], 3w1 [3 times a week for one week], 6 hours/visit/Monday-Friday...."<br><br>Review of patient #2's electronic medical record [Axxess] on 10/13/2020, evidenced patient calendar of visits. This calendar evidenced skilled nurse supervisory visit scheduled on 10/6/2020 indicated as "Not yet started". Clinical record review failed to evidence any home health aide supervisory visits from 9/6/2020-10/13/2020.<br><br>During an interview on 10/13/2020 at 10:22 a.m., patient #2 indicated the only staff who visited | | visits when due and completing the documentation promptly.<br>The DON or her clinical designee will now review all supervisory visits and documentation weekly to ensure that the time frame for all supervisory visits are being maintained and performed by the registered nurse or therapist according to policy and regulation.<br>10% of clinical records will be selected and reviewed quarterly for evidence that supervisory visits were being scheduled, performed, and documented accordingly by the registered nurse or therapist.<br>The Administrator and Director of Nursing (DON) will be responsible to ensure that this deficiency does not recur. | |

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| | were the home health aide and the physical therapy assistant.<br><br>During an interview on 10/14/2020 at 11:55 a.m., the clinical supervisor indicated the agency failed to evidence any home health aide supervisory visits from 9/6/2020-10/13/2020. | | | |
| G 0818<br><br>Bldg. 00 | 484.80(h)(4)(i-vi)<br>HH aide supervision elements<br>Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements:<br>(i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional;<br>(ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family;<br>(iii) Demonstrating competency with assigned tasks;<br>(iv) Complying with infection prevention and control policies and procedures;<br>(v) Reporting changes in the patient's condition; and<br>(vi) Honoring patient rights.<br>Based on record review and interview, the agency failed to ensure the supervising registered nurse ensured home health aide care was complete, safe, and effective in 2 of 2 patients where home visits were conducted (#1, #2)<br><br>The findings include:<br><br>1. Review of an undated agency policy titled "CHARTING". This document had a subcategory titled "PROCEDURE" which stated, "1. Home health Care Registered Nurses: ... B. Review | G 0818 | The administrator and DON reviewed the policy titled “CHARTING” for reeducation and clarification of responsibilities. The administrator and DON met with the home health aides for patients #1 and #2 and counselled them on the importance of documenting accurate vital signs. In addition, 100% of active clinical records were reviewed for this deficiency and all deficiencies found were | 10/21/2020 |

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| | completed Home Health Aide documentation for appropriate content, delivery services, and patient information...."<br><br>2. Clinical record review on 10/13/2020, for patient #1, start of care 4/13/2020 and certification period 8/11/2020 to 10/9/2020 evidenced a document titled "Patient Vital Signs" printed from patient electronic medical record. This log evidenced the following patient vital signs on 8/11/2020 by the HHA [home health aide]: "BP [blood pressure] Sit 128/70 Temp [temperature] 96.2 Resp [respiratory rate] 18 Radial Pulse 70 Weight 125..." These vital signs are repeated for HHA visits on 8/12/2020, 8/13/2020, 8/14/2020, 8/15/2020, 8/16/2020, 8/17/2020, 8/18/2020, 8/19/2020, 8/20/2020, 8/21/2020, 8/22/2020, 8/23/2020, 8/24/2020, 8/25/2020, 8/26/2020, 8/27/2020, 8/28/2020, 8/29/2020, 8/30/2020, 8/31/2020, and 9/1/2020.<br><br>The vital sign log for patient #1 evidenced the following patient vital signs on 9/3/2020 by the HHA [home health aide]: "BP [blood pressure] Sit 132/81 Temp [temperature] 97.0 Resp [respiratory rate] 22 Radial Pulse 73...." These vital signs are repeated for a second HHA visit on 9/3/2020, as well as on 9/4/2020, 9/5/2020, 9/6/2020, 9/7/2020, 9/8/2020, 9/9/2020, 9/10/2020, 9/11/2020, 9/12/2020, 9/13/2020, 9/14/2020, 9/15/2020, and 9/16/2020.<br><br>The vital sign log for patient #1 evidenced the following patient vital signs on 9/17/2020 by the HHA [home health aide]: "BP [blood pressure] Sit 132/69 Temp [temperature] 97.4 Resp [respiratory rate] 22 Radial Pulse 73...." These vital signs are repeated for a second HHA visit on 9/17/2020 as well as on 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, 9/27/2020, 9/28/2020, | | corrected. All field staff were in-serviced by the DON on 10/21/2020 on the responsibility and importance of documenting the correct vital signs for each visit and completing all documentation accurately and at the time of the visit. The home health aides were also retrained on taking patients' vital signs. Supervising nurses were reminded to ensure that home health aides' duties were being correctly supervised.<br>The DON or her clinical designee will now review all progress notes weekly to ensure compliance that patients' vitals are always documented accurately and timely. 10% of clinical records will be selected and reviewed quarterly for evidence that the correct not copied and pasted vital signs for each visit are being documented by the home health aides and the nurses are supervising their duties as according to policies.<br>The DON will be responsible to ensure that this deficiency does not recur. | |

