STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157643	A. BUILDING B. WING	12/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAGON HOME HEALTH CARE INC	3310 HICKORY RD STE B-1A, MISHAWAKA, IN, 46545

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This was a State Complaint and Re-licensure survey conducted at Paragon Home Health Care Inc., a deemed home heath agency, by the Indiana Department of Health (IDOH). Complaint # 94384: substantiated Survey Dates: November 30 (2022), December 1, 2, 5, 6, 7, 8, 9 (2022) Facility ID: 012531 Current Census: 56	N0000		2023-02-17
G0000	INITIAL COMMENTS This was a Federal complaint survey conducted at Paragon	G0000		2023-02-17

	Home Health Care Inc., a deemed home heath agency, by the Indiana Department of Health (IDOH). Complaint # 94384: substantiated with Federal deficiencies Survey Dates: November 30 (2022), December 1, 2, 5, 6, 7, 8, 9 (2022) Facility ID: 012531 Current Census: 56 Based on the Condition-level deficiencies cited at 42 CFR §484.55 Condition of Participation: Comprehensive Assessment of Patients, 42 CFR §484.60 Condition of Participation: Care Planning, Coordination of Services, and Quality of Care; 42 CFR §484.70 Condition of Participation: Infection Prevention and Control, 42 CFR §484.105 Condition of participation: Organization and Administration of Services, and 42 CFR §484.110 Condition of participation: Clinical records during the 12/09/22 survey, and pursuant to section 1891(c)(2)(D) of the Social Security Act on 12/09/22, your			

	agency is precluded from operating a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning 12/09/22 and continuing through 12/08/24. Quality Review Completed 01/19/2023			
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the home health agency's organizational chart failed to ensure the agency's alternate Clinical Supervisor was readily identified by staff. Findings include: An untitled document was	N0440	Corrective Action: In order to correct the abovedeficiency cited, in Management meeting on 1/27/2023, the Director of ClinicalServices and Administrator reviewed, discussed the agency policy 7.11.1 titled"Organization and Services Administration" under Leadership Section.During this meeting, deficiencies cited under N-0440 were reviewed, addressedand discussed in detail.	2023-02-17

	received from the Administrator on 11/30/22, updated June 2022, which evidenced Registered Nurse (RN) #3 was the alternate Clinical Supervisor. On 11/30/22 at 3:07 PM, the Administrator indicated the untitled document received was the agency's organizational chart. During an interview on 12/08/22 at 8:38 PM, RN #1 indicated she didn't know if the agency had an alternate Clinical Supervisor, or who it would be. During an interview on 12/09/22 at 12:12 PM, Employee #5 indicated she had no idea who the alternate Clinical Supervisor was, and she was not aware the agency even had one. During an interview on 12/09/22 at 12:28 PM, Employee #6 indicated the Administrator always told her RN #3 was retiring.		The Administrator has completedreview of agency's document titled "organizational chart" and concluded that itclearly defines in writing the chain of command and the last date it wasupdated. An in-service meeting was conductedby the Administrator and attended by all staff including contracted personnelon 2/2/23 to discuss agency policy 7.11.1 titled "Organization andServices Administration". During this meeting, deficiencies cited under N-0440were reviewed, addressed and discussed in detail with all staff. The Administratoremphasized on the importance that the Organization, services furnished,administrative control, and lines of authority for the delegation ofresponsibility down to the patient care level is clearly set forth in writingand that the Home Health agency staff must be able to readily identify positionsand staff on the organizational chart. All staff understood and acknowledgedthe requirement. All active staff or newly hired staff will be provided orientationand updated copy of	

			the agency's organizational chart and will be educated toreadily identify positions and staff on the organizational chart, organization,services furnished, administrative control, and lines of authority for thedelegation of responsibility down to the patient care level. This correctiveaction will be implemented on 2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there isno recurrence of this deficiency, the HR Manager will utilize an HR audit toolto ensure that all personnel record contents are current and all personnelfiles contain evidence of Staff orientation checklist document signed/dated bystaff and supervisor ensuring that staff has received orientation on organization,services furnished, administrative control, and lines of authority for thedelegation of responsibility down to the patient care level and staff andpositions are readily identifiable on organizational chart. This processof utilizing HR audit tool will help us	

			identify any discrepancies in thepersonnel files and enforce all staff to have their files completed and up todate. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizea HR audit tool and audit 100% of all personnel file records on a monthly basisto ensure that all active personnel file records show documented evidence of a Stafforientation checklist document signed/dated by staff and supervisor ensuringthat staff has received orientation on organization, services furnished,administrative control, and lines of authority for the delegation ofresponsibility down to the patient care level and staff and positions arereadily identifiable by staff on the organizational chart. The Administratorwill review HR Manager's audit findings of all active personnel file records.Monthly reports will be generated and results will be compiled and sent to	

			theAdministrator to ensure that processes have improved. This process willcontinue for each month for the next 3 months until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified withinthe next 3 months, they will continue to be addressed with staff re-trainingand re-education in workshops and in-services and with each individualpersonnel as needed. After 3 months, this process will continue to be monitoredon a quarterly basis and will be included in the quarterly HR audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 100%of personnel file records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations.	

			The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0444	Home health agency administration/management 410 IAC 17-12-1(c)(1) Rule 12 Sec. 1(c) An individual need not be a home health agency employee or be present full time at the home health agency in order to qualify as its administrator. The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (1) Organize and direct the home health agency's ongoing functions. Based on observation, record review, and interview, the home health agency's Administrator failed to organize and direct the home health agency's ongoing functions. Findings include:	N0444	**CorrectiveAction:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/23, the Governing Body,Administrator and Director of Clinical Services reviewed, discussed the agencypolicies 7.11.1 titled "Organization and Services Administration" and7.9.1 titled “Administrator: Defined” under Leadership Section. During thismeeting, deficiencies cited under N-0444 were reviewed, addressed and discussedin detail. The Administrator has completed re-orientationof agency’s policies pertaining to Home health agency administration/management. An in-service meeting was conducted by the Governing Body andattended by the Administrator, Director of Clinical Services and all	2023-02-17

	An agency job description with revised date February 2022, titled "Administrator", stated, "... responsible for all day-to-day operations of Agency ... Directs the Agency's ongoing functions ...." The Administrator failed to ensure the day-to-day operations and direct ongoing functions of the home health agency as evidenced by: The Administrator failed to ensure the home health agency's organizational chart included the role of Marketer; and failed to ensure the agency's alternate Clinical Supervisor was readily identified by staff. Please see tag N0440. The Administrator failed to ensure the agency employed qualified personnel, and/or provided adequate staff education. Please see tag N0446. The Administrator failed to ensure the accuracy of public information materials the agency provided to its patients. Please see tag N0447. The Administrator failed to ensure the Clinical Supervisor		staffincluding contracted personnel on 2/2/23 to discuss the agency policies 7.11.1titled "Organization and Services Administration" and 7.9.1 titled"Administrator: Defined" under Leadership Section. During this meeting,deficiencies cited under N-0444 were reviewed, addressed and discussed indetail with all staff. The Governing Body emphasized on the importance of Homehealth agency administration/management and cumulative citations listed underN-0444. All staff understood and acknowledged the agency's policies pertainingto Homehealth agency administration/management. All new staff will be orientedof this requirement at the time of hire. This corrective action will be implementedon 2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there is norecurrence of this deficiency, the Governing Body will utilize an Administrationaudit tool to ensure that the Administrator	

	(or alternate Clinical Supervisor) was available 24 hours per day, 7 days per week, to meet the agency's clinical supervisory needs, or the medical needs of the patients. Please see tag N0454. The Administrator failed to be responsible for the agency's ongoing quality assurance performance improvement (QAPI) program. Please see tag N0456. The Administrator failed to ensure all personnel records included a signed job description, documentation of orientation to the job, and/or verification of current license. Please see tag N0458. The Administrator failed to ensure the agency's personnel record policy included the requirement for physical examinations, and failed to ensure all employees with direct patient contact had a physical examination prior to first patient contact. Please see tag N0462. The Administrator failed to ensure (per the agency's own policy) the agency completed a		homehealth agency's ongoing functions as per policies and guidelines. This processof utilizing Administration audit tool will help us identify any discrepanciesin the administration/management and implement corrective measures and assessoutcomes. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Governing Body willutilize an Administration audit tool and audit 100% of Administration recordson a monthly basis to ensure documented evidence to organize and direct thehome health agency's ongoing functions as per policies and guidelines.The QAPI Committee will review audit findings of Administration records.Monthly reports will be generated and results will be compiled and sent to theAdministrator and Governing Body to ensure that processes have improved. Thisprocess will continue for each month for the next 3 months until 100%compliance is	

	risk assessment (to determine risk of exposure to TB); and failed to ensure all employees/contracted staff had baseline TB testing upon hire. Please see tag N0464. The Administrator failed to ensure all employee/contracted staff health records were maintained in separate medical files and treated as confidential medical records. Please see tag N0466. The Administrator failed to ensure the home health agency implemented its own policies and procedures for the prevention/control of infection/communicable disease. Please see tag N0470. The Administrator failed to maintain a current quality assessment and performance improvement (QAPI) program. Please see tag N0472. The Administrator failed to ensure contracted staff personnel records were made available to the home health agency upon two (2) hours notice. Please see tag N0482. The Administrator failed to		achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within the next 3 months, they will continue to beaddressed with staff re-training and re-education in workshops and in-servicesand with each individual personnel as needed. After 3 months, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly Administration audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 100% of Administration records quarterlyto ensure compliance is maintained. The QAPI Committee will send a writtenreport to the Governing Body quarterly for their recommendations. The Governing Body will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of	

	developed a policy requiring at least fifteen (15) calendar days' notice before agency services were stopped; or provided the patient, the patient's legal representative, or other individual responsible for the patient's care, at least fifteen (15) calendar days' notice of discharge before the services were stopped. Please see tag N0488. The Administrator failed to ensure the patient had the correct phone number to place a complaint with the Indiana Department of Health (IDOH). Please see tag N0502. The Administrator failed to ensure the patient's rights were maintained to be informed in advance, about the care to be furnished, and the discipline(s)/frequency of visits. Please see tag N0504. The Administrator failed to ensure the patient's rights were maintained to be informed about, and participated in the development of the plan of care. Please see tag N505. The Administrator failed to maintain the patient's right to be provided with the agency's		thisdeficiency.	

	policies and procedures regarding disclosure of clinical records. Please see tag N0508. The Administrator failed to ensure the patient/family received a positive resolution/response to a complaint made, within 24 hours of the agency's receipt of the complaint. Please see tag N0514. The Administrator failed to ensure the agency's policies on advance directives, or the current Indiana Department of Health (IDOH) information on Advance Directives, was provided to all agency patients. Please see tag N0518. The Administrator failed to ensure all patients accepted for care had their needs adequately met. Please see tag N0520. The Administrator failed to ensure all medical care/treatment provided by agency staff followed the written plan of care, or ensured the initial written plan of care was established/reviewed and approved by the certifying physician. Please see tag N0522. The Administrator failed to			

	ensure all patients' plans of care included all required components. Please see tag N0524. The Administrator failed to ensure the patient's plan of care was reviewed by the certifying physician when a significant change in condition occurred that required an updated plan of care, and failed to ensure the patient's plan of care was reviewed by the certifying physician at least every 60 days. Please see tag N0526. The Administrator failed to ensure a written summary report for each patient was sent to the certifying physician at least every 60 days. Please see tag N0529. The Administrator failed to ensure agency staff promptly notified the patient's physician for a significant change in condition; failed to ensure a transfer summary was sent to the receiving facility (per the home health agency's own policy); and/or failed to know which emergent care facility the patient transferred to. Please see tag N0532. The Administrator failed to			

	ensure an RN initiated and/or updated the plan of care based on the patient's needs. Please see tag N0542. The Administrator failed to ensure only qualified licensed professionals accepted and carried out physician orders (either verbal or written). Please see tag N0547. The Administrator failed to ensure the patient's clinical record (electronic medical record/EMR) contained all required components. Please see tag N0608. The Administrator failed to retain all patients' clinical records for 7 years. Please see tag N0612. The Administrator failed to ensure it safeguarded all patients' clinical record information against loss or unauthorized use. Please see tag N0614. The Administrator failed to provide all unlicensed staff with notice of the home health agency's drug testing policy; or ensured unlicensed employees tested negative on the drug test			

	with patients. Please see tag N9999.			
N0446	Home health agency administration/management 410 IAC 17-12-1(c)(3) Rule 12 410 IAC 17-12-1(c)(3) Sec. 1(c)(3) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (3) Employ qualified personnel and ensure adequate staff education and evaluations. Based on observation, record	N0446	**CorrectiveAction:** In order to correct the above deficiency cited, inManagement meeting on 1/27/23, the Director of Clinical Services andAdministrator reviewed, discussed the agency policy 4.8.1 titled "PersonnelRecords" under Human Resources Section. During this meeting, deficienciescited under N-0446 were reviewed, addressed and discussed in detail. The Administrator has completedreview of all personnel files and concluded that all Personnel files are	2023-02-17

	review and interview, the Administrator failed to ensure the agency employed qualified personnel, and/or provided adequate staff education for 1 of 2 Licensed Practical Nurse (LPN) personnel files reviewed (LPN #1), and 3 of 4 Registered Nurse (RN) personnel files reviewed (Clinical Supervisor, alternate Clinical Supervisor, RN #2). Findings include: 1. An agency policy with revised date February 2022, titled "Personnel Records", stated, "... The personnel record ... for an employee will include ... Observed competencies: initial during orientation and ongoing ...." 2. Review on 12/5/22 of a National Library of Medicine web-based reference, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144247/, cite: Nair B. Compression therapy for venous leg ulcers. Indian Dermatol Online J. 2014 Jul;5(3):378-82. doi: 10.4103/2229-5178.137822. PMID: 25165679; PMCID: PMC4144247, titled “Compression therapy for		incompliance with documented evidence of agency/job specific orientation andinitial skills competency check assessment. Anin-service meeting was conducted by the Administrator and attended by allclinicians including contracted personnel on 2/2/23 to discuss agency policy4.13.1 titled "Personnel Records" under Human Resources Section. Duringthis meeting, deficiencies cited under N-0446 were reviewed, addressed and discussedin detail with all staff. The Administrator emphasized on the importance thatthe Home Health agency staff are required to receive agency/job specificorientation and initial skills competency check assessment of all staff,including the staff who will have direct contact with patients. All staffunderstood and acknowledged the requirement. All active staff or newly hiredstaff will provide and the agency will maintain documented evidence of agency/jobspecific orientation and initial skills competency check assessment inPersonnel records. This corrective action will be implemented on	

	venous leg ulcers", stated "... Bandages should generally be applied toe to knee at 50% stretch and with 50% overlap ...." 3. Personnel record review was completed on 12/01/2022 at 11:47 AM for LPN #1, start date 7/29/22, which failed to evidence LPN #1's license was current, agency/job specific orientation was completed, or an initial skills competency check was completed. 4. Personnel record review was completed on 12/01/2022 at 11:47 AM for RN #2, start date 4/27/22, which failed to evidence RN #2's agency/job specific orientation was completed, or an initial skills competency check was completed. 5. Personnel record review was completed on 12/01/2022 at 11:47 AM for the Clinical Supervisor, start date 8/05/18, which failed to evidence the Clinical Supervisor's agency/job specific orientation was completed. 6. A home visit was observed with Patient #6 and the Clinical Supervisor on 12/05/22 at 11:00		2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the HR Manager will utilize an HR audit tool to ensure that allpersonnel record contents are current and all personnel files contain evidenceof agency/job specific orientation and initial skills competency checkassessment. This process of utilizing HR audit tool will help us identify anydiscrepancies in the personnel files and enforce all staff to have their filescompleted and up to date prior to providing patient care in the home. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizea HR audit tool and audit 100% of all personnel file records on a monthly basisto ensure that all	

	AM. Observed the Clinical Manager provide wound care, then apply elastic compression wraps to both of the patients lower legs, starting the wraps from just below the knee and wrapped downward to the toes. During an interview on 12/08/22 at 3:30 PM, the Clinical Supervisor indicated she didn't know elastic compression wraps should be applied from the toes up, or that applying them from the knees downward to the toes could cause disrupted blood flow. During this time, her personnel record was reviewed (for a second time), and the Clinical Supervisor indicated there was no proof of competency for correct application of elastic compression wraps. 7. During an interview on 12/09/22 at 11:53 AM, the Administrator indicated he appointed administrative RN #4 as the alternate Clinical Supervisor as of today (12/09/22). 8. Personnel record review for the alternate Clinical Supervisor was completed on 12/09/22 at 11:55 AM, start date 12/01/22,		active personnel file records show documented evidence of agency/jobspecific orientation and initial skills competency check assessment prior to providingcare, treatment or services for the Agency and/or its patients. TheAdministrator will review HR Manager's audit findings of all active personnelfile records. Monthly reports will be generated and results will be compiledand sent to the Administrator to ensure that processes have improved. Thisprocess will continue for each month for the next 3 months until 100%compliance is achieved and to maintain this level of compliance all new employeesat the time of hire will be oriented with this requirement. If compliance isnot achieved at the desired target of 100% compliance and any deficiencies areidentified within the next 3 months, they will continue to be addressed withstaff re-training and re-education in workshops and in-services and with eachindividual personnel as needed. After 3 months, this process will continue tobe monitored on a quarterly basis and will be included in the quarterly HRaudit review.	

	which failed to evidence the alternate Clinical Supervisor's agency/job specific orientation was completed, or an initial skills competency check was completed. 9. During an interview on 12/09/22 at 11:55 AM, the alternate Clinical Manager indicated she worked a little bit with home health patients at entity #3 from 2010 – 2014, she didn't have any management experience in home health, and she didn't know what you do in home health, because she hasn't been oriented yet. 10. During an interview on 12/09/22 at 1:01 PM, when queried how he ensured administrative RN #4 was qualified for the alternate Clinical Manager position, the Administrator indicated she's been a nurse for 25 years, her resume stated she has a lot of experience, and State will decide if she was qualified or not. When queried the qualifications for Clinical/alternate Supervisor, the Administrator indicated RN, experienced, and worked with agencies.		Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will continueto audit 100% of personnel file records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	

	11. During an interview on 12/09/22 at 2:11 PM, when queried the correct procedure for application of lower extremity elastic compression wraps, the alternate Clinical Supervisor stated, "... I Usually start at the top and work my way down ... I haven't done that very much ...."			
N0447	Home health agency administration/management 410 IAC 17-12-1(c)(4) Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on record review and interview, the Administrator failed to ensure the accuracy of public information materials the agency provided to its patients. Findings include: An undated agency document (home folder spiral booklet) received 11/30/22, titled	N0447	**CorrectiveAction:** Inorder to correct the above deficiency cited, in Management meeting on 1/27/2023,the Administrator and Director of Clinical Services discussed, reviewed andupdated the organization's "Patient Admission Booklet", each patientreceives in writing at the time of initial evaluation visit and it includes publicinformation materials that the Agency provides for its patients. Duringthis management meeting, deficiency cited under N-0447 was corrected. Contactinformation for the State of Indiana Home Health Hotline for Complaints	2023-02-17

	"Patient Admission Booklet" included an untitled document which required the patient's signature. The document stated, "... After 5:00 pm and on weekends or holidays, if any health concern arises which you would like to discuss with the on call nurse, please call ... [agency phone number] ... The nurse may need to refer you to the emergency room ... or arrange a nursing visit for you the next day ...." An agency document titled "Important Contact Information ...." stated, "... Indiana Home Care State Complaint Hotline ... 1-800-252-4343 ...." An additional document titled "Notice of Medicare Non-Coverage" stated, "... Indiana's Quality Improvement Organization at 1-800-288-1499 ...." An additional agency document titled "Admission Instructions to Patient", stated, "... Hot Line Number for State of Indiana ... 1-800-252-4343 ...." On 11/30/22 at 12:13 PM, called 1-800-252-4343. The number reached the Illinois Department of Health.		andcontact information for Quality Improvement Organization for Home Health Agenciesin Notice of Medicare Non-coverage document for State of Indiana was correctedand updated in the agency's Patient Admission/Orientation Packet. An in-service meeting wasconducted by the Administrator and attended by all staff on 2/2/23 to discuss theagency's "Patient Admission Booklet". During this meeting, deficiencies citedunder N-0447 were reviewed, addressed and discussed in detail with all staff. Allstaff was informed and educated on the presence of a most updated version of agency'sPatient Admission/Orientation Packet that included corrected Contactinformation for the State of Indiana Home Health Hotline for Complaints andcontact information for Quality Improvement Organization for Home HealthAgencies in Notice of Medicare Non-coverage document and staff will beinstructed to educate	

	On 11/30/22 at 12:25 PM, called 1-800-288-1499, which indicated the number may have been changed, but "good news", and stated, "... I may be able to help you find better coverage on your health insurance ...." During an interview on 12/08/22 at 4:00 PM, the Administrator indicated the documents were wrong, and they would need to be corrected.		Patients. All newly admitted Patients will receive the mostupdated version of agency's Patient Admission/Orientation Packet that includesContact information for the State of Indiana Home Health Hotline for Complaintsand contact information for Quality Improvement Organization for Home HealthAgencies in Notice of Medicare Non-coverage document. All staff understood andacknowledged the requirement and importance of need to educate Patients on mostupdated version of “agency's Patient Admission/Orientation Packet” as peragency policy. All active patients will sign/date and return an acknowledgmentform stating that they have received updated agency's PatientAdmission/Orientation Packet from clinicians. All new staff will be oriented ofthis requirement at the time of hire. This corrective action will beimplemented on 2/17/2023. **Measuresto assure No recurrence:** Inorder to ensure that there is	

			no recurrence of this deficiency, theAdministrator will utilize an audit tool to keep track of acknowledgment formthat includes the Contact information for the State of Indiana Home HealthHotline for Complaints and contact information for Quality ImprovementOrganization for Home Health Agencies in Notice of Medicare Non-coveragedocument and it will be placed in the patient's clinical records. This processwill involve our clinicians visiting patients' residence to ensure that mostupdated version of "agency's Patient Admission/Orientation Packet is presentand all active patients will sign/date and return an acknowledgment formstating that they received education from clinician. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, theAdministrator will audit 100% active charts to ensure that the clinicians haveprovided and educated the patients' on most current	

			version of the PatientAdmission packet that includes Contact information for the State of IndianaHome Health Hotline for Complaints and contact information for QualityImprovement Organization for Home Health Agencies in Notice of Medicare Non-coveragedocument and that completed acknowledgement form that is signed/dated by thepatient is present in the clinical record on a weekly basis. Reports will begenerated and results will be compiled to ensure clinical records focusing onneed to ensure processes have improved. If any deficiencies are identified,they will continue to be addressed with each personnel as needed. This processwill continue for the next 30 days until 90-100% compliance is achieved. After30 days, this process will continue to be monitored on a quarterly basis andwill be included in the quarterly chart audit review. Quarterly audit resultswill be compiled and sent to the QAPI Committee for review. Once threshold ismet, the Quality Committee will continue to audit 20% of clinical recordsquarterly to ensure	

			compliance is maintained. The Administrator and QAPICommittee will send a written report to the Governing Body quarterly for theirrecommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0454	Home health agency administration/management 410 IAC 17-12-1(d) Rule 12 Sec. 1(d) The person or similarly qualified alternate shall be on the premises or capable of being reached immediately by phone, pager or other means. In addition, the person must be able to: (1) respond to an emergency; (2) provide guidance to staff; (3) answer questions; and (4) resolve issues; within a reasonable amount of time, given the emergency or issue that has been raised. Based on record review and	N0454	**CorrectiveAction:** In order tocorrect the above cited deficiency, The Administrator, Governing Body andDirector of Clinical Services held a Management meeting on 1/27/23 to discussand review the findings/deficiencies identified by the State survey completedon 12/9/22. During this meeting, deficiencies cited under N-0454 were reviewed,addressed and discussed in detail. Agency policiestitled 4.17G.17 “Clinical Manager” and 7.10.1 “Supervision of Staff” wasreviewed and the requirement of ensuring that the Clinical Supervisor oralternate Clinical Supervisor	2023-02-17

	interview, the home health agency failed to ensure the Clinical Supervisor or alternate Clinical Supervisor was available 24 hours per day, 7 days per week, to meet the agency's clinical supervisory needs, or the medical needs of the patients. Findings include: An undated agency document received 11/30/22, titled "Patient Admission Booklet" included an untitled document which required the patient's signature. The document stated, "... After 5:00 pm and on weekends or holidays, if any health concern arises which you would like to discuss with the on call nurse, please call ... [agency phone number] ... The nurse may need to refer you to the emergency room ... or arrange a nursing visit for you the next day ...." During an interview on 12/08/22 at 4:00 PM, the Administrator indicated the document was wrong, and it would need to be corrected. An agency policy revised		was available 24 hours per day, 7 days per week andduring all operating hours, to meet the agency's clinical supervisory needs, orthe medical needs of the patients. TheAdministrator instructed the participants that for the agency to be incompliance, we must ensure a clinical manager is available 24 hours perday, 7 days per week and during all operating hours. This corrective action will be implemented effective 2/17/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of this deficiency, theAdministrator will utilize an HR audit tool for attendance record to ensurethat the Clinical Supervisor or alternate Clinical Supervisor wasavailable 24 hours per day, 7 days per week and during all operating hours, tomeet the agency's clinical supervisory needs, or the medical needs of thepatients. **Monitoring:** In order toensure	

	February 2022, titled "After Hours Accessibility" stated, "... The [Clinical Supervisor] ... and/or ... [alternate Clinical Supervisor] is on-call 24 hours per day on a rotating weekly basis ...." An agency job description submitted 12/06/22, revised February 2022, titled "Director of Clinical Services [Clinical Supervisor]", stated "... Provides 24 hour/day, seven (7) days/week on-call coverage ...." An agency job description submitted 12/06/22, revised February 2022, titled "Clinical Manager [alternate Clinical Supervisor]", stated, "... Available to share on-call ... Acts as [Clinical Supervisor] in the [Clinical Supervisor's] absence ...." During an interview on 11/30/22 at 11:04 AM, the Administrator indicated Registered Nurse (RN) #3 (alternate Clinical Supervisor) was on vacation until 12/15/22. During an interview on 12/08/22 at 3:30 PM, the Clinical Supervisor indicated she was leaving on a flight this evening (12/08/22) for Texas,		effectiveness of this corrective action, theAdministrator will be monitoring daily attendance to ensure that theClinical Supervisor or alternate Clinical Supervisor was available 24 hours perday, 7 days per week and during all operating hours, to meet the agency'sclinical supervisory needs, or the medical needs of the patients. This process will continue for the next 30 days to ensure properimplementation and to achieve 100 % compliance. After 30 days, this processwill continue to be monitored and included in the Quarterly Attendance record reviewto ensure compliance. Quarterly audit results will be compiled and sentto the QAPI Committee for review. Once threshold is met, the Quality Committeewill continue to audit 20% of Human resource records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. The Administrator will beresponsible for corrective action of this deficiency,	

	and would be back at work on Monday (12/12/22). When queried who would cover RN Clinical Supervisor duties, the Clinical Supervisor indicated no one did, this is how the agency operated; if she wasn't available, no one covered; and patients had to wait until she returned. During an interview on 12/08/22 at 8:15 PM, the Administrator indicated there was not an RN available to participate in clinical record review on 12/09/22 (in the Clinical Supervisor's absence). During an interview on 12/08/22 at 8:38 PM, RN #1 indicated they (agency) didn't work weekends as a standard practice, she only agreed to be on call to help out this evening (12/08/22), and she had another full time job, Monday - Friday, 8:00 AM to 5:00 PM, and some weekends/evenings. On 12/09/22 at 11:53 AM, the Administrator indicated RN #3 was actually retired. During an interview on 12/09/22 at 12:28 PM, administrative Employee #6 indicated she worked at the		measure to assure norecurrence and monitoring of this deficiency.	

never met RN #3, and RN #3 wasn't really available, When queried the last time RN #3 saw agency patients or was involved with agency daily operations, administrative Employee #6 stated, "... I would probably say it was probably before I began [working here] ...."

During an interview on 12/09/22 at 1:01 PM, the Administrator stated, "... [name of Clinical Supervisor] is always on call ...." During this time, the agency's on-call log was submitted and reviewed, which evidenced agency patient call logs, with most recent date 7/10/21. The call logs failed to indicate the times of the calls, or nursing visits were made to meet the documented medical needs/requests of the patients. During this time, the on-call schedule/calendar was requested, and the Administrator indicated there wasn't one. When queried what RN was on-call in the absence of the Clinical Manager (until 12/12/22), the Administrator indicated RN #1 was. When queried what would happen if a patient needed an RN before 4:00 PM, the Administrator indicated they would let them

	wait.			
N0456	Home health agency administration/management 410 IAC 17-12-1(e) Rule 12 Sec. 1(e) The administrator shall be responsible for an ongoing quality assurance program designed to do the following: (1) Objectively and systematically monitor and evaluate the quality and appropriateness of patient care. (2) Resolve identified problems. (3) Improve patient care. Based on record review and interview, the Administrator failed to be responsible for the agency's ongoing quality assurance performance improvement (QAPI) program. Findings include: On 12/01/22 at 10:30 AM, the agency's Quality Assurance Performance Improvement (QAPI) binder was submitted and reviewed. The front cover of the binder stated "QAPI 2019 - 2021". The binder failed to evidence any meetings occurred in 2022.	N0456	**CorrectiveAction:** In order to correct the above deficiency cited, the GoverningBody, QAPI Committee, Administrator and Director of Clinical Services reviewedand discussed the agency policy 10.1.1 titled, “Quality Assurance andPerformance (QAPI) Plan and Program”. During this management meeting on 1/27/23,deficiencies cited under N-0456 were reviewed, addressed and discussed indetail. The Administrator has completed re-orientation of agency’spolicies pertaining to responsibility for Home health agency’s ongoing quality assurance performanceimprovement (QAPI) program. An in-service was conducted by the Governing Body on 2/2/23with management, all office and field staff. During the meeting, the GoverningBody discussed the agency policy 10.1.1 titled, “Quality Assurance	2023-02-17

	During an interview 12/09/22 at 1:01 PM, the Administrator indicated he didn't know when the last QAPI meeting was, he attended, he was not sure who else attended, and current area(s) of concern were ongoing staffing issues, lack of nursing staff, and the QAPI goal was to get more staff. When queried if anything else was discussed during the meeting, the Administrator stated "... I don't know off the top of my head ...." On 12/09/22, at 1:16 PM, the Administrator submitted a document dated 10/28/22, titled "QAPI Meeting Minutes". The document failed to evidence any discussion occurred related to staffing needs, or goals to get more staff.		andPerformance (QAPI) Plan and Program" and the importance of the requirement thatthe Home Health Agency Administrator is responsible for an ongoing qualityassurance program. Citations listed in the QAPI program were addressed with alloffice and field staff. The Governing Body re-educated the office and all fieldstaff on the importance of this requirement that the Administrator will beresponsible for an ongoing quality assurance program to objectively and systematically monitorand evaluate the quality and appropriateness of patient care, resolveidentified problems and improve patient care. All staff understood andacknowledged the agency policy 10.1.1 titled, "Quality Assurance andPerformance (QAPI) Plan and Program" and the importance of the requirement thatthat the Home Health Agency Administrator will be responsible for an ongoingquality assurance program. All new staffwill be oriented of this requirement at the time of hire. This corrective action will be implemented effective 2/17/23.	

			Measuresto assure No recurrence: In order to ensure that there is norecurrence of this deficiency, the Administrator will utilize a QAPI audit toolto ensure that the Home Health Agency Administrator has maintainedresponsibility for an ongoing quality assurance program. This process of utilizing QAPI audittool will help us identify any discrepancies in the QAPI Program and implementcorrective measures and assess outcomes. **Monitoring:** In order to ensure implementation and effectiveness ofthis corrective action, the following monitoring process will be put in place,the QAPI Committee will utilize a QAPI audit tool with the help of the Directorof Clinical Services to ensure that the Administrator will maintain responsibilityfor an ongoing quality assurance program. This process will help us identifyand implement	

assessment and performance improvement(QAPI) program and make corrective adjustments in the future. Monthlyreports will be generated by QAPI Committee and results will be compiled andsent to the Administrator to ensure that processes have improved. This processwill continue every month for the next three months until 100% compliance isachieved and to maintain this level of compliance, all new staff at the time ofhire will be oriented with this requirement. If compliance is not achieved atthe desired target of 100% compliance and if any deficiencies are identifiedwithin three months, they will continue to be addressed with staff re-trainingand re-education in workshops and in-services and with each individualpersonnel as needed. Once 100% compliance is achieved, the QAPI Committee willcontinue to audit QAPI documentation on a semi-annual basis to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body semi-annually for their recommendations.

N0458	Home health agency administration/management 410 IAC 17-12-1(f) 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, 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: (1) Receipt of job description. (2) Qualifications. (3) A copy of an employee's national criminal history background check or expanded criminal history check. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home health agency failed to ensure all personnel records included a signed job description, documentation of orientation to the job, and/or verification of current license, for 5 of 6 nursing personnel records reviewed with the Clinical	N0458	**CorrectiveAction:** In order to correct the above deficiency cited, inManagement meeting on 1/27/2023, the Director of Clinical Services andAdministrator reviewed, discussed the agency policy 4.8.1 titled "PersonnelRecords" under Human Resources Section. During this meeting, deficienciescited under N-0458 were reviewed, addressed and discussed in detail. The Administrator has completedreview of all personnel files and concluded that all Personnel files are incompliance and include documented evidence of a copy of current license, signedjob description and received agency/jobspecific orientation. Anin-service meeting was conducted by the Administrator and attended by allclinicians including contracted personnel on 2/2/23 to discuss agency policy4.13.1 titled "Personnel Records" under Human Resources Section. Duringthis meeting, deficiencies cited under N-0458 were reviewed, addressed anddiscussed in detail with all staff. The	2023-02-17

	[RN] #1, RN #2, Licensed Practical Nurse [LPN] #1, Clinical Supervisor, administrative RN #4 [alternate Clinical Supervisor]). Findings include: 1. An agency policy with revised date February 2022, titled "Personnel Records", stated, "... The personnel record ... for an employee will include ... Verification of ... certification and/or licensure ... employee orientation ... Job description: reviewed and signed by the employee ...." 2. Personnel record review was conducted on 12/01/22 at 11:47 AM for LPN #1, start date 7/29/22, which failed to evidence that LPN #1's license was current, or agency/job specific orientation was completed. 3. Personnel record review was conducted on 12/01/22 at 11:47 AM for RN #1, start date 9/29/22, which failed to evidence a signed job description. 4. Personnel record review was conducted on 12/01/22 at 11:47 AM for RN #2, start date		Administrator emphasized on theimportance that the Home Health agency is required to have a copy of currentlicense(s), signed job description(s) and have received agency/job specific orientation(s) for all staff in theirpersonnel records, including the staff who will have direct contact withpatients. All staff understood and acknowledged the requirement. All active staffor newly hired staff will provide and the agency will maintain documentedevidence of a copy of current license, signed job description and agency/job specific orientation in theirPersonnel records. This corrective action will be implemented on 2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the HR Manager will utilize an HR audit tool to ensure that allpersonnel record contents are current and all personnel files contain evidenceof a copy of current license, signed job description and agency/job	

	4/27/22, which failed to evidence agency/job specific orientation was completed. 5. Personnel record review was conducted on 12/01/22 at 11:47 AM for the Clinical Supervisor, start date 8/05/18, which failed to evidence agency/job specific orientation was completed. 6. Personnel record for the alternate Clinical Supervisor was reviewed on 12/09/22 at 11:55 AM, start date 12/01/22, which failed to evidence agency/job specific orientation was completed. 7. During an interview on 12/08/22 at 3:16 PM, the Administrator indicated the alternate Clinical Supervisor was a new employee. 8. During an interview on 12/09/22 at 11:55 AM, the alternate Clinical Manager indicated she hasn't been oriented yet.		processof utilizing HR audit tool will help us identify any discrepancies in thepersonnel files and enforce all staff to have their files completed and up todate prior to providing patient care in the home. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizea HR audit tool and audit 100% of all personnel file records on a monthly basisto ensure that all active personnel file records show documented evidence of a copyof current license, signed job description and agency/job specific orientation. The Administrator will review HRManager's audit findings of all active personnel file records. Monthly reportswill be generated and results will be compiled and sent to the Administrator toensure that processes have improved. This process will continue for each monthfor the next 3 months until 100% compliance is achieved and to maintain	

			thislevel of compliance all new employees at the time of hire will be oriented withthis requirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within the next 3 months, theywill continue to be addressed with staff re-training and re-education inworkshops and in-services and with each individual personnel as needed. After 3months, this process will continue to be monitored on a quarterly basis andwill be included in the quarterly HR audit review. Quarterly audits results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the QAPI Committee will continue to audit 100% of personnel file recordsquarterly to ensure compliance is maintained. The Administrator and QAPICommittee will send a written report to the Governing Body quarterly for theirrecommendations.	

			The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0462	Home health agency administration/management 410 IAC 17-12-1(h) 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 infectious or communicable diseases to patients. Based on record review and interview, the home health agency failed to ensure the personnel record policy included the requirement for physical examinations, and failed to ensure all personnel with direct patient contact had a physical examination prior to first patient contact, for 9 of 12 personnel records reviewed with direct patient contact (Licensed Practical Nurse [LPN]	N0462	**CorrectiveAction:** In order to correct the above deficiency cited, inManagement meeting on 1/27/2023, the Director of Clinical Services andAdministrator reviewed, discussed the agency policy 4.8.1 titled "PersonnelRecords" under Human Resources Section. During this meeting, deficienciescited under N-0462 were reviewed, addressed and discussed in detail. The Administrator has completedreview of all personnel files and concluded that Personnel files for allpersonnel with direct patient contact are in compliance and include documentedevidence of physicalexaminations. Anin-service meeting was conducted by the Administrator and attended by allclinicians including contracted personnel on 2/2/23 to discuss agency	2023-02-17

	#1, LPN #2, Home Health Aide [HHA] #2, Registered Nurse [RN] #2, Clinical Supervisor, Certified Occupational Therapy Assistant [COTA] #1, Occupational Therapist [OT] #2, Physical Therapist [PT] #1, Physical Therapy Assistant [PTA] #3). Findings include: 1. An agency policy with revised date February 2022, titled "Personnel Records", stated, "... The health record ... will include ...." The policy failed to evidence the employee health record must include a physical examination. 2. LPN #1's (first patient contact 7/30/22) personnel record was reviewed on 12/01/22 at 11:47 AM, which failed to evidence a physical exam was completed. 3. LPN #2's (first patient contact 1/03/19) personnel record was reviewed on 12/01/22 at 11:47 AM, which failed to evidence a physical exam was completed. 4. HHA #2's (first patient contact 9/07/22) personnel record was reviewed on 12/01/22 at 11:47 AM, which		policy4.13.1 titled "Personnel Records" under Human Resources Section. Duringthis meeting, deficiencies cited under N-0462 were reviewed, addressed anddiscussed in detail with all staff. The Administrator emphasized on theimportance that the Home Health agency is required to have a physicalexaminations for all personnel with direct patient contact had a physicalexamination prior to first patient contact. All staff understood andacknowledged the requirement. All active staff or newly hired staff will provideand the agency will maintain documented evidence of physical examinations prior tofirst patient contact in their Personnel records. This corrective actionwill be implemented on 2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the HR Manager will utilize an HR audit tool to ensure that allpersonnel record contents are current and all personnel files	

	failed to evidence a physical exam was completed. 5. RN #1's (first patient contact 9/29/22) personnel record was reviewed on 12/01/22 at 11:47 AM, which failed to evidence a physical exam was completed. 6. The Clinical Supervisor's personnel record (first patient contact 8/15/18) evidenced a physical exam was completed on 3/22/22, which was 1,315 days after first patient contact. 7. During an interview on 12/01/22 at 1:00 PM, the Clinical Supervisor confirmed personnel health records for LPN #1, LPN #2, HHA #2, and RN #1 all failed to evidence a physical exam was completed. 8. The Electronic Medical Record (EMR) for Patient #1 (start of care date 10/12/22) was reviewed on 11/30/22 at 5:54 PM. The EMR evidenced COTA #1, OT #2, PT #1, and PTA #3 all provided direct patient care to Patient #1 during the certification period (10/12/22 – 12/10/22). 9. COTA #1's (date of hire 8/22/2019) personnel record was reviewed on 12/06/22 at		physicalexaminations prior to first patient contact, providing care, treatmentor services for the Agency and/or its patients. This process of utilizing HRaudit tool will help us identify any discrepancies in the personnel files andenforce all staff to have their files completed and up to date prior to providingpatient care in the home. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizea HR audit tool and audit 100% of all personnel file records on a monthly basisto ensure that all active personnel file records show documented evidence of a physicalexaminations prior to first patient contact, providing care, treatmentor services for the Agency and/or its patients. The Administrator will reviewHR Manager's audit findings of all active personnel file records. Monthlyreports will be generated and results will be compiled and sent to theAdministrator to ensure that	

	12:56 PM, which failed to evidence a physical exam was completed. 10. OT #2's (date of hire 7/30/2019) personnel record was reviewed on 12/06/22 at 12:56 PM, which evidenced a physical exam (dated 7/17/20) occurred 353 days after hire date. 11. PT #1's (date of hire 9/07/2019) personnel record was reviewed on 12/06/22 at 12:56 PM, which evidenced a physical exam (dated 2/20/20) occurred 166 days after hire date. 12. PTA #3's (date of hire 9/08/2019) personnel record was reviewed on 12/06/22 at 12:56 PM, which failed to evidence a physical exam was completed. 13. During an interview on 12/06/22 at 12:56 PM, the Administrator indicated he couldn’t confirm physical examinations for COTA #1, OT #2, PT #1, and PTA #3 were competed prior to first patient contact.		processes have improved. This process willcontinue for each month for the next 3 months until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified withinthe next 3 months, they will continue to be addressed with staff re-trainingand re-education in workshops and in-services and with each individualpersonnel as needed. After 3 months, this process will continue to be monitoredon a quarterly basis and will be included in the quarterly HR audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 100%of personnel file records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. The Administrator will be	

			responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0464	Home health agency administration/management 410 IAC 17-12-1(i) 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: (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. (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. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test;	N0464	**Corrective Action:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/2023, the Administrator andDirector of Clinical Services reviewed, discussed the agency policies 4.8.1titled "Personnel Records" under Human Resources Section and 5.15.1titled “Occupational Exposure to Tuberculosis/Prevention of Transmission of TBPlan” under Infection Prevention and Control section. During this meeting,deficiencies cited under N-0464 were reviewed, addressed and discussed indetail. The Administrator has completedreview of all personnel files and concluded that Personnel files for allpersonnel with direct patient contact are in compliance and includedocumented evidence of baseline Tuberculosis (TB)	2023-02-17

	must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (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). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; 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 a geographical Tuberculosis (TB) risk assessment (to determine risk of exposure to TB); and failed to ensure all employees/contracted staff had baseline TB testing, for 5 of 12 personnel records reviewed for staff who had direct patient contact (Licensed Practical Nurse [LPN] #1, LPN #2, Home		testing. Anin-service meeting was conducted by the Administrator and attended by allclinicians including contracted personnel on 2/2/23 to discuss agency policies4.8.1 titled "Personnel Records" under Human Resources Section and5.15.1 titled “Occupational Exposure to Tuberculosis/Prevention of Transmissionof TB Plan” under Infection Prevention and Control section. During thismeeting, deficiencies cited under N-0464 were reviewed, addressed and discussedin detail with all staff. The Administrator emphasized on the importance thatthe Home Health agency staff who had direct patient contact are required tohave documented evidence of baseline Tuberculosis (TB) testing prior to providingcare, treatment or services for the Agency and/or its patients and maintain annualtesting of all employees who have contact with patients for tuberculosis. Allstaff understood and acknowledged the requirement. All active staff or newlyhired staff will provide and the agency will maintain acceptableproof/documentatio	

	Health Aide [HHA] #2, Clinical Supervisor, Occupational Therapist [OT] #2). Findings include: 1. An agency policy with revised date February 2022, titled "Personnel Records", stated, "... The health record ... will include ... PPD tests [Purified protein derivative standard; TB skin test] or chest x-ray results based on Agency's TB risk assessment ...." 2. An agency policy with revised date February 2022, titled "Occupational Exposure to Tuberculosis ....", stated, "... The [Clinical Supervisor] will perform annual risk assessment surveillance for the Agency to determine the need, type and frequency of testing/assessment for direct care staff ... During the pre-employment physical employees ... will have baseline PPD skin testing performed ... Employees with positive PPD test results should have a chest [x-ray] as part of the initial evaluation of the PPD test ...." 3. LPN #1's (date of hire 7/29/22, first patient contact 7/30/22) personnel record was reviewed on 12/01/22 at 11:47		n of baseline Tuberculosis (TB) testing status inPersonnel records. This corrective action will be implemented on 2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Administrator will utilize an HR audit tool to ensure that allpersonnel record contents are current and all personnel who had direct patientcontact are required to have documented evidence of baseline Tuberculosis(TB) testing prior to providing care, treatment or services for theAgency and/or its patients and maintain annual testing of all employees whohave contact with patients for tuberculosis. This process of utilizing HR audittool will help us identify any discrepancies in the personnel files and enforceall staff to have their files completed and up to date prior to providingpatient care in the home. **Monitoring:**	

	any TB testing was completed. 4. LPN #2's (date of hire 12/30/18, first patient contact 1/03/19) personnel record was reviewed on 12/01/22 at 11:47 AM, which failed to evidence baseline TB testing was completed. 5. HHA #2's personnel record (first patient contact 9/07/22) personnel record was reviewed on 12/01/22 at 11:47 AM, which failed to evidence any TB testing was completed. 6. The Clinical Supervisor's (date of hire 8/5/18, first patient contact 8/15/18) personnel record was reviewed on 12/01/22 at 11:47 AM, which failed to evidence any TB testing was completed. 7. The Electronic Medical Record (EMR) for Patient #1 (start of care date 10/12/22) was reviewed on 11/30/22 at 5:54 PM. The EMR evidenced OT #2 provided direct patient care to Patient #1 during the certification period (10/12/22 – 12/10/22). 8. OT #2's (date of hire 7/30/19, no first patient contact date) personnel file was reviewed on		Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizea HR audit tool and audit 100% of all personnel file records on a monthly basisto ensure that all active personnel file records show documented evidence of a baselineTuberculosis(TB) testing prior to first patient contact, providing care, treatmentor services for the Agency and/or its patients. The Administrator will reviewHR Manager’s audit findings of all active personnel file records. Monthlyreports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each month for the next 3 months until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified withinthe next 3 months, they will continue to be addressed	

	12/06/22 at 12:56 PM, which failed to evidence any TB testing or chest x-ray was completed. 9. During an interview on 12/06/22 at 11:32 AM, the Administrator indicated Entity #4 never sends the complete personnel file. 10. On 12/01/22 at 1:00 PM, the Clinical Supervisor confirmed her personnel record, LPN #1's, and HHA #2's personnel files all failed to evidence any TB testing was completed; and confirmed LPN #2's personnel record failed to evidence baseline TB testing was completed. 11. During an interview on 12/09/22 at 11:55 AM, the alternate Clinical Supervisor indicated the agency didn't do TB testing for newly hired employees.		with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 3 months, this process will continue to be monitored on aquarterly basis and will be included in the quarterly HR audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 100%of personnel file records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0466	Home health agency administration/management 410 IAC 17-12-1(j)	N0466	**Corrective Action:** In order to correct the abovedeficiency cited, in Management meeting on	2023-02-17

	Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on record review and interview, the home health agency failed to ensure all employee/contracted staff health records were maintained in separate medical files and treated as confidential medical records for 9 of 9 personnel records reviewed which included health records (Licensed Practical Nurse [LPN] #2, Home Health Aide [HHA] #2, Registered Nurse [RN] #1, Clinical Supervisor, Certified Occupational Therapy Assistant [COTA] #1, Occupational Therapist [OT] #2, Physical Therapist [PT] #1, PT #2, Physical Therapy Assistant [PTA] #3). Findings include: 1. An agency policy with revised date February 2022, titled "Personnel Records", stated, "...		andDirector of Clinical Services reviewed, discussed the agency policies 4.8.1titled "Personnel Records" under Human Resources Section and 5.21.1titled “COVID-19Vaccine Mandate Policy” under Infection Prevention and Control section.During this meeting, deficiencies cited under N-0466 were reviewed, addressedand discussed in detail. The Administrator has completedreview of all personnel files and concluded that all employee/contracted staff healthrecords were maintained in separate medical files and treated as confidentialmedical records. Anin-service meeting was conducted by the Administrator and attended by allclinicians including contracted personnel on 2/2/23 to discuss agency policies4.8.1 titled "Personnel Records" under Human Resources Section and5.21.1 titled “COVID-19 Vaccine Mandate Policy” under Infection Preventionand Control section. During this meeting, deficiencies cited under N-0466 werereviewed, addressed and discussed in detail with all staff.	

	The health record ... will include ... PPD tests [Purified protein derivative standard; TB (tuberculosis) skin test] or chest x-ray results based on Agency's TB risk assessment ... Any other Agency required health requirements ... Employee health information must be maintained in files separate from personnel files and in a separate location ...." 2. An agency policy with revised date February 2022, titled "COVID-19 Vaccine Mandate Policy", stated, "... Documentation ... includes one of the following ... record of immunization ... other official documentation ... Employees may request exemption ... Agency will obtain signed and dated documentation ...." 3. During an interview on 12/01/22 at 12:08 PM, the Clinical Manager indicated all employee health records were kept in the same files as other human resource documents in the personnel files. 4. Personnel record review was conducted on 12/01/22 from 11:47 AM – 1:00 PM with the Clinical Supervisor and Person		The Administrator emphasizedon the importance that all employee/contracted staff health records will be maintained inseparate medical files and treated as confidential medical records. Allstaff understood and acknowledged the requirement. For all active staff ornewly hired staff, the agency willmaintain acceptable proof/documentation of staff health records were maintained inseparate medical files and treated as confidential medical records in theirPersonnel records. This corrective action will be implemented on 2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the HR Manager will utilize an HR audit tool to ensure that allpersonnel record contents are current and all employee/contracted staff healthrecords will be maintained in separate medical files and treated asconfidential medical records. This process of utilizing HR audit toolwill help	

	#6. The personnel records for LPN #2, CNA #2, RN #1, and the Clinical Supervisor all evidenced health records and personnel documents were maintained in the same record. 5. Contract personnel record review was conducted with the Administrator on 12/06/22 from 11:32 AM - 12:00 PM. The contracted personnel records for COTA #1, OT #2, PT #1, PT #2, and PTA #3 all evidenced health records and personnel documents were maintained in the same record. 6. During an interview on 12/06/22 at 11:32 AM, the Administrator indicated Entity #4's personnel health records were mixed in with the other personnel documents, and not filed separately.		the personnel files and enforce allstaff to have their files completed and up to date prior to providing patientcare in the home. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizea HR audit tool and audit 100% of all personnel file records on a monthly basisto ensure that all active personnel file records show documented evidence thatall employee/contractedstaff health records will be maintained in separate medical files and treatedas confidential medical records. The Administrator will review HRManager's audit findings of all active personnel file records. Monthly reportswill be generated and results will be compiled and sent to the Administrator toensure that processes have improved. This process will continue for each monthfor the next 3 months until 100% compliance is	

			achieved and to maintain thislevel of compliance all new employees at the time of hire will be oriented withthis requirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within the next 3 months, theywill continue to be addressed with staff re-training and re-education inworkshops and in-services and with each individual personnel as needed. After 3months, this process will continue to be monitored on a quarterly basis andwill be included in the quarterly HR audit review. Quarterly audits resultswill be compiled and sent to the QAPI Committee for review. Once threshold ismet, the QAPI Committee will continue to audit 100% of personnel file recordsquarterly to ensure compliance is maintained. The Administrator and QAPICommittee will send a written report to the Governing Body quarterly for theirrecommendations. The Administrator will be responsible for corrective	

			measure to assure no recurrence and monitoring of thisdeficiency.	
N0470	Home health agency administration/management 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and interview, the home health agency failed ensure they implemented their own policies and procedures for the prevention/control of infection/communicable disease for 2 of 3 home visits observed (Patient #2, 6). Findings include:	N0470	**CorrectiveAction:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/2023, the Administrator,Director of Clinical Services and Alternate Director of Clinical Services reviewed,discussed the agency policies 5.4.1 titled "Exposure Control Plan: OSHA [TheOccupational Safety and Health Administration] Regulations", 5.7.1 titled "HandHygiene Policy and Compliance Program" 5.14.1 titled “Supply Maintenance” and5.21.1 titled “COVID-19 Vaccine Mandate Policy” under Infection Preventionand Control section. During this meeting, deficiencies cited under N-0470 werereviewed, addressed and discussed in detail. Anin-service was conducted by Alternate Director of Clinical Services on 2/2/23 andattended by the Administrator, Director of Clinical Services with all fieldstaff including therapy staff.	2023-02-17

	1. An agency policy with revised date July 2021, titled "Exposure Control Plan: OSHA [The Occupational Safety and Health Administration] Regulations", stated, "... All solutions will be checked for expiration date prior to use ... Other disposable ... solution containers will be discarded after use ...." 2. An agency policy with revised date July 2021, titled "Hand Hygiene Policy and Compliance Program", stated, "... When using [hand sanitizer] ... the procedure is as follows ... Place adequate amount ... on hands ... Using friction, clean ... until hands are completely dry ...." 3. Review of a CDC web base reference on 12/05/22, updated 8/10/21, https://www.cdc.gov/handwashing/hand-sanitizer-use.html, titled "Hand Sanitizer Use Out and About", stated, '... Put enough sanitizer on your hands to cover all surfaces ... Rub your hands together until they feel dry (this should take around 20 seconds) ...." 4. An agency policy dated February 2022, titled "COVID-19 Vaccine Mandate Policy", stated, "... Agency will ensure that all ... staff have received the		During the meeting, the Alternate DCS discussedthe importance of the requirement that hand hygiene, using correct technique. Citationlisted in the site visit were addressed with the field staff. Based on thedeficiency listed, the Alternate DCS will reiterated agency's policy,"Hand Hygiene Policy and Compliance Program 5.7", states that theagency will follow the Centers for Disease Control and Prevention (CDC)guidelines for hand hygiene: Put enough sanitizer on your hands to cover all surfaces... Rub your hands together until they feel dry (this should take around 20seconds) and agency policy “Supply Maintenance” to ensure that the suppliesused are marked with the date they were originally opened, or discarded afteruse. All staff understood and acknowledged the significance of ensuring thatthey follow proper Hand technique and accepted infection control practices mustbe followed as per guidelines and all field staff will be able to demonstrateit as well. All new staff will be oriented of this requirement at the time ofhire. This corrective action will be implemented on	

	applicable vaccine prior to providing care, treatment or services for the agency and/or its patients. Agency will maintain acceptable proof/documentation of vaccination status ... Agency will also track and document any booster doses ... If an employee ... is not fully vaccinated ... will be required to ... Be tested at least weekly ... Use a NIOSH [National Institute of Occupational Safety and Health]- approved N95 or equivalent or higher-level respirator ... Agency will maintain a list of all staff and their vaccination status which includes ... The percent of unvaccinated staff, excluding those staff that have approved exemptions ..." 5. A home visit was observed with Patient #2 and the Clinical Supervisor on 12/05/22 from 2:15 PM - 3:00 PM. Observed the Clinical Manager cleanse the patient's wound with a bottle of previously opened normal saline (NS). The bottle was not marked with the date it was originally opened, or discarded after use. During an interview on		2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there is norecurrence of this deficiency, the Alt DCS will utilize a supervisory visitaudit tool to ensure that hand hygiene techniques and supplies maintenancepolicy followed by all field staff. This process of utilizing supervisory visitaudit tool on all staff will help us identify any discrepancies in the supervisoryvisits pertaining to staff compliance and re-educate all staff includingcontracted personnel on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of the corrective action, thefollowing monitoring process will be put into place. The Alternate DCS will dorandom supervisory visits on all field staff every 2 weeks to monitor andensure that all staff is following the policy for hand hygiene techniques andsupplies	

	12/05/22 at 2:40 PM, the Clinical Supervisor indicated the NS was previously opened, she wasn't sure when, it wasn't marked, and it "usually lasts around 2 weeks". 6. A home visit was observed with Patient #6 and the Clinical Supervisor on 12/05/22 from 11:00 AM - 12:00 PM. Observed the Clinical Supervisor perform hand hygiene with hand sanitizer for 8 seconds, hands remained wet, and she reached into her nursing bag to remove a manual blood pressure cuff. At 11:24 AM, the Clinical Supervisor removed the soiled dressing from the patient's right lower leg, failed to perform hand hygiene, removed the soiled dressing from the patient's left lower leg, performed hand hygiene for 10 seconds, hands remained wet, and reached into shirt pocket to retrieve clean gloves. Neither of the patient's intact skin on the lower legs was cleansed after removal of old dressings, or prior to application of moisturizing cream. At 11:36 AM, the Clinical Supervisor performed hand hygiene for 11 seconds, put her wet hand into her pocket, and donned gloves		are marked with the date it was originally opened, or discarded afteruse. This process will continue for the next 3-6 months until 100% complianceis achieved and to maintain this level of compliance all new employees at thetime of hire will be oriented with this policy. If compliance is not achievedat the desired target of 100% compliance, the Alternate DCS will providere-education of “Hand hygiene and compliance program” and “Supply Maintenance” Policyand procedure in in-service to all field staff and provide individual trainingto all field staff including therapy staff that are not in compliance. TheInfection Control Committee will analyze and track data from infection controlsurveillance system and trend the field staff that are not compliant with “Handhygiene and compliance program” “Supply Maintenance” Policy and procedure asmandated. The Administrator will conduct a meeting with the Clinical Managementteam, Infection Control Committee and field staff to discuss the process. Ifnon-compliance continues, the agency will no longer provide patients tonon-compliant field	

	with difficulty. The Clinical Supervisor sprayed a commercial bottle labeled "Wound Cleanser" onto a hydrofera blue dressing (a bacteriostatic dressing), and indicated the bottle was not filled with wound cleanser, it was actually NS she previously opened and poured into the used wound cleanser bottle. During an interview on 12/08/22 at 1:10 PM, the Clinical Supervisor indicated hand hygiene with sanitizer should take 20 seconds.		staff until acceptable level of compliance is demonstratedand is achieved by the field staff. Once threshold is met the QAPI Committeewill continue to audit 20% of supervisory visits quarterly to ensure complianceis maintained. The Administrator and QAPI Committee will send a written reportto the Governing Body quarterly for their recommendations. The Alternate DCS will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0472	Q A and performance improvement 410 IAC 17-12-2(a) Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements	N0472	**CorrectiveAction:** In order to correct the above deficiency cited, the GoverningBody, QAPI Committee, Administrator and Director of Clinical Services reviewedand discussed the agency policy 10.1.1 titled, “Quality Assurance andPerformance (QAPI) Plan	2023-02-17

	in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview, the home health agency failed to maintain a current quality assessment and performance improvement (QAPI) program. Findings include: An agency policy with revised date February 2022, titled "Quality Assurance and Performance Improvement (QAPI) Plan and Program", stated, "... The agency will establish an ongoing, Agency-wide ... program of [QAPI] ... and maintain documentary evidence of its program ...." An agency job description with revised date February 2022, titled "Administrator", stated, "... Responsibilities ... Directs and monitors organizational [QAPI] activities ...." On 12/01/22 at 10:30 AM, the home health agency's QAPI binder was submitted by the Administrator for review. The		and Program". During this management meeting on 1/27/23,deficiencies cited in QAPI documentation under N-0472 were reviewed, addressedand discussed in detail. The Administrator has completed re-orientation of agency'spolicies pertaining to maintaining Home health agency's ongoing quality assurance performanceimprovement (QAPI) program. The Administrator concluded that the agency will maintainand document a current quality assessment and performance improvement (QAPI)program. An in-service was conducted by the Governing Body on 2/2/23with all office and field staff. During the meeting, the Governing Body discussedthe agency policy 10.1.1 titled, "Quality Assurance and Performance (QAPI) Planand Program" and the importance of the requirement that the Home Health Agencymust maintain and document a current quality assessment and	

	2021", evidenced documents dated for 2021, but failed to evidence documented meetings, agendas, or data collected for any date(s) in 2022. During an interview on 12/09/22 at 1:01 PM, when queried when the last QAPI meeting was conducted, the Administrator indicated he didn't know off the top of his head, and he would need to check in the QAPI binder. During this time, the Administrator obtained and submitted the QAPI binder (for a second review), which then contained a document dated 10/28/22, titled "QAPI Meeting Minutes". When queried if he attended the meeting, the Administrator indicated he did, and couldn't remember who else attended without checking the meeting notes. When queried the agency's current area(s) of concern for QAPI discussed during the 10/28/22 meeting, the Administrator indicated staffing issues were ongoing, with the lack of nursing personnel. When queried to describe the agency's current performance improvement project, the		performanceimprovement (QAPI) program. Citations listed were addressed with alloffice and field staff. The Governing Body re-educated the office and all fieldstaff on the importance of this requirement that the Home Health Agency must maintain,and evaluate a quality assessment and performance improvement program. Theprogram must reflect the complexity of the home health organization andservices (including those services provided directly or under arrangement). Thehome health agency must take actions that result in improvements in the homehealth agency's performance across the spectrum of care. The home health agency'squality assessment and performance improvement program must use objective measures.All staff understood and acknowledged the agency policy 10.1.1 titled, "QualityAssurance and Performance (QAPI) Plan and Program" and the importance of therequirement that that the Home Health Agency must maintain and document a currentquality assessment and performance improvement (QAPI) program. All new staff	

	Administrator stated, "... Getting more staff ... we have ads in Indeed ...." When queried if additional trends were noted which required agency intervention for improvement during the QAPI meeting on 10/28/22, the Administrator stated, "I don't know off the top of my head ...." An agency document submitted by the Administrator on 12/09/22 at 1:16 PM, dated 10/28/22, titled "QAPI Meeting Minutes", failed to evidence any documented concerns with staffing issues, or agency interventions/goals for staffing concerns.		will be oriented of thisrequirement at the time of hire. This corrective action will be implemented on 2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there is norecurrence of this deficiency, the QAPI Committee will utilize a QAPI audittool to ensure that the Home Health Agency maintains and documents a currentquality assessment and performance improvement (QAPI) program. This process ofutilizing QAPI audit tool will help us identify any discrepancies in the QAPIProgram and implement corrective measures and assess outcomes. **Monitoring:** In order to ensure implementation and effectiveness ofthis corrective action, the following monitoring process will be put in place,the QAPI Committee will utilize a QAPI audit tool with the help of the Directorof Clinical Services	

			will maintain anddocument acurrent quality assessment and performance improvement (QAPI) program.This process will help us identify and implement improvements in maintaining a currentquality assessment and performance improvement (QAPI) program and makecorrective adjustments in the future. Monthly reports will be generated by QAPICommittee and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue every month for thenext three months until 100% compliance is achieved and to maintain this levelof compliance, all new staff at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and if any deficiencies are identified within three months, theywill continue to be addressed with staff re-training and re-education inworkshops and in-services and with each individual personnel as needed. Once100% compliance is achieved, the QAPI Committee will continue to audit QAPIdocumentation on a	

			semi-annual basis to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody semi-annually for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0482	Q A and performance improvement 410 IAC 17-12-2(f) Rule 12 Sec. 2(f) When contracting temporary services from another licensed home health agency, organization, or independent contractor, the personnel records shall be maintained at the office of the employer and shall be available to the home health agency upon two (2) hours notice. Based on record review and interview, the home health agency failed to ensure contracted staff personnel records were made available upon two (2) hours notice, for 5 of 5 contracted staff personnel records requested (Certified	N0482	**Corrective Action:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/2023, the Administrator andDirector of Clinical Services reviewed, discussed the agency policy 4.9.1titled "Contractual Staff" under Human Resources Section. During thismeeting, deficiencies cited under N-0482 were reviewed, addressed and discussedin detail. The Administrator has completedreview of all contract files and concluded amended all contracts to reflect the personnelrecords shall be maintained at the office of the	2023-02-17

	Occupational Therapy Assistant [COTA] #1, Occupational Therapist [OT] #1, Physical Therapist [PT] #1, PT #2, Physical Therapy Assistant [PTA] #3). Findings include: An agency document received 12/06/22, effective date 1/01/22, titled "Paragon Home Health Care Contractor Agreement", stated"... The Contractor [Entity #4, contracted therapy services] shall perform [sic] to all administrative and personnel policies of agency including personnel and health qualifications ...." On 12/01/22, at 1:03 PM, request was made to the Administrator for complete/full contracted staff personnel records, for COTA #1, OT #1, PT #1, PT #2, and PTA #3. As of 4:00 PM (2 hours and 57 minutes) on 12/01/22, the files were not received for review. On 12/06/22, at 10:12 AM, the Administrator indicated Entity #4 dropped off the records Thursday (12/01/22) evening after the surveyor was gone for		employer and shall beavailable to the home health agency upon two (2) hours' notice .	

	greater than 2 hours after the request for records was made.		Anin-service meeting was conducted by the Administrator and attended by all contractedpersonnel on 2/2/23 to discuss agency policy 4.9.1 titled "ContractualStaff" under Human Resources Section. During this meeting, deficienciescited under N-0482 were reviewed, addressed and discussed in detail with allstaff. The Administrator emphasized on the importance that all personnelrecords of the contracted staff shall be maintained at the office of theemployer and shall be available to the home health agency upon two (2) hours'notice. All contracted staff understood and acknowledged the requirement.For all active contracts or newly acquired contracts, the agency will ensure that the all contractsreflect thepersonnel records of the contracted staff shall be maintained at the office ofthe employer and shall be available to the home health agency upon two (2)hours' notice. This corrective action will be implemented on 2/17/2023. **Measuresto assure No**	

			recurrence: In order to ensure that there is no recurrence of thisdeficiency, the HR Manager will utilize a Contracts audit tool to ensure thatthe all contracts reflect the personnel records of the contracted staff shall be maintainedat the office of the employer and shall be available to the home health agencyupon two (2) hours' notice. This process of utilizing Contracts audittool will help us identify any discrepancies in the Contract files and takecorrective measures. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizea Contracts audit tool and audit 100% of all contract files on a monthly basisto ensure that all active contract records show documented evidence that theall contracts reflect the personnel records of the contracted staff shall be	

			employer and shall be available to the home health agencyupon two (2) hours' notice. The Administrator will review HR Manager'saudit findings of all active contract files. Monthly reports will be generatedand results will be compiled and sent to the Administrator to ensure thatprocesses have improved. This process will continue for each month for the next3 months until 100% compliance is achieved and to maintain this level ofcompliance all new contracts will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within the next 3 months, they will continue to beaddressed with contracted staff re-training and re-education in workshops andin-services and with each individual personnel as needed. After 3 months, thisprocess will continue to be monitored on a quarterly basis and will be includedin the quarterly HR audit review. Quarterly audits results will be compiled andsent to the QAPI Committee for review. Once threshold is met, the QAPICommittee will continue to audit 100% of	

			personnel file records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) 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. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (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. (2) The patient refuses the home health agency's services.	N0488	**CorrectiveAction:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services reviewed,discussed the current agency policy “Discharge / Transfer / Referral ofPatients" During this meeting, deficiencycited under N-0488 was reviewed policy was updated and corrected on 1/27/23. Itwas concluded that the agency policy titled, “Discharge Criteria and Planning"has been updated effective 1/27/23 to reflect the procedure requiring a noticeof	2023-02-17

	(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 (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. Based on record review and interview, the home health agency failed to ensure they developed a policy requiring at least fifteen (15) calendar days' notice before agency services were stopped; or provided the patient, the patient's legal representative, or other individual responsible for the patient's care, at least fifteen (15) calendar days' notice of discharge before the services were stopped, for 2 of 2 discharged clinical records		discharge of service at least fifteen calendar days before the services arestopped. The discharge policy section in “Patient Admission Booklet” has beencorrected to reflect the procedure requiring a notice of discharge of serviceat least fifteen calendar days before the services are stopped. An in-service meeting wasconducted by the Administrator and attended by all staff including contractedpersonnel on 2/2/23 to discuss the updated policy. All staff were informed ofthis update to agency policy titled, “Discharge Criteria and Planning” that wascorrected to requiring a notice of discharge of service at least fifteencalendar days before the services are stopped . All staff understood andacknowledged the requirement and importance of need to educate Patients on mostupdated version of “agency's Patient Admission/Orientation Packet” as peragency policy. All active patients will sign/date and return an acknowledgmentform stating that they have received	

	reviewed where the patient did not request discharge from the agency (#1, 5). 1. An undated agency document (home folder spiral booklet) received 11/30/22, titled "Patient Admission Booklet", stated, "... Discharge Policy ... Staff will notify you within two (2) to fourteen (14) days of pending discharge ...." 2. An agency policy with revised date February 2021, titled "Patient Admission Criteria", stated, "... When services are to be terminated, the patient will be notified two (2) working days in advance of the date of termination stating the reason, as possible ...." 3. An agency policy with revised date February 2022, titled "Discharge Criteria and Planning", stated, "... The patient is informed of discharge plan in a timely manner ...."		updated agency's PatientAdmission/Orientation Packet from clinicians. All new staff will be oriented ofthis requirement at the time of hire. This corrective action will beimplemented on 2/17/23. **Measuresto assure No recurrence:** In order to ensure that there isno recurrence of this deficiency, the DCS will utilize a chart audit tool toensure that all clinical records for upcoming discharge reflect documentationof a notice of discharge of service at least fifteen calendar days before theservices are stopped. This process of utilizing chart audit tool on upcomingdischarges will help us identify any discrepancies in the clinical records andre-educate all staff including contracted personnel to have a notice ofdischarge of service at least fifteen calendar days before the services arestopped given to the patient and documented in the clinical record.	

	4. An agency policy with revised date February 2022, titled "Patient Bill of Rights and Responsibilities", stated, "... Agency Discharge Criteria ... Patient will be discharged from Agency based on Agency Discharge Criteria Policy ...." 5. During an interview on 12/08/22 at 4:00 PM, the Administrator indicated he wasn't sure how many days' notice for discharge was required, and stated "... [Patient Handbook] I'm not sure ... it says 2-14 [days' notice for discharge] ...." 6. Clinical record review for Patient #1 (start of care date 10/12/22, certification period 10/12/22 - 12/10/22, discharge date 11/28/22) was completed on 12/06/22. An unsigned agency document received 11/30/22, titled "Home Health Certification and Plan of Care" evidenced skilled nursing was ordered weekly for 9 weeks, and home health aide (HHA) services was ordered twice weekly for 8 weeks. The electronic medical record (EMR) failed to evidence any visits were made the week of 11/27/22 (week #7), any		**Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, theDCS will audit 100% active charts on a weekly basis for upcoming dischargesthat are due in fifteen (15) days to ensure a written notice of discharge ofservice at least fifteen calendar days before the services are stopped given tothe patient and documented in the clinical record. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each week for thenext 30 days until 90-100% compliance is achieved and to maintain this level ofcompliance, all new staff at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 90-100%compliance and if any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this	

	discharge notice was given to the patient, the patient's legal representative, or other individual responsible for the patient's care, and the patient was discharged on 11/28/22 (week #8). During an interview on 12/06/22 at 2:00 PM, the Clinical Supervisor indicated they didn't always do "in person" discharge visits, it depended on the nurse's schedule, and there was no documented notice of discharge in Patient #1's EMR. 7. Clinical record review for Patient #5 (start of care date 9/06/22, certification period 9/06/22 - 11/04/22, discharge date 11/04/22) was completed on 12/09/22. An agency document dated 9/06/22, titled "Home Health Certification and Plan of Care" evidenced skilled nursing was ordered weekly for 9 weeks. The EMR failed to evidence any nursing visits were made the week of 10/30/22 (week #9), any discharge notice was given to the patient, the patient's legal representative, or other individual responsible for the patient's care, and the patient was discharged on		process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of individualized Plan of Cares inclinical records on a quarterly basis to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. The DCS will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	

	11/04/22 (week #9). During an interview on 12/09/22 at 2:26 PM, when queried if Patient #5's EMR included documentation of discharge notice, the alternate Clinical Supervisor stated, "... No, it doesn't look like it ...."			
N0502	Patient Rights 410 IAC 17-12-3(b)(2)(C) Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (C) Place a complaint with the department regarding treatment or care furnished by a home health agency. Based on record review and interview, the home health agency failed to ensure the patient had the correct phone number to place a complaint with the Indiana Department of Health (IDOH). Findings include: An agency document titled "Important Contact Information ...." stated, "... Indiana Home Care State Complaint Hotline ...	N0502	**CorrectiveAction:** Inorder to correct the above deficiency cited, in Management meeting on1/27/2023, the Administrator and Director of Clinical Services discussed,reviewed and updated the organization's "Patient Admission Booklet",each patient receives in writing at the time of initial evaluation visit and itincludes public information materials that the Agency provides for its patients. Duringthis management meeting, deficiency cited under N-0502 was corrected. Contactinformation for the State of Indiana Home Health Hotline for Complaints was correctedand updated in the agency's Patient	2023-02-17

	1-800-252-4343 ...." An agency document titled "Admission Instructions to Patient", stated, "... Hot Line Number for State of Indiana ... 1-800-252-4343 ...." On 11/30/22 at 12:13 PM, called 1-800-252-4343. The number reached the Illinois Department of Health. During an interview on 12/08/22 at 4:00 PM, the Administrator indicated the documents were wrong, and they would need to be corrected.		Admission/Orientation Packet. An in-service meeting wasconducted by the Administrator and attended by all staff on 2/2/23 to discussthe agency's "Patient Admission Booklet". During this meeting, deficienciescited under N-0502 were reviewed, addressed and discussed in detail with allstaff. All staff were informed and educated on the presence of a most updatedversion of agency'sPatient Admission/Orientation Packet that included corrected Contactinformation for the State of Indiana Home Health Hotline for Complaints andstaff were instructed to educate Patients. All newly admitted Patients willreceive the most updated version of agency's Patient Admission/Orientation Packet thatincludes Contact information for the State of Indiana Home Health Hotline forComplaints. All staff understood and acknowledged the requirement andimportance of need to educate Patients on most updated version of "agency'sPatient Admission/Orientation Packet"	

			as per agency policy. All active patientswill sign/date and return an acknowledgment form stating that they have receivedupdated agency's Patient Admission/Orientation Packet from clinicians. All newstaff will be oriented of this requirement at the time of hire. This correctiveaction will be implemented effective 2/17/23. **Measuresto assure No recurrence:** Inorder to ensure that there is no recurrence of this deficiency, theAdministrator will utilize an audit tool to keep track of acknowledgment form thatincludes the Contact information for the State of Indiana Home Health Hotlinefor Complaints and it will be placed in the patient's clinical records. Thisprocess will involve our clinicians visiting patients' residence to ensure thatmost updated version of "agency's Patient Admission/Orientation Packet is presentand all active patients will sign/date and return an acknowledgment formstating that they received education from clinician.	

			Monitoring: Inorder to ensure implementation and effectiveness of this corrective action, theAdministrator will audit 100% active charts to ensure that the clinicians haveprovided and educated the patients' on most current version of the PatientAdmission packet that includes Contact information for the State of IndianaHome Health Hotline for Complaints and that completed acknowledgement form thatis signed/dated by the patient is present in the clinical record on a weeklybasis. Reports will be generated and results will be compiled to ensureclinical records focusing on need to ensure processes have improved. If anydeficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for the next 30 days until90-100% compliance is achieved. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audit results will be	

			compiled and sent to the QAPICommittee for review. Once threshold is met, the Quality Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0504	Patient Rights 410 IAC 17-12-3(b)(2)(D)(i) Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and	N0504	**Corrective Action:**	2023-02-17

	(BB) frequency of visits proposed to be furnished. Based on observation, record review, and interview, the home health agency failed to ensure the patient's rights were maintained to be informed in advance, about the care to be furnished, and the discipline(s)/frequency of visits, for 3 of 3 home visits observed (#2, 6, 8). Findings include: 1. An undated agency document (home folder spiral booklet) received 11/30/22, titled "Patient Admission Booklet" included a document titled "Patient Rights", which stated, "... The patient and representative ... have the right to be informed of ... in advance of and during treatment ... The care to be furnished ... The disciplines that will furnish the care ... The frequency of visits ...." 2. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22, certification period 10/07/22 - 12/05/22). A document dated 10/06/22,		In order to correct the abovedeficiency cited, in Management meeting on 1/27/23, the Administrator andDirector of Clinical Services reviewed and discussed Agency policies 9.3.1 titled, “PatientAdmission Criteria” and 9.4.1 titled, “AdmissionInformation”. During this meeting, deficiencies cited under N-0504 citationwere reviewed and discussed in detail. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff. During the meeting, the DCS discussed Agency policies 9.3.1 titled,“Patient Admission Criteria” and 9.4.1titled, “Admission Information” and the importance of the requirement that patient'srights will be maintained to be informed in advance, about the care to befurnished, and the discipline(s)/frequency of visits. The Director of ClinicalServices emphasized that the clinicians must inform the patients in advance,about the care to be furnished, and the discipline(s)/frequency visits and mustcomplete the Consent for Service form in its entirety	

	titled "Home Health Certification and Plan of Care" indicated skilled nursing was ordered 3 times weekly for 8 weeks, and then once for 1 week, to provide wound care to the patient's right lateral (outside) ankle. A home visit was observed with Patient #2 and the Clinical Supervisor on 12/05/22, from 2:15 - 3:00 PM. The patient's home folder was reviewed, which evidenced a document titled "Paragon Home Healthcare ... Consent for Service". The document stated, "... service(s) and visit frequencies are ...." The document failed to include the frequency of skilled nursing visits. During an interview on 12/08/22 at 12:03 PM, the Clinical Supervisor indicated the skilled nursing visit on 12/05/22 was a recertification visit, and she did not review the services, frequency, or treatment the agency would provide for the next certification period. 3. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date		and document thefrequency of visits and must review the services, frequency, or treatment theagency would provide for the next certification period. Citations listed in theclinical record reviews were addressed. All staff understood and acknowledgedthe agency policies 9.3.1 titled, “Patient Admission Criteria” and 9.4.1 titled, “Admission Information” and therequirement that that the clinicians must inform the patients in advance, aboutthe care to be furnished, and the discipline(s)/frequency visits and mustcomplete the Consent for Service form is completed in its entirety and documentsthe frequency of visits and the clinicians must review the services, frequency,or treatment the agency would provide for the next certification period at thetime of recertification. All new employees will be oriented of this requirementat the time of hire. This corrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there is	

	10/07/22, certification period 10/07/22 - 12/05/22). A document dated 10/07/22, titled "Home Health Certification and Plan of Care" indicated skilled nursing was ordered once for 1 week, 3 times weekly for 8 weeks, and then once for 1 week, to provide wound care to both of the patient's lower extremities. A home visit was observed with Patient #6 and the Clinical Supervisor on 12/05/22, from 11:00 AM - 12:00 PM. The patient's home folder was reviewed, which evidenced a document titled "Paragon Home Healthcare ... Consent for Service". The document stated, "... service(s) and visit frequencies are ...." The document failed to include the frequency of skilled nursing visits. During an interview on 12/08/22 at 1:10 PM, the Clinical Supervisor indicated the skilled nursing visit on 12/05/22 was a recertification visit, and she did not review the services, frequency, or treatment the agency would provide for the next certification period.		norecurrence of this deficiency, the DCS will utilize a chart audit tool to ensurethat the Consent for Service form is completed in its entirety and document thefrequency of visits and the clinicians must review the services, frequency, ortreatment the agency would provide for the next certification period anddocumentation is present in the clinical record. This process of utilizingactive chart audit tool will help us identify any discrepancies in the clinicalrecords and re-educate all staff including contracted personnel on the abovementioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, the DCSwill audit 100% of all new admissions on a weekly basis to ensure that theConsent for Service form is completed in its entirety and document thefrequency of visits and the clinicians must review the services, frequency,	

	4. Clinical record review for Patient #8 was completed on 12/09/22 (start of care date 8/11/22, certification period 10/10/22 - 12/08/22). A document dated 10/05/22, titled "Home Health Certification and Plan of Care" indicated skilled nursing was ordered once weekly for 9 weeks, Physical Therapy (PT) was ordered (no frequency/duration on plan of care), and home health aide (HHA) services was ordered twice weekly for 9 weeks. A home visit was observed with Patient #8 and HHA #1 on 12/07/22, from 11:15 AM - 12:00 PM. The patient's home folder was reviewed, which evidenced a document titled "Paragon Home Healthcare ... Consent for Service". The document stated, "... service(s) and visit frequencies are ...." The document failed to include the frequency of skilled nursing visits, HHA or PT. During an interview on 12/09/22 at 1:19 PM, the alternate Clinical Supervisor indicated the patients should have written documents that included which disciplines		provide for the next certification period anddocumentation is present in the clinical record. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each week for thenext 30 days until 90-100% compliance is achieved and to maintain this level ofcompliance, all new staff at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 90-100%compliance and if any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of individualized Plan of Cares inclinical records on a quarterly basis to ensure	

	provided care, and the frequencies of visits.		compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0505	Patient Rights 410 IAC 17-12-3(b)(2)(D)(ii) Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment. Based on observation, record	N0505	**Corrective Action:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/23, the Administrator andDirector of Clinical Services reviewed and discussed Agency policies 9.3.1 titled, "PatientAdmission Criteria" and 9.4.1 titled, "AdmissionInformation". During this meeting, deficiencies cited under N-0505citation were reviewed and discussed in detail. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff. During the meeting, the DCS discussed	2023-02-17

	health agency failed to ensure the patient's were informed of their rights and participated in the development of the plan of care, for 2 of 2 home visits conducted. (#2, 6). Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ....", stated, "... The individualized plan of care must specify ... needs ... as identified in the comprehensive assessment ... Skilled professionals follow the plan of care and minimally perform ... Development and evaluation of the plan of care in partnership with the patient, caregiver and/or representative ...." 2. An agency policy with revised date February 2022, titled "Patient Bill of Rights and Responsibilities" stated, "... Patients have the right ... [to] Participate in, be informed about ... in advance of and during treatment ... with respect to ... Establishing and revising the plan of care ...." 3. An agency policy with revised date February 2021, titled "Reassessments/Update		Agency policies 9.3.1 titled,“Patient Admission Criteria” and 9.4.1titled, “Admission Information” and the importance of the requirement that patient'smust be informed of their rights and participate in the development of the planof care. The Director of Clinical Services emphasized that the clinicians must informthe Patient or Family member about the discipline’s visit to recertify homehealth services; and review the plan of care with patient or Family, for anyrevisions/updates to the plan of care for the next certification period. Citationslisted in the clinical record reviews were addressed. All staff understood andacknowledged the agency policies 9.3.1 titled, “Patient Admission Criteria”and 9.4.1 titled, “Admission Information”andthe requirement that that the clinicians must inform the Patient or Familymember about the discipline’s visit to recertify home health services; andreview the plan of care with patient or Family, for any revisions/updates tothe plan of care for the next certification period at the time	