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| | 9/29/2020, 9/30/2020, 10/1/2020, 10/2/2020, and 10/5/2020.<br><br>During an interview on 10/14/2020 at 1:30 p.m., employee B stated about the findings, "It's being copied and pasted. They'd have to be supervised."<br><br>3. Clinical record review on 10/13/2020, for patient #2, start of care 7/8/2020 and certification period 9/6/2020 to 11/4/2020 evidenced a document titled "Patient Vital Signs" printed from patient electronic medical record. This log evidenced the following patient vital signs on 9/7/2020 by the HHA [home health aide]: "BP [blood pressure] Sit 122/62 Temp [temperature] 98 Resp [respiratory rate] 19 Radial Pulse 84...." These vital signs are repeated for HHA visits on 9/8/2020, 9/9/2020, 9/10/2020, 9/14/2020, 9/15/2020, 9/16/2020, 9/17/2020, 9/21/2020, 9/22/2020, and 9/24/2020.<br><br>During an interview on 10/14/2020 at 11:45 a.m., employee B stated about the findings, "It doesn't reflect what happened that week. It looks as if it is copied." Employee B indicated the agency failed to ensure the home health aide care was being appropriately supervised by the nurse.<br><br>17-14-1(n) | | | |
| G 0948<br><br>Bldg. 00 | 484.105(b)(1)(ii)<br>Responsible for all day-to-day operations<br>(ii) Be responsible for all day-to-day operations of the HHA;<br><br>Based on record review and interview, the administrator failed to maintain administrative control of the home health agency.<br><br>The findings include: | G 0948 | The Administrator and Director of Nursing (DON) reviewed the Home Health Agency's policies; particularly Policy 2.4 Administrative Control and the Responsibilities of the | 11/11/2020 |

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| | An agency policy approved on 11/5/2001, titled "7.5 Quality Assessment and Improvement" stated "Policy and Procedure ... Responsibilities: The President and/or the Administrator will assume the responsibility for effectively tracking and Follow up of all patient complaints or feedback ... Purpose: To monitor data from patient satisfaction surveys to identify areas of improvement ... Methodology: The home health Director of Nursing or Administrative assistant or Designated person shall contact the selected patients via telephone, complete the data collection sheets, and make recommendations for corrective Action on identified problem areas, and submit to the Quality Assurance Committee on a quarterly basis and annual basis a summary of data collected ... [sic]"<br><br>An undated policy titled "Emergency Preparedness Management Policy B-400" had an area subtitled "Training" which stated "Agency staff members will participate in an annual desktop drill to determine the effectiveness and efficiency of the current plan and any forms developed for use in a disaster.... "<br><br>An agency policy revised on 10/19/2006, titled "9.3 Skilled Therapy Services" stated "Therapy assistant services shall be provided as follows: Services furnished by a qualified physical therapist assistant [PTA] or qualified occupational therapy assistant may be furnished under the supervision of a qualified physical or occupational therapist.... "<br><br>During the entrance conference on 10/7/2020, at 9:35 AM, employee A, administrator, indicated the active patient census for that day was 66, then added it might be 71. On 10/7/2020, at 1:40 PM, the | | Administrator and DON, amongst others for reeducation and clarification of responsibilities. The Board of Directors met on 11/11/2020 and employed the services of a consulting firm with over 15 years of Home Health experience to provide consulting guidance to the Administrator and Director of Nursing (DON) in order to improve compliance with State and Federal rules and improve and ensure the quality of services provided by the agency. The issues stated with this deficiency including Emergency Preparedness Management, the correct daily census Geographic Area Served, Clinical Laboratory Improvement Amendments (CLIA), Quality Assurance and Performance Improvement (QAPI) program and ISDH Advanced Directives have been corrected.<br>This correction will be monitored with weekly meetings of the Administrator and Director of Nursing and then monthly with Consultants for the next 3 months and annually during the Professional Advisory Committee meeting to ensure that quality of services are being provided by the agency.<br>The Board of Directors, the Administrator and Director of Nursing (DON) are responsible for monitoring this corrective action to ensure that this deficiency does not recur. | |

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| PROCARE HOME HEALTH SERVICES | 8300 BROADWAY STREET STE F2A<br>MERRILLVILLE, IN 46410 |

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| | Indiana State form titled "Facility Census - Home Health" was submitted. This document had an area subtitled "Total # [number] of Active Patients" which stated "68." The administrator failed determine the correct daily census.<br><br>Record review of the agency's active patient list on 10/7/2020, evidenced the patient's home addresses were in Lake and Porter Counties in Indiana.<br><br>On 10/7/2020, at 1:40 PM, the Indiana State form titled "Home Health Agencies Hospice Agencies Geographic Area Served" was submitted. This document had an area subtitled "Please Check4 [sic] The Counties Served By Your Agency" which Lake County was the only location indicated, of the 92 counties listed. The administrator failed to indicate the correct counties serviced by the agency.<br><br>On 10/14/2020, at 2:20 PM, the agency's Clinical Laboratory Improvement Amendments (CLIA) certification was requested. The document submitted was titled "Centers For Medicare & Medicaid Services Clinical Laboratory Improvement Amendments Certificate Of Waiver" and issues to ProCare Home Health Services and stated "Effective Date 12/28/2017 ... Expiration Date 12/27/2019 ... " The administrator failed to maintain the required CLIA certification in order to perform patient laboratory examinations or procedures.<br><br>Record review of the agency's Quality Assurance and Performance Improvement (QAPI) binder failed to evidence the measurable outcome for the focus of the pain rating assessments that was to be completed by 7/27/2020. Record review of the agency's QAPI binder failed to evidence | | | |

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| | documentation of other problem areas of focus, with measurable outcomes and/or results. Record review failed to evidence meeting minutes prior to July 2020.<br><br>Record review on 10/14/2020, of the agency's emergency preparedness binder evidenced a document titled "Emergency Preparedness Tabletop Exercise" which was presented by employee A, administrator, on 1/10/2018. The emergency preparedness binder failed to evidence a training exercise conducted within the last year as required.<br><br>During an interview on 10/14/2020, at 2:40 PM, employee A acknowledged there had not been an emergency preparedness training exercise in 1 year and 10 months.<br><br>Record review on 10/7/2020, evidenced a sample admission packet that was received from employee B, clinical manager. The sample admission packet contained an Indiana State Department of Health (ISDH)document titled "Advanced Directives ... Your Right to Decide" that was last revised on July 1, 2013. This document did not reflect the most current version of the ISDH Advanced Directives, that was last revised on November 1, 2018.<br><br>During an interview on 10/7/2020 at 11:02 AM, employee B indicated the packet received was the most current admission information distributed to all patients.<br><br>During an interview on 10/14/2020, at 2:15 PM, the budget from 2019, the projected budget for 2020, and the governing body meeting minutes were requested. Employee A indicated they did not have access to the documents requested because | | | |

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| | they were stored in another employees computer, who was off work during the survey. The administrator failed to demonstrate administrative control.<br><br>During an interview on 10/13/2019, at 3:38 PM, employee A indicated the PTA's were not supervised like the home health aides. A PTA would make their own decision or assessment while they worked with the patient to achieve the primary functional goal.<br><br>17-12-1(c)(1) | | | |
| G 1024<br><br>Bldg. 00 | 484.110(b)<br>Authentication<br>Standard: Authentication.<br>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.<br>Based on record review and interview, the agency failed to ensure all clinical record entries are legible, clear, complete, and appropriately authenticated in 2 out of a total of 8 clinical records reviewed (#1, #4)<br><br>The findings include:<br><br>1. Clinical record review on 10/13/2020 for patient #1, start of care 4/13/2020 and certification period 8/11/2020 to 10/9/2020 evidenced an agency document titled "30-DAY SUMMARY/CASE CONFERENCE", dated 9/10/2020 and signed by employee B. This document had a subcategory titled "Summary of Care Provided" which stated "HHA [home health aide] assisted with personal | G 1024 | The Director of Nursing (DON) reviewed the policies for the 30-day summary/case conference, the Skilled Nurse discharge summary and communication notes for re-education and clarification. The document titled “Summary of Care Provided” for patient #1 was reviewed and corrected to reflect that the patient was not incontinent. The document titled “SN Discharge Summary and Communication Note” for patient #4 was reviewed and corrected to reflect the accurate reason for discharge. In | 10/21/2020 |