	Assessment", stated, "... the comprehensive assessment must be updated and revised ... Recertification ... the last five days ... of the current period ...." 4. A home visit was observed with Patient #2 and the Clinical Supervisor on 12/05/22, from 2:15 - 3:00 PM. The Clinical Supervisor failed to inform the Patient or Family member this skilled nursing visit was to recertify home health services; and failed to review the plan of care with patient or Family, for any revisions/updates to the plan of care for the next certification period. During an interview on 12/08/22 at 12:03 PM, the Clinical Supervisor indicated the skilled nursing visit on 12/05/22 was a recertification visit, and she did not review the plan of care with the Patient or Family. 5. A home visit was observed with Patient #6 and the Clinical Supervisor on 12/05/22, from 11:00 AM - 12:00 PM. The Clinical Supervisor failed to inform the Patient this skilled nursing visit was to recertify home health services; and failed to review the plan of care with		ofrecertification. All new employees will be oriented of this requirement at thetime of hire. This corrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the DCS will utilize a chart audit tool toensure that the Patient or Family member about the discipline's visit torecertify home health services; and review the plan of care with patient orFamily, for any revisions/updates to the plan of care for the nextcertification period at the time of recertification and documentation ispresent in the clinical record. This process of utilizing active chart audittool will help us identify any discrepancies in the clinical records andre-educate all staff including contracted personnel on the above mentionedrequirement. **Monitoring:**	

	the patient's involvement, for revisions/updates to the plan of care for the next certification period. During an interview on 12/08/22 at 1:10 PM, the Clinical Supervisor indicated the skilled nursing visit on 12/05/22, was a recertification visit, and she did not review the plan of care with the Patient.		In orderto ensure implementation and effectiveness of this corrective action, the DCSwill audit 100% of all new admissions on a weekly basis to ensure the Patientor Family member about the discipline's visit to recertify home health services;and review the plan of care with patient or Family, for any revisions/updatesto the plan of care for the next certification period at the time ofrecertification and documentation is present in the clinical record. Weeklyreports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 90-100% compliance isachieved and to maintain this level of compliance, all new staff at the time ofhire will be oriented with this requirement. If compliance is not achieved atthe desired target of 90-100% compliance and if any deficiencies are identifiedwithin 30 days, they will continue to be addressed with staff re-training andre-education in workshops	

			and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofindividualized Plan of Cares in clinical records on a quarterly basis to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0508	Patient Rights 410 IAC 17-12-3(b)(2)(E) Rule 12 Sec. 3(b)(2)(E) (b) The patient has the right to exercise his	N0508	**CorrectiveAction:** Inorder to correct the above deficiency cited, in Management meeting on1/27/2023, the Administrator and Director of Clinical Services	2023-02-17

	or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (E) Confidentiality of the clinical records maintained by the home health agency. The home health agency shall advise the patient of the agency's policies and procedures regarding disclosure of clinical records. Based on record review and interview, the home health agency failed to ensure the patient's right to be provided with the agency's policies and procedures regarding disclosure of clinical records. Findings include: An undated agency document received 11/30/22, titled "Patient Admission Booklet", evidenced a document titled "Paragon Home Healthcare ... Consent for Service", which stated, "... I have received ... a copy of the agency's Notice of Privacy Practices explaining my rights under the Health Insurance Portability and Accountability Act [HIPAA] of 1996 ...." A document evidenced in the agency home folder titled "Confidentiality", stated, "... AGENCY will maintain		discussed,reviewed and updated the organization's "Patient Admission Booklet". Duringthis management meeting, deficiency cited under N-0508 was corrected. Informationon Agency'sNotice of Privacy Practices, or HIPAA guidelines for disclosure of protectedhealth information was corrected and updated in the agency's PatientAdmission/Orientation Packet. An in-service meeting wasconducted by the Administrator and attended by all staff on 2/2/23 to discussthe agency’s “Patient Admission Booklet”. During this meeting, deficienciescited under N-0508 were reviewed, addressed and discussed in detail with allstaff. All staff were informed and educated on the presence of a most updatedversion of agency'sPatient Admission/Orientation Packet that included Agency'sNotice of Privacy Practices, or HIPAA guidelines for disclosure of protectedhealth information	

	confidentiality of all records ... in accordance with HIPAA guidelines ...." The document/home folder failed to include a copy of the home health agency's Notice of Privacy Practices, or HIPAA guidelines for disclosure of protected health information. An agency policy with revised date March 2018, titled "Patient Confidentiality", stated, "... Patients may access their records in accordance with HIPAA policies. At time of admission, each patient will receive a copy of the Agency's HIPAA Privacy Notice and an explanation of privacy rights ...." During an interview on 12/08/22 at 4:00 PM, the Administrator indicated he wasn't sure if the home folder booklet contained agency specific policies, and the booklet would need to be corrected.		document and staff will be instructed to educatePatients. All newly admitted Patients will receive the most updated version of agency'sPatient Admission/Orientation Packet that includes Agency'sNotice of Privacy Practices, or HIPAA guidelines for disclosure of protectedhealth information document. All staff understood and acknowledgedthe requirement and importance of need to educate Patients on most updatedversion of “agency's Patient Admission/Orientation Packet” as per agencypolicy. All active patients will sign/date and return an acknowledgment formstating that they have received updated agency's Patient Admission/OrientationPacket from clinicians. All new staff will be oriented of this requirement atthe time of hire. This corrective action will be implemented effective 2/17/23. **Measuresto assure No recurrence:** Inorder to ensure that there is no recurrence of this deficiency,	

			audit tool to keep track of acknowledgment formthat states the Agency's Notice of Privacy Practices, or HIPAA guidelines fordisclosure of protected health information document was received by thepatients and it will be placed in the patient's clinical records. This processwill involve our clinicians visiting patients' residence to ensure that mostupdated version of "agency's Patient Admission/Orientation Packet is presentand all active patients will sign/date and return an acknowledgment formstating that they received education from clinician. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, theAdministrator will audit 100% active charts to ensure that the clinicians haveprovided and educated the patients' on most current version of the PatientAdmission packet that includes Agency's Notice of Privacy Practices, or HIPAAguidelines for disclosure	

			document andthat completed acknowledgement form that is signed/dated by the patient ispresent in the clinical record on a weekly basis. Reports will be generated andresults will be compiled to ensure clinical records focusing on need to ensureprocesses have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue forthe next 30 days until 90-100% compliance is achieved. After 30 days, thisprocess will continue to be monitored on a quarterly basis and will be includedin the quarterly chart audit review. Quarterly audit results will be compiledand sent to the QAPI Committee for review. Once threshold is met, the QualityCommittee will continue to audit 20% of clinical records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. The Administrator will be	

			responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on observation, record review, and interview, the Registered Nurse (RN) failed to conduct the initial evaluation within 48 hours of referral to determine eligibility for the Medicare home health benefit, including homebound status (Please see tag G0514); failed to complete a comprehensive assessment including the administration of the OASIS (Outcome and Assessment Information Set) during the last 5 days of every 60 day certification period (Please see	G0510	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023 and reviewed, discussed the agency policytitled "Initial and Comprehensive Assessment", policy titled"Admission Criteria and Process Policy" and agency policy titled Reassessments/Updateof the Comprehensive Assessment". During this meeting, deficienciescited under G-0510 were reviewed, addressed and discussed in detail. An in-service meeting was conductedby the Director of Clinical Services and attended by all clinicians includingcontracted personnel on 2/2/23 to discuss "Initial and ComprehensiveAssessment", "Admission Criteria and Process and "Reassessments/Update of	2023-02-02

	comprehensive assessment was completed for patients who were hospitalized during the certification period (Please see tag G0548); and failed to complete a comprehensive assessment upon discharge (Please see tag G0550). This practice had the potential to affect all patients serviced by the agency. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for the Condition of Participation 42 CFR §484.55: Comprehensive Assessment of Patients.		theComprehensive Assessment". Policy. The Director of ClinicalServices emphasized that the HHA must provide, a patient-specific,comprehensive assessment. For Medicare beneficiaries, the HHA must verify thepatient's eligibility for the Medicare home health benefit including homeboundstatus, both at the time of the initial assessment visit and at the time of thecomprehensive assessment. All staff understood and acknowledged therequirement the HHA must provide, a patient-specific, comprehensive assessment.For Medicare beneficiaries, the HHA must verify the patient's eligibility forthe Medicare home health benefit including homebound status, both at the timeof the initial assessment visit and at the time of the comprehensive assessment.Deficienciescited under G-0510 were reviewed, addressed and discussed in detail with staff.All new staff will be oriented of this requirement at the time of hire. Thiscorrective action will be implemented on 2/2/23.	

			Measures to assure Norecurrence: In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all clinical records include patient-specific,comprehensive assessment and for Medicare beneficiaries, verification of thepatient's eligibility for the Medicare home health benefit including homeboundstatus, both at the time of the initial assessment visit and at the time of thecomprehensive assessment. This process of utilizing chart audit toolwill help us identify any discrepancies in the clinical records and re-educateall staff including contracted personnel to have patient-specific, comprehensiveassessment and the documentation must be present in the clinical record. **Monitoring:** Inorder to ensure implementation and	

			effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all new admissionson a weekly basis to ensure that all clinical records show evidence of patient-specific,comprehensive assessment and for Medicare beneficiaries, verification of thepatient's eligibility for the Medicare home health benefit including homeboundstatus, both at the time of the initial assessment visit and at the time of thecomprehensive assessment. Weekly reports will be generated and resultswill be compiled and sent to the Administrator to ensure that processes haveimproved. This process will continue for each week for the next 30 days until100% compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. If complianceis not achieved at the desired target of 100% compliance and any deficienciesare identified within 30 days, they will continue to be addressed with staffre-training and re-education in workshops	

			and in-services and with eachindividual personnel as needed. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will continueto audit 20% of clinical records quarterly to ensure compliance is maintained.The Administrator and QAPI Committee will send a written report to theGoverning Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0514	Patient Rights 410 IAC 17-12-3(c) Rule 12 Sec. 3(c)	N0514	**Corrective Action:** Inorder to correct the above deficiency cited, the Administrator and Director of ClinicalServices held a	2023-02-17

	(c) The home health agency shall do the following: (1) Investigate complaints made by a patient or the patient's family or legal representative regarding either of the following: (A) Treatment or care that is (or fails to be) furnished. (B) The lack of respect for the patient's property by anyone furnishing services on behalf of the home health agency. (2) Document both the existence of the complaint and the resolution of the complaint. Based on record review and interview, the home health agency failed to ensure the patient/family were provided a resolution of their complaint in 2 of 2 complaints reviewed in the agency complaint log. (patients #20, #21) Findings include: 1. An agency policy, with revised date February 2022, titled "Complaint Resolution", stated, "... Agency will ... Investigate complaints made by a patient ... family ... including ... misappropriation of patient property by anyone furnishing services on behalf of the Agency ... Should the patient not receive a positive response to complaints within 24 hours, the patient is encouraged to speak to the Administrator ...."		management meeting on 1/27/2023 and reviewed, discussed theagency policy titled "Complaint Resolution" under Patient Rights andResponsibilities section. During this meeting, deficiencies cited under N-0514were reviewed, addressed and discussed in detail. It was concluded thateffective 2/2/2023, all patient/family will be provided a resolution of their complaintand it will be documented on the complaint form. An in-service meeting wasconducted by the Administrator and attended by the Director of ClinicalServices, Alternate Director of Clinical Services, all clinicians, officestaff, including contracted personnel on 2/2/2023 to discuss agency policytitled "Complaint Resolution" under Patient Rights andResponsibilities section. The Administrator reiterated the importance ofaccurately investigating, resolving and documenting all complaints as perAgency Policy and provide all staff copy of Agency Policy	

	2. During an interview on 11/30/22 at 11:04 AM, the Clinical Supervisor indicated either she or Employee #7 (Intake Coordinator) was in charge of complaints. 3. An agency document received on 11/30/22, titled "Patient Grievance/Complaint Form", indicated a complaint was received by the agency on 9/12/22, and was signed by the Clinical Supervisor on 9/16/22 (greater than 24 hours after the complaint was received). The document included a blank space to insert the date a written response was provided to the complainant (Patient #21), which was blank. The complainant, staff at Entity #4 (contract therapy staff), alleged Patient #21 noticed some Pizza Hut gift cards were missing from the home, and Home Health Aide (HHA) #1 may have taken them. The section for resolution indicated HHA #1 was questioned, she denied taking the gift cards, and was removed from caring for the patient. The document also indicated HHA #1 was re-educated about taking gifts from patients, and was asked to apologize to the patient. The		"ComplaintResolution" and "Complaint form". All clinicians, office staff, includingcontracted personnel will be re-educated on accurately completing the"complaint form" as per policy. All staff understood and acknowledged therequirement mentioned above. All new staff will be oriented of this requirementat the time of hire. This corrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Office Manager will utilize a Complaintaudit tool to ensure that all patient/family complaints are being investigated,resolved and documented as per Agency policy. This process of utilizing Complaintaudit tool for staff will help us identify any discrepancies in the process ofinvestigation, resolution and documentation of complaints. **Monitoring:**	

	document failed to evidence the complainant received notification of a response/resolution at any time after the complaint was received by the agency, if the gift cards were located and/or returned, or the patient satisfaction with the outcome. 4. An agency document received on 11/30/22, titled "Patient Grievance/Complaint Form", indicated a complaint was received by the agency on 10/03/22, and was signed by the Clinical Supervisor on 10/05/22 (greater than 24 hours after the complaint was received). The document included a blank space to insert the date a written response was provided to the complainant (Patient #20), which was blank. The complainant alleged her wedding ring was missing, and the only one in the house besides family was Home Health Aide (HHA) #1. The section for resolution indicated HHA #1 was questioned, she denied taking the ring, and was removed from caring for the patient. The document also indicated there was a pending police case, and failed to evidence the complainant		Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place; the Office Manager willutilize a Complaint audit tool and audit 100% of all complaints on a monthlybasis to ensure that all patient/family complaints show evidence of investigation,resolution and its documentation. The Director of Clinical Services will reviewOffice Manager's audit findings of all complaints. Monthly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each month for thenext 3 months until 100% compliance is achieved and to maintain this level ofcompliance, all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within the next 3 months, theywill continue to be addressed with staff re-training	

	received notification of a response/resolution at any time after the complaint was received by the agency. 5. HHA #1's personnel record was reviewed with the Clinical Supervisor on 12/01/22 at 11:47 AM. The record failed to evidence any re-education or disciplinary action was documented regarding misappropriation of patient property. 6. During an interview on 12/01/22 at 12:10 PM, the Clinical Supervisor indicated HHA #1 admitted she took the gift cards (Patient #21) because the patient gave them to her, and the Clinical Supervisor indicated she told HHA #1 to give them back. The Clinical Supervisor indicated they found no proof HHA #1 took the wedding ring (Patient #20), the agency did not follow up with the police to find out what they determined, and HHA #1 currently saw patients for the agency.		and re-education inworkshops and in-services and with each individual personnel as needed. After 3months, this process will continue to be monitored on a quarterly basis andwill be included in the quarterly Complaint audit review. Quarterly auditsresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the QAPI Committee will continue to audit 100% of Complaintrecords quarterly to ensure compliance is maintained. The Administrator andQAPI Committee will send a written report to the Governing Body quarterly fortheir recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
G0514	RN performs assessment	G0514	**Corrective Action:**	2023-02-02

	484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the Registered Nurse (RN) failed to conduct the initial evaluation within 48 hours of referral to determine eligibility for the Medicare home health benefit, including homebound status, for 7 of 8 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7), and 1 of 1 random patient selected who's initial assessment was pending (#9). 1. An agency policy with revised date February 2022, titled "Initial Assessments ....", stated, "... Each patient admitted ... will have appropriate initial assessments performed and documented ... The initial assessment bridges the gap between when the first patient encounter occurs and when the plan of care can be implemented ... "Immediate care and support needs" are		In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023 and reviewed, discussed the agency policy"Initial and Comprehensive Assessment" and policy titled"Admission Criteria and Process Policy". During this meeting, deficienciescited under G-0514 were reviewed, addressed and discussed in detail. An in-service meeting was conductedby the Director of Clinical Services and attended by all clinicians includingcontracted personnel on 2/2/23 to discuss "Initial and ComprehensiveAssessment" and "Admission Criteria and Process Policy". The Director ofClinical Services emphasized on the importance of the initial assessment to becompleted by Registered Nurse (RN) within 48 hours of the referral to determineeligibility for the Medicare home health benefit, including homebound status; andif for any reason, the clinician is unable to complete it, physician must benotified, and new order must be	

	those items and services that will maintain the patient's health and safety through this interim period ... until the Agency can complete the comprehensive assessment and implement the plan of care ... A RN [Registered Nurse] ... must conduct the initial assessment visit within 48 hours of referral ... is conducted to determine the immediate care and support needs of the patient ...." 2. An agency policy with revised date February 2021, titled "Patient Admission Criteria", stated, "... When a telephone referral is received by the agency, a referral form is completed by a [sic] RN ... Each referral is evaluated by the Clinical Manager ... to determine the appropriateness of home care ... One home evaluation visit may be made before deciding to accept the patient for home care ... All initial evaluation visits are made by a [sic] RN ...." 3. An agency job description signed by Employee #7 (Referral/Intake Supervisor) and the Administrator on 9/10/18, titled "Referral/Intake Supervisor", stated "...		obtained. All staff understood and acknowledgedthe requirement the initial assessment to be completed by Registered Nurse (RN)within 48 hours of the referral to determine eligibility for the Medicare homehealth benefit, including homebound status. Deficiencies cited under G-0514were reviewed, addressed and discussed in detail with staff. All new staff willbe oriented of this requirement at the time of hire. This corrective actionwill be implemented on 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active clinical records include initialassessment to be completed within 48 hours of the referral to determineeligibility for the Medicare home health benefit, including homebound status.This process of utilizing active chart audit tool on all new admissions willhelp us	

	Responsible for managing all aspects of the patient intake process ... Essential Job Functions ... Ensures seamless transition of patients to home care by providing direct oversight of patient education and preparation of home care, plan of care initiation, and coordination of care with multiple service providers ... Position Qualifications ... 1. Registered Nurse with current licensure ... 2. Bachelor's degree in Nursing ...." The document evidenced the position qualifications "1. Registered Nurse with current licensure [and] 2. Bachelor's degree in Nursing" were crossed out and initialed by the Administrator. 4. During an interview on 12/05/22 at 3:00 PM, The Clinical Manager indicated she was not involved with referrals or the intake process, she never saw any paperwork about new referrals until after Employee #7 processed the paperwork, Employee #7 decided if the patients were accepted for care or not, Employee #7 did all the "leg work", Employee #7 told her (the Clinical Manager) when to admit the patient, and the patients were almost always		identify any discrepancies in the clinical records and re-educate allstaff including contracted personnel to have initial assessment to be completedwithin 48 hours of the referral to determine eligibility for the Medicare homehealth benefit, including homebound status and the documentation must bepresent in the clinical record. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all new admissionson a weekly basis to ensure that all active clinical records show evidence thatall initial assessments to be completed within 48 hours of the referral to determineeligibility for the Medicare home health benefit, including homebound status.Weekly reports will be generated and results will be	

	admitted well after the referral dates. When queried if Employee #7 was an RN or licensed practical nurse (LPN), the Clinical Supervisor stated "... No ..." 5. During an interview on 12/06/22 at 11:25 AM, when queried to describe the referral/home care admission process, Employee #7 indicated when she received a referral, she decided if they (the agency) could accept it or not based on the service area and what type of insurance the patient had, and she would let the referring entity/person know if the agency could accept the patient or not; she (Employee #7) would verify the insurance, make sure the agency had all required paperwork, such as the history and physical (H&P), wound orders, or anything like that, and then after that, she entered the referral into the system (electronic medical record [EMR]), notified the RN, called the patient, and set up a time to do the admission for home care services. When queried how quickly an RN saw the patient after a referral was received by the agency, Employee #7 it was supposed to be within 24-48 hours, but it was usually more like a week, it depended on insurance verification and RN availability		compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified within 30days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations.	

N0518	Patient Rights 410 IAC 17-12-3(e) Rule 12 Sec. 3(e) (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 furnished before care is provided. Based on record review and interview, the home health agency failed to ensure the agency's policies on advance directives, or the current Indiana Department of Health (IDOH) information on Advance Directives, were provided to all agency patients. Findings include: An undated agency document received 11/30/22, titled "Patient Admission Booklet", evidenced a document titled "Patient Rights", which failed to evidence the patient had the right to receive written information, in advance of the provision of care/services, concerning the agency's policies on advance directives, which	N0518	**CorrectiveAction:** Inorder to correct the above deficiency cited, in Management meeting on1/27/2023, the Administrator and Director of Clinical Services discussed,reviewed and updated the organization's "Patient Admission Booklet",each patient receives in writing at the time of initial evaluation visit and itincludes public information materials that the Agency provides for its patients. Duringthis management meeting, deficiency cited under N-0518 was corrected. IndianaDepartment of Health (IDOH) information on Advance Directives was correctedand updated with the current version in the agency's PatientAdmission/Orientation Packet. An in-service meeting wasconducted by the Administrator and attended by all staff on 2/2/23 to discussthe agency’s “Patient Admission	2023-02-17

	also included a description of current IDOH law. The booklet also failed to include the agency's policies on advance directives. An additional IDOH document dated 7/01/2013, titled "Advance Directives ... Your Right to Decide" was not the current version (November 2018). An agency policy, with revised date March 2018, titled "... Advance Directives", stated, "... Prior to coming under Agency care, the patient will be provided with written information concerning the patient's rights under state law ... Each patient will also be informed of Agency's written policies regarding respecting the implementation of the patient's advance directive ...." The policy failed to include Indiana's current law on advance directives. During an interview on 12/08/22 at 4:00 PM, the Administrator indicated he didn't know what year the most recent IDOH information on Advance Directives was published, the agency had the		deficienciescited under N-0518 were reviewed, addressed and discussed in detail with allstaff. All staff were informed and educated on the presence of a most updatedversion of agency'sPatient Admission/Orientation Packet that included current version IndianaDepartment of Health (IDOH) information on Advance Directives and staff wereinstructed to educate Patients. All newly admitted Patients will receive the mostupdated version of agency's Patient Admission/Orientation Packet that includescurrent version Indiana Department of Health (IDOH) information on AdvanceDirectives. All staff understood and acknowledged the requirement andimportance of need to educate Patients on most updated version of “agency'sPatient Admission/Orientation Packet” as per agency policy. All active patientswill sign/date and return an acknowledgment form stating that they have receivedupdated agency's Patient Admission/Orientation Packet from clinicians. All newstaff will be oriented of this requirement at the time of hire.	

	2013 version, and he didn't see the agency's policies on advance directives in the patient admission booklet.		This correctiveaction will be implemented effective 2/17/23. **Measuresto assure No recurrence:** Inorder to ensure that there is no recurrence of this deficiency, theAdministrator will utilize an audit tool to keep track of acknowledgment formthat includes the current version Indiana Department of Health (IDOH)information on Advance Directives and it will be placed in the patient'sclinical records. This process will involve our clinicians visiting patients' residenceto ensure that most updated version of "agency's Patient Admission/Orientation Packetis present and all active patients will sign/date and return an acknowledgmentform stating that they received education from clinician. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, theAdministrator will audit 100% active charts to ensure that the clinicians	

			haveprovided and educated the patients' on the most current version of the PatientAdmission packet that includes current version Indiana Department of Health (IDOH)information on Advance Directives and that completed acknowledgementform that is signed/dated by the patient is present in the clinical record on aweekly basis. Reports will be generated and results will be compiled to ensureclinical records focusing on need to ensure processes have improved. If anydeficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for the next 30 days until90-100% compliance is achieved. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audit results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the Quality Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing	

			Body quarterly for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0520	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on observation, record review and interview, the home health agency failed to ensure all patients were only accepted for care if their needs could adequately be met for 1 of 1 patient selected without record review (#9). Findings include: An agency policy with revised date February 2021, titled	N0520	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy9.3.1 titled “Patient Admission Criteria”. During this management meeting on 1/27/23,deficiencies cited in clinical records under N-0520 were reviewed and discussedin detail. The Director of Clinical Services has completedre-orientation of agency’s policy pertaining to the requirement. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff including contracted staff. During the meeting, the Director of	2023-02-17

	"Patient Admission Criteria" stated, "... Patients will be accepted for care only if Agency can meet a patient's identified needs ... personnel to provide needed services are available ...." An agency job description, with revised date February 2022, titled "Administrator", stated, "... Responsibilities ... Directs staff in performance of their duties including admission .. and provision of service to patients ...." An agency policy with revised date February 2022, titled "Initial Assessments/Comprehensive Assessments" stated, "... A RN ... must conduct the initial assessment visit within 48 hours of referral ...." During an interview on 12/08/22 at 3:30 PM, the Clinical Supervisor indicated she was leaving on a flight this evening (12/08/22) for Texas, and would be back at work on Monday (12/12/22). When queried who would cover RN Clinical Supervisor duties, the Clinical Supervisor indicated no one did, this is how the agency		ClinicalServices discussed agency policy 9.3.1 titled “Patient Admission Criteria” and theimportance of the requirement that all patients will only be accepted for careif their needs could adequately be met and documentation must be present in theclinical record. Citations listed in the record reviews were addressed with alloffice and field staff. The Director of Clinical Services re-educated all staffon the importance of this requirement. All staff understood and acknowledgedthe agency policy 9.3.1 titled “Patient Admission Criteria” and the requirementthat all patients will only be accepted for care if their needs couldadequately be met and documentation must be present in the clinical record. Allnew staff will be oriented of this requirement at the time of hire. Thiscorrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there is no recurrenceof this deficiency,	

	operated; and if she wasn't available, no one covered, and patients had to wait until she returned. On 12/09/22 at 12:55 PM, observed a phone call in progress with Employee #7 (Referral/Intake Supervisor), who indicated to the person on the phone that there was no nurse available today (12/09/22) for an admission visit. During an interview on 12/09/22 at 12:58 PM, administrative Employee #7 indicated family of patient #9 called to see when the nurse was coming out to admit the patient for home care, and she gave family the Clinical Supervisor's number to schedule a time for Monday (12/12/22). During this time, all referral documents for Patient #9 was requested and received, which included: 1. A document from entity #1 (a hospital), dated 12/01/22, titled "Home Care: Start of Care Orders ...." indicated skilled nursing, physical therapy (PT) and home health aide (HHA) services were ordered on 12/01/22.		will utilize a chartaudit tool to ensure that all patients were accepted for care if their needscould adequately be met and documentation must be present in the clinicalrecord. This process of utilizing chart audit tool will help us identify anydiscrepancies in clinical records and take corrective measures accordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all dischargedpatients on a weekly basis to ensure that all transferred or discharged patientclinical records show evidence that all patients were accepted for care iftheir needs could adequately be met and documentation must be present in theclinical record. Weekly reports will be generated and results will be compiledand sent to the Administrator to ensure	

	2. A document from entity #1, dated 12/01/22, titled "Home Discharge Instructions", indicated the patient was discharged from entity #1 on 12/01/22, and stated, "... Follow up Instructions ... with ... Paragon Home Care ... Within 1 to 2 days ... Nursing visit for staples removal on Friday 12/09/22 ...." During an interview on 12/09/22 at 1:01 PM, when queried about Patient #9's referral and status of admission, the Administrator indicated he didn't know about it. During an interview on 12/09/22 at 3:49 PM, when queried why Patient #9 wasn't admitted today, Employee #7 indicated Patient #9 was never scheduled to begin today, she thought there was a misunderstanding between Employee #6 (agency office staff) and Person #2 (family of Patient #9), and Person #2 scheduled with the Clinical Supervisor already for a Monday (12/12/22) admission. When queried when the referral was approved/ready, administrative Employee #7		that processes have improved. Thisprocess will continue for each week for the next 30 days until 100% complianceis achieved and to maintain this level of compliance all new employees at thetime of hire will be oriented with this requirement. If compliance is notachieved at the desired target of 100% compliance and any deficiencies areidentified within 30 days, they will continue to be addressed with staffre-training and re-education in workshops and in-services and with eachindividual personnel as needed. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will continueto audit 20% of clinical records quarterly to ensure compliance is maintained.The Administrator and QAPI Committee will send a written report to theGoverning Body quarterly for their recommendations.	

	when she gave it to the Clinical Supervisor "the other day", and then stated, "... Wait, I don't think it was approved. It's pending ... ya ... it's not ready yet." During an interview on 12/09/22 at 4:01 PM, Person #2 indicated Patient #9 got out of the hospital about 2 weeks ago, she called Paragon Home Health Care about 2 days after Patient #9 was discharged from the hospital to get services started, and they (Paragon staff) told her they were waiting on a nurse and paperwork. Person #2 indicated she didn't hear back from Paragon, so she called again about a week later with no results, and called again today (12/09/22). When queried if she requested a delay in the start of home care services, Person #2 indicated they did not, and indicated when she called the Clinical Supervisor today to schedule the admission nursing visit, the Clinical Supervisor told her the delay was because they (Paragon Home Health Care) was waiting until after the patient got her staples out today to begin home health services, and she would be		The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	there Monday 12/12/22 at 1:00 PM.			
N0522	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: Based on observation, record review, and interview, the home health agency failed to ensure all medical care/treatment provided by agency staff followed the written plan of care for 7 of 8 clinical records reviewed (#1, 2, 3, 4, 6, 7, 8); or ensured the initial written plan of care was established/reviewed and approved by the certifying physician, for 4 of 4 clinical records reviewed with the initial certification period (#1, 5, 6, 7). Findings include: 1. An agency policy with revised date February 2022, titled "Plan	N0522	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policies titled9.9.1 "Care Planning Process" and 9.10.1 “Plan of Care – CMS #485 andPhysician Orders”. During this meeting, deficiencies cited under N-0522citation were reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency’s policies pertaining to therequirement. Anin-service meeting was conducted by the Director of Clinical Services andattended by all staff, including contracted staff on 2/2/23 to discuss policyof “Care Planning Process” and “Plan of Care – CMS #485 and Physician Orders”.The Director of Clinical Services emphasized on the importance	2023-02-17

	Physician/Practitioner Orders", stated, "... Skilled nursing and other home health services will be in accordance with a Plan of Care ... Each Plan of Care must be signed and dated by the physician ... If a physician/practitioner refers a patient under a plan of care that cannot be completed until after an initial evaluation visit, the physician is consulted to approve additions or modifications to the original plan ... Orders for therapy services include the specific procedures ... and the amount, frequency and duration ... All patient care orders, including verbal orders, must be recorded in the plan of care ... The plan of care may include orders for treatment or services received from physicians other than the [certifying] physician ... Such orders must be approved by the [certifying] physician and incorporated into an updated plan of care ...."		that allmedical care/treatment provided by agency staff must follow the written plan ofcare and Physician orders and ensure the initial written plan of care isestablished/reviewed and approved by the certifying physician. TheDirector of Clinical Services specifically addressed the issues citedpertaining to visit frequencies not being followed as per plan of care,providing teaching to the patients/families, wound care orders and woundmeasurements, assessment of the port-a-cath, the JP drain, provided colostomyteaching, or instruction on colostomy care, aide frequencies not being followedand review, approval, or signed plan of care by the certifying physician. Allstaff were re-educated on the requirement. Citations listed in the clinicalrecord reviews were addressed. All staff understood and acknowledged therequirement and the need to provide services that are ordered by thephysician as indicated in the plan of care and physician orders. Thiscorrective action will be implemented effective 2/17/23.	

N0524	Patient Care 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on observation, record	N0524	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policies titled9.9.1 "Care Planning Process" and 9.10.1 “Plan of Care – CMS #485 andPhysician Orders”. During this meeting, deficiencies cited under N-0524citation were reviewed and discussed in detail. The Director of Clinical Services has completedre-orientation of agency’s policies pertaining to the requirement. Anin-service meeting was conducted by the Director of Clinical Services andattended by all staff, including contracted staff on 2/2/23 to discuss policyof “Care Planning Process” and “Plan of Care – CMS #485 and Physician Orders”.The Director of Clinical Services emphasized on the importance that allpatients' plans of care included one or more of the following: all servicesprovided, all pertinent diagnoses, the patient's mental status, types	2023-02-17

	health agency failed to ensure all patients' plans of care included one or more of the following: all services provided, all pertinent diagnoses, the patient's mental status, types of services and/or equipment required, frequency and duration of visits, nutritional requirements, medications and treatments, safety measures to protect against injury, therapy modalities specifying length of treatment, and any other appropriate items identified by the agency's own policy, for 8 of 8 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8). Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ... and Physician/Practitioner Orders", stated, "Each patient must receive an individualized written plan of care, including any revisions or additions ... must specify the care and services necessary to meet the patient-specific needs ... specify the patient and caregiver training ... identifies patient-specific measurable outcomes and goals ... Patient specific goals must be		ofservices and/or equipment required, frequency and duration of visits,nutritional requirements, medications and treatments, safety measures toprotect against injury, therapy modalities specifying length of treatment, andany other appropriate items. Citations listed in the clinical recordreviews were addressed. All staff were re-educated on the requirement. Allstaff understood and acknowledged the requirement and the need to includeall items in the plan of care. All new employees will be oriented of thisrequirement at the time of hire. This corrective action will be implementedeffective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services will utilizea chart audit tool to ensure that all active patient records for patientsreceiving home health services show evidence that all patients' plans of care includedone or more of the	

	individualized to the patient ... as well as patient preferences ... All pertinent diagnoses ... mental, psychosocial and cognitive status ... supplies and equipment required ... frequency and duration of visits ... Rehabilitation potential ... Functional limitations ... Activities permitted ... Nutritional requirements ... All medications and treatments ... Safety measures to protect against injury ... A description of the patient's risk for emergency department visits and hospital readmissions, and all necessary interventions to address the underlying risk factors ... Patient-specific interventions and education ... measurable outcomes and goals identified by ... the patient ... All patient care orders, including verbal orders, must be recorded in the plan of care ... The plan of care may include orders for treatment or services received from physicians other than the [certifying] physician ... Such orders must be approved by the [certifying]] physician ... and incorporated into an updated plan of care ...." 2. Clinical record review for Patient #1 was completed on		all pertinent diagnoses,the patient's mental status, types of services and/or equipment required,frequency and duration of visits, nutritional requirements, medications andtreatments, safety measures to protect against injury, therapy modalitiesspecifying length of treatment, and any other appropriate items. Thisprocess of utilizing active chart audit tool on all active patients will helpus ensure that the policy is being followed and identify any discrepancies inthe clinical records and re-educate all staff of the above mentionedrequirement. **Monitoring:** In order to ensure implementationand effectiveness of this corrective action, the following monitoring processwill be put in place, the Director of Clinical Services will utilize a chartaudit tool and audit 100% of all active patient records on a weekly basis toensure that allpatients' plans of care included one or more of	

	12/06/22 (Start of care date 10/12/22, discharge date 11/28/22). A document dated and signed by Person #7 (a physician), titled "Progress Note", evidenced diagnoses included seizures and anemia, a history of hypertension (high blood pressure), and swelling of both lower extremities; medications included Aricept (to treat Alzheimer's Disease) 10 milligrams (mg) daily, Voltaren gel (a topical pain reliever), triamcinolone cream (a steroid cream to help relieve redness, itching, swelling, or other discomfort caused by skin conditions), turmeric (herbal remedy to reduce swelling), and was not taking folic acid; equipment included a motorized scooter and a semi-electric hospital bed. A document dated 10/12/22, titled "Start of Care" (initial comprehensive assessment) evidenced the patient was a high fall risk, experienced a stroke with dysphagia (difficulty swallowing) and right side affected, had pain that affected ability to transfer/walk, a skin area was identified under the right abdominal fold which required intervention (family		servicesprovided, all pertinent diagnoses, the patient's mental status, types ofservices and/or equipment required, frequency and duration of visits,nutritional requirements, medications and treatments, safety measures toprotect against injury, therapy modalities specifying length of treatment, andany other appropriate items. Weekly reports will be generated and results will be compiledand sent to the Administrator to ensure that processes have improved. Thisprocess will continue for each week for the next 30 days until 100% complianceis achieved and to maintain this level of compliance all new employees at thetime of hire will be oriented with this requirement. If compliance is notachieved at the desired target of 100% compliance and any deficiencies are identifiedwithin 30 days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits	

	applied petroleum jelly and placed a wash cloth under the fold), incontinent of urine, was a moderate nutritional risk, unable to stand, transfer, or walk, and had significant memory loss so that supervision was required. A document received 11/30/22, titled "Home Health Certification and Plan of Care" (start of care date 10/12/22, certification period 10/12/22 - 12/10/22), failed to evidence the patient's diagnoses of seizures, anemia, hypertension, swelling of both lower extremities, or stroke with dysphagia and right side affected; failed to evidence medications included the patient took 10 mg of Aricept daily (plan of care indicated 5 mg daily), the patient used Voltaren gel (a topical pain reliever), triamcinolone cream, turmeric, and evidenced the patient took folic acid (physician progress note indicated the patient was not taking folic acid); equipment included a motorized scooter and a semi-electric hospital bed; interventions/goals for the skin area identified under the right abdominal fold, incontinence of		results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	urine, moderate nutritional risk, unable to stand, transfer, or walk; safety measures included requirement for supervision due to significant memory loss; or mental status included significant memory loss. The plan of care stated, "... Risk of Hospitalization ... Multiple hospitalizations ... in the past 6 months ... Currently taking 5 or more medications ... Patient and caregiver communicate care preferences ... Yes ... Patient and caregiver communicate any specific information about a personal goal(s) the patient would like to achieve from this home health admission ... Yes ....", and goals included "demonstrated compliance with medication" and "verbalized pain control". The plan of care also failed to evidence interventions to mitigate risks for hospitalization, the patient's care preferences or personal goal(s), measurable goals, or interventions to mitigate medication compliance or pain relief/control goals. During an interview on 12/06/22 at 2:00 PM, when queried how the patient's plan			

	Supervisor stated "It autogenerates ... We have to add some stuff ... It picks up what it wants ...." During an interview on 12/06/22 at 2:46 PM, the Clinical Supervisor indicated she expected to see all wound care/treatment orders on the plans of care, treatment provided to Patient #1's abdominal fold, but the EMR didn't pull it over from the comprehensive assessment. When queried about durable medical equipment (DME) and supplies on the plans of care, the Clinical Supervisor stated "... We don't fill in the DME and supplies [on the plans of care] unless we are actually providing it ... 99% of the time they have their own [supplies to use] ...." The Clinical Supervisor also indicated all diagnoses should be on the plans of care, but "Joint Commission" (a company contracted by Medicare to ensure federal regulations are met) told us if it's a resolved diagnosis, it doesn't have to be on there (the plan of care); the agency did not obtain copies of advance directives for the clinical record, and there were no patient goals on the plans of			

	care. The Clinical Supervisor additionally stated, "... The EMR is not good ...." 3. A home visit was observed with Patient #2 and the Clinical Supervisor on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Manager provided wound care to the patient's left lateral (outside of foot) ankle. Supplies used included normal saline (sterile salt water), collagen pad (used to encourage tissue regeneration), foam adhesive cover dressing, and a compression stocking. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document dated 10/06/22, titled "Recertification (follow up) Assessment" (a comprehensive reassessment) evidenced the patient required daily diabetic foot examinations, edema (swelling) to both lower legs, blood sugar levels were checked daily before breakfast (fasting), blood sugar levels ranged between 70-200 (fasting blood sugar level of 99 or lower is normal), moderate nutritional risk, risk for falls, and the patient had severe shortness of			

	upon exertion. A document titled "Home Health Certification and Plan of Care" for certification period 10/07/22 - 12/05/22, evidenced the patient took levothyroxine (to treat hypothyroidism), duloxetine (to treat depression and anxiety, and is also used for pain caused by nerve damage/pain associated with diabetic peripheral neuropathy), repaglinide (to treat high blood sugar levels in patients with type 2 [adult onset] diabetes), and Eliquis (used to reduce the risk of stroke and blood clot formation in patients with atrial fibrillation [irregular heart rhythm]); and skilled nursing interventions included to teach disease process, diet, home safety/falls prevention, medications, wound care/dressing change. The plan of care failed to evidence diagnoses of hypothyroidism, depression and/or anxiety, diabetic peripheral neuropathy, diabetes with hyperglycemia (high blood sugar levels), or atrial fibrillation. The plan of care failed to			

	evidence supplies included normal saline, collagen pad, foam adhesive cover dressing, or a compression stocking; or the patient's wound care/treatment orders. The plan of care failed to evidence orders for daily diabetic foot examinations (or who performed the examination), interventions to mitigate edema (swelling) to both lower legs, orders to check daily fasting blood sugar levels (or who performed the check), interventions to mitigate high blood sugar levels, interventions for moderate nutritional risk and risk for falls; interventions to mitigate severe shortness of breath/shortness of breath upon exertion; or any patient stated goals.			