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| | care, incontinent care, and ADL's [activities of daily living] per POC [plan of care] under supervision of an RN [registered nurse]."<br><br>Clinical record review on 10/13/2020, for patient #1, evidenced an agency document titled "HHA Care Plan", dated 8/10/2020 and signed by employee B. This document had a subcategory titled "Plan Details", in which "Incontinence Care" was not indicated as part of the care plan.<br><br>During an interview on 10/14/2020 at 1:30 p.m., employee B indicated patient #1 was not incontinent. When queried, employee B stated the documentation in the 30-day summary "doesn't pertain to this patient".<br><br>2. Clinical record review on 10/13/2020 for patient #4 with start of care 1/31/2018 and certification period 1/31/2018 to 3/5/2018 evidenced an agency document titled "SN DISCHARGE SUMMARY", dated 3/5/2018, signed by employee B. This document stated, " ... Reason for D/C [discharge]: Goals Met...."<br><br>Clinical record review evidenced an agency document titled "COMMUNICATION NOTE", dated 3/5/2018, signed by employee A. This document stated, "Patient request discharge to outpatient."<br><br>During an interview on 10/14/2020 at 1:47 p.m., employee B indicated it was "not clear" why the patient was discharged.<br><br>17-15-1(a)(7) | | addition, 100% of active clinical records were reviewed for this deficiency and all deficiencies found were corrected. Also, 100% of discharged clinical records for the last 3 months were reviewed for this deficiency and all deficiencies found were corrected.<br>All field staff were in-serviced by the DON on 10/21/2020 on their duties, responsibilities, and the importance of prompt, accurate and appropriately authenticated documentation. Also, the DON retrained the field staff on the importance of consistency in communication and documentation of patient's care across all patient care records, including the 30-day summary/case conference and discharge summary.<br>The DON or her clinical designee will now review all the clinical documentations weekly to ensure all communications pertaining to of patient's care are consistent across all documents and are legible, clear, complete, accurate and appropriately authenticated.<br>10% of clinical records will be selected and reviewed quarterly for evidence that all clinical record entries are legible, clear, complete, accurate and appropriately authenticated.<br>The DON will be responsible to ensure that these deficiencies do not recur. | |

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| N 0000<br><br>Bldg. 00 | A State survey was conducted at ProCare Home Health Services by the Indiana Department of Health in accordance with 410 IAC 17.<br><br>Survey Dates: 10/7/20, 10/8/20, 10/9/20, 10/13/20, and 10/14/20<br><br>IN00289478 - substantiated with related findings<br>IN00255912 - substantiated with related findings<br><br>Facility ID: 003042<br><br>Skilled Unduplicated Census: 224<br><br>Active Census: 68<br><br>Discharged Census: 222<br><br>2 home visits with clinical record reviews<br><br>1 home visit without clinical record review<br><br>6 clinical record reviews<br><br>At this State survey, ProCare Home Health Services was found to not be in compliance with 410 IAC 17. | N 0000 | | |
| N 0458<br><br>Bldg. 00 | 410 IAC 17-12-1(f)<br>Home health agency administration/management<br>Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, | | | |