During an interview on 12/06/22 at 3:11 PM, when queried if the patient's wound care treatment orders was on the plan of care, the Clinical Supervisor indicated the plan of care would show to measure it (wound[s]) weekly, the name and location of the wound, and she would expect to see treatment orders on the on the plan of care.

4. Clinical Record review for Patient #3 was completed on 12/08/22. A document received from Entity #10 (hospital based wound clinic) on 12/02/22, dated 9/29/22, titled “Progress Note Details”, stated, “... patient was seen today for follow up and management of L [left] groin and L buttock wound ... Patient has a medical history of ... Hypertension [high blood pressure] ... Coronary Artery Disease ... Depression ... Colostomy [an opening into the colon from the outside of the body, to provide a new path for waste material to leave the body after part of the colon has been removed] ... [patient] ... instructed to check her blood sugars once a day but no diagnosis of [diabetes] ... Wound Assessment(s) ... Left

	Groin is a full thickness Surgical Wound ... Not Healed ... Left Buttock is ... Stage 2 Pressure Injury [wound with partial-thickness skin loss into but no deeper than the layers of the skin, including intact or ruptured blisters] ... The patient is obese ... Diagnosis ... Other obesity due to excess calories ... Wound Orders ... Left Groin ... Clean wound with Normal Saline – With wound vac [medical device to provide negative pressure wound therapy] ... Change dressing two times weekly ... NPWT [negative pressure wound therapy] Pressure 125 mmHG [millimeters of mercury- a unit of pressure equal to the pressure that can support a column of mercury 1 millimeter high] – Cavilon [medication is used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations], benzoin [gum resin used especially in treating skin irritation], duoderm [breathable dressings for the management of light to moderately draining wounds] to periwound [skin areas around outside border of wound]; ... Crushed Flagyl [an antibiotic medication], Promogran [a dressing to			

	maintain a physiologically moist microenvironment at the wound surface, which is conducive to wound healing] to the wound base, white foam to the wound base, black foam into empty space ... Wound ... Left Buttock ... Clean wound with ... soap and water ... Continue using foam and drape as needed for open areas ... Change 3x [3 times] weekly or as needed ... Use wheelchair cushion ... shift position in chair every 15 minutes ... Mattress Overlay/Specialty bed or mattress ... turn every 2 hours ... Dietary ... Increased protein ... 50-60 grams daily for wound healing ... Supplement with a daily multivitamin ... Ensure [nutritional supplement drink] ... Juven powder [powdered nutritional supplement for wound healing] ... orders to Paragon Homecare ... The goal ... is to keep the wound clean and free of ... infections ...." A document titled "Home Health Certification and Plan of Care", for certification period 9/28/22 – 11/26/22 evidenced primary diagnosis of multiple sclerosis (a disease that impacts the brain, spinal cord and optic nerves, which make up the			

	central nervous system and controls everything we do); other diagnoses included ulceration of vulva (the outer part of the female genitalia), prediabetes (a serious health condition where blood sugar levels are higher than normal, but not high enough yet to be diagnosed as type 2 diabetes), and ST elevation (STEMI) myocardial infarction (A heart attack with a completely blocked coronary artery). The plan of care failed to evidence other pertinent diagnoses of Hypertension, Coronary Artery Disease, Depression, Left Buttock Stage 2 Pressure Injury, or Other obesity due to excess calories. Medications on the plan of care included Norco (an opioid narcotic medication to treat pain), alpha lipoic acid (a medication used to manage and treat chronic diseases associated with oxidative stress, such as diabetic neuropathy, and slow down the onset of metabolic syndrome [a condition that includes high blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol levels] by acting as			

	an antioxidant), hydrochlorothiazide and lopressor (both to treat high blood pressure), and sertraline (to treat depression). The plan of care failed to evidence medications also included a daily multivitamin, or crushed flagyl, used in wound treatment. Nutritional requirements on the plan of care evidenced a "regular diet" (does not include any dietary restrictions). The plan of care failed to include nutritional/dietary requirements included increased protein intake of 50-60 grams daily for wound healing, use of Ensure nutritional supplement drink, and Juven powdered supplement for wound healing. Interventions on the plan of care included to teach disease process, diet, home safety/fall prevention, signs and symptoms of infection, medications; wound care site was the left groin, measure wound(s) weekly, teach wound care/dressing, and suprapubic catheter (a tube inserted in the lower abdomen, directly into the bladder to drain urine) insertion every month. The plan			

	interventions to mitigate pain, use of narcotic medications, management of hypertension, coronary artery disease, or depression; methods to reduce obesity, daily blood sugar level monitoring, wound treatment orders for the left groin or left buttock; interventions for assessment/management of suprapubic catheter insertion site or colostomy site; or interventions for prevention of new/worsening skin breakdown. Goals on the plan of care stated "... Stabilization of cardiovascular pulmonary condition by 2 weeks (date) [no date entered] ... Demonstrates competence in following medical regime by 2 weeks (date) [no date entered] ... Demonstrates independence in skin care by end of cert [certification] period (date) [no date entered] ... Wound healing without complications by end of cert [certification] period (date) [no date entered] ...." The plan of care failed to evidence patient stated goals, Entity #10's wound care goal, or patient-specific measurable outcomes/goals for Multiple Sclerosis, coronary artery disease, hypertension, pain,			

	prediabetes, target fasting blood sugar levels, target weight, infection prevention/control, prevention of new/worsening skin breakdown, or suprapubic catheter and colostomy statuses. During an interview on 12/08/22 at 2:30 PM, the Clinical Supervisor confirmed the patient went to the wound clinic on 9/29/22, the plan of care (for certification period 9/28/22 – 11/26/22) was still a "draft", and was not yet completed. 5. Clinical Record review for Patient #4 was completed on 12/09/22. A document dated 11/2122, titled "Recertification (follow up) Assessment", evidenced the patient was a high fall risk, lived in her own house and had no available caregiver; risks for hospital admission included 2 or more falls- or any fall with injury- in the past 12 months, and currently taking 5 or more medications; patient had a stasis ulcer (a wound caused by impaired circulation) of the left medial (inside) lower leg,			

	included: cleansed with normal saline and patted dry; hydrofera blue pad (provides wound protection and addresses bacteria and yeast) applied to the wound bed, covered with gauze pads, secured with gauze roll and tubigrip (elastic, tubular compression bandage, cut to length); the actual wound care order were to apply a cotton layer wrap over the wound dressing, compression wrap, and coban (a self-adherent elastic wrap), but the patient refused because it was too tight; and had difficulty breathing during routine activities of daily living. A document dated 11/17/22, titled "Progress Note Details" evidenced the patient was seen at Entity #12 (a bone and joint clinic) by Person #13 (a podiatrist who specialized in injury, wound, and diseases of the foot and lower leg); the patient had an unhealed wound on the left, medial lower leg, and an unhealed wound to the left, lateral (outside) lower leg; wound orders included: cleanse with normal saline, apply hydrofera blue to wound bed, cover with gauze and softroll			

	with surepress and secure with coban; and nurse to change next week. A document for certification period 11/22/22 - 1/20/23, titled "Home Health Certification and Plan of Care" evidenced the document was a "draft", the patient's primary diagnosis was Hypertensive heart disease with heart failure (heart's problems developed over a long period of time, caused by high blood pressure); other pertinent diagnoses included chronic (long standing) atrial fibrillation, and pleural effusion (fluid accumulation around the lungs due to poor pumping by the heart or by inflammation); skilled nursing was ordered "one visit every other week for monthly lab work"; and risk of hospitalization included the patient currently took 5 or more medications. The plan of care failed to evidence wound diagnoses. Interventions on the plan of care included to evaluate cardiopulmonary status (heart and lung function), nutrition, hydration and elimination; teach			

	safety/fall prevention; and monthly INR (a blood test to determine therapeutic drug levels for warfarin/coumadin [blood thinner]). The plan of care failed to evidence skilled interventions to mitigate exacerbation of hypertensive heart disease with heart failure, chronic atrial fibrillation, or pleural effusion; interventions to reduce risk of hospitalization, any wound care/treatment orders, or interventions to prevent new or worsening wounds. Goals on the plan of care stated "... Demonstrates compliance with medication by 2 weeks (date) [no date entered] ... Demonstrates competence in following medical regime by 2 weeks (date) [no date entered] ... Demonstrates independence in skin care by end of cert [certification] period (date) [no date entered] ... Wound healing without complications by end of cert [certification] period (date) [no date entered] .... Aide [Home Health Aide [HHA]) ... Assumes responsibility for personal care needs by end of cert [certification] period (date) [no date entered] ...." The plan			

orders/interventions for a HHA to provide care/services; and failed to evidence patient stated goals, patient-specific measurable outcomes/goals for hypertensive heart disease with heart failure, chronic atrial fibrillation, pleural effusion, or new/worsening wounds.

During an interview on 12/09/22 at 1:41 PM, the alternate Clinical Manager stated, "... This plan of care is missing pretty much everything ...."

6. Clinical record review for Patient #5 was completed on 12/09/22 (start of care date 9/06/22). A document dated 9/26/22, titled "Start of Care ...." (the initial comprehensive assessment) evidenced the patient was a high fall risk, lived alone around the clock, lived in a senior living community with no available caregiver, had dysphagia (trouble swallowing), patient checked own fasting blood sugar daily, levels were between 70-150 (99 and below is normal), had a stage 2 pressure injury to the left buttock, and a surgical wound to the abdomen; wound care

	included: both wounds cleansed with normal saline and patted dry, abdominal wound was packed with wet gauze pads, covered buttock wound with collagen and secured it with a bordered foam bandage, covered the abdominal wound with an abdominal pad and secured it with soft cloth surgical tape; was incontinent of urine, high nutritional risk, and the reason for home care admission was wound care and therapy services. A document dated 7/16/22, with Entity #14 (a hospital) letterhead, titled "Internal Med History and Physical ....", evidenced the patient had a small bowel obstruction, and was admitted to Entity #14 for surgery. A document for certification period 9/06/22 - 11/04/22, titled "Home Health Certification and Plan of Care" evidenced Skilled Nursing, Physical Therapy (PT), and Occupational Therapy (OT) services were ordered, diet was regular with no concentrated sugar, and the patient had wounds to the abdomen and			

	was pressure ulcer of left buttock, stage 2; other pertinent diagnoses included intestinal obstruction, encounter for surgical aftercare following surgery on the digestive system, and diabetes. Medications on the plan of care included norco for pain, docusate sodium (stool softener), and senna laxative. Interventions on the plan of care included skilled observation for wound care, evaluate nutrition, hydration and elimination, signs and symptoms of infection; teach disease process, diet, home safety/fall prevention, and signs/symptoms of infection; and evaluate wound(s) for healing, measure wound(s) weekly, teach wound care/dressing. The plan of care failed to evidence skilled interventions to mitigate pain, prevent constipation or other bowel complications after surgery, interventions to reduce risk of hospitalization, any wound care/treatment orders, or interventions to prevent new or worsening wounds. During an interview on			

12/09/22 at 2:26 PM, the alternate Clinical Supervisor indicated she expected to see wound care orders for the nurse to follow on the plans of care, as well as all treatments and interventions/teaching specific to the patient, and every time the orders changed, the plans of care should be updated.

7. A home visit was observed with Patient #6 and the Clinical Supervisor on 12/05/22 from 11:00 AM - 12:05 PM. The patient indicated she was allergic to Penicillin, but didn't see the allergy listed on her home plan of care. The Clinical Supervisor indicated the EMR didn't always pull things into the plan of care correctly. The patient indicated she went to the wound clinic (Entity #1) about every month, that's who managed her leg wounds, and indicated Person #11 was her primary care physician (PCP), whom she saw in October (2022) for a flu shot. The Clinical Supervisor performed wound care to each lower extremity, and applied over the counter moisturizer cream to intact skin on both lower legs. The patient complained of pain during the wound care, and indicated she

took tramadol (an opioid pain medication for moderate to severe pain). The patient indicated she no longer used triamcinolone cream (used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) on her lower legs. Wound supplies included normal saline (sterile salt water), gauze pads, hydrofera blue pads (a bacteriostatic dressing), optilock pads (highly absorbent pads) elastic compression wraps, elastic gauze wraps, incontinence pads, and abdominal pads (thick cotton pads to absorb drainage). Equipment included a cane, walker, and wheelchair.

Clinical record review for Patient #6 was completed on 12/08/22. A document from Entity #1, dated 9/30/22, titled "Physician Order Details", indicated wound care/treatment frequency for each lower leg was ordered to be done every other day.

A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced the document was a

	nursing was ordered, diagnoses included chronic venous hypertension (a condition that results from weakened lower extremity veins that have lost their ability to return blood to the heart, which causes high blood pressure in the legs), and chronic non-pressure ulcers (wounds caused by insufficient blood flow, or poor circulation) to both lower legs; and allergies included erythromycin (antibiotic) and adhesive tape. The plan of care failed to evidence Entity #1 managed the patients wounds, entity #1 ordered wound care every other day, or allergies also included penicillin. Medications on the plan of care included triamcinolone cream to be applied 3 times daily to both lower legs, milk of magnesia every 6 hours as needed for constipation, and tramadol 3 times daily for pain. The plan of care failed to evidence triamcinolone cream was discontinued, or the patient currently used over the counter moisturizer lotion to both lower legs. Supplies/equipment on the plan of care failed to evidence elastic			

	compression wraps, elastic gauze wraps, incontinence pads, abdominal pads (thick cotton pads to absorb drainage), cane, or wheelchair. Interventions on the plan of care included to evaluate the cardiopulmonary, nutrition, hydration, elimination statuses, and signs/symptoms of infection; teach disease process, diet, home safety/fall prevention, signs and symptoms of infection, medications; wound care site was the left groin, measure wound(s) weekly, teach wound care/dressing. The plan of care failed to include interventions to mitigate pain or constipation, or exacerbation of chronic venous hypertension. Goals on the plan of care stated "... Demonstrates compliance with medication by 2 weeks (date) [no date entered] ... Stabilization of cardiovascular pulmonary condition by 2 weeks (date) [no date entered] ... Demonstrates competence in following medical regime by 2 weeks (date) [no date entered] ... Pain controlled at acceptable level by end of cert [certification] period (date) [no			

	date entered] ... Demonstrates independence in skin care by end of cert [certification] period (date) [no date entered] ... Wound healing without complications by end of cert [certification] period (date) [no date entered] ...." The plan of care failed to evidence patient stated goals, or patient-specific measurable outcomes/goals for constipation, exacerbation of chronic venous hypertension, or new/worsening wounds. During an interview on 12/08/22 at 1:10 PM, when queried, the Clinical Supervisor indicated they didn't do every other day visits because they don't work weekends, the patient was seen by the agency for wound care ordered by the wound clinic (Entity #1), Person #11 was not part of Entity #1, he was the PCP, the plans of care were autogenerated, and stuff was missing. 8. Clinical record review for patient #7 was completed on 12/09/22 (start of care date 11/09/22). A document dated 10/26/22 titled "Home Care-Start of Care Orders ....", indicated the patient had a new			

	in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon to drain waste) placed 10/25/22, port-a-cath (a surgically implanted device which allows easy access to a patient's veins) placement 10/25/22, and had colon cancer. A document dated 11/03/22, titled "Progress Notes", indicated Paragon Home Health Care accepted the patient for services, the patient had a port-a-cath to the left upper chest with steri-strips (porous surgical tape strips used to close small wounds) in place, patient was on a full liquid diet (includes all foods that are liquid or will turn to liquid at room or body temperature), needs included home health care for negative pressure wound treatment, colostomy and Jackson Pratt (JP) drain (a closed-suction medical device that is commonly used as a post-operative drain for collecting bodily fluids from surgical sites) care/teaching. A document titled "Home Health Certification and Plan of Care" (certification period			

	11/09/22 - 1/07/23) evidenced skilled nursing was ordered; medications included colace (a stool softener) twice daily and ondanestron (to resolve nausea) every 6 hours as needed; supplies included negative pressure wound therapy (NPWT) equipment (a power operated device with a suction pump, tubing and a dressing to remove excess wound drainage and promote healing), but failed to evidence dressing supplies needed for the NPWT; and an ostomy (not specified as colostomy) pouch, but failed to evidence the size of the pouch the patient used, or any other required colostomy supplies to maintain the colostomy. The plan of care failed to evidence the patient had a port-a-cath, or the patient's ordered diet. Interventions/orders on the plan of care included SN (skilled nurse) for assessment (no further details provided), wound care, ostomy teaching, instruct ostomy care, and monitor JP drain site for signs of infection; and risk of hospitalization included the patient took 5 or more medications. The plan of care failed to evidence nursing interventions to reduce the risk			

	of hospitalization, for care/management the colostomy, JP drain, or port-a-cath; location of the colostomy, JP drain, or port-a-cath; teaching interventions to prevent colostomy complications, signs and symptoms of the stoma (the surgical opening of the colostomy) that must be immediately reported to nurse/physician, or when to go directly to the emergency department (ED), full liquid diet, mitigation of nausea, how to properly drain the JP drain, JP drain precautions, or signs and symptoms of infection to the port-a-cath site. Two goals were evidenced on the plan of care, which stated, "... Patient and significant other will become independent in ostomy care by 12/31/2022 ... Abdomen wound will heal by 12/31/2022 ..." The plan of care failed to evidence patient stated goal(s), or any other goals related to infection prevention/control, patency of the colostomy, removal of the JP drain, dietary advancement, or wound healing. During an interview on			

	12/09/22 at 2:30 PM, Employee #6 indicated the plan of care and other orders weren't completed or signed by the physician. The alternate Clinical Supervisor indicated the plan of care was a "hot mess", and it was "missing everything". 9. A home visit was observed with Patient #8 and HHA #1 on 12/07/22 from 11:15 AM - 12:00 PM. The patient was pleasant and confused. The patient's medications were reviewed with family (primary caregiver, who administered all medications), who indicated the medication list on the plan of care was a "super old" medication list, and it was from before she ever had home care, like when she was in the nursing home. Family indicated the patient didn't take norco (narcotic pain relief), or use any skin barrier cream as indicated on the plan of care. Family indicated the patient's current medications included: Aleve (over the counter [OTC], nonsteroidal anti-inflammatory drug used to treat pain) 220 mg (milligrams) with 2 tabs of tylenol 325 mg, both 2-3 times daily, and tramadol 50 mg. Family stated, "... She takes it [tramadol] when it rains ...."			

	Informed family the bottle of tramadol expired 5/17/22. Additional medications included guanfacine (used to treat attention deficit hyperactivity disorder and high blood pressure), esomeprazole magnesium (an anti-acid), Vitamin D3, 1000 IU (International Unit) every morning, senna plus every morning unless loose stools, and humalog sliding scale 100 U (Units)/ml (milliliter): family checked patient's blood sugar level 4 times daily- before meals and bedtime; for blood sugar level less than 60, call physician, 110-125= 1U (Unit), 126-140= 2U, 141-160= 3U, 161-180= 4U, 181-200= 5U, 201-240= 6U, 241-280= 7U, 281-320= 8U, 321-360= 9U, greater than 360= 10U and call physician. Clinical record review for Patient #8 was completed on 12/09/22. A document titled "Home Health Certification and Plan of Care" (certification period 11/09/22 - 1/07/23) failed to evidence the patient's medications included Aleve 220 mg with 2 tabs of tylenol 325 mg, both 2-3 times daily, and tramadol 50 mg "when it rains", guanfacine, esomeprazole			

	magnesium, Vitamin D3, 1000 IU every morning, senna plus every morning unless loose stools, and humalog sliding scale 100 U (Units)/ml (milliliter): family checked patient's blood sugar level 4 times daily- before meals and bedtime; for blood sugar level less than 60, call physician, 110-125= 1U (Unit), 126-140= 2U, 141-160= 3U, 161-180= 4U, 181-200= 5U, 201-240= 6U, 241-280= 7U, 281-320= 8U, 321-360= 9U, greater than 360= 10U and call physician. The plan of care failed to evidence the patient's current medication list. During an interview on 12/09/22 at 1:19 PM, the Administrator indicated he expected the nurses to check the patient's medications every visit, and indicated the agency's EMR software wouldn't allow them to update the medication list. The alternate Clinical Supervisor indicated she expected to see all supplies and equipment on the plans of care, and interventions and goals should be patient-specific, based on the diagnoses. The Administrator then indicated the EMR was the problem, and			

	indicated patient #8's plan of care didn't look good. When queried how the contents of the plans of care were determined, the Administrator indicated he wasn't clinical, so he couldn't answer that. The alternate Clinical Supervisor indicated the plan of care should be based on the comprehensive assessment and diagnoses.			
N0526	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1(a)(2) The total medical plan of care shall be reviewed by the attending physician, dentist, chiropractor, optometrist or podiatrist, and home health agency personnel as often as the severity of the patient's condition requires, but at least once every two (2) months. Based on record review and interview, the home health agency failed to ensure the patient's plan of care was reviewed by the certifying physician for 4 of 4 clinical records reviewed where a significant change in condition occurred that required an updated plan of care (#1, 3, 4, 5); and failed to ensure the	N0526	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policies titled9.9.1 "Care Planning Process" and 9.10.1 “Plan of Care – CMS #485 andPhysician Orders”. During this meeting, deficiencies cited under N-0526 citationwere reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency’s policies pertaining to therequirement. Anin-service meeting was	2023-02-17

	patient's plan of care was reviewed by the certifying physician at least every 60 days, for 2 of 4 clinical records reviewed with more than one certification period (#3, 4). Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ....", stated, "... Each Plan of Care must be signed and dated by the physician ... which is established, periodically reviewed (every 60 days or more frequently when indicated by changes in the patient's condition) and signed by a physician or authorized practitioner ... The physician ... who establishes the Plan of Care must sign and date the recertification ... complete the certification when the Plan of Care is established ... a Plan of Care that cannot be completed until an evaluation visit, the physician/practitioner is consulted to approve additions or modifications ... will be reviewed and signed by the physician ... and Agency personnel ... as often ... as the ... patient's condition requires ... but at least once every sixty (60) days ... Orders for therapy services include the specific procedures ... and the amount,		conducted by the Director of Clinical Services andattended by all staff, including contracted staff on 2/2/23 to discuss policyof “Care Planning Process” and “Plan of Care – CMS #485 and Physician Orders”.The Director of Clinical Services emphasized on the importance that thepatient's plan of care must be reviewed by the certifying physician where a significant change in conditionoccurred that required an updated planof care and ensure the patient's plan ofcare must be reviewed by the certifying physician at least every 60 days. Citationslisted in the clinical record reviews were addressed. All staff were re-educatedon the requirement. All staff understood and acknowledged the requirement andthe need for the plan of care to be reviewed by certifying physician where asignificant change in condition occurred, requiring an updated plan of care andfor the plan of care to be reviewed by the certifying physician at least every60 days.. All new employees will be oriented of this requirement at the timeof hire. This corrective action will be implemented effective 2/17/23.	

N0527	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on observation, record review, and interview, the Registered Nurse (RN) failed to notify the patient's certifying physician of new or worsening wound(s), for 2 of 2 home visits observed with patients who had at least 1 wound (#2, 6). Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ....", stated, "... In the event of a change in patient condition ... the Agency will notify both the responsible [certifying] physician/practitioner and the physician(s) associated with the relevant aspect of care ...." 2. A home visit was observed	N0527	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policies titled9.9.1 "Care Planning Process" and 9.10.1 “Plan of Care – CMS #485 andPhysician Orders”. During this meeting, deficiencies cited under N-0527citation were reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency’s policies pertaining to therequirement. Anin-service meeting was conducted by the Director of Clinical Services andattended by all staff, including contracted staff on 2/2/23 to discuss policyof “Care Planning Process” and “Plan of Care – CMS #485 and Physician Orders”.The Director of Clinical Services emphasized on the importance that theclinicians of the home health agency shall promptly alert the personresponsible for the medical component of the	2023-02-17

	Supervisor on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Supervisor indicated the patient had 1 wound on the right lateral (outside) ankle, to which she provided wound care/treatment. Observed the patient's left foot was swollen, dark red/purple in color, had several small raised blisters on the 2nd toe, and 2 dark purple areas on the ball (bottom, where the toes attach to the foot) of the left foot, by the great and 5th toe joints. The Clinical Supervisor indicated the left foot was like that for the last couple of weeks. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document dated 12/02/22, titled "Wound Care Worksheet" failed to evidence the blisters or darkened skin areas on the left foot/toes. A document dated 12/05/22, titled "Wound Care Worksheet" failed to evidence the blisters or darkened skin areas on the left foot/toes. A document dated 12/05/22, titled "Skilled Nurse Visit", failed to evidence the Clinical		patient's care to any changes thatsuggest a need to alter the medical plan of care. Citations listed in theclinical record reviews were addressed. All staff were re-educated onthe requirement. All staff understood and acknowledged the requirement andnotify the patient's certifying physician of new or worsening wound(s). All newemployees will be oriented of this requirement at the time of hire. Thiscorrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active patient records show evidence that the clinicians promptlyalert the person responsible for the medical component of the patient's care toany changes that suggest a need to alter the medical plan of care. Thisprocess of utilizing active chart audit tool on all active patients will helpus	

	Manager documented the left foot was dark red/purple in color, had several small raised blisters on the 2nd toe, the 2 dark purple areas on the ball of the left foot, or the physician was notified of the new/worsening wound(s). During an interview on 12/08/22 at 12:03 PM, the Clinical Supervisor indicated she did not document the blisters or darkened areas on the patient's left foot, or contact the patient's physician, because the patient was seen at Entity #2 (a wound clinic) every other week and they wrote wound care orders. 3. A home visit was observed with Patient #6 and the Clinical Supervisor on 12/05/22 from 11:00 AM - 12:05 PM. The patient indicated she went to the wound clinic about every month, Entity #1 managed her leg wounds, and indicated Person #11 was her primary care physician (PCP). The Clinical Supervisor indicated she notified Entity #1 about the worsening wound on the left lower leg, and they would probably debride (the process of removing dead tissue from wounds) it tomorrow during the		followed and identify any discrepancies inthe clinical records and re-educate all staff of the above mentionedrequirement. **Monitoring:** In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place, the Directorof Clinical Services will utilize a chart audit tool and audit 100% of all activepatient records on a weekly basis to ensure that the clinicians promptlyalert the person responsible for the medical component of the patient's care toany changes that suggest a need to alter the medical plan of care.. Weekly reports will be generatedand results will be compiled and sent to the Administrator to ensure thatprocesses have improved. This process will continue for each week for the next30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire	

	patient's appointment. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date 10/07/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced Person #11 was the certifying physician, and failed to evidence Entity #1 wrote orders for the patient's care/treatment. A document dated 12/05/22, titled "Skilled Nurse Visit", indicated the patient's wound was worse, and Entity #1 was notified. The document failed to evidence Person #11 was notified. During an interview on 12/08/22 at 1:10 PM, when queried, the Clinical Supervisor indicated Patient #6 received home care for wound care, which was ordered by Entity #1, the patient's certifying physician (Person #11) was not affiliated with Entity #1, and Person #11 was not notified of the worsening wound.		will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of	

			this deficiency.	
N0529	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the home health agency failed to ensure a written summary report for each patient was sent to the certifying physician at least every 60 days, for 4 of 4 clinical records reviewed who received services for more than 60 days (#2, 3, 4, 8). Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ....", stated, "... Recertification of the Plan of	N0529	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policies titled9.9.1 "Care Planning Process" and 9.10.1 “Plan of Care – CMS #485 andPhysician Orders”. During this meeting, deficiencies cited under N-0529citation were reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency’s policies pertaining to therequirement. Anin-service meeting was conducted by the Director of Clinical Services and attendedby all staff, including contracted staff on 2/2/23 to discuss policy of “CarePlanning Process” and “Plan of Care – CMS #485 and Physician Orders”. The Directorof Clinical Services emphasized on the importance that a written summary report	2023-02-17

	60 days ... after an initial 60-day episode ... include[s] ... revised plan of care must reflect current information ... and contain information concerning the patient's progress toward the measurable outcomes and goals ... must be communicated to ... all physicians/practitioners issuing orders for the ... plan of care ...." 2. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document titled "Home Health Certification and Plan of Care" for certification period 10/07/22 - 12/05/22 failed to evidence information concerning the patient's progress toward measurable outcomes and goals. The electronic medical record (EMR) failed to evidence any other documented 60 day summary report. 3. Clinical record review for Patient #3 was completed on 12/08/22 (start of care date 1/31/22). A document titled "Home Health Certification and Plan of Care" for certification period 9/28/22 - 11/26/22 failed to evidence information concerning the patient's		for each patientmust be sent to the certifying physician at least every 60 days. Citationslisted in the clinical record reviews were addressed. All staff was re-educatedon the requirement. All staff understood and acknowledged the requirement tosend awritten summary report for each patient to the certifying physician at leastevery 60 days. All new employees will be oriented of this requirement at thetime of hire. This corrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active patient records show evidence that a written summary report for eachpatient must be sent to the certifying physician at least every 60 days .This process of utilizing active chart audit tool on all active patients willhelp us ensure that the policy is being followed and identify any discrepanciesin the	

	progress toward measurable outcomes and goals. The EMR failed to evidence any other documented 60 day summary report. 4. Clinical Record review for Patient #4 was completed on 12/09/22 (start of care date 1/26/22). A document for certification period 11/22/22 - 1/20/23, titled "Home Health Certification and Plan of Care" failed to evidence information concerning the patient's progress toward measurable outcomes and goals. The EMR failed to evidence any other documented 60 day summary report. 5. Clinical record review for Patient #8 was completed on 12/09/22 (start of care date 8/11/22). A document titled "Home Health Certification and Plan of Care" for certification period 11/09/22 - 1/07/23 failed to evidence information concerning the patient's progress toward measurable outcomes and goals. The EMR failed to evidence any other documented 60 day summary report. 6. During an interview on		all staff of the above mentionedrequirement. **Monitoring:** In order to ensure implementationand effectiveness of this corrective action, the following monitoring processwill be put in place, the Director of Clinical Services will utilize a chartaudit tool and audit 100% of all active patient records on a weekly basis toensure that a writtensummary report for each patient must be sent to the certifying physician atleast every 60 days. Weeklyreports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified within 30days,	

	12/09/22 at 2:00 PM, the alternate Clinical Supervisor indicated a clinical summary should be sent to the physician, she wasn't sure how often it should be sent, and she wasn't sure if the agency sent them or not. The Administrator then indicated the agency did, and they were sent every 60 days. When queried where the EMR evidenced documentation of a 60 day summary, or evidenced it was sent to the physician, the Administrator stated, "... It's not in the EMR but we fax it ...It is it's own document ....", he wasn't sure if it was included in the updated plans of care, and the EMR didn't evidence the physicians were sent the summaries. Upon survey exit, no additional information or documents were submitted for review.		they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0532	Patient Care 410 IAC 17-13-1(d)	N0532	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of	2023-02-17

	Rule 13 Sec. 1(d) Home health agency personnel shall promptly notify a patient's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the patient. In the case of a medical emergency, the home health agency must know in advance which emergency system to contact. Based on record review and interview, the home health agency failed to ensure agency staff promptly notified the patient's physician for a significant change in condition; failed to ensure a transfer summary was sent to the receiving facility and/or failed to know which emergent care facility the patient transferred to, for 3 of 3 clinical records reviewed with patients who required emergent medical care/hospitalization (#1, 3, 5). Findings include: 1. An agency policy with revised date February 2022, titled "Transfer/Referral Criteria and Planning", stated, "... When a patient's care needs change to require ... specialized services not provided by the agency, the Agency must inform ... the		Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policy titled 9.29.1"Transfer/Referral Criteria and Planning". During this meeting,deficiencies cited under N-0532 citation were reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency's policies pertaining to therequirement. Anin-service meeting was conducted by the Director of Clinical Services andattended by all staff, including contracted staff on 2/2/23 to discuss policyof "Transfer/Referral Criteria and Planning". The Director ofClinical Services emphasized on the importance that Home Health Agency staff must promptlynotify the patient's physician for a significant change in condition, knowwhich emergent care facility the patient transferred to and ensure to send atransfer summary to the receiving facility. Citations listed in the clinicalrecord reviews were addressed. All staff was re-educated on the	

	physician/practitioner who is responsible for the patient's home health plan of care ... Appropriate parties will be informed immediately ... This is accomplished by ... A written Transfer Summary ... will be completed ... will be provided ...." 2. Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date 10/12/22). An undated, unsigned document titled "Transferred to an inpatient facility ....", evidenced the patient was transferred 10/14/22. The document failed to evidence the certifying physician was notified, and the electronic medical record (EMR) indicated the document was "In Progress". A document dated 10/18/22, titled “Home Discharge Instructions”, evidenced the patient was hospitalized for emergent care at Entity #10 from 10/15/22 – 10/18/22, for seizures. During an interview on 12/06/22 at 2:00 PM, when queried to describe the agency's process for patients		requirement. Allstaff understood and acknowledged the requirement to promptly notify the patient'sphysician for a significant change in condition, know which emergent carefacility the patient transferred to and ensure to send a transfer summary tothe receiving facility. All new employees will be oriented of this requirementat the time of hire. This corrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active patient records show evidence that the patient's physician is promptlynotified for a significant change in condition, know which emergent carefacility the patient transferred to and ensure to send a transfer summary tothe receiving facility. This process of utilizing active chart audittool on all active patients will help us ensure that	

	who required emergent care, the Clinical Supervisor indicated they created the "Transferred to an inpatient facility ...." document within 48 hours, the last page of the document was the summary, and it had to be sent to the hospital. When queried, the Clinical Supervisor indicated the EMR failed to evidence the physician was notified of the patient's emergent care, or the summary was faxed to Entity #10. The Administrator stated "... I could get the fax ...." Upon survey exit, no further information or documents were submitted. During an interview on 12/08/22 at 2:30 PM, the Clinical Supervisor indicated documents marked in the EMR as “drafts” and/or “In Progress” were incomplete documents, and were not faxed yet. 3. Clinical record review for Patient #3 was completed on 12/08/22 (start of care date 1/31/22). A document titled "Transferred to an inpatient facility ....", evidenced the patient was transferred to Entity #10 for evaluation. The EMR failed to evidence the certifying nurse practitioner was notified,		the policy is beingfollowed and identify any discrepancies in the clinical records and re-educateall staff of the above mentioned requirement. **Monitoring:** In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place, the Directorof Clinical Services will utilize a chart audit tool and audit 100% of all activepatient records on a weekly basis to ensure that the patient's physician is promptlynotified for a significant change in condition, know which emergent carefacility the patient transferred to and ensure to send a transfer summary tothe receiving facility.Weekly reports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 100% compliance is achievedand to maintain this	

	or a summary was sent. A document received from Entity #1 on 12/02/22, dated 10/17/22, titled "Discharge Summary", evidenced the patient required emergent care, and was hospitalized from 10/10/22 – 10/17/22, due to a new infected wound, and osteomyelitis (inflammation of bone caused by infection). During an interview on 12/02/22 at 2:50 PM, Person #17 indicated the patient was hospitalized at Entity #1, not Entity #10. The EMR failed to evidence the correct emergent care facility the patient transferred to. During an interview on 12/08/22 at 2:30 PM, the Clinical Supervisor indicated the EMR didn't evidence the certifying practitioner was immediately notified, or a summary was faxed to the hospital. 4. Clinical record review for Patient #5 was completed on 12/09/22 (start of care date 9/06/22). A document titled "Transferred to an inpatient facility ....", evidenced the patient was transferred to Entity		level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified within 30days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. The Administratorand QAPI Committee will send a written report to the Governing Body quarterlyfor their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no	

	#14 for evaluation. A document received from Entity #14 on 12/08/22, titled "Medical Chart Patient Admission", evidenced the patient was admitted 9/21/22, discharged 9/22/22, and stated, "... Admitting Diagnosis ... Acute [sudden onset] Hypotension [low blood pressure] ... AFib [atrial fibrillation, an irregular heart rhythm] ...." A document received from Entity #14 on 12/08/22, titled "Discharge Summary", evidenced the patient required emergent treatment for cardiac conditions and medications were changed. During an interview on 12/09/22 at 2:26 PM, the Administrator indicated the EMR didn't evidence the date or time the physician was notified or if a summary was sent, and they needed to keep track of this.		recurrence andmonitoring of this deficiency.	
N0542	Scope of Services 410 IAC 17-14-1(a)(1)(C) Rule 14 Sec. 1(a) (1)(C) Except where services	N0542	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of	2023-02-17

	are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. Based on record review and interview, the home health agency failed to ensure a Registered Nurse (RN) initiated and/or updated the plan of care based on the patient's needs, for 3 of 8 clinical records reviewed (#1, 3, 5). Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ... and Physician/Practitioner Orders", stated, "... home health services will be in accordance with a Plan of Care ... orders are accepted only by personnel authorized to do so by applicable state laws ... by a RN ... It is the RN's ... responsibility to make any necessary revisions to the Plan of Care ...." 2. An agency document with effective date 2/01/2016, titled, "General Contract for Services", evidenced the home health agency contracted with Entity #8, who corrected deficiencies		amanagement meeting on 1/27/2023, reviewed and discussed agency policy titled 9.10.1"Plan of Care – CMS #485 and Physician Orders". During this meeting,deficiencies cited under N-0542 citation were reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency's policies pertaining to therequirement. The Administrator has amended the agreement to reflect that the contractedentity for general quality assurance services shall only notify the Directorof Clinical Services of any discrepancies in clinical records and onlyqualified and authorized RN staff will update Plan of cares, Physician Orders intheir clinical records. The Administrator has also updated the Job Descriptionfor InReferral/Intake Supervisor to Office Manager. All referrals/orders effective1/27/23 will only be accepted by RN. Anin-service meeting was conducted by the Director of Clinical Services andattended by all staff, including contracted	

	documentation and processes. The contract failed to evidence Entity #8's staff qualifications included current professional licensure to receive/create/alter physician orders. During an interview on 12/05/22 at 3:00 PM, the Clinical Supervisor indicated Entity #8 changed her clinical documents, physician's orders, and plans of care without her consent, and she complained to the Administrator about it. During an interview on 12/06/22 1:47 PM, the Administrator indicated the staff at Entity #8 were not nurses, and declined to respond as to why unlicensed staff were creating/modifying physician orders and plans of care in the patients' electronic medical record (EMR). During an interview on 12/08/22 at 2:30 PM, the Clinical Supervisor indicated the agency's plans of care were autogenerated, and Entity #8 staff initiated/modified plans of care. 3. An agency job description signed by Employee #7 and the Administrator on 9/10/18, titled		staff on 2/2/23 to discuss policyof “Plan of Care – CMS #485 and Physician Orders”. The Director of ClinicalServices emphasized on the importance that the Registered Nurse (RN) must initiateand/or update the plan of care based on the patient's needs. Citations listedin the clinical record reviews were addressed. All staff was re-educatedon the requirement. All staff understood and acknowledged the requirement thatthe RegisteredNurse (RN) will initiate and/or update the plan of care based on the patient'sneeds. All new employees will be oriented of this requirement at the time ofhire. This corrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active patient records show evidence that the Registered Nurse (RN) initiatedand/or	

	"Referral/Intake Supervisor", stated "... Essential Job Functions ... plan of care initiation ... Position Qualifications ... 1. Registered Nurse with current licensure ... 2. Bachelor's degree in Nursing ...." The document evidenced the position qualifications "1. Registered Nurse with current licensure [and] 2. Bachelor's degree in Nursing" were crossed out and initialed by the Administrator. During an interview on 12/05/22 at 3:00 PM, when queried if Employee #7 was a RN or licensed practical nurse (LPN), the Clinical Supervisor stated "... No ...." During an interview on 12/06/22 at 1:37 PM, the Administrator indicated the Referral/Intake Supervisor didn't need to be a RN. 4. During an interview on 12/08/22 at 12:12 PM, the Clinical Supervisor indicated people with "administrative privileges" in the EMR could create/alter/delete documents, which also included physician orders and plans of care; and Employee #7 and Entity #8 both		updated the plan of care based on the patient's needs. Thisprocess of utilizing active chart audit tool on all active patients will helpus ensure that the policy is being followed and identify any discrepancies inthe clinical records and re-educate all staff of the above mentionedrequirement. **Monitoring:** In order to ensure implementation andeffectiveness of this corrective action, the following monitoring process willbe put in place, the Director of Clinical Services will utilize a chart audittool and audit 100% of all active patient records on a weekly basis to ensurethat the Registered Nurse (RN) initiated and/or updated the plan of care basedon the patient's needs. Weeklyreports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 100% compliance is achievedand to	

	had those privileges. 5. Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date 10/12/22). A document received 11/30/22, titled "Home Health Certification and Plan of Care" for certification period 10/12/22 - 12/10/22, evidenced the patient received skilled nursing services, the document was a "draft", and failed to evidence a RN initiated, modified, or completed the plan of care. 6. Clinical record review for Patient #3 was completed on 12/08/22 (start of care date 1/31/22). A document titled "Home Health Certification and Plan of Care" for certification period 9/28/22 - 11/26/22, evidenced the patient received skilled nursing services, the document was a "draft", and failed to evidence a RN initiated, modified, or completed the plan of care. On 12/02/22, at 11:41 AM, the EMR evidenced documents titled "Home Health Certification and Plan of Care", for certification periods 5/31/22 - 7/29/22, 7/30/22 - 9/27/22, and 9/28/22, were all "in		maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified within 30days, they will continue to be addressed with staff re-training and re-educationin workshops and in-services and with each individual personnel as needed.After 30 days, this process will continue to be monitored on a quarterly basisand will be included in the quarterly chart audit review. Quarterly auditsresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the QAPI Committee will continue to audit 20% of clinicalrecords quarterly to ensure compliance is maintained. The Administrator andQAPI Committee will send a written report to the Governing Body quarterly fortheir recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency,	

	progress", and were all last updated by Entity #8. During an interview on 12/08/22 at 2:30 PM, the Clinical Supervisor indicated all plans of care were autogenerated by the EMR, confirmed Entity #8 updated the plans of care, and all documents marked as "drafts" or "in progress" were not yet completed. 7. Clinical record review for Patient #5 was completed on 12/09/22 (start of care date 9/06/22). Review of the EMR on 12/02/22 at 4:30 PM, evidenced a document for certification period 9/06/22 - 11/04/22, dated 9/26/22, titled "Home Health Certification and Addendum to Plan of Care", which was "in progress", and was last updated by Entity #8.		measure to assure no recurrence andmonitoring of this deficiency.	
N0543	Scope of Services 410 IAC 17-14-1(a)(1)(D)	N0543	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and	2023-02-17

	Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on record review and interview, the Registered Nurse failed to initiate appropriate preventive and rehabilitative nursing assessments/procedures, for 2 of 2 home visits observed with a RN (#2, 6). Findings include: 1. An agency policy with revised date February 2021, titled "Reassessments ....", stated, "... Staff will additionally reassess each patient with each home visit on an ongoing basis ...." 2. An agency job description received on 12/06/22, revised date February 2022, titled "Director of Clinical Services [Clinical Supervisor]", stated, "... Assures ongoing assessment of patient/family needs and implementation of ... plan of care ... fulfills job requirements ...." 3. Review on 12/5/22 of a National Library of Medicine		discussed agency policy titled 9.7.1"Reassessments/Update of the Comprehensive assessment". During thismeeting, deficiencies cited under N-0543 citation were reviewed and discussedin detail. The Director of Clinical Serviceshas completed re-orientation of agency's policies pertaining to therequirement. Anin-service meeting was conducted by the Director of Clinical Services andattended by all staff, including contracted staff on 2/2/23 to discuss policyof "Reassessments/Update of the Comprehensive assessment". The Directorof Clinical Services emphasized on the importance that except where services are limited totherapy only, the registered nurse shall initiate appropriate preventive andrehabilitative nursing procedures. Citations listed in the clinical recordreviews were addressed. All staff was re-educated on the requirement. Allstaff understood and acknowledged the requirement for the registered nurse to	

	web-based reference, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144247/, cite: Nair B. Compression therapy for venous leg ulcers. Indian Dermatol Online J. 2014 Jul;5(3):378-82. doi: 10.4103/2229-5178.137822. PMID: 25165679; PMCID: PMC4144247, titled "Compression therapy for venous leg ulcers", stated "... Bandages should generally be applied toe to knee at 50% stretch and with 50% overlap ...."		initiateappropriate preventive and rehabilitative nursing procedures. All new employeeswill be oriented of this requirement at the time of hire. This correctiveaction will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active patient records show evidence that the registered nurse initiatedappropriate preventive and rehabilitative nursing procedures. Thisprocess of utilizing active chart audit tool on all active patients will helpus ensure that the policy is being followed and identify any discrepancies inthe clinical records and re-educate all staff of the above mentionedrequirement. **Monitoring:**	

	4. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced the patient's primary diagnosis was diabetes, and an additional diagnosis of a chronic non-pressure ulcer to the right ankle, and unspecified systolic (congestive) heart failure (impairment of the left side of the heart); skilled nursing orders included to teach disease process and diet, provide wound care to the right ankle, and evaluate wound for healing. A home visit was observed with Patient #2 and the Clinical Supervisor on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Supervisor indicated the patient had 1 wound on the right lateral (outside) ankle, to which she provided wound care/treatment. Observed the patient's left foot was swollen, dark red/purple in color (indicative of impaired circulation), had several small raised blisters on the 2nd toe, and 2 dark purple areas on the ball (bottom, where the toes		In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place, the Directorof Clinical Services will utilize a chart audit tool and audit 100% of all activepatient records on a weekly basis to ensure that the registered nurse initiatedappropriate preventive and rehabilitative nursing procedures. Weekly reports will be generatedand results will be compiled and sent to the Administrator to ensure thatprocesses have improved. This process will continue for each week for the next30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will	

	attach to the foot) of the left foot, by the great and 5th toe joints. The Clinical Supervisor indicated the left foot was like that for the last couple of weeks. The patient indicated he needed his toenails trimmed, and asked the Clinical Supervisor to trim them. The Clinical Supervisor indicated she couldn't trim them, but she'd have another agency nurse do it. The Clinical Supervisor failed to provide any skilled teaching during the visit; failed to assess for presence of pedal pulses (throbbing of arteries on the top of the foot, to assess blood flow) or perform a diabetic foot exam (assess if the patient had sensation, adequate blood flow, inspect between toes, assess for ingrown toenails); and failed to trim the patient's toenails per the patient's request. During an interview on 12/08/22 at 12:03 PM, the Clinical Supervisor indicated the home visit for patient #2 on 12/05/22, was a comprehensive reassessment for recertification of home care services, and stated, "... No, I did not check the pedal pulses ... I checked them the first time I saw him ... No, I didn’t teach anything		beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	during the visit ... I taught him in the past ....", and indicated she did not assess pedal pulses, or the left foot blisters on the 2nd toe, or the 2 dark purple areas on the ball of the left foot. When queried if she performed a complete comprehensive reassessment on the patient during the home visit on 12/05/22, the Clinical Supervisor indicated she did not, but the electronic medical record (EMR) auto-filled most of that information. When queried why she failed to trim the patient's toenails, the Clinical Supervisor indicated she made someone bleed before while cutting their toenails, so she won't do it anymore. When queried if she arranged to ensure the patient's toenails were trimmed, the Clinical Supervisor indicated she didn't. 5. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date 10/07/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced diagnoses included chronic venous hypertension (a condition that results from weakened lower extremity veins			

	that have lost their ability to return blood to the heart, which causes high blood pressure in the legs), and chronic non-pressure ulcers (wounds caused by insufficient blood flow, or poor circulation) to both lower legs; skilled nursing orders included to evaluate cardiopulmonary status, teach disease process and diet, and measure wounds weekly (documented as length x width x depth). A home visit was observed with Patient #6 and the Clinical Supervisor on 12/05/22, from 11:00 AM - 12:05 PM. The Clinical Supervisor performed wound care to each lower extremity, measured the wound on the front of the left lower leg (length, 7.5 cm [centimeters], width 13.0 cm), and a wound on the inside of the left lower leg (2.0 cm x 2.0 cm). Both of the patient's lower legs were swollen. The Clinical Supervisor applied elastic compression wraps to both of the patients lower legs, starting the wraps from just below the knee and wrapped downward to the toes. The patient indicated she was concerned about her blood pressure, and she didn't eat			

anything yet today. The Clinical Supervisor failed to provide any skilled teaching during the visit; failed to apply the elastic compression bandages as indicated in professional guidance, measure the depth of either wound, or assess for presence of pedal pulses (throbbing of arteries on the top of the foot, to assess blood flow).

During an interview on 12/08/22 at 1:10 PM, the Clinical Supervisor indicated the home visit for patient #6 on 12/05/22, was a comprehensive reassessment for recertification of home care services; and confirmed she applied the patient's elastic compression bandages from the top to bottom of the leg/foot, she didn't know they should be applied from the toes upward to below the knee, she didn't measure the depths of the wounds, didn't assess pedal pulses, or provide any skilled teaching during the home visit. When queried if she performed a complete comprehensive reassessment on the patient during the home visit on 12/05/22, the Clinical Supervisor indicated she did not, she

	couldn't do some of the assessments required during a comprehensive assessment/reassessment because she had a bad elbow, and she just asked the patients questions instead of actually assessing them. 6. During an interview on 12/09/22 at 2:00 PM, the Administrator indicated he expected the nurse to assess everything during a comprehensive assessment visit, create a new plan of care, and review goals again.			
G0546	Last 5 days of every 60 days unless: 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. Based on observation, record review, and interview, the Registered Nurse (RN) failed to complete a comprehensive assessment including the	G0546	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/23 and reviewed, discussed the agency policy "Reassessments/Updateof the Comprehensive Assessment" Policy. During this meeting, deficienciescited under G-0546 were reviewed, addressed and discussed in detail.	2023-02-02

	administration of the OASIS (Outcome and Assessment Information Set) during the last 5 days of every 60 day certification period, for 2 of 2 home visits observed with an RN (#2, 6). Findings include: 1. An agency policy, revised date February 2022, titled "Reassessments/Update of the Comprehensive Assessment" stated, "... The comprehensive assessment (including OASIS data elements) ... must be updated and revised ... Recertification ... the last five days of every 60 days ...." 2. An agency job description received on 12/06/22, revised date February 2022, titled "Director of Clinical Services [Clinical Supervisor]", stated, "... Assures ongoing assessment of patient/family needs ...." 3. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced the last 5 days of the		Anin-service meeting was conducted by the Director of Clinical Services andattended by all clinicians including contracted personnel on 2/2/23 to discuss "Reassessments/Updateof the Comprehensive Assessment" Policy. The Director of Clinical Servicesemphasized on the importance of the requirement that the qualified Cliniciansmust completea comprehensive assessment including the administration of the OASIS (Outcomeand Assessment Information Set) during the last 5 days of every 60 daycertification period. All staff understood and acknowledged therequirement to complete a comprehensive assessment including the administrationof the OASIS (Outcome and Assessment Information Set) during the last 5 days ofevery 60 day certification period and deficiencies cited under G-0546 werereviewed, addressed and discussed in detail with staff. All new staff will beoriented of this requirement at the time of hire. This corrective action willbe implemented on 2/2/23.	

	was 12/01/22 - 12/05/22. A home visit was observed with Patient #2 and the Clinical Manager on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Manager failed to complete a comprehensive reassessment of the patient. During an interview on 12/08/22 at 12:03 PM, the Clinical Supervisor indicated the home visit for patient #2 on 12/05/22 was a comprehensive reassessment for recertification of home care services. When queried if she performed a complete comprehensive reassessment including assessment of the OASIS on the patient during the home visit on 12/05/22, the Clinical Manager indicated she didn't, and indicated the electronic medical record (EMR) software auto-filled most of that (on the comprehensive reassessment document) anyways. 4. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date 10/07/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care"		**Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active clinical records include acompleted comprehensiveassessment including the administration of the OASIS (Outcome and AssessmentInformation Set) during the last 5 days of every 60 day certification period.This process of utilizing active chart audit tool on all new admissions willhelp us identify any discrepancies in the clinical records and re-educate allstaff including contracted personnel to have a completed comprehensiveassessment including the administration of the OASIS (Outcome and AssessmentInformation Set) during the last 5 days of every 60 day certification periodand the documentation must be present in the clinical record. **Monitoring:**	

	evidenced the last 5 days of the patient's certification period was 12/01/22 - 12/05/22. A home visit was observed with Patient #6 and the Clinical Manager on 12/05/22, from 11:00 AM - 12:05 PM. The Clinical Manager failed to complete a comprehensive reassessment of the patient. During an interview on 12/08/22 at 1:10 PM, the Clinical Manager indicated the home visit for patient #6 on 12/05/22 was a comprehensive reassessment for recertification of home care services. When queried if she performed a complete comprehensive reassessment including assessment of the OASIS on the patient during the home visit on 12/05/22, the Clinical Manager indicated she didn't, and she couldn't do some of the assessments required during a comprehensive assessment/reassessment because she had a bad elbow, and she just asked the patients questions instead of actually assessing them. 5. During an interview on 12/09/22 at 2:00 PM, the		Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all new admissionson a weekly basis to ensure that all active clinical records show evidence ofcompleted comprehensiveassessment including the administration of the OASIS (Outcome and AssessmentInformation Set) during the last 5 days of every 60 day certification period.Weekly reports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified within 30days, they will continue to be addressed with staff re-training	

	Administrator indicated he expected the nurse to assess everything (the patient) during a comprehensive assessment visit.		andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review. Quarterlyaudits results will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the QAPI Committee will continue to audit 20% of clinicalrecords quarterly to ensure compliance is maintained. The Administrator andQAPI Committee will send a written report to the Governing Body quarterly fortheir recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0547	Scope of Services 410 IAC 17-14-1(a)(1)(H) Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the	N0547	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on	2023-02-17

	registered nurse shall do the following: (H) Accept and carry out physician, chiropractor, podiatrist, dentist, optometrist, licensed advanced practice registered nurse, and a licensed physician assistant orders (oral and written). Based on record review and interview, the home health agency failed to ensure only qualified licensed professionals accepted and carried out physician orders, for 5 of 8 clinical records reviewed (#1, 2, 3, 4, 7). Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ... and Physician/Practitioner Orders", stated, "... Verbal orders are accepted only by personnel authorized to do so by applicable state laws and regulations [licensed skilled professionals] ... Verbal orders are put in writing, signed, timed and dated with the date of receipt by a [sic] RN [registered nurse] or therapist ... It is the RN's or therapist's responsibility to make any necessary revisions		1/27/2023, reviewed and discussed agency policy titled 9.10.1“Plan of Care – CMS #485 and Physician Orders”. During this meeting,deficiencies cited under N-0547 citation were reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency’s policies pertaining to therequirement. The Administrator has amended the agreement to reflect that thecontracted entity for general quality assurance services shall notify the Directorof Clinical Services of any discrepancies in clinical records and only qualifiedlicensed professionals accepted and carried out physician orders, in clinicalrecords. The Administrator has also updated the Job Description for In Referral/IntakeSupervisor to Office Manager. All referrals/orders effective 2/2/23 will onlybe accepted by RN as per Agency policy. Anin-service meeting was conducted by the Director of Clinical Services andattended by	

	to the Plan of Care based on that order(s) ... The plan of care may include orders for treatment or services received from physicians other than the [certifying] physician ... Such orders must be approved by the [certifying] physician and incorporated into an updated plan of care ...." 2. An agency document with effective date 2/01/2016, titled, "General Contract for Services", evidenced the home health agency contracted with Entity #8 to provide Quality Assurance/Compliance for preparations of Federal and State re-certification surveys; identify, correct, and help implementation process of deficiencies identified in Administrative/Clinical documentation and processes; and any plan of correction following surveys. The contract failed to evidence staff qualifications included current professional licensure to receive/alter physician orders, or other documents which required the author's credentials as a skilled licensed professional. 3. Clinical record review for		staff on 2/2/23 to discuss policyof “Plan of Care – CMS #485 and Physician Orders”. The Director of ClinicalServices emphasized on the importance that the qualified licensed professionals must acceptand carry out physician orders. Citations listed in the clinical record reviewswere addressed. All staff were re-educated on the requirement. Allstaff understood and acknowledged the requirement that only qualifiedlicensed professionals must accept and carry out physician orders. All newemployees will be oriented of this requirement at the time of hire. Thiscorrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services will utilizea chart audit tool to ensure that all active patient records show evidence that only qualifiedlicensed professionals must accepted and carried out	

	Patient #1 was completed on 12/06/22. The electronic medical record (EMR) indicated a verbal order was received on 10/12/22 at 10:36 AM, titled "Referred for Admission", was last updated by Person #21 (staff of Entity #8), and was not signed/authenticated by a licensed skilled professional (RN). During an interview on 12/06/22 at 1:47 PM, the Administrator indicated Person #21 was a quality assurance person he contracted with (Entity #8) to provide assistance with clinical record compliance and accuracy, and this person was not a licensed skilled professional. During an interview on 12/08/22 at 12:12 PM, the Clinical Supervisor indicated people with administrative privileges in the EMR can create/alter/delete documents which also included orders, Person #21 was "Quality Assurance", and Employee #7 (Intake Coordinator) both had those privileges. A document received 11/30/22, was verbal order, dated		utilizing active chart audit tool on all active patients willhelp us ensure that the policy is being followed and identify any discrepanciesin the clinical records and re-educate all staff of the above mentionedrequirement. **Monitoring:** In order to ensure implementationand effectiveness of this corrective action, the following monitoring process willbe put in place, the Director of Clinical Services will utilize a chart audittool and audit 100% of all active patient records on a weekly basis to ensurethat only qualifiedlicensed professionals must accepted and carried out physician orders. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each week for thenext 30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time	

	11/28/22 at 10:14 AM, titled "Discharge from Agency", was last updated by Employee #7, and was not signed by a licensed skilled professional (RN). During an interview on 12/09/22 at 12:12 PM, Employee #5 indicated Employee #7, was not a licensed skilled professional. During an interview on 12/06/22 at 1:47 PM, when queried why boxes on the orders were checked that indicated a clinician “read back and verified” orders, the Clinical Supervisor stated "... Maybe we’re going by what the patient said ...." When queried why unlicensed skilled professionals created orders in the EMR, the Administrator declined to provide a response. When queried, Employee #7 indicated she created the verbal order, dated 11/28/22 at 10:14 AM, titled "Discharge from Agency", but then recanted her statement and indicated it was a "communication note". 4. Clinical record review for Patient #2 was completed on 12/02/22 and 12/08/22. A		of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of	

	verbal order document received 12/02/22 at 11:30 AM, dated 9/26/22 at 7:20 PM, was last updated by Person #21, and failed to evidence a licensed skilled professional (RN) signed the order. During an interview on 12/08/22 at 12:12 PM, the Clinical Supervisor indicated the order was generated by an unlicensed skilled professional (Person #21), the order was no longer evidenced in the EMR, she didn't delete it, the order must have been deleted some time after 12/02/22, and Person #21 had administrative privileges to delete documents in the EMR. 5. Clinical record review for Patient #3 was completed on 12/02/22 and 12/08/22. The EMR evidenced a document titled "Home Health Certification and Addendum to Plan of Care" for certification period 9/28/22 - 11/26/22, was last updated by Person #21, and failed to evidence a signature/authentication by a licensed skilled professional (RN). During an interview on		this deficiency.	

12/08/22 at 2:30 PM, the Clinical Supervisor indicated Person #21 was the last person that updated Patient #3's plan of care for certification period 9/28/22 - 11/26/22, and it wasn't signed by a RN yet.

6. Clinical record review for Patient #4 was completed on 12/09/22. A verbal order dated 9/21/22, titled "Recertification Assessment" failed to evidence it was signed/authenticated with date and time of signature by a licensed skilled professional.

During an interview on 12/09/22 at 1:59 PM, Employee #6 indicated the order was not completed by a skilled licensed professional.

7. Clinical record review for Patient #7 was completed on 12/09/22. A document for start of care 11/09/22, certification period 11/09/22 - 1/07/22, titled "Home Health Certification and Plan of Care" failed to evidence the document was completed, dated, or signed/authenticated by a licensed skilled professional.

Three additional orders in the EMR, two orders dated

	11/09/22, and 11/28/22, all failed to indicate they were completed, or signed/authenticated by a licensed skilled professional. During an interview on 12/09/22 at 2:30 PM, Employee #6 indicated the orders were not completed by a licensed skilled professional.			
G0548	Within 48 hours of the patient's return 484.55(d)(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner - ordered resumption date; Based on record review and interview, the Registered Nurse failed to ensure a comprehensive assessment was completed for 1 of 3 clinical records reviewed with patients	G0548	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/23 and reviewed, discussed the agency policy "Reassessments/Updateof the Comprehensive Assessment" Policy. During this meeting, deficiencies citedunder G-0548 were reviewed, addressed and discussed in detail.	2023-02-02

	who were hospitalized during the certification period (#1). Findings include: An agency policy, revised date February 2022, titled "Reassessments/Update of the Comprehensive Assessment" stated, "... The comprehensive assessment (including OASIS data elements) ... must be updated and revised ... Resumption of care: [within] 48 hours of the patient's return home from a hospital admission ...." An agency job description received on 12/06/22, revised date February 2022, titled "Director of Clinical Services [Clinical Supervisor]", stated, "... Assures ongoing assessment of patient/family needs ...." Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date 10/12/22). An undated, unsigned document titled "Transferred to an inpatient facility ....", evidenced the patient was transferred on 10/14/22, and the electronic medical record (EMR) indicated the document was "In Progress".		Anin-service meeting was conducted by the Director of Clinical Services andattended by all clinicians including contracted personnel on 2/2/23 to discuss "Reassessments/Updateof the Comprehensive Assessment" Policy. The Director of Clinical Servicesemphasized on the importance of the requirement that the qualified Cliniciansmust complete a comprehensive assessment including the administration of the Resumptionof Care OASIS (Outcome and Assessment Information Set) within 48 hours of thepatient's return to the home from a hospital admission of 24 hours or more forany reason other than diagnostic tests, or on physician or allowed practitioner- ordered resumption date. All staff understood and acknowledged therequirement to complete a comprehensive assessment including the administrationof the Resumption of Care OASIS (Outcome and Assessment Information Set) within48 hours of the patient's return to the home from a hospital admission of 24hours or more for any reason other than diagnostic tests, or on physician or	

	A document dated 10/18/22, titled “Home Discharge Instructions”, evidenced the patient was hospitalized for emergent care at Entity #10 (a hospital) from 10/15/22 – 10/18/22, for seizures. A document dated 10/19/22, titled "Resumption of care (after inpatient stay)" (a comprehensive reassessment with OASIS items) stated, "... Status ... In Progress ...." The document failed to evidence a comprehensive reassessment was completed. During an interview on 12/08/22 at 2:30 PM, the Clinical Manager indicated documents marked in the EMR as “drafts” and/or “In Progress” were incomplete documents.		allowedpractitioner - ordered resumption date. and deficiencies cited under G-0548 werereviewed, addressed and discussed in detail with staff. All new staffwill be oriented of this requirement at the time of hire. This correctiveaction will be implemented on 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active clinical records include acompleted comprehensiveassessment including the administration of the Resumption of Care OASIS(Outcome and Assessment Information Set) within 48 hours of the patient'sreturn to the home from a hospital admission of 24 hours or more for any reasonother than diagnostic tests, or on physician or allowed practitioner - orderedresumption date. This process of utilizing active chart audit tool onall new admissions will help us identify any	

			discrepancies in the clinicalrecords and re-educate all staff including contracted personnel to have acompleted comprehensiveassessment including the administration of the Resumption of Care OASIS(Outcome and Assessment Information Set) within 48 hours of the patient'sreturn to the home from a hospital admission of 24 hours or more for any reasonother than diagnostic tests, or on physician or allowed practitioner - orderedresumption date and the documentation must be present in the clinicalrecord. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all new admissionson a weekly basis to ensure that all active clinical records show evidence	

			comprehensiveassessment including the administration of the Resumption of Care OASIS(Outcome and Assessment Information Set) within 48 hours of the patient'sreturn to the home from a hospital admission of 24 hours or more for any reasonother than diagnostic tests, or on physician or allowed practitioner - orderedresumption date. Weekly reports will be generated and results will becompiled and sent to the Administrator to ensure that processes have improved.This process will continue for each week for the next 30 days until 100%compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be	

			included in the quarterlychart audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0550	At discharge 484.55(d)(3) At discharge. Based on record review and interview, the Registered Nurse (RN) failed to complete a comprehensive assessment upon discharge, for 3 of 3 clinical records reviewed for patients who were discharged	G0550	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held a managementmeeting on 1/27/23 and reviewed, discussed the agency policy "Reassessments/Updateof the Comprehensive Assessment" Policy. During this meeting, deficienciescited under G-0550	2023-02-02

	from the agency (#1, 5, 7). Findings include: 1. An agency policy, revised date February 2022, titled "Reassessments/Update of the Comprehensive Assessment" stated, "... The comprehensive assessment (including OASIS data elements) ... must be updated and revised ... [when] discharged from agency ... within 2 calendar days of the discharge ... date ...." 2. An agency job description received on 12/06/22, revised date February 2022, titled "Director of Clinical Services [Clinical Manager]", stated, "... Assures ongoing assessment of patient/family needs ...." 3. Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date 10/12/22, discharge date 11/28/22). The electronic medical record evidenced a comprehensive reassessment with OASIS items stated, "... Status ... In Progress ...." The document failed to evidence a comprehensive reassessment was completed. During an interview on12/06/22		were reviewed, addressed and discussed in detail. Anin-service meeting was conducted by the Director of Clinical Services andattended by all clinicians including contracted personnel on 2/2/23 to discuss "Reassessments/Updateof the Comprehensive Assessment" Policy. The Director of Clinical Servicesemphasized on the importance of the requirement that the qualified Cliniciansmust completea comprehensive assessment upon discharge for patients discharged from agency. Deficienciescited under G-0550 were reviewed, addressed and discussed in detail with staff.All staff understood and acknowledged the requirement that the qualifiedClinicians must complete a comprehensive assessment upon discharge for patientsdischarged from agency. All new staff will be oriented of thisrequirement at the time of hire. This corrective action will be implemented on 2/2/23.	

	at 2:00 PM, when queried to describe the discharge process, the Clinical Manager indicated they don't always do discharges "in person", it depended on their schedules, and sometimes they did it over the phone. When queried if a discharge comprehensive assessment was completed for patient #1, the Clinical Manager indicated it was "in progress". During an interview on 12/08/22 at 2:30 PM, the Clinical Manager indicated documents marked in the EMR as “drafts” and/or “In Progress” were incomplete documents. 4. Clinical record review for Patient #5 was completed on 12/09/22 (start of care date 9/06/22, discharge date 11/04/22). The EMR failed to evidence a discharge comprehensive assessment was completed. During an interview on 12/09/22 at 2:26 PM, the alternate Clinical Manager indicated the discharge comprehensive assessment wasn't completed, and it was almost entirely blank. 5. Clinical record review for		**Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services will utilizea chart audit tool to ensure that all discharged clinical records include acompleted comprehensiveassessment upon discharge for patients discharged from agency. Thisprocess of utilizing chart audit tool on all new discharges will help usidentify any discrepancies in the clinical records and re-educate all staffincluding contracted personnel to have a completed comprehensive assessment upondischarge for patients discharged from agency and the documentation mustbe present in the clinical record. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all new	

	patient #7 was completed on 12/09/22 (start of care date 11/09/22, discharge date 11/28/22). The EMR failed to evidence a comprehensive assessment was completed. During an interview on 12/09/22 at 2:30 PM, the alternate Clinical Manager indicated there wasn't a completed discharge comprehensive assessment in the patient's EMR.		admissionson a weekly basis to ensure that all discharged clinical records show evidence ofcompleted comprehensiveassessment upon discharge for patients discharged from agency. Weeklyreports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process will continuefor each week for the next 30 days until 100% compliance is achieved and tomaintain this level of compliance all new employees at the time of hire will beoriented with this requirement. If compliance is not achieved at the desiredtarget of 100% compliance and any deficiencies are identified within 30 days,they will continue to be addressed with staff re-training and re-education inworkshops and in-services and with each individual personnel as needed. After30 days, this process will continue to be monitored on a quarterly basis andwill be included in the quarterly chart audit review. Quarterly audits resultswill be compiled and sent to the QAPI Committee for review. Once threshold ismet,	

			the QAPI Committee will continue to audit 20% of clinical recordsquarterly to ensure compliance is maintained. The Administrator and QAPICommittee will send a written report to the Governing Body quarterly for theirrecommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of	G0570	**Corrective Action:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/23, the Administrator andDirector of Clinical Services reviewed and discussed Agency policies 9.3.1 titled,"Patient Admission Criteria", 9.9.1 titled, “Care Planning Process”and 9.10.1 titled, “Plan of Care-CMS#485and Physician Orders”. During this meeting, deficiencies cited under G-0570citation were reviewed	2023-02-02

	care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review, and interview, the Administrator failed to ensure: all patients' needs were met; all medical care/treatment provided by agency staff followed the written plan of care (Please see tag G0572); failed to ensure all patients' plans of care included all required elements (Please see tag G0574); failed to ensure the patient's plan of care was reviewed by the certifying physician when a significant change in condition occurred, and/or at least every 60 days (Please see tag G0588) This practice had the potential to affect all patients serviced by the agency. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for the Condition of Participation 42 CFR §484.60: Care Planning,		and discussed in detail. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff. During the meeting, the DCS discussed Agency policies 9.3.1 titled,"Patient Admission Criteria", 9.9.1 titled, “Care Planning Process”and 9.10.1 titled, “Plan of Care-CMS#485and Physician Orders” and the importance of the requirement that all patients'needs will be met, all medical care/treatment provided by agency staff followsthe written plan of care, all patients' plans of care included all requiredelements and the patient's plan of care is reviewed by the certifying physicianwhen a significant change in condition occurred, and/or at least every 60 days.Citations listed in the clinical record reviews were addressed. All staffunderstood and acknowledged the agency policies 9.9.1 titled, “Care PlanningProcess” and 9.10.1 titled, “Plan of Care-CMS#485 and Physician Orders” 9.12.1titled, “Professional Standards of Practice” and the requirement that all patients'needs will be met, all	

	Coordination of Services, and Quality of Care A standard level deficiency was also cited at this level. Based on observation, record review, and interview, the home health agency failed to ensure it only accepted patients for services if the needs of the patient could be met for 2 of 2 records reviewed with home visits by a Registered Nurse (RN) (#2, 6), and 1 of 1 patient accepted for care, with a pending initial evaluation date (#9); and failed to ensure each patient had a written plan of care, for 5 of 8 clinical records reviewed. (#1, 3, 5, 6, 7) The findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ... and Physician/Practitioner Orders", stated, "... home health services will be in accordance with a Plan of Care ...." 2. An agency policy with revised		medical care/treatment provided by agency staff followsthe written plan of care, all patients' plans of care included all requiredelements and the patient's plan of care is reviewed by the certifying physicianwhen a significant change in condition occurred, and/or at least every 60 days.All new employees will be oriented of this requirement at the time of hire.This corrective action will be implemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the DCS will utilize a chart audit tool toensure that all patients' needs were met, all medical care/treatment providedby agency staff followed the written plan of care, all patients' plans of careincluded all required elements and the patient's plan of care was reviewed bythe certifying physician when a significant change in condition occurred, and/orat least every 60 days is present in the clinical record. This process ofutilizing active	

	date February 2021, titled "Patient Admission Criteria" stated, "... Patients will be accepted for care only if Agency can meet a patient's identified needs ... personnel to provide needed services are available ...." 3. During an interview on 12/08/22 at 12:12 PM, the Clinical Manager stated "... No one works on Saturdays ... We don’t have staff for Saturdays ...." 4. During an interview on 12/08/22 at 3:30 PM, the Clinical Manager indicated she was leaving on a flight this evening (12/08/22), and would be back at work on Monday (12/12/22). When queried who would cover Registered Nurse (RN) Clinical Manager duties, the Clinical Manager indicated no one did, this was how the agency operated; if she wasn't available, no one covered, and patients had to wait until she returned. 5. On 12/09/22 at 12:55 PM, observed a phone call in progress with Employee #7 (Referral/Intake Supervisor), who indicated to the person on		chart audit tool on all new admissions will help us identifyany discrepancies in the clinical records and re-educate all staff includingcontracted personnel on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, the DCSwill audit 100% of all new admissions on a weekly basis to ensure that allpatients' needs were met, all medical care/treatment provided by agency stafffollowed the written plan of care, all patients' plans of care included allrequired elements and the patient's plan of care was reviewed by the certifyingphysician when a significant change in condition occurred, and/or at leastevery 60 days is present in the clinical record. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each	

	the phone that there was no nurse available today (12/09/22) for an admission visit (Patient #9). During an interview on 12/09/22 at 12:58 PM, Employee #7 indicated family of patient #9 called to see when the nurse was coming out to admit the patient for home care, and she gave family the Clinical Manager's number to schedule a time for Monday (12/12/22). During this time, all referral documents for Patient #9 was requested and received, which included:		week for thenext 30 days until 100% compliance is achieved and to maintain this level ofcompliance, all new staff at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and if any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of individualized Plan of Cares inclinical records on a quarterly basis to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations.	

	A document from entity #1 (a hospital), dated 12/01/22, titled "Home Care: Start of Care Orders ...." which indicated skilled nursing, physical therapy (PT) and home health aide (HHA) services were ordered on 12/01/22. A document from entity #1, dated 12/01/22, titled "Home Discharge Instructions", which indicated the patient was discharged from entity #1 on 12/01/22, and stated, "... Follow up Instructions ... with ... Paragon Home Care ... Within 1 to 2 days ... Nursing visit for staples removal on Friday 12/09/22 ...." During an interview on 12/09/22 at 1:01 PM, when queried about Patient #9's referral and status of admission, The Administrator indicated he didn't know about the referral.		The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	During an interview on 12/09/22 at 3:49 PM, when queried why Patient #9 wasn't admitted today (or sooner), Employee #7 indicated Patient #9 was never scheduled to begin today, and Person #2 already scheduled with the Clinical Manager for an initial evaluation on Monday (12/12/22). During an interview on 12/09/22 at 4:01 PM, Person #2 (family) indicated Patient #9 got out of the hospital about 2 weeks ago, she called Paragon Home Health Care about 2 days after Patient #9 was discharged from the hospital to get services started, and they (Paragon staff) told her they were waiting on a nurse and paperwork. Person #2 indicated she didn't hear back from Paragon, so she called again about a week later with no results, and called again today (12/09/22). When queried if she requested a delay in the start of home care services, Person #2 indicated she did not, and indicated when she called the Clinical Manager today to schedule the admission nursing visit, the Clinical Manager told her the delay was because they (Paragon Home Health Care)			

	were waiting until after the patient got her staples out today to begin home health services, and she would be there Monday 12/12/22 at 1:00 PM. The home health agency accepted the patient for services, but failed to ensure personnel was immediately available to meet the patient's needs. 6. Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date 10/12/22). A document received 11/30/22, titled "Home Health Certification and Plan of Care" for certification period 10/12/22 - 12/10/22, evidenced the document was a "draft", and failed to evidence it was completed. The electronic medical record (EMR) evidenced the document was "in progress". During an interview on 12/06/22 at 2:46 PM, the Clinical Manager indicated the plan of care was not completed. 7. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document dated 7/27/22, titled "[Entity #9, a			

	wound clinic]", evidenced a referral from Entity #9 was received by the home care agency. A document dated 7/26/22, signed by Person #19 (Patient #2's certifying physician), titled "Physician Order Details", stated, "... Admit to Home Health for wound care ... Dressing changes to be completed by home health on Tuesday ... Thursday ... Saturday ...." A document for certification period 8/08/22 - 10/06/22, titled "Home Health Certification and Plan of Care" evidenced home care services were initiated 12 days after the referral was received, skilled nursing was ordered twice the first week, then weekly for 8 weeks. The home health agency accepted the patient for services, services were delayed, and failed to ensure personnel provided wound care on Tuesdays, Thursdays, and Saturdays as ordered by the patient's certifying physician. A document dated 10/18/22, titled "Physician Order Details",			

	health to continue wound care every other day. A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced skilled nursing was ordered 3 times weekly for 8 weeks, then once per week for 1 week. The agency failed to ensure personnel provided wound care as ordered (every other day) to meet the patient's needs. During an interview on 12/06/22 at 3:11 PM, the Clinical Manager indicated she received the patient's information on 8/02/22 (Tuesday), the patient went to wound clinic on 8/04/22 (Thursday), and she did the initial evaluation/comprehensive assessment on 8/08/22 (Monday), and stated "... because I don't work on Saturdays ...." When queried what agency staff worked on Saturdays, the Clinical Manager stated, "... No one ...." The Clinical Manager indicated the patient referral was originally given to another nurse, the other nurse said it was too far			

	(travel), so it came to her (Clinical Manager). When queried why the patient wasn't getting nursing visits every other day as ordered, the Clinical Manager stated, "... We don't work on Saturdays, and the [family] agreed it was okay ...." During an interview on 12/09/22 at 2:00 PM, when queried of her expectations when the wound clinic ordered wound treatment on Tuesdays, Thursdays and Saturdays, the alternate Clinical Manager stated, "... They better go on those days because that's a written order ....", and indicated if the order wasn't followed, it shouldn't be because the nurse didn't want to work on Saturdays. 8. Clinical record review for Patient #3 was completed on 12/08/22 (start of care date 1/31/22). A document titled "Home Health Certification and Plan of Care" for certification period 9/28/22 - 11/26/22, evidenced the document was a "draft", and failed to evidence it was completed. On 12/02/22, at 11:41 AM, the			

	EMR evidenced 3 additional documents, titled "Home Health Certification and Plan of Care", for certification periods 5/31/22 - 7/29/22, 7/30/22 - 9/27/22, and 9/28/22 - 11/26/22, which evidenced they were all "in progress", and failed to evidence any were completed. During an interview on 12/08/22 at 2:30 PM, the Clinical Manager indicated all plans of care were autogenerated by the EMR, and all documents marked as "drafts" or "in progress" were not yet completed. 9. Clinical record review for Patient #5 was completed on 12/09/22 (start of care date 9/06/22). Review of the EMR on 12/02/22 at 4:30 PM evidenced a document for certification period 9/06/22 - 11/04/22, dated 9/26/22, titled "Home Health Certification and Addendum to Plan of Care" (a revised plan of care), was "in progress", and failed to evidence it was completed. 10. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date			

	9/15/22, titled "Progress Note Details", evidenced Entity #12 (a wound clinic) ordered wound care to be performed every 2 days. A document dated 9/30/22, titled "Physician Orders Details", evidenced Entity #12 ordered wound care to be performed every 2 days. A document dated 10/28/22, titled "Physician Orders Details" evidenced Entity #12 ordered wound care to be performed every 2 days. A document dated 12/06/22, titled "Physician Orders Details" evidenced Entity #12 ordered wound care to be performed every 2 days. A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" skilled nursing was ordered was once weekly for 1 week, 3 times weekly for 8 weeks (weeks 2-9), then once weekly for 1 week, and the document was a "draft". The home health agency accepted the patient for services, but failed to ensure personnel provided wound care every 2 days as ordered by			

Entity #12, and failed to ensure the plan of care was completed.

During an interview on 12/08/22 at 1:10 PM, when queried why agency staff failed to provide nursing visits every 2 days, the Clinical Manager stated, "... we don't work weekends ... it's like every other day [3 times per week] ... well ... except the weekends ...."

11. Clinical record review for Patient #7 was completed on 12/09/22. A document for start of care 11/09/22, certification period 11/09/22 - 1/07/22, titled "Home Health Certification and Plan of Care" evidenced the document was a "draft", and failed to evidence the document was completed.

During an interview on 12/09/22 at 2:30 PM, Employee #6 indicated the plan of care was not completed.

12. During an interview on 12/05/22 at 3:00 PM, the Clinical Manager indicated she was very behind with the completion of her documentation.