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| | certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:<br>(1) Receipt of job description.<br>(2) Qualifications.<br>(3) A copy of limited criminal history pursuant to IC 16-27-2.<br>(4) A copy of current license, certification, or registration.<br>(5) Annual performance evaluations.<br>Based on record review and interview, the home health agency failed to ensure personnel records included the receipt of a job description, a copy of a criminal background check, a copy of current certification, documentation of orientation to the job, and an annual performance evaluation in 4 of 8 employee records reviewed. (employees C,E,F,G)<br><br>The findings include:<br><br>1. An agency policy dated 10/31/2017 titled "Job Description", stated "POLICY ... All personnel will receive a copy of their Job Descriptions during orientation. One copy will be signed and placed in their personnel file."<br><br>An undated agency policy with title "Personnel-Employment" stated " ... POLICY ... ProCare will ... request criminal background check and review Nurse Aide Registry ... provide competency evaluation ... register all aides with ISDH [Indiana State Department of Health] ..."<br><br>2. Personnel record review on 10/13/2020 of employee C, HHA [home health aide], with start date 12/20/2018, failed to evidence a performance evaluation. | N 0458 | The Administrator and personnel officer audited all the personnel folders and ensured that all the required documentations were included in the personnel folders of each staff member. These included but not limited to documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Staff members were asked to bring in documentation when necessary like CPR cards and vehicle insurance amongst all the needed documentation.<br>An audit tool has been developed to track and flag employee's requirements bi-monthly and information collected during the bi-monthly pay dates.<br>The Administrator and Personnel | 11/10/2020 |

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| | 3. Personnel record review on 10/13/2020 of employee E, PTA [physical therapy assistant], evidenced a PTA certification which expired on 6/30/2020. Employee E's employee record failed to evidence a current certification and documentation of orientation to the job.<br><br>4. Personnel record review on 10/13/2020 of employee F, RN [registered nurse], with start date 11/3/2016 and first patient contact date of 11/8/2016, failed to evidence a completion of a national criminal background check.<br><br>5. Personnel record review on 10/13/2020 of employee G, RN, with start date 2/9/2020 and first patient contact date of 2/21/2020, failed to evidence a receipt of a job description, a copy of a criminal background check, documentation of orientation to the job, and an annual performance evaluation.<br><br>6. During an interview on 10/14/2020 at 10:25 a.m., employee A and employee B both indicated that signed job descriptions, criminal background checks, certifications, documentation of orientation and performance evaluations should be located in employee files. | | Officer will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. | |
| N 0462<br><br>Bldg. 00 | 410 IAC 17-12-1(h)<br>Home health agency administration/management<br>Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread | | | |

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| | infectious or communicable diseases to patients.<br>Based on record review and interview, the home health agency failed to ensure personnel records included a physical examination which ensured the employee is free from communicable and infectious diseases in 1 of 8 employee records reviewed (D).<br><br>The findings include:<br><br>Review of an agency policy dated 10/19/2006, titled "Employment Health Requirements", stated " ... A home health care staff member who has accepted employment with the agency and having direct patient contact must submit ... a physical examination by a physician or nurse practitioner not more than one hundred eighty (180) days before the date the employee has direct patient contact..."<br><br>Personnel record review on 10/13/2020 of employee D, HHA [home health aide], with start date 7/8/2014 and first patient contact date of 7/21/2014, failed to evidence a physical examination which ensured the employee is free from communicable disease. During a home visit on 10/9/2020 at 12:06 p.m., employee D indicated she had been the HHA for that patient for "years".<br><br>During an interview on 10/14/2020 at 10:25 a.m., employee A indicated all employees who have direct patient contact should have a physical examination, which ensured the employee is free from communicable diseases, located in employees medical record. | N 0462 | The Administrator and personnel officer audited all the personnel folders and ensured that all the pre-employment documents, particularly the ones needed prior to patient contact were included in the personnel folders of each staff member and contract staff. A comprehensive physical examination by a physician within 180 days before the date that the employee has direct patient contact, showing that staff are free of infectious or communicable diseases and will not spread such to patients are now in staff folders.<br>An audit tool has been developed to track and flag employee's requirements bi-monthly and information collected during the bi-monthly pay dates.<br>The Administrator, the Director of Nursing (DON) and Personnel Officer will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. | 11/11/2020 |
| N 0464 | 410 IAC 17-12-1(i)<br>Home health agency | | | |

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| Bldg. 00 | administration/management<br>Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows:<br>(1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative.<br>(2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered.<br>(3) Any person with:<br>(A) a documented:<br>(i) history of tuberculosis;<br>(ii) previously positive test result for tuberculosis; or<br>(iii)completion of treatment for tuberculosis; or<br>(B) newly positive results to the tuberculin skin test;<br>must have one (1) chest rediograph to exclude a diagnosis of tuberculosis.<br>(4) After baseline testing, tuberculosis screening must:<br>(A) be completed annually; and<br>(B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).<br>(5) Any person having a positive finding on a | | | |