G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review, and interview, the home health agency failed to ensure all medical care/treatment provided by agency staff followed the written plan of care; and/or failed to ensure the plan of care was reviewed and signed by the certifying physician, for 8 of 8 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8). Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ... and Physician/Practitioner Orders", stated, "... Skilled nursing and other home health services will	G0572	**Corrective Action:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/23, the Administrator andDirector of Clinical Services reviewed and discussed Agency policies 9.9.1 titled, “CarePlanning Process” and 9.10.1 titled,“Plan of Care-CMS#485 and Physician Orders” and 9.12.1 titled, “ProfessionalStandards of Practice”. During this meeting, deficiencies cited underG-0572 citation were reviewed and discussed in detail. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff. During the meeting, the DCS discussed Agency policies 9.9.1 titled,“Care Planning Process” and 9.10.1 titled, “Plan of Care-CMS#485 and PhysicianOrders” and 9.12.1 titled, “Professional Standards of Practice” and theimportance of the requirement that each patient must receive the home healthservices that are written in an individualized plan of care that identifiespatient-specific measurable outcomes and	2023-02-02

	be in accordance with a Plan of Care ... Each Plan of Care must be signed and dated by the physician ... If a physician/practitioner refers a patient under a plan of care that cannot be completed until after an initial evaluation visit, the physician is consulted to approve additions or modifications to the original plan ... Orders for therapy services include the specific procedures ... and the amount, frequency and duration ... All patient care orders, including verbal orders, must be recorded in the plan of care ... The plan of care may include orders for treatment or services received from physicians other than the [certifying] physician ... Such orders must be approved by the [certifying] physician and incorporated into an updated plan of care ...." 2. An agency policy with revised date February 2017, titled "Professional Standards of Practice", stated, "... Agency staff will provide care, treatment and services to each patient according to the plan of care ...." 3. Clinical record review for Patient #1 was completed on		goals, and which is established,periodically reviewed, and signed by a doctor of medicine, osteopathy, orpodiatry acting within the scope of his or her state license, certification, orregistration. If a physician or allowed practitioner refers a patient under aplan of care that cannot be completed until after an evaluation visit, thephysician or allowed practitioner is consulted to approve additions ormodifications to the original plan. The Director of Clinical Services emphasizedthat all medical care/treatment provided by agency staff must follow the writtenplan of care and ensure the plan of care was reviewed and signed by thecertifying physician. Citations listed in the clinical record reviews wereaddressed. All staff understood and acknowledged the agency policies 9.9.1titled, “Care Planning Process” and 9.10.1 titled, “Plan of Care-CMS#485 andPhysician Orders” 9.12.1 titled, “Professional Standards of Practice” and therequirement that all medical care/treatment provided by agency staff must followthe written plan of care and ensure the plan of care was	

	12/06/22 (Start of care date 10/12/22). A document received 11/30/22, titled "Home Health Certification and Plan of Care" for certification period 10/12/22 - 12/10/22, indicated the document was a "draft", Skilled Nursing was ordered weekly for 9 weeks; Physical Therapy (PT), Occupational Therapy (OT) was ordered to evaluate and treat; and Home Health Aide (HHA) services were ordered twice weekly for 8 weeks. The initial plan of care failed to evidence it was reviewed, approved, or signed by the certifying physician. The electronic medical record (EMR) failed to evidence the PT evaluation dated 10/13/22, and OT evaluation dated 10/26/22, were sent to the certifying physician to update the initial plan of care, and failed to evidence an HHA plan of care. The EMR failed to evidence any nursing visits were documented as completed after the start of care visit on 10/12/22. No HHA visits were documented as completed for the week of 10/12/22 (week 1), only 1 HHA visit was made the week of 10/16/22 (week 2), no HHA visits were documented as		reviewed and signed bythe certifying physician. All new employees will be oriented of thisrequirement at the time of hire. This corrective action will be implementedeffective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the DCS will utilize a chart audit tool to ensurethat all medical care/treatment provided by agency staff must follow the writtenplan of care and ensure the plan of care must be reviewed and signed by thecertifying physician is present in the clinical record. This process ofutilizing active chart audit tool on all new admissions will help us identifyany discrepancies in the clinical records and re-educate all staff includingcontracted personnel on the above mentioned requirement. **Monitoring:**	

	completed week of 10/30/22 (week 4), week of 11/06/22 (week 5), or week of 11/13/22 (week 6), week of 11/20/22 (week 7). The agency's skilled nursing and HHA staff failed to follow visit frequencies as ordered on the plan of care. During an interview on 12/06/22 at 1:47 PM, the Administrator indicated there were no signed orders from any physician for Patient #1. During an interview on 12/06/22 at 2:00 PM, the Clinical Manager indicated she previously saw a Home Health Aide (HHA) plan of care in the electronic medical record (EMR) for Patient #1, but could not find it now. When queried if therapy evaluations and therapy plans of care were sent to the certifying physician for approval/signature, the Clinical Manager stated "Yes ....", but indicated she couldn't see in the EMR where Patient #1's Physical Therapy (PT) or Occupational Therapy (OT) evaluations/plans of care were sent to the certifying physician for approval/signature. Employee #6 (Office Staff) indicated she did not send therapy		In orderto ensure implementation and effectiveness of this corrective action, the DCSwill audit 100% of all new admissions on a weekly basis to ensure that allmedical care/treatment provided by agency staff must follow the written plan ofcare and ensure the plan of care must be reviewed and signed by the certifyingphysician is present in the clinical record. Weekly reports will be generated and results will be compiled and sentto the Administrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 100% compliance is achievedand to maintain this level of compliance, all new staff at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and if any deficiencies are identified within30 days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on	

	evaluations/plans of care to the physicians for signature. The Administrator then queried if they were required to send therapy evaluations/plans of care to the certifying physician for approval/signature. When queried what was considered to be the updated plan of care, the Clinical Manager stated "... We get orders and they stay separate from the plan of care ...." When queried if she would expect the Therapists to contact the certifying physician for review and approval of therapy plans of care/orders, the Clinical Supervisor stated "Yes ....", and the Administrator stated "... we would just send the eval [evaluation] [to the certifying physician] ... the eval should go to the physician ....". When queried how the patient's plan of care was created, the Clinical Manager stated "It autogenerates ... We have to add some stuff ... It picks up what it wants ...." 4. A home visit was observed with Patient #2 and the Clinical Manager on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Manager provided wound care to the patient's left lateral (outside of foot) ankle. The		aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofindividualized Plan of Cares in clinical records on a quarterly basis to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	wound was cleansed with normal saline (sterile salt water), a collagen pad (stimulates new tissue growth) was applied to the wound bed, a foam adhesive dressing was applied, and an elastic stocking was applied to the lower leg/foot. Observed an Entity #9 document (a wound clinic the patient attended for treatment and orders), dated 11/29/22, which indicated the wound care was ordered to be performed every other day by the agency nurse. During this visit, the Clinical Manager failed to provide any teaching to the patient or family. During an interview on 12/06/22 at 3:11 PM, when queried why she didn't follow Entity #9's orders to change the dressing every other day, the Clinical Manager indicated agency staff didn't work on Saturdays, and family agreed it was okay to just change the dressing 3 times weekly. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document titled "Home Health Certification and Plan of Care" for certification period 10/07/22			

	- 12/05/22, indicated Skilled Nursing was ordered 3 times weekly for 8 weeks, then once for 1 week, orders included skilled nurse to teach diet, disease process, home safety/fall prevention, signs/symptoms of infection, and to provide wound care, but failed to evidence specific wound care orders. The EMR failed to evidence any nursing visits were made the week of 10/07/22, only 2 visits were made during the weeks of 10/09/22 and 10/16/22, and failed to evidence the nurse attempted a third visit either week; failed to evidence any nursing visits were made during the week of 11/27/22 (week 9); and there were no orders for the visit that occurred on 12/05/22 (week of 12/04/22, week 10). The agency's skilled nursing staff failed to follow visit frequencies as ordered on the plan of care. During an interview on 12/08/22 at 12:03 PM, the Clinical Manager indicated she didn't teach anything during the visit on 12/05/22, the patient was referred from Entity #9,			

visits, and they followed Entity #9 orders for wound care.

5. Clinical record review for Patient #3 was completed on 12/08/22 (start of care date 1/31/22). A document titled "Home Health Certification and Plan of Care" for certification period 9/28/22 - 11/26/22, indicated Skilled Nursing was ordered one time week of 9/28/22 (week 1), then twice weekly for 8 weeks, for wound care to the left groin. The record failed to evidence a nursing visit was performed the week of 9/28/22 (week 1). The agency's skilled nursing staff failed to follow visit frequencies as ordered on the plan of care.

During an interview on 12/08/22 at 2:30 PM, the Clinical Manager indicated the visit during week #1 was a missed visit because the patient went to the wound clinic on 9/29/22 (Thursday) week 1, they don’t work weekends, so no other visit was attempted that week.

6. Clinical Record review for Patient #4 was completed on 12/09/22 (start of care date

certification period 11/22/22 - 1/20/23, titled "Home Health Certification and Plan of Care" evidenced skilled nursing was ordered "one visit every other week for monthly lab work". The record evidenced a skilled nursing visit was made on 11/23/22, and as of 12//09/22 at 1:56 PM (sixteen days later), no other skilled nursing visits were made. The record failed to evidence the agency's skilled nursing staff followed visit frequencies as ordered on the plan of care, any lab results, when the last time labs were obtained, or when the next time labs were due.

During an interview on 12/09/22 at 1:41 PM, the alternate Clinical Manager indicated she expected to see when the nurse last drew labs, the next time it was due, and there were no lab results in the EMR.

7. Clinical record review for Patient #5 was completed on 12/09/22 (start of care date 9/06/22). A document dated 9/26/22, titled "Start of Care ...." (the initial comprehensive assessment) evidenced the

	treatments to the patient's abdomen and left buttock. A document for certification period 9/06/22 - 11/04/22, titled "Home Health Certification and Plan of Care" evidenced skilled nursing was ordered once weekly for 9 weeks, PT and OT was ordered to "evaluate and treat", the patient had wounds to the abdomen and left buttock, but failed to include wound care orders for either wound. During an interview on 12/09/22 at 2:26 PM, the alternate Clinical Manager indicated if visit frequencies weren't followed, the visits would need to be made up, or the plan of care should be updated with new frequency orders; she expected to see wound care orders for the nurse to follow on the plans of care; every time the orders changed, the plans of care should be updated; and she didn't see evidence PT or OT evaluations were sent to the certifying physician for review/approval or signature. 8. A home visit was observed			

	Manager on 12/05/22 from 11:00 AM - 12:05 PM. The patient indicated she went to the wound clinic (Entity #1) about every month, that's who managed her leg wounds, and indicated Person #11 was her primary care physician (PCP), whom she saw in October (2022) for a flu shot. The Clinical Manager performed extensive wound care to each lower extremity, measured lengths/widths of each wound, but failed to measure the depth of either wound, or provide any teaching during the visit. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date 10/07/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced skilled nursing was ordered once for the first week, 3 times weekly for 8 weeks, and 1 time for 1 week; the patient had wounds to both lower legs, an order to measure wounds weekly (length x width x depth), wound care was ordered, other orders included to teach disease process, diet, home safety/falls prevention, signs/symptoms of			

	care/dressing. The plan of care stated "...Draft ....", and indicated Person #11 was the certifying physician; and failed to evidence any wound care treatment orders from Entity #1, or evidence Person #11 reviewed, approved, or signed the plan of care. The EMR evidenced only 2 visits were made the week of 10/16/22 (week 3), 10/23/22 (week 4), and 11/13/22 (week 7), and failed to evidence the nurse attempted to schedule a third visit during those weeks. The agency's skilled nursing staff failed to follow visit frequencies as ordered on the plan of care. A document from Entity #1, dated 9/30/22, titled "Physician Order Details", indicated wound care/treatment frequency for each lower leg was ordered to be done every other day. The EMR failed to evidence nursing visits were made every other day. During an interview on 12/08/22 at 1:10 PM, when queried, the Clinical Manager indicated they didn't do every other day visits because they			

	don't work weekends, 3 times a week was almost like every other day except for the weekends, the patient was seen by the agency for wound care ordered by the wound clinic (Entity #1), Person #11 was not part of Entity #1, he was the PCP [primary care practitioner], and the plan of care wasn't signed by Person #11. When queried if the physician was notified of the deviation from ordered skilled nursing visit frequencies, the Clinical Manager indicated the EMR should auto populate an order. Upon survey exit, nothing further was submitted for review. 9. Clinical record review for patient #7 was completed on 12/09/22 (start of care date 11/09/22). A document dated 10/26/22 titled "Home Care-Start of Care Orders ....", indicated the patient had a new colostomy placed 10/25/22, port-a-cath (a surgically implanted device which allows easy access to a patient's veins) placement 10/25/22, and had colon cancer. A document dated 11/03/22, titled "Progress Notes",			

	indicated Paragon Home Health Care accepted the patient for services, the patient had a port-a-cath to the left upper chest with steri-strips (porous surgical tape strips used to close small wounds) in place, needs included home health care for negative pressure wound treatment, colostomy and Jackson Pratt (JP) drain (a closed-suction medical device that is commonly used as a post-operative drain for collecting bodily fluids from surgical sites) care/teaching. A document titled "Home Health Certification and Plan of Care" (certification period 11/09/22 - 1/07/23) evidenced skilled nursing was ordered twice the first week, then 3 times weekly for 8 weeks. Orders included assessment, wound care, ostomy teaching, instruct ostomy care, and monitor JP drain site for signs of infection. The record evidenced only 1 skilled nursing visit was made during the week of 11/13/22 (week 2), no skilled nursing visits were made after 11/15/22 (week 3), and there was no order to discharge the patient from services			

	[week 4]). The agency's skilled nursing staff failed to follow visit frequencies as ordered on the plan of care. Documents dated 11/11/22, 11/14/22, 11/21/22, 11/23/22, 11/25/22, titled "Skilled Nurse Visit", failed to evidence the nurse assessed the port-a-cath, the JP drain, provided colostomy teaching, or provided/instructed on colostomy care. During an interview on 12/09/22 at 2:30 PM, Employee #6 indicated the plan of care and other orders weren't completed or signed by the physician. The alternate Clinical Manager indicated she would expect the nurse to do what was ordered on the plan of care, the plan of care was a "hot mess", and it was "missing everything". 10. Clinical record review for Patient #8 was completed on 12/09/22 (start of care date 8/11/22). A document titled "Home Health Certification and Plan of Care" (certification period 11/09/22 - 1/07/23) evidenced Home Health Aide (HHA) services were ordered			

	twice weekly for 9 weeks. The record failed to evidence 2 HHA visits were made during the week of 10/30/22 (week 4), and failed to evidence the HHA attempted to re-schedule the visit for later the same week. The agency's HHA staff failed to follow visit frequencies as ordered on the plan of care. During an interview on 12/09/22 at 1:19 PM, the alternate Clinical Manager indicated staff should try to re-schedule missed visits, especially if the missed visit was early in the week.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations;	G0574	**Corrective Action:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/23, the Administrator andDirector of Clinical Services reviewed and discussed Agency policies 9.9.1 titled, "CarePlanning Process" and 9.10.1 titled,"Plan of Care-CMS#485 and Physician Orders" and 9.12.1 titled, "ProfessionalStandards of Practice". During this meeting, deficiencies cited underG-0574 citation were reviewed and	2023-02-02

	(viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to ensure all patients' plans of care included one or more of the following: all services provided, all pertinent diagnoses, the patient's mental status, types of services and/or equipment required, frequency and duration of visits, nutritional requirements, medications and treatments, safety measures to protect against injury, therapy modalities specifying length of treatment, and any other appropriate items identified by the agency's own policy, for 8 of 8 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8).		discussed in detail. Anin-service was conducted by the Director of Clinical Services on 2/223 with allstaff. During the meeting, the DCS discussed Agency policies 9.9.1 titled,“Care Planning Process” and 9.10.1 titled, “Plan of Care-CMS#485 and PhysicianOrders” and the importance of the requirement that the individualized planof care included one or more of the following: all services provided, allpertinent diagnoses, the patient's mental status, types of services and/orequipment required, frequency and duration of visits, nutritional requirements,medications and treatments, safety measures to protect against injury, therapymodalities specifying length of treatment, and any other appropriate itemsidentified by the agency's own policy. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the agencypolicies 9.9.1 titled, “Care Planning Process” and 9.10.1 titled, “Plan ofCare-CMS#485 and Physician Orders” and the requirement that	

	Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ... and Physician/Practitioner Orders", stated, "Each patient must receive an individualized written plan of care, including any revisions or additions ... must specify the care and services necessary to meet the patient-specific needs ... specify the patient and caregiver training ... identifies patient-specific measurable outcomes and goals ... Patient specific goals must be individualized to the patient ... as well as patient preferences ... All pertinent diagnoses ... mental, psychosocial and cognitive status ... supplies and equipment required ... frequency and duration of visits ... Rehabilitation potential ... Functional limitations ... Activities permitted ... Nutritional requirements ... All medications and treatments ... Safety measures to protect against injury ... A description of the patient's risk for emergency department visits and hospital readmissions, and all necessary interventions to address the underlying risk factors ...		individualizedplan of care includes one or more of the following: all services provided, allpertinent diagnoses, the patient's mental status, types of services and/orequipment required, frequency and duration of visits, nutritional requirements,medications and treatments, safety measures to protect against injury, therapymodalities specifying length of treatment, and any other appropriate itemsidentified by the agency's own policy. All new employees will be oriented ofthis requirement at the time of hire. This corrective action will be implementedeffective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the DCS will utilize a chart audit tool toensure that individualized plan of care includes one or more of the following:all services provided, all pertinent diagnoses, the patient's mental status,types of services and/or equipment required, frequency and	

	Patient-specific interventions and education ... measurable outcomes and goals identified by ... the patient ... All patient care orders, including verbal orders, must be recorded in the plan of care ... The plan of care may include orders for treatment or services received from physicians other than the [certifying] physician ... Such orders must be approved by the [certifying]] physician ... and incorporated into an updated plan of care ...." 2. Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date 10/12/22, discharge date 11/28/22). A document dated and signed by Person #7 (a physician), titled "Progress Note", evidenced diagnoses included seizures and anemia, a history of hypertension (high blood pressure), and swelling of both lower extremities; medications included Aricept (to treat Alzheimer's Disease) 10 milligrams (mg) daily, Voltaren gel (a topical pain reliever), triamcinolone cream (a steroid cream to help relieve redness, itching, swelling, or other discomfort caused by skin conditions), turmeric (herbal		requirements, medications and treatments, safety measures toprotect against injury, therapy modalities specifying length of treatment, andany other appropriate items identified by the agency's own policy are presentin the clinical record. This process of utilizing active chart audit tool onall new admissions will help us identify any discrepancies in the clinicalrecords and re-educate all staff including contracted personnel on the abovementioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, the DCSwill audit 100% of all new admissions on a weekly basis to ensure that individualizedplan of care includes one or more of the following: all services provided, allpertinent diagnoses, the patient's mental status, types of services and/orequipment required, frequency and duration of visits, nutritional	

	remedy to reduce swelling), and was not taking folic acid; equipment included a motorized scooter and a semi-electric hospital bed. A document dated 10/12/22, titled "Start of Care" (initial comprehensive assessment) evidenced the patient was a high fall risk, experienced a stroke with dysphagia (difficulty swallowing) and right side affected, had pain that affected ability to transfer/walk, a skin area was identified under the right abdominal fold which required intervention (family applied petroleum jelly and placed a wash cloth under the fold), incontinent of urine, was a moderate nutritional risk, unable to stand, transfer, or walk, and had significant memory loss so that supervision was required. A document received 11/30/22, titled "Home Health Certification and Plan of Care" (start of care date 10/12/22, certification period 10/12/22 - 12/10/22), failed to evidence the patient's diagnoses of seizures, anemia, hypertension, swelling of both lower extremities, or stroke with		treatments, safety measures to protect against injury, therapymodalities specifying length of treatment, and any other appropriate items identifiedby the agency's own policy is present in the clinical record. Weekly reportswill be generated and results will be compiled and sent to the Administrator toensure that processes have improved. This process will continue for each weekfor the next 30 days until 100% compliance is achieved and to maintain this level of compliance, all new staff at the timeof hire will be oriented with this requirement. If compliance is not achievedat the desired target of 100% compliance and if any deficiencies are identifiedwithin 30 days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will	

	dysphagia and right side affected; failed to evidence medications included the patient took 10 mg of Aricept daily (plan of care indicated 5 mg daily), the patient used Voltaren gel (a topical pain reliever), triamcinolone cream, turmeric, and evidenced the patient took folic acid (physician progress note indicated the patient was not taking folic acid); equipment included a motorized scooter and a semi-electric hospital bed; interventions/goals for the skin area identified under the right abdominal fold, incontinence of urine, moderate nutritional risk, unable to stand, transfer, or walk; safety measures included requirement for supervision due to significant memory loss; or mental status included significant memory loss. The plan of care stated, "... Risk of Hospitalization ... Multiple hospitalizations ... in the past 6 months ... Currently taking 5 or more medications ... Patient and caregiver communicate care preferences ... Yes ... Patient and caregiver communicate any specific information about a personal goal(s) the patient would like to achieve from this		continue to audit 20% ofindividualized Plan of Cares in clinical records on a quarterly basis to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	home health admission ... Yes ....", and goals included "demonstrated compliance with medication" and "verbalized pain control". The plan of care also failed to evidence interventions to mitigate risks for hospitalization, the patient's care preferences or personal goal(s), measurable goals, or interventions to mitigate medication compliance or pain relief/control goals. During an interview on 12/06/22 at 2:00 PM, when queried how the patient's plan of care was created, the Clinical Manager stated, "It autogenerates ... We have to add some stuff ... It picks up what it wants ...." During an interview on 12/06/22 at 2:46 PM, the Clinical Manager indicated she expected to see all wound care/treatment orders on the plans of care, treatment provided to Patient #1's abdominal fold, but the EMR didn't pull it over from the comprehensive assessment. When queried about durable medical equipment (DME) and supplies on the plans of care,			

	We don't fill in the DME and supplies [on the plans of care] unless we are actually providing it ... 99% of the time they have their own [supplies to use] ...." The Clinical Manager also indicated all diagnoses should be on the plans of care, but "Joint Commission" (a company contracted by Medicare to ensure federal regulations are met) told us if it's a resolved diagnosis, it doesn't have to be on there (the plan of care); the agency did not obtain copies of advance directives for the clinical record, and there were no patient goals on the plans of care. The Clinical Manager additionally stated, "... The EMR is not good ...." 3. A home visit was observed with Patient #2 and the Clinical Manager on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Manager provided wound care to the patient's left lateral (outside of foot) ankle. Supplies used included normal saline (sterile salt water), collagen pad (used to encourage tissue regeneration), foam adhesive cover dressing, and a compression stocking. Clinical record review for Patient			

	#2 was completed on 12/08/22 (start of care date 8/08/22). A document dated 10/06/22, titled "Recertification (follow up) Assessment" (a comprehensive reassessment) evidenced the patient required daily diabetic foot examinations, edema (swelling) to both lower legs, blood sugar levels were checked daily before breakfast (fasting), blood sugar levels ranged between 70-200 (fasting blood sugar level of 99 or lower is normal), moderate nutritional risk, risk for falls, and the patient had severe shortness of breath/shortness of breath upon exertion. A document titled "Home Health Certification and Plan of Care" for certification period 10/07/22 - 12/05/22, evidenced the patient took levothyroxine (to treat hypothyroidism), duloxetine (to treat depression and anxiety, and is also used for pain caused by nerve damage/pain associated with diabetic peripheral neuropathy), repaglinide (to treat high blood sugar levels in patients with type 2 [adult onset] diabetes), and Eliquis (used to reduce the risk of stroke and blood clot			

	fibrillation [irregular heart rhythm]); and skilled nursing interventions included to teach disease process, diet, home safety/falls prevention, medications, wound care/dressing change. The plan of care failed to evidence diagnoses of hypothyroidism, depression and/or anxiety, diabetic peripheral neuropathy, diabetes with hyperglycemia (high blood sugar levels), or atrial fibrillation. The plan of care failed to evidence supplies included normal saline, collagen pad, foam adhesive cover dressing, or a compression stocking; or the patient's wound care/treatment orders. The plan of care failed to evidence orders for daily diabetic foot examinations (or who performed the examination), interventions to mitigate edema (swelling) to both lower legs, orders to check daily fasting blood sugar levels (or who performed the check), interventions to mitigate high blood sugar levels, interventions			

and risk for falls; interventions to mitigate severe shortness of breath/shortness of breath upon exertion; or any patient stated goals.

During an interview on 12/06/22 at 3:11 PM, when queried if the patient's wound care treatment orders were on the plan of care, the Clinical Manager indicated the plan of care would show to measure it (wound[s]) weekly, the name and location of the wound, and she would expect to see treatment orders on the on the plan of care.

4. Clinical Record review for Patient #3 was completed on 12/08/22. A document received from Entity #10 (hospital based wound clinic) on 12/02/22, dated 9/29/22, titled "Progress Note Details", stated, "... patient was seen today for follow up and management of L [left] groin and L buttock wound ... Patient has a medical history of ... Hypertension [high blood pressure] ... Coronary Artery Disease ... Depression ... Colostomy [an opening into the colon from the outside of the body, to provide a new path for

	body after part of the colon has been removed] ... [patient] ... instructed to check her blood sugars once a day but no diagnosis of [diabetes] ... Wound Assessment(s) ... Left Groin is a full thickness Surgical Wound ... Not Healed ... Left Buttock is ... Stage 2 Pressure Injury [wound with partial-thickness skin loss into but no deeper than the layers of the skin, including intact or ruptured blisters] ... The patient is obese ... Diagnosis ... Other obesity due to excess calories ... Wound Orders ... Left Groin ... Clean wound with Normal Saline – With wound vac [medical device to provide negative pressure wound therapy] ... Change dressing two times weekly ... NPWT [negative pressure wound therapy] Pressure 125 mmHG [millimeters of mercury- a unit of pressure equal to the pressure that can support a column of mercury 1 millimeter high] – Cavilon [medication is used as a moisturizer to treat or prevent dry, rough, scaly, itchy skin and minor skin irritations], benzoin [gum resin used especially in treating skin irritation], duoderm [breathable dressings for the management			

	of light to moderately draining wounds] to periwound [skin areas around outside border of wound]; ... Crushed Flagyl [an antibiotic medication], Promogran [a dressing to maintain a physiologically moist microenvironment at the wound surface, which is conducive to wound healing] to the wound base, white foam to the wound base, black foam into empty space ... Wound ... Left Buttock ... Clean wound with ... soap and water ... Continue using foam and drape as needed for open areas ... Change 3x [3 times] weekly or as needed ... Use wheelchair cushion ... shift position in chair every 15 minutes ... Mattress Overlay/Specialty bed or mattress ... turn every 2 hours ... Dietary ... Increased protein ... 50-60 grams daily for wound healing ... Supplement with a daily multivitamin ... Ensure [nutritional supplement drink] ... Juven powder [powdered nutritional supplement for wound healing] ... orders to Paragon Homecare ... The goal ... is to keep the wound clean and free of ... infections ...." A document titled "Home			

	Care", for certification period 9/28/22 – 11/26/22 evidenced primary diagnosis of multiple sclerosis (a disease that impacts the brain, spinal cord and optic nerves, which make up the central nervous system and controls everything we do); other diagnoses included ulceration of vulva (the outer part of the female genitalia), prediabetes (a serious health condition where blood sugar levels are higher than normal, but not high enough yet to be diagnosed as type 2 diabetes), and ST elevation (STEMI) myocardial infarction (A heart attack with a completely blocked coronary artery). The plan of care failed to evidence other pertinent diagnoses of Hypertension, Coronary Artery Disease, Depression, Left Buttock Stage 2 Pressure Injury, or Other obesity due to excess calories. Medications on the plan of care included Norco (an opioid narcotic medication to treat pain), alpha lipoic acid (a medication used to manage and treat chronic diseases associated with oxidative stress, such as diabetic neuropathy, and slow down the onset of			

	metabolic syndrome [a condition that includes high blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol levels] by acting as an antioxidant), hydrochlorothiazide and lopressor (both to treat high blood pressure), and sertraline (to treat depression). The plan of care failed to evidence medications also included a daily multivitamin, or crushed flagyl, used in wound treatment. Nutritional requirements on the plan of care evidenced a "regular diet" (does not include any dietary restrictions). The plan of care failed to include nutritional/dietary requirements included increased protein intake of 50-60 grams daily for wound healing, use of Ensure nutritional supplement drink, and Juven powdered supplement for wound healing. Interventions on the plan of care included to teach disease process, diet, home safety/fall prevention, signs and symptoms of infection, medications; wound care site was the left groin, measure			

	care/dressing, and suprapubic catheter (a tube inserted in the lower abdomen, directly into the bladder to drain urine) insertion every month. The plan of care failed to evidence skilled interventions to mitigate pain, use of narcotic medications, management of hypertension, coronary artery disease, or depression; methods to reduce obesity, daily blood sugar level monitoring, wound treatment orders for the left groin or left buttock; interventions for assessment/management of suprapubic catheter insertion site or colostomy site; or interventions for prevention of new/worsening skin breakdown. Goals on the plan of care stated "... Stabilization of cardiovascular pulmonary condition by 2 weeks (date) [no date entered] ... Demonstrates competence in following medical regime by 2 weeks (date) [no date entered] ... Demonstrates independence in skin care by end of cert [certification] period (date) [no date entered] ... Wound healing without complications by end of cert [certification] period (date) [no date entered] ...." The plan			

	patient stated goals, Entity #10's wound care goal, or patient-specific measurable outcomes/goals for Multiple Sclerosis, coronary artery disease, hypertension, pain, prediabetes, target fasting blood sugar levels, target weight, infection prevention/control, prevention of new/worsening skin breakdown, or suprapubic catheter and colostomy statuses. During an interview on 12/08/22 at 2:30 PM, the Clinical Manager confirmed the patient went to the wound clinic on 9/29/22, the plan of care (for certification period 9/28/22 – 11/26/22) was still a "draft", and was not yet completed. 5. Clinical Record review for Patient #4 was completed on 12/09/22. A document dated 11/21/22, titled "Recertification (follow up) Assessment", evidenced the patient was a high fall risk, lived in her own house and had no available caregiver; risks for hospital admission included 2 or more falls- or any fall with injury- in the past 12 months, and currently taking 5 or more			

	medications; patient had a stasis ulcer (a wound caused by impaired circulation) of the left medial (inside) lower leg, wound care was provided which included: cleansed with normal saline and patted dry; hydrofera blue pad (provides wound protection and addresses bacteria and yeast) applied to the wound bed, covered with gauze pads, secured with gauze roll and tubigrip (elastic, tubular compression bandage, cut to length); the actual wound care order were to apply a cotton layer wrap over the wound dressing, compression wrap, and coban (a self-adherent elastic wrap), but the patient refused because it was too tight; and had difficulty breathing during routine activities of daily living. A document dated 11/17/22, titled "Progress Note Details" evidenced the patient was seen at Entity #12 (a bone and joint clinic) by Person #13 (a podiatrist who specialized in injury, wound, and diseases of the foot and lower leg); the patient had an unhealed wound on the left, medial lower leg, and an unhealed wound to the left, lateral (outside) lower leg;			

	wound orders included: cleanse with normal saline, apply hydrofera blue to wound bed, cover with gauze and softroll (thick cotton padded roll), wrap with surepress and secure with coban; and nurse to change next week. A document for certification period 11/22/22 - 1/20/23, titled "Home Health Certification and Plan of Care" evidenced the document was a "draft", the patient's primary diagnosis was Hypertensive heart disease with heart failure (heart's problems developed over a long period of time, caused by high blood pressure); other pertinent diagnoses included chronic (long standing) atrial fibrillation, and pleural effusion (fluid accumulation around the lungs due to poor pumping by the heart or by inflammation); skilled nursing was ordered "one visit every other week for monthly lab work"; and risk of hospitalization included the patient currently took 5 or more medications. The plan of care failed to evidence wound diagnoses. Interventions on the plan of			

	care included to evaluate cardiopulmonary status (heart and lung function), nutrition, hydration and elimination; teach disease process, diet, home safety/fall prevention; and monthly INR (a blood test to determine therapeutic drug levels for warfarin/coumadin [blood thinner]). The plan of care failed to evidence skilled interventions to mitigate exacerbation of hypertensive heart disease with heart failure, chronic atrial fibrillation, or pleural effusion; interventions to reduce risk of hospitalization, any wound care/treatment orders, or interventions to prevent new or worsening wounds. Goals on the plan of care stated "... Demonstrates compliance with medication by 2 weeks (date) [no date entered] ... Demonstrates competence in following medical regime by 2 weeks (date) [no date entered] ... Demonstrates independence in skin care by end of cert [certification] period (date) [no date entered] ... Wound healing without complications by end of cert [certification] period (date) [no date entered] .... Aide [Home Health Aide [HHA]) ...			

	Assumes responsibility for personal care needs by end of cert [certification] period (date) [no date entered] ....” The plan of care failed to evidence orders/interventions for a HHA to provide care/services; and failed to evidence patient stated goals, patient-specific measurable outcomes/goals for hypertensive heart disease with heart failure, chronic atrial fibrillation, pleural effusion, or new/worsening wounds. During an interview on 12/09/22 at 1:41 PM, the alternate Clinical Manager stated, "... This plan of care is missing pretty much everything ...." 6. Clinical record review for Patient #5 was completed on 12/09/22 (start of care date 9/06/22). A document dated 9/26/22, titled "Start of Care ...." (the initial comprehensive assessment) evidenced the patient was a high fall risk, lived alone around the clock, lived in a senior living community with no available caregiver, had dysphagia (trouble swallowing), patient checked own fasting blood sugar daily, levels were between 70-150 (99 and below			

	is normal), had a stage 2 pressure injury to the left buttock, and a surgical wound to the abdomen; wound care provided during the visit included: both wounds cleansed with normal saline and patted dry, abdominal wound was packed with wet gauze pads, covered buttock wound with collagen and secured it with a bordered foam bandage, covered the abdominal wound with an abdominal pad and secured it with soft cloth surgical tape; was incontinent of urine, high nutritional risk, and the reason for home care admission was wound care and therapy services. A document dated 7/16/22, with Entity #14 (a hospital) letterhead, titled "Internal Med History and Physical ....", evidenced the patient had a small bowel obstruction, and was admitted to Entity #14 for surgery. A document for certification period 9/06/22 - 11/04/22, titled "Home Health Certification and Plan of Care" evidenced Skilled Nursing, Physical Therapy (PT), and Occupational Therapy (OT)			

	services were ordered, diet was regular with no concentrated sugar, and the patient had wounds to the abdomen and left buttock. Primary diagnosis was pressure ulcer of left buttock, stage 2; other pertinent diagnoses included intestinal obstruction, encounter for surgical aftercare following surgery on the digestive system, and diabetes. Medications on the plan of care included norco for pain, docusate sodium (stool softener), and senna laxative. Interventions on the plan of care included skilled observation for wound care, evaluate nutrition, hydration and elimination, signs and symptoms of infection; teach disease process, diet, home safety/fall prevention, and signs/symptoms of infection; and evaluate wound(s) for healing, measure wound(s) weekly, teach wound care/dressing. The plan of care failed to evidence skilled interventions to mitigate pain, prevent constipation or other bowel complications after surgery, interventions to reduce risk of hospitalization, any			

	wound care/treatment orders, or interventions to prevent new or worsening wounds. During an interview on 12/09/22 at 2:26 PM, the alternate Clinical Manager indicated she expected to see wound care orders for the nurse to follow on the plans of care, as well as all treatments and interventions/teaching specific to the patient, and every time the orders changed, the plans of care should be updated. 7. A home visit was observed with Patient #6 and the Clinical Manager on 12/05/22 from 11:00 AM - 12:05 PM. The patient indicated she was allergic to Penicillin, but didn't see the allergy listed on her home plan of care. The Clinical Manager indicated the EMR didn't always pull things into the plan of care correctly. The patient indicated she went to the wound clinic (Entity #1) about every month, that's who managed her leg wounds, and indicated Person #11 was her primary care physician (PCP), whom she saw in October (2022) for a flu shot. The Clinical Manager performed wound care to each lower extremity,			

	and applied over the counter moisturizer cream to intact skin on both lower legs. The patient complained of pain during the wound care, and indicated she took tramadol (an opioid pain medication for moderate to severe pain). The patient indicated she no longer used triamcinolone cream (used to help relieve redness, itching, swelling, or other discomfort caused by skin conditions) on her lower legs. Wound supplies included normal saline (sterile salt water), gauze pads, hydrofera blue pads (a bacteriostatic dressing), optilock pads (highly absorbent pads) elastic compression wraps, elastic gauze wraps, incontinence pads, and abdominal pads (thick cotton pads to absorb drainage). Equipment included a cane, walker, and wheelchair. Clinical record review for Patient #6 was completed on 12/08/22. A document from Entity #1, dated 9/30/22, titled "Physician Order Details", indicated wound care/treatment frequency for each lower leg was ordered to be done every other day. A document for certification			

	period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced the document was a draft (not completed), skilled nursing was ordered, diagnoses included chronic venous hypertension (a condition that results from weakened lower extremity veins that have lost their ability to return blood to the heart, which causes high blood pressure in the legs), and chronic non-pressure ulcers (wounds caused by insufficient blood flow, or poor circulation) to both lower legs; and allergies included erythromycin (antibiotic) and adhesive tape. The plan of care failed to evidence Entity #1 managed the patients wounds, entity #1 ordered wound care every other day, or allergies also included penicillin. Medications on the plan of care included triamcinolone cream to be applied 3 times daily to both lower legs, milk of magnesia every 6 hours as needed for constipation, and tramadol 3 times daily for pain. The plan of care failed to evidence triamcinolone cream was discontinued, or the patient currently used over the counter			

	moisturizer lotion to both lower legs. Supplies/equipment on the plan of care failed to evidence elastic compression wraps, elastic gauze wraps, incontinence pads, abdominal pads (thick cotton pads to absorb drainage), cane, or wheelchair. Interventions on the plan of care included to evaluate the cardiopulmonary, nutrition, hydration, elimination statuses, and signs/symptoms of infection; teach disease process, diet, home safety/fall prevention, signs and symptoms of infection, medications; wound care site was the left groin, measure wound(s) weekly, teach wound care/dressing. The plan of care failed to include interventions to mitigate pain or constipation, or exacerbation of chronic venous hypertension. Goals on the plan of care stated "... Demonstrates compliance with medication by 2 weeks (date) [no date entered] ... Stabilization of cardiovascular pulmonary condition by 2 weeks (date) [no date entered] ... Demonstrates competence in			

following medical regime by 2 weeks (date) [no date entered] ... Pain controlled at acceptable level by end of cert [certification] period (date) [no date entered] ... Demonstrates independence in skin care by end of cert [certification] period (date) [no date entered] ... Wound healing without complications by end of cert [certification] period (date) [no date entered] ...." The plan of care failed to evidence patient stated goals, or patient-specific measurable outcomes/goals for constipation, exacerbation of chronic venous hypertension, or new/worsening wounds.

During an interview on 12/08/22 at 1:10 PM, the Clinical Manager indicated they didn't do every other day visits because they don't work weekends, the patient was seen by the agency for wound care ordered by the wound clinic (Entity #1), Person #11 was not part of Entity #1, he was the PCP, the plans of care were autogenerated, and stuff was missing.

8. Clinical record review for patient #7 was completed on 12/09/22 (start of care date

	11/09/22). A document dated 10/26/22 titled "Home Care-Start of Care Orders ....", indicated the patient had a new colostomy (a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon to drain waste) placed 10/25/22, port-a-cath (a surgically implanted device which allows easy access to a patient's veins) placement 10/25/22, and had colon cancer. A document dated 11/03/22, titled "Progress Notes", indicated Paragon Home Health Care accepted the patient for services, the patient had a port-a-cath to the left upper chest with steri-strips (porous surgical tape strips used to close small wounds) in place, patient was on a full liquid diet (includes all foods that are liquid or will turn to liquid at room or body temperature), needs included home health care for negative pressure wound treatment, colostomy and Jackson Pratt (JP) drain (a closed-suction medical device that is commonly used as a post-operative drain for collecting bodily fluids from			

surgical sites) care/teaching.

A document titled "Home Health Certification and Plan of Care" (certification period 11/09/22 - 1/07/23) evidenced skilled nursing was ordered; medications included colace (a stool softener) twice daily and ondanestron (to resolve nausea) every 6 hours as needed; supplies included negative pressure wound therapy (NPWT) equipment (a power operated device with a suction pump, tubing and a dressing to remove excess wound drainage and promote healing), but failed to evidence dressing supplies needed for the NPWT; and an ostomy (not specified as colostomy) pouch, but failed to evidence the size of the pouch the patient used, or any other required colostomy supplies to maintain the colostomy. The plan of care failed to evidence the patient had a port-a-cath, or the patient's ordered diet.

Interventions/orders on the plan of care included SN (skilled nurse) for assessment, wound care, ostomy teaching, instruct ostomy care, and monitor JP drain site for signs of infection; and risk of hospitalization; and

	included the patient took 5 or more medications. The plan of care failed to evidence nursing interventions to reduce the risk of hospitalization, for care/management the colostomy, JP drain, or port-a-cath; location of the colostomy, JP drain, or port-a-cath; teaching interventions to prevent colostomy complications, signs and symptoms of the stoma (the surgical opening of the colostomy) that must be immediately reported to nurse/physician, or when to go directly to the emergency department (ED), full liquid diet, mitigation of nausea, how to properly evacuate the JP drain, JP drain precautions, or signs and symptoms of infection to the port-a-cath site. Two goals were evidenced on the plan of care, which stated, "... Patient and significant other will become independent in ostomy care by 12/31/2022 ... Abdomen wound will heal by 12/31/2022 ..." The plan of care failed to evidence patient stated goal(s), or any other goals related to infection prevention/control, patency of the colostomy, removal of the			

	JP drain, dietary advancement, or wound healing. During an interview on 12/09/22 at 2:30 PM, Employee #6 indicated the plan of care and other orders weren't completed or signed by the physician. The alternate Clinical Manager indicated the plan of care was a "hot mess", and it was "missing everything". 9. A home visit was observed with Patient #8 and HHA #1 on 12/07/22 from 11:15 AM - 12:00 PM. The patient was pleasant and confused. The patient's medications were reviewed with family (primary caregiver, who administered all medications), who indicated the medication list on the plan of care was a "super old" medication list, and it was from before she ever had home care, like when she was in the nursing home. Family indicated the patient didn't take norco (narcotic pain relief), or use any skin barrier cream as indicated on the plan of care. Family indicated the patient's current medications included: Aleve (over the counter [OTC], nonsteroidal anti-inflammatory drug used to treat pain) 220 mg (milligrams) with 2 tabs of			

	tylenol 325 mg, both 2-3 times daily, and tramadol 50 mg. Family stated, "... She takes it [tramadol] when it rains ...." Informed family the bottle of tramadol expired 5/17/22. Additional medications included guanfacine (used to treat attention deficit hyperactivity disorder and high blood pressure), esomeprazole magnesium (an anti-acid), Vitamin D3, 1000 IU (International Unit) every morning, senna plus every morning unless loose stools, and humalog sliding scale 100 U (Units)/ml (milliliter): family checked patient's blood sugar level 4 times daily- before meals and bedtime; for blood sugar level less than 60, call physician, 110-125= 1U (Unit), 126-140= 2U, 141-160= 3U, 161-180= 4U, 181-200= 5U, 201-240= 6U, 241-280= 7U, 281-320= 8U, 321-360= 9U, greater than 360= 10U and call physician. Clinical record review for Patient #8 was completed on 12/09/22. A document titled "Home Health Certification and Plan of Care" (certification period 11/09/22 - 1/07/23) failed to evidence the patient's medications included Aleve 220			

	mg with 2 tabs of tylenol 325 mg, both 2-3 times daily, and tramadol 50 mg "when it rains", guanfacine, esomeprazole magnesium, Vitamin D3, 1000 IU every morning, senna plus every morning unless loose stools, and humalog sliding scale 100 U (Units)/ml (milliliter): family checked patient's blood sugar level 4 times daily- before meals and bedtime; for blood sugar level less than 60, call physician, 110-125= 1U (Unit), 126-140= 2U, 141-160= 3U, 161-180= 4U, 181-200= 5U, 201-240= 6U, 241-280= 7U, 281-320= 8U, 321-360= 9U, greater than 360= 10U and call physician. The plan of care failed to evidence the patient's current medication list. During an interview on 12/09/22 at 1:19 PM, the Administrator indicated he expected the nurses to check the patient's medications every visit, and indicated the agency's EMR software wouldn't allow them to update the medication list. The alternate Clinical Manager indicated she expected to see all supplies and equipment on the plans of care, and interventions and goals			

	based on the diagnoses. The Administrator then indicated the EMR was the problem, and the alternate Clinical Manager indicated patient #8's plan of care didn't look good. When queried how the contents of the plans of care were determined, the Administrator indicated he wasn't clinical, so he couldn't answer that. The alternate Clinical Manager indicated the plan of care should be based on the comprehensive assessment and diagnoses.			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the home health agency failed to ensure the patient's plan of care was reviewed by the certifying physician, for 4 of 4 clinical records reviewed where a significant change in condition occurred that required an updated plan of care (#1, 3, 4,	G0588	**Corrective Action:** In order to correct the above deficiencycited, the Administrator and Director of Clinical Services held a managementmeeting on 1/27/2023, reviewed and discussed agency policy 9.10.1 "Plan of Care– CMS #485 and Physician Orders". During this meeting, deficiencies cited underG-0588 citation were reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency's policies pertaining to	2023-02-02

	5); and failed to ensure the patient's plan of care was reviewed by the certifying physician at least every 60 days, for 2 of 4 clinical records reviewed with more than one certification period (#3, 4). Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ... and Physician/Practitioner Orders", indicated each Plan of Care must be signed and dated by the physician, and the plan of care must be established and periodically reviewed every 60 days, or more frequently when indicated by changes in the patient's condition. 2. Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date 10/12/22). A document received 11/30/22, titled "Home Health Certification and Plan of Care" for certification period 10/12/22 - 12/10/22, indicated the document was a "draft", and failed to evidence the patient had a diagnosis of seizures. A document dated 10/18/22, titled “Home Discharge Instructions”, evidenced the		therequirement. Anin-service meeting was conducted by the Director of Clinical Services andattended by all staff, including contracted staff on 2/2/23 to discuss policy “Planof Care – CMS #485 and Physician Orders”. The Director of Clinical Services emphasizedon the importance that the patient's plan of care must be reviewed by the certifyingphysician where a significant change incondition occurred that required an updated plan of care and ensure thepatient's plan of care must be reviewed by the certifying physician at leastevery 60 days. Citations listed in the clinical record reviews were addressed. Allstaff were re-educated on the requirement. All staff will understand andacknowledge the requirement and the need for the plan of care to be reviewed bycertifying physician where a significant change in condition occurred, requiring anupdated plan of care and for the plan of care to be reviewed by the certifyingphysician at least every 60 days.. All new employees will be oriented ofthis requirement at the time	

	patient was hospitalized at Entity #10 from 10/15/22 – 10/18/22, for seizures. This document evidenced the patient experienced a significant change in condition which required an updated plan of care. A document received 12/02/22, titled "Home Health Certification and Addendum to Plan of Care" for certification period 10/12/22 - 12/10/22, evidenced the document was a “draft”, the resumption of care date was 10/19/22, and failed to evidence the document was completed, signed by an agency licensed skilled professional, or by the certifying physician. During an interview on 12/06/22 at 1:47 PM, the Administrator indicated there were no signed orders from any physician for Patient #1. During an interview on 12/06/22 at 2:00 PM, when queried what was considered to be the updated plan of care, the Clinical Manager stated "... We get orders and they stay separate from the plan of care ...." When queried how the patient's plan of care was		of hire. This corrective action will beimplemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services will utilizea chart audit tool to ensure that all active patient records for patientsreceiving home health services show evidence that the patient's plan of care is reviewedby the certifying physician where asignificant change in condition occurred that required an updated plan of care and ensure the patient's plan of care be reviewed by the certifyingphysician at least every 60 days. This process of utilizing active chartaudit tool on all active patients will help us ensure that the policy is beingfollowed and identify any discrepancies in the clinical records and re-educateall staff of the above mentioned requirement. **Monitoring:**	

	created, the Clinical Manager stated, "It autogenerates ... We have to add some stuff ... It picks up what it wants ...." 3. Clinical record review for Patient #3 was completed on 12/08/22 (start of care date 1/31/22). The EMR evidenced a document titled "Home Health Certification and Plan of Care" for recertification period 4/01/22 – 5/30/22, which was signed by the certifying physician and received by the agency on 5/31/22. The EMR failed to evidence any subsequent Plans of Care were completed or sent to the certifying physician. Documents titled "Home Health Certification and Plan of Care", for certification periods 5/31/22 – 7/29/22, 7/30/22 – 9/27/22, 9/28/22 – 11/26/22, and 11/27/22 – 1/25/23, indicated they were "In Progress". A document received from Entity #1 on 12/02/22, dated 10/17/22, titled "Discharge Summary", evidenced the patient was hospitalized from 10/10/22 – 10/17/22, due to a new infected wound, and osteomyelitis (inflammation of		In order to ensure implementationand effectiveness of this corrective action, the following monitoring processwill be put in place, the Director of Clinical Services will utilize a chartaudit tool and audit 100% of all active patient records on a weekly basis toensure that the patient's plan of care is reviewed by the certifying physician where a significant change in conditionoccurred that required an updated planof care and ensure the patient's plan ofcare be reviewed by the certifying physician at least every 60 days. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each week for thenext 30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed	

	bone caused by infection). This document evidenced the patient experienced a significant change in condition and required an updated plan of care. A document dated 10/18/22, titled “Medical Authorization/Verbal Order”, evidenced the order was written by Person #15, who wasn’t the Patient’s certifying physician. The order indicated the patient had a peripherally inserted central catheter (PICC) line (long catheter that is inserted through a peripheral vein, often in the arm, into a larger vein in the body, used when intravenous treatment is required over a long period). Orders included use/management of the PICC line, intravenous (IV) antibiotics to be administered at least daily from 10/18/22 through 11/29/22, and weekly lab draws. This document also evidenced the patient experienced a significant change in condition which required an updated plan of care. A document received on 12/08/22, not signed/dated by agency staff, titled "Home		with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Director of Clinical Serviceswill be responsible for corrective action of this deficiency, measure to assureno recurrence and monitoring of this deficiency.	

	Addendum to Plan of Care", evidenced the document was a "draft", the resumption of care date was 10/18/22, and indicated it was "In Progress". During an interview on 12/08/22 at 2:30 PM, the Clinical Manager indicated documents marked in the EMR as "drafts" and/or "In Progress" were incomplete documents, and were not yet sent to the physician for review/signature. 4. Clinical Record review for Patient #4 was completed on 12/09/22 (start of care date 1/26/22). A document dated 9/21/22, titled "Recertification", stated, "... wounds have healed ... discharged from wound clinic ...." A document for certification period 9/23/22 – 11/21/22, titled "Home Health Certification and Plan of Care" failed to evidence the patient had any wounds. A document dated 10/19/22, titled Skilled Nurse Visit", indicated the patient had a new venous stasis ulcer (a wound caused by impaired circulation). This document evidenced the patient experienced a			

	significant change in condition which required an updated plan of care. The EMR failed to evidence an updated plan of care. A document dated 10/19/22 at 10:59 PM, titled “Change Visit Frequency”, stated, “... Physicians Orders ... change the SN [skilled nursing] frequency to 3 times a week ... for wound care to the [left] lower limb for venous stasis ulcer ....” The EMR failed to evidence the order was sent to, or signed by the certifying physician. A document dated 11/21/22, titled “Recertification" indicated the skilled nurse performed wound care/treatment to the patient’s left lower leg stasis ulcer. A document received 11/30/22, for certification period 11/22/22 - 1/20/23, titled "Home Health Certification and Plan of Care" evidenced the document was a “Draft”, failed to evidence signatures from a licensed skilled professional or the certifying physician, and failed to evidence it was sent to the certifying physician; and failed to evidence the plan of care was			

	updated to include diagnosis of venous stasis ulcer, increased nursing visit frequency, or any wound care orders. During an interview on 12/09/22 at 1:41 PM, Employee #6 indicated the plan of care and other orders in the EMR were incomplete and that's why they haven't been sent to the physician for review/approval and signature. 5. Clinical record review for Patient #5 was completed on 12/09/22 (start of care date 9/06/22). A document received from Entity #14 (a hospital) on 12/08/22, titled "Medical Chart Patient Admission", evidenced the patient was admitted 9/21/22, discharged 9/22/22, and stated, "... Admitting Diagnosis ... Acute [sudden onset] Hypotension [low blood pressure] ... AFib [atrial fibrillation, an irregular heart rhythm] ...." A document received from Entity #14 on 12/08/22, titled "Discharge Summary", evidenced the patient required emergent treatment for cardiac conditions and medications			

	evidenced the patient experienced a significant change in condition which required an updated plan of care. A document for certification period 9/06/22 - 11/04/22, titled “Home Health Certification and Addendum to Plan of Care”. The EMR evidenced the document was “In Progress”, and failed to evidence it was sent to the certifying physician. During an interview on 12/09/22 at 2:26 PM, the alternate Clinical Manager indicated the plan of care should be updated with new frequency orders, and every time the orders changed, the plans of care should be updated.			
N0604	Scope of Services 410 IAC 17-14-1(m) Rule 14 Sec. 1(m) The home health aide must report any changes observed in the patient's conditions and needs to the supervisory nurse or therapist.	N0604	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policy	2023-02-17

	Based on observation, record review, and interview, the Home Health Aide (HHA) failed to report changes in the patient's personal care needs to the Clinical Supervisor for 1 of 1 home visit observed with a HHA (#8). Findings include: An agency job description with revised date 2008, titled "Home Health Aide", stated "... Responsibilities ... Performs personal care and bath as ordered ... Reports changes in the patient's condition and needs to the RN [Registered Nurse] ...." Clinical record review for Patient #8 was completed on 12/09/22 (start of care date 8/11/22). A document dated 10/05/22, titled "Home Health Aide Care Plan", indicated tasks assigned by the RN to be completed every HHA visit included shampoo hair and nail care. A document dated 12/07/22, titled "Home Health Aide Visit Record", failed to evidence the		titled4.11.1 “Home Health Aide Supervision”. During this meeting, deficiencies citedunder N-0604 citation were reviewed and discussed in detail.	

	hair, or performed nail care; and failed to evidence the RN was notified. A home visit was observed with Patient #8 and HHA #1 on 12/07/22 from 11:15 AM - 12:00 PM. The Patient indicated she was freezing cold, and did not want her hair washed. HHA #1 did not wash the patient's hair or perform nail care. During an interview on 12/09/22 at 1:19 PM, the alternate Clinical Supervisor indicated the HHA should be doing everything on the aide care plan, the HHA should notify the RN if something on the care plan wasn't completed, and it should be documented; indicated the HHA failed to document nail care or shampoo hair; and indicated the HHA should document if the patient refused a task ordered on the aide plan of care, document the reason why the patient refused, and document the nurse was notified.		Anin-service meeting was conducted by the Director of Clinical Services andattended by all staff, including home health aide staff and contracted staff on2/2/23 to discuss policy of "Home Health Aide Supervision". The Director ofClinical Services emphasized on the importance that the home health aide staff must report anychanges observed in the patient's conditions and personal care needs to the supervisorynurse or therapist. Citations listed in the clinical record reviews wereaddressed. All staff were re-educated on the requirement. Allstaff understood and acknowledged the requirement that the homehealth aide staff must report any changes observed in the patient's conditionsand personal care needs to the supervisory nurse or therapist. All newemployees will be oriented of this requirement at the time of hire. Thiscorrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there	

			isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active patient records show evidence that the home health aide staff reported any changesobserved in the patient's conditions and personal care needs to the supervisorynurse or therapist. This process of utilizing active chart audit tool onall active patients will help us ensure that the policy is being followed andidentify any discrepancies in the clinical records and re-educate all staff ofthe above mentioned requirement. **Monitoring:** In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place, the Directorof Clinical Services will utilize a chart audit tool and audit 100% of all activepatient records on a weekly basis to ensure that the homehealth aide staff reported any changes	

			conditions andpersonal care needs to the supervisory nurse or therapist. Weekly reports will be generatedand results will be compiled and sent to the Administrator to ensure thatprocesses have improved. This process will continue for each week for the next30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The	

			Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0608	Clinical Records 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care.	N0608	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policy titled11.1.1 "Medical Record Content". During this meeting, deficienciescited under N-0608 citation were reviewed and discussed in detail. The Administrator and Director ofClinical Services has completed re-orientation of agency's policies pertainingto therequirement. Anin-service meeting was	2023-02-17

	(6) A discharge summary. Based on record review and interview, the home health agency failed to ensure the patient's clinical record contained one or more of the following: all clinical documents, the name of the patient's certifying physician, signed and dated clinical notes that were completed the day service was rendered, and/or a discharge summary; a copy of the patient's advance directive, the name of the patient's power of attorney and/or healthcare power of attorney, and results of all diagnostic tests performed for 8 of 8 clinical records reviewed (#1, 2, 3, 4, 5, 6, 7, 8). Findings include: 1. An agency policy with revised date February 2022, titled "Medical Record Content", stated, "... The Agency will provide an accurate and current medical record for every patient ... All entries in the patient record must also be timed ... Physician's/Practitioner's name and referral source ... copy of advance directive ... name of power of attorney and/or		conducted by the Director of Clinical Services andattended by all staff, including contracted staff on 2/2/23 to discuss policyof " Medical Record Content ". The Director of Clinical Services emphasizedon the importance that the patient's clinical records contain one or moreof the following: all clinical documents, the name of the patient's certifyingphysician, signed and dated clinical notes that were completed the day servicewas rendered, and/or a discharge summary; a copy of the patient's advancedirective, the name of the patient's power of attorney and/or healthcare powerof attorney, and results of all diagnostic tests performed. Citations listed inthe clinical record reviews were addressed. All staff were re-educatedon the requirement. All staff understood and acknowledged the requirement thatthe patient'sclinical records contain one or more of the following: all clinical documents,the name of the patient's certifying physician, signed and dated clinical notesthat were completed the day service was rendered, and/or a discharge summary; acopy of the patient's advance directive, the name of	

	healthcare power of attorney ... Initial and ongoing assessments ... Results of all diagnostic ... tests performed ... A completed discharge summary when patient is discharged from the agency ...." 2. Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date 10/12/22, discharge date 11/28/22). A document received 11/30/22, titled "Home Health Certification and Plan of Care" for certification period 10/12/22 - 12/10/22, Skilled Nursing was ordered weekly for 9 weeks, Home Health Aide (HHA) services were ordered twice weekly for 8 weeks, the patient's Advance Directives included a living will and a DNR ("Do Not Resuscitate"). The EMR failed to evidence a HHA Care Plan, or copies of the DNR and living will. A document dated 10/14/22, titled "Transferred to an inpatient facility ....", stated, "... Status ... In Progress ...." The document was not completed, or signed and dated by a clinician. A document dated 10/19/22,		the patient's power ofattorney and/or healthcare power of attorney, and results of all diagnostictests performed. All new employees will be oriented of this requirement at thetime of hire. This corrective action will be implemented effective 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active patient records show evidence that the patient's clinical records contain oneor more of the following: all clinical documents, the name of the patient'scertifying physician, signed and dated clinical notes that were completed theday service was rendered, and/or a discharge summary; a copy of the patient'sadvance directive, the name of the patient's power of attorney and/orhealthcare power of attorney, and results of all diagnostic tests performed.This process of utilizing active chart audit tool on all active patients willhelp us	

	titled "Resumption of care", ...", stated, "... Status ... In Progress ...." The document was not completed, or signed and dated by a clinician. A document dated 10/19/22, titled "Home Health Certification and Addendum to Plan of Care", indicated Person #7 was the patient's certifying physician, and stated, "... Draft ...." The document was not completed, or signed and dated by a clinician. A document dated 11/28/22, titled "... Discharge from agency", stated "... Status ... In Progress ...." The document was not completed, or signed and dated by a clinician. During an interview on 12/06/22 at 1:47 PM, Employee #6 indicated Patient #1 was the patient who had a different physician than was listed in the EMR and clinical documents, Person #7 sent all orders back, and said he wasn't the patient's physician. When queried who was the patient's actual physician, Employee #7 indicated she didn't know, and stated, "... I still have not contacted the patient to find		ensure that the policy is being followed and identify any discrepanciesin the clinical records and re-educate all staff of the above mentionedrequirement. **Monitoring:** In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place, the Directorof Clinical Services will utilize a chart audit tool and audit 100% of all activepatient records on a weekly basis to ensure that the patient'sclinical records have documented evidence of all applicable clinical documents,the name of the patient's certifying physician, signed and dated clinical notesthat were completed the day service was rendered, and/or a discharge summary; acopy of the patient's advance directive, the name of the patient's power ofattorney and/or healthcare power of attorney, and results of all diagnostictests performed. Weeklyreports will be generated	

	out ...." When queried how long the agency was aware that Person #7 wasn't Patient #1's physician, Employee #6 stated, "... I'd say about November [2022] ...." As of 12/06/22, the EMR failed to evidence the patient's actual physician's name. During an interview on 12/06/22 at 2:00 PM, the Clinical Supervisor indicated she previously saw HHA Care Plan in the electronic medical record (EMR) for Patient #1, but could not find it now. Upon survey exit, nothing further was submitted for review. During an interview on 12/06/22 at 2:00 PM, the Clinical Supervisor indicated the last page of the discharge comprehensive assessment was the discharge summary. During an interview on 12/06/22 at 2:46 PM, the Clinical Supervisor stated, "... No, we don't have a copy of the DNR ... We don't get copies of Advance Directives ...." 3. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document titled "Home Health Certification and Plan of Care" for certification period 10/07/22 - 12/05/22,		and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified within 30days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations.	

N0612	Clinical Records 410 IAC 17-15-1(b) Rule 15 Sec. 1(b) Original clinical records shall be retained for the length of time as required by IC 16-39-7 after home health services are terminated by the home health agency. Policies shall provide for retention even if the home health agency discontinues operations. Based on record review and interview, the home health agency failed to retain all patients' clinical records for 7 years, for 10 of 10 random patients sampled without clinical record review (#10, 11, 12, 13, 14, 15, 16, 17, 18, 19), and per the agency's own admission, 1 of 1 active patient records reviewed with missing clinical record documents (#4). Findings include: 1. An agency policy with revised date February 2022, titled "Medical Record Content", stated, "... The Agency will ... maintain an individual and accurate medical record for each patient ... in compliance with all federal/state laws and regulations ...." The policy failed	N0612	**CorrectiveAction:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/2023, the Governing Body,Administrator and Director of Clinical Services reviewed, discussed the agencypolicy 11.1.1 titled "Medical Record Retention" under Record of Care,Treatment and Services Section. During this meeting, deficiencies cited under N-0612were reviewed, addressed and discussed in detail. The Administrator has completed re-orientationof agency's policies pertaining to Medical Record Retention. TheAdministrator has also updated the Medical Record Retention policy toreflect Indiana'srequirement to retain medical records for 7 years. The Administrator has alsogained access to the previous EMR to ensure availability of medical records. An in-service meeting was conducted by the Governing Body andwill be attended by the Administrator, Director of Clinical Services and all	2023-02-17

	requirement to retain medical records for 7 years. 2. An agency policy with revised date October 2017, titled "Medical Record Retention", stated, "... patient medical records are retained minimally for five (5) years after the discharge of the patient, unless state law stipulates a longer period of time ...." 3. During an interview on 11/30/22 at 11:15 AM, the Clinical Supervisor indicated the home health agency was required to store medical records for 7 years. 4. On 12/09/22 at 1:01 PM, the home health agency's "On-Call Log" was submitted for review. Dates reviewed were 2/06/21 to 12/09/22, with the newest entry dated 7/10/21. Patients #10, 11, 12, 13, 14, 15, 16, 17, 18, and 19 were documented by name with concerns, but clinical records for patients #10-19 were not evidenced in the agency's electronic medical record (EMR) software. 5. During an interview on 12/06/22 at 1:09 PM, Person #7 submitted referral information for Patient #4 and indicated the		staffincluding contracted personnel on 2/2/23 to discuss the agency policy 11.1.1titled "Medical Record Retention" under Record of Care, Treatment andServices Section During this meeting, deficiencies cited under N-0612 werereviewed, addressed and discussed in detail with all staff. The Governing Body emphasizedon the importance of the requirement that the all patients' clinical records mustbe retained for 7 years. All staff understood and acknowledged theagency's policy pertaining to medical record retention. All new staffwill be oriented of this requirement at the time of hire. This corrective action will be implementedon 2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there is norecurrence of this deficiency, the Governing Body will utilize an Administrationaudit tool to ensure that the all patients' clinical records must beretained for 7 years as perpolicies and guidelines. This process of utilizing Administration audit toolwill help us identify any	

	dates would be wrong, because when they switched from Entity #5 to Entity #6 about a year ago, they had to enter Patient #4 as a new admit, and had no older clinical records for Patient #4. Patient #4's referral documents submitted on 12/06/22, evidenced a physician order dated 10/28/21, for home health nursing services. 6. During an interview on 12/06/22 at 1:09 PM, when queried if the agency had access to clinical records stored within Entity #5's software, the Administrator indicated the agency did not, and could only get access to the medical records if he paid additional money. 7. Clinical record review for Patient #4 was completed on 12/09/22. A document dated 1/26/22, titled "Home Health Certification and Plan of Care" evidenced the patient's start of care date was 1/26/22. The EMR failed to include any clinical records prior to 1/26/22. 8. During an interview on 12/09/22 at 2:51 PM, when queried why Patients' #10, 11,		discrepancies and implement corrective measures andassess outcomes. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Governing Body willutilize an Administration audit tool and audit 100% of Administration records forthe next 30 days to ensure that all patients' clinical records must beretained for 7 years as per policy and guidelines and document thefindings in the Administration audit tool. The QAPI Committee willreview audit findings of Administration records. Monthly reports will begenerated and results will be compiled and sent to the Administrator andGoverning Body to ensure that processes have improved. This process willcontinue for each month for the next 3 months until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement.	

	12, 13, 14, 15, 16, 17, 18, and 19's clinical records weren't evidenced in the home health agency's current EMR software, the Administrator indicated he had no access to those medical records, as they were from the previous EMR company.		If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified withinthe next 3 months, they will continue to be addressed with staff re-trainingand re-education in workshops and in-services and with each individualpersonnel as needed. After 3 months, this process will continue to be monitoredon a quarterly basis and will be included in the quarterly Administration auditreview. Quarterly audits results will be compiled and sent to the QAPI Committeefor review. Once threshold is met, the QAPI Committee will continue to audit100% of Administration records quarterly to ensure compliance is maintained.The QAPI Committee will send a written report to the Governing Body quarterlyfor their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	

N0614	Clinical Records 410 IAC 17-15-1(c) Rule 15 Sec. 1(c) Clinical record information shall be safeguarded against loss or unauthorized use. Written procedures shall govern use and removal of records and conditions for release of information. Patient's written consent shall be required for release of information not authorized by law. Current service files shall be maintained at the parent or branch office from which the services are provided until the patient is discharged from service. Closed files may be stored away from the parent or branch office provided they can be returned to the office within seventy-two (72) hours. Closed files do not become current service files if the patient is readmitted to service. Based on observation, record review, and interview, the home health agency failed to ensure it safeguarded all patients' clinical record information against loss or unauthorized use. Findings include: An agency policy with revised date March 2018, titled "Patient Confidentiality", stated, "... Home care records will not be left in unattended areas in the office, e.g., the reception area.	N0614	**CorrectiveAction:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/2023, the Governing Body,Administrator and Director of Clinical Services reviewed, discussed the agencypolicy 6.4.1 titled "Patient Confidentiality" under InformationManagement Section. During this meeting, deficiencies cited under N-0614 werereviewed, addressed and discussed in detail. The Administrator has completedre-orientation of agency's policies pertaining to Patient Confidentiality. TheAdministrator has placed all clinical records in metal locked filing cabinets. An in-service meeting was conducted by the Governing Body andattended by the Administrator, Director of Clinical Services and all staffincluding contracted personnel on 2/2/23 to discuss the agency policy 6.4.1titled "Patient Confidentiality" under Information Management Section.During this meeting,	2023-02-17

	kept stored in metal file cabinets to minimize the possibility of damage from fire and water. Charts will be protected against unauthorized corruption, damage, and/or intrusion ... all home care records will be maintained in metal locked filing cabinets or locked file room ...." On 11/30/22, 12/01, 12/05, 12/06, 12/07, 12/08, and 12/09 (2022), observed 3 bankers boxes stacked on the floor next to the wall in the main reception area of the home health agency. The boxes were not in locked cabinets. During an interview on 12/09/22 at 2:50 PM, when queried of the 3 bankers boxes contents, the Administrator lifted the lid of the topmost box and indicated all 3 boxes contained old patient discharged records, and he needed to put them away. Observed the box with the lid removed, which contained file folders with patient names and clinical documents.		deficiencies cited under N-0614 will be reviewed,addressed and discussed in detail with all staff. The Governing Body willemphasize on the importance that the clinical records, its contents, and the informationcontained therein must be safeguarded against loss or unauthorized use. Allstaff understood and acknowledged the agency's policy pertaining to safeguardingall patients' clinical record information against loss or unauthorized use.All new staff will be oriented of this requirement at the time of hire. This corrective action will be implementedon 2/17/2023. **Measuresto assure No recurrence:** In order to ensure that there is norecurrence of this deficiency, the Governing Body will utilize anAdministration audit tool to ensure that the clinical records, its contents, andthe information contained therein must be safeguarded against loss or unauthorizeduse. as per policies and guidelines. This processof utilizing	

			help us identify any discrepanciesand implement corrective measures and assess outcomes. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Governing Body willutilize an Administration audit tool and audit 100% of Administration records forthe next 30 days to ensure that the clinical records, its contents, and theinformation contained therein must be safeguarded against loss or unauthorizeduse as per policy and guidelines and document the findings in theAdministration audit tool. The QAPI Committee will review audit findingsof Administration records. Monthly reports will be generated and results willbe compiled and sent to the Administrator and Governing Body to ensure thatprocesses have improved. This process will continue for each month for the next3 months until 100% compliance is achieved and to maintain this level ofcompliance	

			all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within the next 3 months, theywill continue to be addressed with staff re-training and re-education inworkshops and in-services and with each individual personnel as needed. After 3months, this process will continue to be monitored on a quarterly basis andwill be included in the quarterly Administration audit review. Quarterly auditsresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the QAPI Committee will continue to audit 100% of Administrationrecords quarterly to ensure compliance is maintained. The QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. The Administrator will be responsible for corrective actionof this deficiency,	

			recurrence and monitoring of thisdeficiency.	
G0680	Infection prevention and control 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. Based on observation, record review, and interview, the Administrator failed to ensure agency personnel followed infection control precautions for the prevention/control of infection/communicable disease (Please see tag G0682); and failed to track and document the COVID-19 vaccination status of all agency personnel, and/or track and document if agency personnel received any COVID-19 booster doses (Please see tag G0687). This practice had the potential to affect all patients serviced by the agency. The cumulative effect of these systemic problems resulted in the home health agency's	G0680	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/23 and reviewed, discussed the agency policy "COVID-19Vaccine Mandate Policy". During this meeting, deficiencies cited under G-0680were reviewed, addressed and discussed in detail. Anin-service meeting was conducted by the Administrator and attended by all staffincluding contracted personnel on 2/2/23 to discuss "COVID-19 VaccinationPolicy". The Administrator emphasized on the importance that the home healthagency staff are fully vaccinated and that all required staff have received theapplicable vaccine prior to providing care, treatment or services for theAgency and/or its patients or have exemption for COVID-19 vaccination(s)documentation in	2023-02-02

	of quality health care in a safe environment for the Condition of Participation 42 CFR §484.70: Infection Prevention and Control.		their personnel files. Deficiencies cited under G-0680 werereviewed, addressed and discussed in detail with all staff. All staff understoodand acknowledged the requirement. All active staff or newly hired staff will provideand the agency will maintain acceptable proof/documentation of vaccinationstatus which includes the employee's name, type of vaccination administered,date(s) of administration and name of the healthcare professional(s) or clinic site(s)that administered the vaccine(s), any COVID-19 booster doses and have proof ofexemption for COVID-19 vaccination(s). This corrective action will beimplemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is no recurrence of thisdeficiency, the HR Manager will utilize a HR audit tool to track and documentthat all active staff is fully vaccinated and that all required staff hasreceived the applicable vaccine booster	

			care,treatment or services for the Agency and/or its patients or have proof of exemptionfor COVID-19 vaccination(s). This process of utilizing HR audit tool for staffwill help us track and identify any discrepancies in the personnel file recordsand enforce all staff to have their files completed and up to date beforeproviding care to our patients or services to our agency. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizea HR audit tool and audit 100% of all personnel file records on a monthly basisto ensure that all active personnel file records show evidence of acceptableproof/documentation of full vaccination status which includes the employee'sname, type of vaccination administered, date(s) of administration and name ofthe healthcare professional(s) or clinic site(s)	

			any COVID-19 booster doses and have proof of exemption for COVID-19vaccination(s). The Office Manager will review HR Manager's audit findings ofall active personnel file records. Monthly reports will be generated andresults will be compiled and sent to the Administrator to ensure that processeshave improved. This process will continue for each month for the next 3 monthsuntil 100% compliance is achieved and to maintain this level of compliance allnew employees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within the next 3 months, they will continue to beaddressed with staff re-training and re-education in workshops and in-servicesand with each individual personnel as needed. After 3 months, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly HR audit review. Quarterly audits results will be compiled and sentto the QAPI Committee for review. Once threshold is met, the QAPI Committeewill	

			continue to audit 100% of personnel file records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.	G0682	**CorrectiveAction:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/2023, the Administrator,Director of Clinical Services and Alternate Director of Clinical Services reviewed,discussed the agency policies 5.4.1 titled "Exposure Control Plan: OSHA [TheOccupational Safety and Health Administration] Regulations", 5.7.1 titled "HandHygiene Policy and Compliance Program" 5.14.1 titled “Supply Maintenance” and5.21.1 titled “COVID-19	2023-02-02

	Based on observation, record review, and interview, the Administrator failed to ensure agency personnel followed infection control precautions for the prevention/control of infection/communicable disease for 3 of 3 home visits observed (Patient #2, 6, 9). Findings include: 1. An agency policy with revised date July 2021, titled "Exposure Control Plan: OSHA [The Occupational Safety and Health Administration] Regulations", stated, "... All solutions will be checked for expiration date prior to use ... Other disposable ... solution containers will be discarded after use ...." 2. An agency policy with revised date July 2021, titled "Hand Hygiene Policy and Compliance Program", stated, "... When using [hand sanitizer] ... the procedure is as follows ... Place adequate amount ... on hands ... Using friction, clean ... until hands are completely dry ...." 3. An agency policy dated February 2022, titled "COVID-19 Vaccine Mandate Policy", stated, "... If an employee ... is not fully		Vaccine Mandate Policy" under Infection Preventionand Control section. During this meeting, deficiencies cited under G-0682 werereviewed, addressed and discussed in detail. Anin-service was conducted by Alternate Director of Clinical Services on 2/2/23 andattended by the Administrator, Director of Clinical Services with all fieldstaff including therapy staff. During the meeting, the Alternate DCS discussedthe importance of the requirement that hand hygiene, using correct technique. Citationlisted in the site visit were addressed with the field staff. Based on thedeficiency listed, the Alternate DCS reiterated agency's policy, "HandHygiene Policy and Compliance Program 5.7", states that the agency willfollow the Centers for Disease Control and Prevention (CDC) guidelines for handhygiene: Put enough sanitizer on your hands to cover all surfaces ... Rub yourhands together until they feel dry (this should take around 20 seconds) andagency policy "Supply Maintenance" to ensure that the supplies used are markedwith the date they were originally	

	... Use a NIOSH [National Institute of Occupational Safety and Health]-approved N95 or equivalent or higher-level respirator ...." 4. Review of a CDC web base reference on 12/05/22, updated 8/10/21, https://www.cdc.gov/handwashing/hand-sanitizer-use.html, titled "Hand Sanitizer Use Out and About", stated, "... Put enough sanitizer on your hands to cover all surfaces ... Rub your hands together until they feel dry (this should take around 20 seconds) ...." 5. A home visit was observed with Patient #2 and the Clinical Manager on 12/05/22 from 2:15 PM - 3:00 PM. Observed the Clinical Manager cleanse the patient's wound with a bottle of previously opened normal saline (NS, sterile salt water). The bottle was not marked with the date it was originally opened (NS should be discarded within 28 days of being opened). During an interview on 12/05/22 at 2:40 PM, the Clinical Manager indicated the		opened, or discarded after use. All staff understoodand acknowledged the significance of ensuring that they follow proper Handtechnique and accepted infection control practices must be followed as perguidelines and all field staff will be able to demonstrate it as well. All new staffwill be oriented of this requirement at the time of hire. Thiscorrective action will be implemented effective 2/2/23. **Measuresto assure No recurrence:** In order to ensure that there is norecurrence of this deficiency, the Alt DCS will utilize a supervisory visitaudit tool to ensure that hand hygiene techniques and supplies maintenancepolicy followed by all field staff. This process of utilizing supervisory visitaudit tool on all staff will help us identify any discrepancies in the supervisoryvisits pertaining to staff compliance and re-educate all staff includingcontracted personnel on the above mentioned requirement.	

	wasn't sure when, it wasn't marked, and it "usually lasts around 2 weeks". 6. A home visit was observed with Patient #6 and the Clinical Manager on 12/05/22 from 11:00 AM - 12:00 PM. The Clinical Manager perform hand hygiene with hand sanitizer for 8 seconds, hands remained wet, and she reached into her nursing bag to remove a manual blood pressure cuff. At 11:24 AM, the Clinical Manager removed the soiled dressing from the patient's right lower leg, failed to perform hand hygiene, removed the soiled dressing from the patient's left lower leg, performed hand hygiene for 10 seconds, hands remained wet, and reached into shirt pocket to retrieve clean gloves. Neither of the patient's intact skin on the lower legs was cleansed after removal of old dressings, or prior to application of moisturizing cream. At 11:36 AM, the Clinical Manager performed hand hygiene for 11 seconds, put her wet hand into her pocket, and donned gloves with difficulty. The Clinical Manager sprayed a commercial bottle labeled "Wound Cleanser" onto a		**Monitoring:** In orderto ensure implementation and effectiveness of the corrective action, thefollowing monitoring process will be put into place. The Alternate DCS will dorandom supervisory visits on all field staff every 2 weeks to monitor andensure that all staff is following the policy for hand hygiene techniques andsupplies are marked with the date it was originally opened, or discarded afteruse. This process will continue for the next 3-6 months until 100% compliance is achieved and to maintain this level of compliance all new employees at thetime of hire will be oriented with this policy. If compliance is not achievedat the desired target of 100% compliance, the Alternate DCS will provide re-educationof “Hand hygiene and compliance program” and “Supply Maintenance” Policy andprocedure in in-service to all field staff and provide individual training toall field staff including therapy staff that are not in compliance. TheInfection Control Committee will analyze	

	hydrofera blue dressing (a bacteriostatic dressing), and indicated the bottle was not filled with wound cleanser, it was actually NS she previously opened and poured into the used wound cleanser bottle. 7. A home visit was observed with Patient #9 and Home Health Aide (HHA) #1 on 12/07/22 from 11:00 AM - 12:15 PM. HHA #1 wore a disposable paper mask during the home visit. Personnel record review for HHA #1 was completed on 12/01/22, which failed to evidence proof HHA #1 was vaccinated for COVID-19. During an interview on 12/01/22 at 12:10 PM, Employee #6 and the Clinical Manager both indicated HHA #1's personnel record failed to include proof HHA #1 was fully vaccinated for COVID-19.		and track data from infection controlsurveillance system and trend the field staff that are not compliant with “Handhygiene and compliance program” “Supply Maintenance” Policy and procedure asmandated. The Administrator will conduct a meeting with the Clinical Managementteam, Infection Control Committee and field staff to discuss the process. Ifnon-compliance continues, the agency will no longer provide patients tonon-compliant field staff until acceptable level of compliance is demonstratedand is achieved by the field staff. Once threshold is met the QAPI Committeewill continue to audit 20% of supervisory visits quarterly to ensure complianceis maintained. The Administrator and QAPI Committee will send a written reportto the Governing Body quarterly for their recommendations. The Alternate DCS will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	

G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and	G0687	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/23 and reviewed, discussed the agency policy "COVID-19Vaccine Mandate Policy". During this meeting, deficiencies cited under G-0687were reviewed, addressed and discussed in detail. Anin-service meeting was conducted by the Administrator and attended by all staffincluding contracted personnel on 2/2/23 to discuss "COVID-19 VaccinationPolicy". The Administrator emphasized on the importance that the home healthagency staff are fully vaccinated and that all required staff have received theapplicable vaccine prior to providing care, treatment or services for theAgency and/or its patients or have exemption for COVID-19 vaccination(s)documentation in their personnel files. All staff understood and acknowledgedthe requirement.	2023-02-02

	(ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status		All active staff or newly hired staff will provide and theagency will maintain acceptable proof/documentation of vaccination status whichincludes the employee's name, type of vaccination administered, date(s) ofadministration and name of the healthcare professional(s) or clinic site(s)that administered the vaccine(s), any COVID-19 booster doses and have proof ofexemption for COVID-19 vaccination(s). This corrective action will beimplemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is no recurrence of thisdeficiency, the HR Manager will utilize a HR audit tool to track and documentthat all active staff is fully vaccinated and that all required staff hasreceived the applicable vaccine booster doses prior to providing care,treatment or services for the Agency and/or its patients or have proof ofexemption for COVID-19 vaccination(s). This process of utilizing HR audit tool forstaff will help us track	

	of all staff specified in paragraph (d)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;		and identify any discrepancies in the personnel file recordsand enforce all staff to have their files completed and up to date beforeproviding care to our patients or services to our agency. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizea HR audit tool and audit 100% of all personnel file records on a monthly basisto ensure that all active personnel file records show evidence of acceptableproof/documentation of full vaccination status which includes the employee'sname, type of vaccination administered, date(s) of administration and name ofthe healthcare professional(s) or clinic site(s) that administered thevaccine(s), any COVID-19 booster doses and have proof of exemption for COVID-19vaccination(s). The Office Manager will review HR Manager's audit findings ofall active personnel file records.	

	(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Based on record review and interview, the home health agency failed to track and document the COVID-19 vaccination status of all agency personnel, and/or track and document if agency personnel received any COVID-19 booster doses, for 10 of 12 personnel records reviewed that did not have documented proof of exemption for COVID-19 vaccination(s) (Licensed Practical Nurse [LPN] #1, Home Health Aide #1, HHA #2, Registered Nurse [RN] #1, RN #2, alternate Clinical Manager, Certified Occupational Therapy Assistant [COTA] #1, Physical Therapist [PT] #1, PT #2, Physical Therapy Assistant [PTA] #3). Findings include: 1. An agency policy dated		Monthly reports will be generated andresults will be compiled and sent to the Administrator to ensure that processeshave improved. This process will continue for each month for the next 3 monthsuntil 100% compliance is achieved and to maintain this level of compliance allnew employees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within the next 3 months, they will continue to beaddressed with staff re-training and re-education in workshops and in-servicesand with each individual personnel as needed. After 3 months, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly HR audit review. Quarterly audits results will be compiled and sentto the QAPI Committee for review. Once threshold is met, the QAPI Committeewill continue to audit 100% of personnel file records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the	

	February 2022, titled "COVID-19 Vaccine Mandate Policy", stated, "... Agency will ensure that all ... staff have received the applicable vaccine prior to providing care, treatment or services for the agency and/or its patients. Agency will maintain acceptable proof/documentation of vaccination status ... Agency will also track and document any booster doses ... If an employee ... is not fully vaccinated ... will be required to ... Be tested at least weekly ... Use a NIOSH [National Institute of Occupational Safety and Health]-approved N95 or equivalent or higher-level respirator ... Agency will maintain a list of all staff and their vaccination status which includes ... The percent of unvaccinated staff, excluding those staff that have approved exemptions ...." 2. Personnel records were reviewed on 12/01/22 from 11:47 AM - 1:00 PM with the Clinical Manager and Person #6 (office staff): LPN #1's personnel record (date of hire 7/29/22, first patient contact 7/30/22) failed to		Governing Body quarterly for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	

	evidence any proof LPN #1 was fully vaccinated for COVID-19, or received any booster doses. RN #1's Personnel record (date of hire 9/29/22, first patient contact 9/29/22) failed to evidence any proof RN #1 was fully vaccinated for COVID-19, or received any booster doses. RN #2's personnel record (date of hire 4/27/22, first patient contact 4/27/22) failed to evidence any proof RN #1 was fully vaccinated for COVID-19, or received any booster doses. HHA #1's personnel record (date of hire 1/06/21, first patient contact 1/08/21) failed to evidence any proof CNA #1 was fully vaccinated for COVID-19, or received any booster doses. HHA #2's personnel record (first patient contact 9/07/22) failed to evidence if CNA #2 received any COVID-19 booster doses. 3. During an interview on 12/08/22 at 3:16 PM, the Administrator indicated the alternate Clinical Manager was a new hire. 4. During an interview on			

	12/08/22 at 3:16 PM, Employee #6 (office staff) indicated the alternate Clinical Manager was going to bring them (physical, TB test, COVID-19 vaccine card) in today (12/08/22), but she went home sick. 5. During an interview on 12/09/22 at 11:55 AM, the alternate Clinical Manager indicated she didn't tell anyone she planned on dropping off her COVID-19 vaccine card yesterday (12/08/22). 6. Contracted personnel records were reviewed with the Administrator on 12/06/22 from11:32 AM – 12:00 PM. COTA #1's personnel file (no date of hire, no first patient contact date) failed to evidence if COTA #1 received any COVID-19 booster doses. PT #1's personnel file (no date of hire, no first patient contact date) failed to evidence if PT #1 received any COVID-19 booster doses.			