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| | tuberculosis evaluation may not:<br>(A) work in the home health agency; or<br>(B) provide direct patient contact;<br>unless approved by a physician to work.<br>(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:<br>(A) working for the home health agency; or<br>(B) having direct patient contact;<br>has had a negative finding on a tuberculosis examination within the previous twelve (12) months. | | | |
| | Based on record review and interview, the home health agency failed to ensure that all employees having direct patient contact were evaluated for tuberculosis in 1 of 8 employee records reviewed (G).<br><br>The findings include:<br><br>Review of an agency policy dated 10/19/2006, titled "Employment Health Requirements", stated " ... A home health care staff member who has accepted employment with the agency and having direct patient contact must submit ... any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test ... unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative...."<br><br>Personnel record review on 10/13/2020 of employee G, RN [registered nurse] with start date 2/9/2020 and first patient contact date of 2/21/2020, failed to evidence the employee was evaluated for tuberculosis.<br><br>During an interview on 10/14/2020 at 10:25 a.m., employee A indicated all employees who have | N 0464 | The Administrator and personnel officer audited all the personnel folders and ensured that all the preemployment documents, particularly that needed prior to patent contact were included in the personnel folders of each staff member and contract staff.<br>Documentation to show that staff have been evaluated for tuberculosis and screening for tuberculosis as required are now in staff folders.<br>An audit tool has been developed to track and flag employee's requirements bi-monthly and information collected as needed during the bi-monthly pay dates.<br><br>The Administrator, the Director of Nursing (DON) and Personnel Officer will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur. | 11/10/2020 |

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| | direct patient contact should have documentation of evaluation for tuberculosis in employee medical record. | | | |
| N 0488<br><br>Bldg. 00 | 410 IAC 17-12-2(i) and (j)<br>Q A and performance improvement<br>Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped.<br><br>(j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances:<br>(1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient.<br>(2) The patient refuses the home health agency's services.<br>(3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or<br>(4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge.<br>Based on record review the administrator failed to ensure a policy was in place that required the agency to give notice of discharge to the patient at least 15 days in advance. | N 0488 | The Administrator and Director of Nursing (DON) revised the Discharge Policy 3.4 to include that: at least fifteen (15) calendar | 11/05/2020 |

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| | 157538 | A. BUILDING 00<br>B. WING | 10/14/2020 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| PROCARE HOME HEALTH SERVICES | 8300 BROADWAY STREET STE F2A<br>MERRILLVILLE, IN 46410 |

| (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 |
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| | The findings include:<br><br>A hand written policy dated 10/27/2017, titled "Addendum to Discharge Policy 3.4" stated "Discharge planning is started at patient admission. Patient will be informed of the policy at admission by the admitting clinician. In case the patient is short term, that is less than 30 days; the information will service as the 15 day notice.... " This agency policy was not compliant with current Indiana State regulations of notifying the patient 15 days in advance of discharge.<br><br>During the daily conference on 10/7/2020, at 4:20 PM, employee A, administrator, acknowledged the policy failed to include a 15 day discharge notice that included all patients who received care. | | days notification of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care before the services are stopped.<br>The Administrator and DON are responsible to ensure that this deficiency does not recur. | |
| N 0506<br><br>Bldg. 00 | 410 IAC 17-12-3(b)(2)(D)(iii)<br>Patient Rights<br>Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows:<br>(2) The patient has the right to the following:<br>(D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows:<br>(iii) The home health agency shall advise the patient of any change in the plan of care, including reasonable discharge notice.<br>Based on record review and interview, the agency failed to ensure a 15 day discharge notice in 1 of 3 discharged patients, in a total sample of 8 records reviewed. (#8)<br><br>The findings include:<br><br>Clinical record review on 10/13/2020, for patient | N 0506 | The Administrator and DON in-serviced the clinical staff and home health aides on the agency's revised discharge policy 3.4 of at least fifteen (15) calendar days notification of discharge of service to the patient, the patient's legal representative, or other | 11/12/2020 |

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| | #8, start of care 2/28/2019, evidenced an agency document titled "Oasis-D Discharge" that was electronically signed by employee B, clinical supervisor, on 4/25/2019. This document was a summary of the patients care such as vital signs, head-to-toe assessment, and of goals the patient achieved over the course of the certification period.<br><br>Record review evidenced an agency document titled "Skilled Nurse Visit" which was electronically signed by employee B on 4/19/2019. This document had an area subtitled "Discharge Planning" which had indicated discharge planning had been discussed with the patient and caregiver. This section also stated "patient to be discharged once all PT [physical therapy] goals are met ... "<br><br>During an interview on 10/13/2020 at 3:36 PM, employee B indicated discharge plans were discussed prior to the patients discharge on 4/26/2019. The clinical record failed to evidence discharge plans were discussed at least 15 days in advance. | | individual responsible for the patient's care before the services are stopped. Patients are now informed at start of care of the discharge policy with emphasis that there will be at least fifteen (15) calendar days notification of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care before the services are stopped except for emergency situations regarding safety, patient refusal, lack of funds and lack of physician order. The DON or clinical designee will review all progress notes weekly to ensure compliance with the revised Discharge Policy. Also, during the monthly case conference meetings, the discharge policy will be emphasized.<br><br>The Administrator and DON are responsible to ensure that this deficiency does not recur. | |
| N 0518<br><br>Bldg. 00 | 410 IAC 17-12-3(e)<br>Patient Rights<br>Rule 12 Sec. 3(e)<br>(e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is | | | |

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| | furnished before care is provided.<br>Based on record review and interview, the administrator failed to ensure the correct information was distributed to the home health agency's patients on advanced directives.<br><br>The findings include:<br><br>Record review on 10/7/2020, evidenced a sample admission packet that was received from employee B, clinical supervisor. The sample admission packet contained an Indiana State Department of Health (ISDH) document titled "Advanced Directives ... Your Right to Decide" that was last revised on July 1, 2013. This document did not reflect the most current version of the ISDH Advanced Directives, that was last revised on November 1, 2018.<br><br>During an interview on 10/7/2020 at 11:02 AM, employee B indicated the packet received was the most current admission information distributed to all patients. | N 0518 | The sample admission packet as at 10/08/2020 now contains the most current version of the Indiana State Department of Health (ISDH) document titled "Advanced Directives ... Your Right to Decide", that was last revised on November 1, 2018.<br>The home health agency has now informed and distributed the written information to the patient, concerning its policies on advance directives, including the description of the applicable state law. The correct information has now been distributed to the home health agency's patients on advanced directives.<br>Administrator and DON will ensure the correct information is given to all patients before care is provided will ensure that this deficiency does not recur. | 11/11/2020 |
| N 9999<br><br>Bldg. 00 | 410 IAC 17-9-16 "Home health aide" defined<br>Authority: IC 16-27-1-7 Affected: IC 16-27-1 Sec. 16. "Home health aide" means an individual who provides home health aide services. The term does not include the following: (1) A health care professional. (2) A volunteer who provides home health aide services without compensation. (3) An immediate member of the patient's family. (Indiana State Department of Health; 410 IAC 17-9-16) | N 9999 | The home health agency no longer has an immediate member of a patient's family providing home health aide services to agency patients. This deficiency was corrected on 11/02/2020 in accordance with Indiana State Department of Health; 410 IAC 17-9-16 stating that an immediate member of the patient's family should not provide care while employed under home health | 11/02/2020 |

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| | Based on observation and interview the home health agency failed to ensure employees who provided home health aide services to agency patients were not an immediate member of the patient's family, in 1 of 2 home visits conducted. (#1)<br><br>The findings include:<br><br>Observation of a home visit on 10/9/2020 at 11:55 a.m., evidenced employee H, HHA [home health aide] giving report on patient #1 to employee D, HHA.<br><br>During an interview on 10/9/2020 at 12:02 p.m., employee D indicated patient #1 was the aunt of employee H.<br><br>During an interview on 10/14/2020 at 1:30 p.m., employee B indicated employee patient #1 was the aunt of employee H. | | agency.<br>The Administrator, the Director of Nursing (DON) or her designee and the scheduler will monitor staff scheduling weekly to ensure that home health aides are not assigned to their immediate family member.<br><br>The Administrator, the Director of Nursing (DON) and Personnel Officer will be responsible these corrective measures are in place to ensure that this deficiency will not recur. | |