	PT #2's personnel file (no date of hire, no first patient contact date) failed to evidence if PT #2 received any COVID-19 booster doses. PTA #3's personnel file (no date of hire, no first patient contact date) failed to evidence any proof CNA #1 was fully vaccinated for COVID-19, or received any booster doses. During an interview on 12/06/22 at 11:32 AM, the Administrator indicated Entity #4 (contracted therapy services) never sends the complete personnel file.			
G0708	Development and evaluation of plan of care 484.75(b)(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); Based on observation, record review, and interview, the Registered Nurse (RN) failed to review the plan of care in partnership with the patient and/or caregiver for 2 of 2 home visits observed with an RN (#2, 6).	G0708	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policy 9.10.1"Plan of Care – CMS #485 and Physician Orders". During this meeting,deficiencies cited under G-0708 citation were reviewed and discussed in detail. The Director of Clinical	2023-02-02

	Findings include: 1. An agency policy with revised date February 2022, titled "Plan of Care ....", stated, "... plan of care must be reviewed and revised ... no less frequently than every 60 days ... Revisions to the plan of care ... must be communicated to the patient, representative ...." 2. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced the patient required a review/evaluation of the plan of care for recertification of services between 12/01/22 and 12/05/22. A home visit was observed with Patient #2 and the Clinical Supervisor on 12/05/22 from 2:15 PM - 3:00 PM, with family (primary caregiver) also present. The Clinical Manager failed to review the patient's plan of care with the patient/family. During an interview on 12/08/22 at 12:03 PM, the Clinical Manager indicated the		Serviceshas completed re-orientation of agency's policies pertaining to therequirement. Anin-service meeting was conducted by the Director of Clinical Services andattended by all staff, including contracted staff on 2/2/23 to discuss policy "Planof Care – CMS #485 and Physician Orders". The Director of Clinical Services emphasizedon the importance that the Registered Nurse (RN) or any cliniciansqualified to develop Plan of cares must review the plan of care in partnershipwith the patients and/or caregivers. Citations listed in the clinical recordreviews were addressed. All staff were re-educated on the requirement. Allstaff understood and acknowledged the requirement that the RegisteredNurse (RN) or any clinicians qualified to develop Plan of cares must review theplan of care in partnership with the patients and/or caregivers. All newemployees will be oriented of this requirement at the time of hire. Thiscorrective action will be implemented effective 2/2/23.	

	12/05/22 was a comprehensive reassessment for recertification of home care services, and she didn't review the plan of care with the patient/family during the recertification visit. 3. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date 10/07/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced the patient required a review/evaluation of the plan of care for recertification of services between 12/01/22 and 12/05/22. A home visit was observed with Patient #6 and the Clinical Manager on 12/05/22, from 11:00 AM - 12:05 PM. The Clinical Manager failed to review the patient's plan of care with the patient/family. During an interview on 12/08/22 at 1:10 PM, the Clinical Manager indicated the home visit for patient #6 on 12/05/22 was a comprehensive reassessment for recertification of home care services, and she didn't review the plan of care		**Measures to assure Norecurrence:** In order to ensure that there isno recurrence of this deficiency, the Director of Clinical Services willutilize a chart audit tool to ensure that all active patient records forpatients receiving home health services show evidence that the RegisteredNurse (RN) or any clinicians qualified to develop Plan of cares have reviewedthe plan of care in partnership with the patients and/or caregivers.This process of utilizing active chart audit tool on all active patients willhelp us ensure that the policy is being followed and identify any discrepanciesin the clinical records and re-educate all staff of the above mentionedrequirement. **Monitoring:** In order to ensure implementationand effectiveness of this corrective action, the following monitoring processwill be put in place, the Director of Clinical Services will	

	the recertification visit. 4. During an interview on 12/09/22 at 2:00 PM, the Administrator indicated he expected the nurse to create a new plan of care, and review goals again.		utilize a chartaudit tool and audit 100% of all active patient records on a weekly basis toensure that the RegisteredNurse (RN) or any clinicians qualified to develop Plan of cares have reviewedthe plan of care in partnership with the patients and/or caregivers. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each week for thenext 30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI	

			Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0714	Patient and caregiver education 484.75(b)(5) Patient and caregiver education; Based on observation, record review, and interview, the Registered Nurse failed to provide patient and/or caregiver education as ordered on the patient's plan of care, for 2 of 2 home visits observed with an RN (#2, 6).	G0714	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policy 9.10.1"Plan of Care – CMS #485 and Physician Orders". During this meeting,deficiencies cited under G-0714 citation were reviewed and discussed in detail.	2023-02-02

	Findings include: 1. An agency policy with revised date February 2017, titled "Professional Standards of Practice", stated, "... Agency staff will provide care, treatment and services to each patient according to the plan of care ...." 2. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced the patient's primary diagnosis was diabetes, and an additional diagnosis of a chronic non-pressure ulcer to the right ankle, and unspecified systolic (congestive) heart failure (impairment of the left side of the heart); skilled nursing orders included to teach disease process and diet. A home visit was observed with Patient #2 and the Clinical Manager on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Manager indicated the patient had 1 wound on the right lateral (outside) ankle, to which she provided wound care/treatment. Observed the		The Director of Clinical Serviceshas completed re-orientation of agency's policies pertaining to therequirement.	

	patient's left foot was swollen, dark red/purple in color (indicative of impaired circulation), had several small raised blisters on the 2nd toe, and 2 dark purple areas on the ball (bottom, where the toes attach to the foot) of the left foot, by the great and 5th toe joints. The Clinical Manager indicated the left foot was like that for the last couple of weeks. The Clinical Manager failed to provide skilled teaching related to prevention of new or worsening wounds or elevation of legs to reduce swelling and improve circulation. During an interview on 12/08/22 at 12:03 PM, the Clinical Manager indicated the home visit for patient #2 on 12/05/22, was a comprehensive reassessment for recertification of home care services, and stated, "... No, I didn't teach anything during the visit ... I taught him in the past ...." 3. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date 10/07/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health		Anin-service meeting was conducted by the Director of Clinical Services and to beattended by all staff, including contracted staff on 2/2/23 to discuss policy "Planof Care – CMS #485 and Physician Orders". The Director of Clinical Serviceswill emphasize on the importance that the Registered Nurses (RN) or qualifiedclinicians must provide patient and/or caregiver education as ordered on thepatient's plan of care. Citations listed in the clinical record reviews wereaddressed. All staff were re-educated on the requirement. All staff understoodand acknowledged the requirement that the Registered Nurses (RN) or qualifiedclinicians must provide patient and/or caregiver education as ordered on thepatient's plan of care. All new employees will be oriented of this requirementat the time of hire. This corrective action will be implemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there	

	Certification and Plan of Care" evidenced diagnoses included chronic venous hypertension (a condition that results from weakened lower extremity veins that have lost their ability to return blood to the heart, which causes high blood pressure in the legs), and chronic non-pressure ulcers (wounds caused by insufficient blood flow, or poor circulation) to both lower legs. Skilled nursing orders included to teach disease process and diet. A home visit was observed with Patient #6 and the Clinical Manager on 12/05/22, from 11:00 AM - 12:05 PM. The patient indicated she was concerned about her blood pressure being too high, and she didn't eat anything yet today. The Clinical Manager failed to provide skilled teaching related to the patient's complaint of high blood pressure, or dietary requirements included eating 3 well balanced meals daily, and importance of good nutritional intake to promote wound healing. During an interview on 12/08/22 at 1:10 PM, the		isno recurrence of this deficiency, the Director of Clinical Services will utilizea chart audit tool to ensure that all active patient records for patientsreceiving home health services show evidence that the Registered Nurses (RN) or qualifiedclinicians have provided patient and/or caregiver education as ordered on thepatient's plan of care. This process of utilizing active chart audittool on all active patients will help us ensure that the policy is beingfollowed and identify any discrepancies in the clinical records and re-educateall staff of the above mentioned requirement. **Monitoring:** In order to ensure implementationand effectiveness of this corrective action, the following monitoring processwill be put in place, the Director of Clinical Services will utilize a chartaudit tool and audit 100% of all active patient records on a weekly basis toensure that the RegisteredNurses (RN) or qualified clinicians have	

	Clinical Manager indicated the home visit for patient #6 on 12/05/22, was a comprehensive reassessment for recertification of home care services, and indicated she didn't provide any skilled teaching during the home visit.		caregivereducation as ordered on the patient's plan of care. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each week for thenext 30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI	

			Committee will senda written report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review, and interview, the Registered Nurse (RN) failed to ensure the Home Health Aide (HHA) provided care/services as ordered/included on the plan of care for 3 of 3 clinical records reviewed with patients who received HHA services (#1, 5, 8).	G0800	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023, reviewed and discussed agency policy 9.10.1"Plan of Care – CMS #485 and Physician Orders". During this meeting,deficiencies cited under G-0800 citation were reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency's policies pertaining to therequirement. Anin-service meeting was	2023-02-02

	Findings include: 1. An agency job description with revised date 2008, titled "Home Health Aide (HHA)", stated "... Responsibilities ... Performs personal care and bath as ordered ... Reports changes in the patient's condition and needs to the RN [Registered Nurse] ...." 2. Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date 10/12/22). A document received 11/30/22, titled "Home Health Certification and Plan of Care" for certification period 10/12/22 - 12/10/22, indicated the document was a "draft", Home Health Aide (HHA) services were ordered twice weekly for 8 weeks, and stated, "... [HHA] for personal care and ADL [activities related to personal care, such as bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating]. The initial plan of care failed to evidence specific tasks the HHA should perform with the patient. The electronic medical record (EMR) failed to evidence an HHA plan of care with specific tasks the HHA		conducted by the Director of Clinical Services andattended by all staff, including home health aides and contracted staff on 2/2/23to discuss policy “Plan of Care – CMS #485 and Physician Orders”. The Directorof Clinical Services emphasized that the Registered Nurses (RN) or qualifiedclinicians must ensure that the Home Health Aides (HHA) provide care/servicesas ordered/included on the plan of care. Citations listed in the clinicalrecord reviews were addressed. All staff were re-educated on the requirement. Allstaff understood and acknowledged the requirement that the RegisteredNurses (RN) or qualified clinicians must ensure that the Home Health Aides(HHA) provide care/services as ordered/included on the plan of care. All new employees will be oriented of thisrequirement at the time of hire. This corrective action will be implementedeffective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there	

	should perform with the patient. During an interview on 12/06/22 at 2:00 PM, the Clinical Manager indicated she previously saw a HHA plan of care in the EMR for Patient #1, but could not find it now. When queried what was considered to be the updated plan of care, the Clinical Manager stated "... We get orders and they stay separate from the plan of care ...." 3. Clinical record review for Patient #5 was completed on 12/09/22 (start of care date 9/06/22). A document for certification period 9/06/22 - 11/04/22, titled "Home Health Certification and Plan of Care" failed to evidence HHA services were ordered. A document received from Entity #14 (a hospital) on 12/08/22, titled “Medical Chart Patient Admission”, evidenced the patient was admitted 9/21/22, and discharged 9/22/22. A document for certification period 9/06/22 - 11/04/22, dated 9/26/22, titled “Home Health Certification and		isno recurrence of this deficiency, the Director of Clinical Services will utilizea chart audit tool to ensure that all active patient records for patientsreceiving home health services show evidence that the Home Health Aides (HHA)provided care/services as ordered/included on the plan of care. Thisprocess of utilizing active chart audit tool on all active patients will helpus ensure that the policy is being followed and identify any discrepancies inthe clinical records and re-educate all staff of the above mentionedrequirement. **Monitoring:** In order to ensure implementationand effectiveness of this corrective action, the following monitoring processwill be put in place, the Director of Clinical Services will utilize a chartaudit tool and audit 100% of all active patient records on a weekly basis toensure thatthe Home Health Aides (HHA) provided care/services as ordered/included on theplan of care. Weekly reports will be	

	failed to evidence HHA services were ordered. The EMR evidenced documents titled "Home Health Aide Visit Record" for dates 10/18/22, 10/25/22, 10/28/22, 11/01/22, and 11/04/22, but failed to evidence orders for HHA services. During an interview on 12/09/22 at 2:26 PM, the alternate Clinical Manager indicated the plan of care should be updated with new orders, and every time the orders changed, the plans of care should be updated. 4. Clinical record review for Patient #8 was completed on 12/09/22 (start of care date 8/11/22). A document dated 10/05/22, titled "Home Health Aide Care Plan", indicated tasks assigned by the RN to be completed every HHA visit included shampoo hair and nail care.		generated and results will becompiled and sent to the Administrator to ensure that processes have improved.This process will continue for each week for the next 30 days until 100%compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations.	

G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on observation, record review, and interview, the home health agency failed to ensure the Administrator was responsible for all day-to-day operations of the home health agency (Please see tag G0948); the Clinical Manager provided oversight of all patient care services and personnel (Please see tag G0958); the Clinical Manager failed to provide oversight of patient and personnel assignments (Please see tag G0960); the Clinical Manager failed to ensure coordination of care occurred with other agency personnel, physician(s), and other entities	G0940	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy9.13.1 titled “Coordination of Patient Care” and Director of Clinical ServicesJob description. During this management meeting on 1/27/23, deficiencies citedin clinical records under G-0940 were reviewed and discussed in detail. The Director of Clinical Services has completedre-orientation of agency’s policy and Director of Clinical Services jobdescription pertaining to the requirement. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff including contracted staff. During the meeting, the Director of ClinicalServices discussed agency policy 9.3.1 titled “Patient Admission Criteria” and9.13.1 titled “Coordination of Patient Care” and the importance of the requirementthat the Administrator is responsible for all day-to-day operations of the	2023-02-02

	meet the patient's needs (Please see tag G0962); the Clinical Manager evaluated each patient referral to determine the appropriateness for home care (Please see tag G0964); the Clinical Manager failed to ensure the patients' needs were assessed (Please see tag G0966); and the Clinical Manager failed to ensure clinical services were provided in accordance with current clinical practice guidelines and accepted professional standards of practice (Please see tag G0984). This practice had the potential to affect all patients serviced by the agency. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR §484.105: Organization and Administration of Services.		homehealth agency, the Clinical Manager must provide oversight of all patient careservices and personnel, the Clinical Manager must provide oversight of patientand personnel assignments the Clinical Manager will ensure coordination of careoccurred with other agency personnel, physician(s), and other entities whoprovided care/treatment to meet the patient's needs, the Clinical Managerevaluates each patient referral to determine the appropriateness for home care,the Clinical Manager will ensure the patients' needs were assessed, theClinical Manager will ensure clinical services were provided in accordance withcurrent clinical practice guidelines and accepted professional standards ofpractice and documentation must be present in the clinical record. Citationslisted in the record reviews were addressed with all office and field staff.The Director of Clinical Services re-educated all field staff on the importanceof this requirement. All staff understood and acknowledged the agency policy9.3.1titled “Patient Admission Criteria” and 9.13.1 titled “Coordination of	

			PatientCare" and the requirement that the Administrator is responsible for allday-to-day operations of the home health agency, the Clinical Manager mustprovide oversight of all patient care services and personnel, the ClinicalManager must provide oversight of patient and personnel assignments theClinical Manager will ensure coordination of care occurred with other agencypersonnel, physician(s), and other entities who provided care/treatment to meetthe patient's needs, the Clinical Manager evaluates each patient referral todetermine the appropriateness for home care, the Clinical Manager will ensurethe patients' needs were assessed, the Clinical Manager will ensure clinicalservices were provided in accordance with current clinical practice guidelinesand accepted professional standards of practice and documentation must bepresent in the clinical record. All new staff will be oriented of thisrequirement at the time of hire. This corrective action will be implementedeffective 2/2/23.	

			Measures to assure Norecurrence: In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize anAdministration audit tool and chart audit tool to ensure that the Administratorperformed their responsibility for all day-to-day operations of the home healthagency, the Clinical Manager provided oversight of all patient care servicesand personnel, the Clinical Manager provided oversight of patient and personnelassignments the Clinical Manager ensured coordination of care occurred withother agency personnel, physician(s), and other entities who providedcare/treatment to meet the patient's needs, the Clinical Manager evaluated eachpatient referral to determine the appropriateness for home care, the ClinicalManager ensured the patients' needs were assessed, the Clinical Manager ensuredclinical services were provided in accordance with current clinical practiceguidelines and accepted	

			professional standards of practice and documentationmust be present in the clinical record. This process of utilizing chart audittool will help us identify any discrepancies in clinical records and takecorrective measures accordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize an Administration audit tool and chart audit tool andaudit 100% of all discharged patients on a weekly basis to ensure that all transferredor discharged patient clinical records show evidence that the Administrator performedtheir responsibility for all day-to-day operations of the home health agency,the Clinical Manager provided oversight of all patient care services andpersonnel, the Clinical Manager provided oversight of patient and personnel assignmentsthe	

			Clinical Manager ensured coordination of care occurred with other agencypersonnel, physician(s), and other entities who provided care/treatment to meetthe patient's needs, the Clinical Manager evaluated each patient referral todetermine the appropriateness for home care, the Clinical Manager ensured thepatients' needs were assessed, the Clinical Manager ensured clinical serviceswere provided in accordance with current clinical practice guidelines andaccepted professional standards of practice and documentation must be presentin the clinical record. Weekly reports will be generated and results will becompiled and sent to the Administrator to ensure that processes have improved.This process will continue for each week for the next 30 days until 100%compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training	

			and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA;	G0948	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency	2023-02-02

	Based on observation, record review, and interview, the Administrator failed to be responsible for all day-to-day operations of the home health agency. Findings include: The Administrator failed to ensure the Registered Nurse (RN) conducted the initial evaluation within 48 hours of referral to determine eligibility for the Medicare home health benefit, including homebound status. Please see tag G0514. The Administrator failed to ensure a comprehensive assessment including the administration of the OASIS (Outcome and Assessment Information Set) during the last 5 days of every 60 day certification period. Please see tag G0546. The Administrator failed to ensure a comprehensive assessment was completed for patients who were hospitalized during the certification period. Please see tag G0548. The Administrator failed to ensure a comprehensive assessment was completed		policy7.9.1 titled "Administrator: Defined" and Administrator Job description. Duringthis management meeting on 1/27/23, deficiencies cited in clinical records underG-0948 were reviewed and discussed in detail. The Administrator has completed re-orientation of agency'spolicy pertaining to the requirement. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff including contracted staff. During the meeting, the Director of ClinicalServices will discuss agency policy 7.9.1 titled "Administrator: Defined" andthe importance of the requirement that the Administrator is responsible for allday-to-day operations of the home health agency. Citations listed in the recordreviews were addressed with all office and field staff. The Director of ClinicalServices re-educated all field staff on the importance of this requirement. Allstaff understood and acknowledged the agency policy 7.9.1 titled"Administrator: Defined" and the requirement that the Administrator	

	upon discharge. Please see tag G0550. The Administrator failed to ensure agency personnel followed infection control precautions for the prevention/control of infection/communicable disease. Please see tag G0682. The Administrator failed to track and document the COVID-19 vaccination status of all agency personnel, and/or track and document if agency personnel received any COVID-19 booster doses. Please see tag G0687. The Administrator failed to ensure the RN reviewed the plan of care in partnership with the patient and/or caregiver. Please see tag G0708. The Administrator failed to ensure the RN provided the patient and/or caregiver education as ordered on the patient's plan of care. Please see tag G0714. The Administrator failed to ensure the Home Health Aide (HHA) provided care/services as ordered/included on the plan of care. Please see tag G0800.		isresponsible for all day-to-day operations of the home health agency. All newstaff will be oriented of this requirement at the time of hire. This correctiveaction will be implemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize anAdministration audit tool and chart audit tool to ensure that the Administratorperformed their responsibility for all day-to-day operations of the home healthagency and documentation must be present in the clinical record. This processof utilizing chart audit tool will help us identify any discrepancies in clinicalrecords and take corrective measures accordingly. **Monitoring:** In orderto ensure	

	The Administrator failed to ensure the Clinical Manager was available during all operating hours. Please see tag G0950. The Administrator failed to ensure the Clinical Manager provided oversight of all patient care services and personnel. Please see tags G0958, G0960, G0962, G0964, G0966, and G0984. The Administrator failed to ensure all clinical records were documented accurately, and adhered to current clinical record documentation standards of practice. Please see Tag G1008. The Administrator failed to ensure the clinical record evidenced the name/contact information for the patient's primary care physician/practitioner (Please see tag G1020); The Administrator failed to ensure a transfer and/or discharge summary completed and sent to the appropriate physician/practitioner and/or or receiving facility. Please see tag G1022. The Administrator failed to		effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize an Administration audit tool and chart audit tool andaudit 100% of all discharged patients on a weekly basis to ensure that all transferredor discharged patient clinical records show evidence that the Administrator performedtheir responsibility for all day-to-day operations of the home health agencyand documentation must be present in the clinical record. Weekly reports willbe generated and results will be compiled and sent to the Administrator toensure that processes have improved. This process will continue for each weekfor the next 30 days until 100% compliance is achieved and to maintain thislevel of compliance all new employees at the time of hire will be oriented withthis requirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed.	

	retain all patients' clinical records per State/Federal regulation. Please see tag G1026. The Administrator failed to ensure it safeguarded all patients' clinical record information against loss or unauthorized use. Please see tag G1028.		After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
G0950	Ensure clinical manager is available 484.105(b)(1)(iii) (iii) Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours; Based on record review, and	G0950	**CorrectiveAction:** In order tocorrect the above cited deficiency, The Administrator, Governing Body andDirector of Clinical Services held a Management meeting on 1/27/23 to discussand review the findings/deficiencies	2023-02-02

	interview, the home health agency failed to ensure the Clinical Manager was available during all operating hours. Findings include: An agency job description with revised date February 2022, titled "Director of Clinical Services", stated, "... the Director of Clinical Services [Clinical Manager] is available at all times during operating hours (or appoints a similarly qualified alternate) ...." An agency policy revised February 2022, titled "After Hours Accessibility" stated, "... The [Clinical Manager] ... and/or ... [alternate Clinical Manager] is on-call 24 hours per day on a rotating weekly basis ...." An agency job description submitted 12/06/22, revised February 2022, titled "Clinical Manager [alternate Clinical Manager]", stated, "... Available to share on-call ... Acts as [Clinical Manager] in the [Clinical Manager's] absence ...." During an interview on 11/30/22 at 11:04 AM, the Administrator indicated		identified by the State survey completedon 12/9/22. During this meeting, deficiencies cited under G-950 were reviewed,addressed and discussed in detail. Agency policiestitled 4.17G.17 “Clinical Manager” and 7.10.1 “Supervision of Staff” wasreviewed and the requirement of ensuring that the Clinical Supervisor oralternate Clinical Supervisor was available during all operating hours, 24hours per day, 7 days per week, to meet the agency's clinical supervisoryneeds, or the medical needs of the patients. TheAdministrator instructed the participants that for the agency to be incompliance, we must ensure a clinical manager is available during alloperating hours, 24 hours per day, 7 days per week. This corrective action will be implemented effective 2/2/23. All participants understood and acknowledgedthe requirement. All new staff will be oriented of this requirement at the time ofhire. This corrective action will be implemented effective 2/2/23.	

	(alternate Clinical Manager) was on vacation until 12/15/22. During an interview on 12/09/22 at 11:53 AM, the Administrator indicated RN #3 (alternate Clinical Manager)was actually retired. During an interview on 12/08/22 at 3:30 PM, the Clinical Manager indicated she was leaving on a flight this evening, and would be back at work on Monday (12/12/22). When queried who would cover RN Clinical Manager duties in her absence, the Clinical Manager indicated no one did, this was how the agency operated; if she wasn't available, no one covered; and patients had to wait until she returned. During an interview on 12/08/22 at 8:15 PM, the Administrator indicated there was not a RN available to participate in the survey process for clinical record review on Friday, 12/09/22 during regular business hours. During an interview on 12/08/22 at 8:38 PM, RN #1 indicated they (agency) didn't work weekends as a standard practice, she only agreed to be		**Measuresto assure No recurrence:** In order to ensure that there is no recurrence of this deficiency, theAdministrator will utilize an HR audit tool for attendance record to ensurethat the Clinical Supervisor or alternate Clinical Supervisor wasavailable during all operating hours, 24 hours per day, 7 days per week, tomeet the agency's clinical supervisory needs, or the medical needs of thepatients. **Monitoring:** In order toensure implementation and effectiveness of this corrective action, the Administratorwill be monitoring daily attendance to ensure that theClinical Supervisor or alternate Clinical Supervisor was available during alloperating hours, 24 hours per day, 7 days per week, to meet the agency'sclinical supervisory needs, or the medical needs of the patients. This process will continue for the next 30 days to ensure properimplementation and to achieve 100 %	

	on call to help out this evening (12/08/22), and she had another full time job, Monday - Friday, 8:00 AM to 5:00 PM, and some weekends/evenings. During an interview on 12/09/22 at 12:28 PM, Employee #6 (Office staff) indicated she worked at the agency for just over a year, she never met RN #3, and RN #3 wasn't really available, When queried the last time RN #3 saw agency patients or was involved with agency daily operations, administrative Employee #6 stated, "... I would probably say it was probably before I began ...." During an interview on 12/09/22 at 1:01 PM, when queried who was delegated to act on behalf of the Clinical Manager during her absence, the Administrator indicated RN #1 was. When queried what would happen if a patient needed an RN before 5:00 PM, the Administrator indicated they would let them wait.		compliance. After 30 days, this processwill continue to be monitored and included in the Quarterly Attendance record reviewto ensure compliance. Quarterly audit results will be compiled and sentto the QAPI Committee for review. Once threshold is met, the Quality Committeewill continue to audit 20% of Human resource records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. The Administrator will beresponsible for corrective action of this deficiency, measure to assure norecurrence and monitoring of this deficiency.	
G0958	Clinical manager 484.105(c)	G0958	**Corrective Action:** In order to correct the above	2023-02-02

	Standard: Clinical manager. One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following-- Based on record review and interview, the Clinical Manager failed to provide oversight of all personnel, for 13 of 13 personnel records reviewed (Licensed Practical Nurse [LPN] #1, LPN #2, Certified Nursing Assistant [CNA] #1, CNA #2, Registered Nurse [RN] #1, RN #2, Clinical Manager, alternate Clinical Manager, Certified Occupational Therapy Assistant [COTA] #1, Occupational Therapist [OT] #2, Physical Therapist [PT] #1, PT #2, Physical Therapy Assistant [PTA] #3). Findings include: 1. An agency policy with revised date February 2021, titled "Coordination of Patient Care" stated, "... The Director of Clinical Services [Clinical Manager] provides oversight of all patient care services. Oversight includes ... Coordinating patient care ... Coordinating referrals ...		deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy9.13.1 titled “Coordination of Patient Care” and Director of Clinical ServicesJob description. During this management meeting on 1/27/23, deficiencies citedin clinical records under G-0958 were reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency’s policy and Director of ClinicalServices job description pertaining to the requirement. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff including contracted staff. During the meeting, the Director of ClinicalServices discussed agency policy 9.13.1 titled “Coordination of Patient Care” andthe importance of the requirement that the Clinical Manager provides oversightof all patient care services and personnel and documentation must be present inthe clinical record. Citations listed in the record reviews were addressed	

	Ensuring that patient needs are continually assessed ... Ensuring the development, implementation and updates of the individualized plan of care ... Provides the physician/practitioner with ... changes in condition ...." 2. An agency job description with revised date February 2010, signed by the Clinical Manager on 8/10/21, titled "Clinical Director", indicated the Clinical Manager (Clinical Director) was responsible for the overall management of home health clinical services, hires and evaluates agency personnel, implements and evaluates the orientation program for new personnel, and oversees the maintenance of patient clinical records. 3. An agency policy with revised date February 2022, titled "Personnel Records", evidenced personnel records will include verification of certification and/or licensure and employee orientation, PPD tests (Purified protein derivative standard) (tuberculosis [TB] skin test) or chest x-ray results. 4. An agency policy with revised		withall office and field staff. The Director of Clinical Services re-educated allstaff on the importance of this requirement. All staff understood andacknowledged the agency policy 9.13.1 titled "Coordination of Patient Care" andthe requirement that the Clinical Manager provides oversight of all patientcare services and personnel and documentation must be present in the clinicalrecord. All new staff will be oriented of this requirement at the time of hire.This corrective action will be implemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize achart audit tool to ensure the Clinical Manager provided oversight of allpatient care services and personnel and documentation must be present in theclinical record. This process of utilizing chart audit tool will help usidentify any discrepancies in clinical records	

	date February 2022, titled "Occupational Exposure to Tuberculosis ....", stated, "... During the pre-employment physical employees ... will have baseline PPD skin testing performed ... Employees with positive PPD test results should have a chest [x-ray] as part of the initial evaluation of the PPD test ...." 5. An agency document received 12/06/22, effective date 1/01/22, titled "Paragon Home Health Care Contractor Agreement", stated"... The Contractor [Entity #4, contracted therapy services] shall perform [sic] to all administrative and personnel policies of agency including personnel and health qualifications ...." 6. Personnel records were reviewed on 12/01/22 from 11:47 AM - 1:00 PM with the Clinical Manager and Person #6 (office staff): LPN #1's personnel record (date of hire 7/29/22, first patient contact 7/30/22) failed to evidence LPN #1's license was current, agency/job specific orientation was completed, or		measuresaccordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all dischargedpatients on a weekly basis to ensure that all transferred or discharged patientclinical records show evidence that the Clinical Manager provided oversight ofall patient care services and personnel assignments and documentation must bepresent in the clinical record. Weekly reports will be generated and resultswill be compiled and sent to the Administrator to ensure that processes haveimproved. This process will continue for each week for the next 30 days until100% compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not	

	any TB testing was completed. RN #1's Personnel record failed to evidence a signed job description. RN #2's personnel record (date of hire 4/27/22, first patient contact 4/27/22) failed to evidence agency/job specific orientation was completed, or any TB testing was completed. The Clinical Manager's personnel record (date of hire 8/5/18, first patient contact 8/15/18) failed to evidence agency/job specific orientation was completed, or any TB testing was completed. LPN #2's personnel record (date of hire 12/30/18, first patient contact 1/03/19) failed to evidence any TB testing was completed in 2018, 2019, 2020, or 2021. CNA #1's personnel record (date of hire 1/06/21, first patient contact 1/08/21) failed to evidence any TB testing was completed. CNA #2's personnel record (first patient contact 9/07/22) failed to evidence any baseline TB		achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	hire. 7. Personnel record for the alternate Clinical Manager (date of hire 12/01/22) was reviewed on 12/09/22 at 11:55 AM, which failed to evidence agency/job specific orientation was completed, or baseline TB testing was completed upon hire. During an interview on 12/08/22 at 3:16 PM, the Administrator indicated the alternate Clinical Supervisor was a new employee. During an interview on 12/09/22 at 11:55 AM, the alternate Clinical Manager indicated she didn't receive orientation. During an interview on 12/08/22 at 3:16 PM, Employee #6 (office staff) indicated the alternate Clinical Manager was going to bring them (physical, TB test, COVID-19 vaccine card) in today (12/08/22), but she went home sick. During an interview on 12/09/22 at 11:55 AM, the alternate Clinical Manager indicated she didn't tell anyone she planned on dropping of a			

	physical, COVID-19 vaccine card, or TB test yesterday, and the agency did not do TB testing upon hire. 8. Contracted personnel records were reviewed with the Administrator on 12/06/22 from11:32 AM – 12:00 PM. OT #1's personnel file (no date of hire, no first patient contact date) failed to evidence a job description, or agency/job specific orientation was completed. PT #1's personnel file (no date of hire, no first patient contact date) failed to evidence a job description, or agency/job specific orientation was completed. PT #2's personnel file (no date of hire, no first patient contact date) failed to evidence a job description, or agency/job specific orientation was completed. PTA #3's personnel file (no date of hire, no first patient contact date) failed to evidence a job description, or agency/job specific orientation was completed.			

	During an interview on12/06/22 at 11:32 AM, the Administrator indicated Entity #4 (contracted therapy services) never sends the complete personnel file, and they only send what state required.			
G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, Based on record review and interview, the Clinical Manager failed to provide oversight of patient and personnel assignments. Findings include: An agency policy with revised date February 2021, titled "Coordination of Patient Care" stated, "... The Director of Clinical Services provides oversight of all patient care services. Oversight includes ... Coordinating patient care ...." An agency job description with revised date February 2022,	G0960	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy9.13.1 titled "Coordination of Patient Care" and Director of Clinical ServicesJob description. During this management meeting on 1/27/23, deficiencies citedin clinical records under G-0960 were reviewed and discussed in detail. The Director of Clinical Serviceshas completed re-orientation of agency's policy and Director of ClinicalServices job description pertaining to the requirement. Anin-service was conducted by	2023-02-02

	titled "Director of Clinical Services", stated, "... the Director of Clinical Services [Clinical Manager] ... participates in all activities relevant to professional services furnished, including ... assignment of personnel ...." An agency job description signed by Employee #7 (Referral/Intake Supervisor/Office Manager) and the Administrator on 9/10/18, titled "Referral/Intake Supervisor", stated "... Responsible for managing all aspects of the patient intake process ... Essential Job Functions ... Ensures seamless transition of patients to home care by providing direct oversight of patient education and preparation of home care, plan of care initiation, and coordination of care with multiple service providers ...." During an interview on 12/05/22 at 3:00 PM, The Clinical Manager indicated Employee #7 told her when to admit the patients, and she didn't know anything about newly referred patients until she was assigned to go admit them by Employee #7. When queried		the Director of Clinical Services on 2/2/23 withall staff including contracted staff. During the meeting, the Director of ClinicalServices discussed agency policy 9.13.1 titled “Coordination of Patient Care” andthe importance of the requirement that the Clinical Manager provides oversightof patient and personnel assignments and documentation must be present in the clinicalrecord. Citations listed in the record reviews were addressed with all officeand field staff. The Director of Clinical Services re-educated all staff on theimportance of this requirement. All staff understood and acknowledged theagency policy 9.13.1 titled “Coordination of Patient Care” and the requirement thatthe Clinical Manager provides oversight of patient and personnel assignmentsand documentation must be present in the clinical record. All new staff will beoriented of this requirement at the time of hire. This corrective action willbe implemented effective 2/2/23. **Measures to assure**	

	if Employee #7 was an RN or licensed practical nurse (LPN), the Clinical Manager stated, "... No ..." During an interview on 12/06/22 at 11:25 AM, Employee #7 indicated she notified the RN, called the patient, and set up a time to do the admission for home care services. During an interview on 12/06/22 at 1:37 PM, the Administrator indicated they (agency) didn't need an RN to do the patient "intake part", they had a Clinical Manager that Employee #7 could consult if she needed anything. The Clinical Manager indicated she was made aware of patient referrals only after everything was ready and insurance was cleared, Employee #7 would sent her the patient's information to do an admission visit.		**Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize achart audit tool to ensure the Clinical Manager provided oversight of patientand personnel assignments and documentation must be present in the clinicalrecord. This process of utilizing chart audit tool will help us identify anydiscrepancies in clinical records and take corrective measures accordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all dischargedpatients on a weekly basis to ensure that all transferred or discharged patientclinical records show evidence that the Clinical	

			ofpatient and personnel assignments and documentation must be present in theclinical record. Weekly reports will be generated and results will be compiledand sent to the Administrator to ensure that processes have improved. Thisprocess will continue for each week for the next 30 days until 100% complianceis achieved and to maintain this level of compliance all new employees at thetime of hire will be oriented with this requirement. If compliance is notachieved at the desired target of 100% compliance and any deficiencies areidentified within 30 days, they will continue to be addressed with staffre-training and re-education in workshops and in-services and with eachindividual personnel as needed. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will continueto audit 20% of clinical records quarterly to ensure compliance is	

			maintained.The Administrator and QAPI Committee will send a written report to theGoverning Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0962	Coordinate patient care 484.105(c)(2) Coordinating patient care, Based on observation, record review, and interview, the Clinical Manager failed to ensure coordination of care occurred with other agency personnel, physician(s), and other entities who provided care/treatment to meet the patient's needs, for 2 of 2 home visits observed (#2, 6). Findings include: 1. An agency policy with revised date February 2021, titled "Coordination of Patient Care"	G0962	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy9.13.1 titled “Coordination of Patient Care”. During this management meeting on1/27/23, deficiencies cited in clinical records under G-0962 were reviewed anddiscussed in detail. The Director of Clinical Services has completedre-orientation of agency’s policy pertaining to the requirement. Anin-service was conducted by the Director of Clinical Services	2023-02-02

	stated, "... The Agency must ... Assure communication with all physicians/practitioners involved in the plan of care ... Coordinate care delivery to meet the patient's needs ...."		on 2/2/23 withall staff including contracted staff. During the meeting, the Director of ClinicalServices discussed agency policy 9.13.1 titled “Coordination of Patient Care” andthe importance of the requirement to ensure coordination of care occurs withother agency personnel, physician(s), and other entities who provided care/treatmentto meet the patient's needs and documentation must be present in the clinicalrecord. Citations listed in the record reviews were addressed with all officeand field staff. The Director of Clinical Services re-educated all staff on theimportance of this requirement. All staff understood and acknowledged theagency policy 9.13.1 titled “Coordination of Patient Care” and the requirement toensure coordination of care occurs with other agency personnel, physician(s),and other entities who provided care/treatment to meet the patient's needs anddocumentation must be present in the clinical record. All new staff will beoriented of this requirement at the time of hire. This corrective action willbe implemented effective 2/2/23.	

	2. A home visit was observed with Patient #2 and the Clinical Manager on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Manager indicated the patient had 1 wound on the right lateral (outside) ankle, to which she provided wound care/treatment, and Entity #9 (a wound clinic) managed the patient's wound. Observed the patient's left foot was swollen, dark red/purple in color (indicative of impaired circulation), had several small raised blisters on the 2nd toe, and 2 dark purple areas on the ball (bottom, where the toes attach to the foot) of the left foot, by the great and 5th toe joints. The Clinical Manager indicated the left foot was like that for the last couple of weeks. The patient indicated he needed his toenails trimmed, and asked the Clinical Manager to trim them. The Clinical Manager indicated she couldn't trim them, but she'd have another agency nurse do it. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document for certification period 10/07/22 - 12/05/22,		**Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize achart audit tool to ensure coordination of care occurred with other agencypersonnel, physician(s), and other entities who provided care/treatment to meetthe patient's needs and documentation must be present in the clinical record.This process of utilizing chart audit tool will help us identify anydiscrepancies in clinical records and take corrective measures accordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all dischargedpatients on a weekly basis to ensure that all transferred or discharged	

	Certification and Plan of Care" evidenced the patient's primary diagnosis was diabetes, and an additional diagnosis of a chronic non-pressure ulcer to the right ankle, and unspecified systolic congestive heart failure (impairment of the left side of the heart). A document dated 12/05/22, titled "Skilled Visit Note" failed to evidence the Clinical Manager coordinated care with another agency nurse or a podiatrist to ensure the patient's toenails would get trimmed, failed to evidence coordination with Entity #9 for new skin areas on the left foot/toes, and failed to evidence coordination with the patient's certifying physician (Person #19) for recertification of home care services. During an interview on 12/08/22 at 12:03 PM, the Clinical Manager indicated the home visit for patient #2 on 12/05/22 was a comprehensive reassessment for recertification of home care services, she didn't coordinate care with anyone to ensure the patient's toenails were trimmed, or coordinate with Entity #9 for		patientclinical records show evidence that coordination of care occurred with otheragency personnel, physician(s), and other entities who provided care/treatmentto meet the patient's needs and documentation must be present in the clinicalrecord. Weekly reports will be generated and results will be compiled and sentto the Administrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified within 30days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee	

	new skin areas on the left foot/toes, because he went to wound clinic every other week, and they'd see it. The Clinical Manager also indicated there should be evidence she coordinated with the wound clinic on her start of care comprehensive assessment (8/08/22), as the patient was referred by Entity #9. 3. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date 10/07/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced diagnoses included chronic venous hypertension (a condition that results from weakened lower extremity veins that have lost their ability to return blood to the heart, which causes high blood pressure in the legs), and chronic non-pressure ulcers (wounds caused by insufficient blood flow, or poor circulation) to both lower legs, and skilled nursing frequency was once weekly for 1 week, 3 times weekly for 8 weeks (weeks 2-9), then once weekly for 1 week. The electronic medical record (EMR) evidenced a missed visit		forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the Governing Bodyquarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence and monitoringof this deficiency.	

	during the week of 10/16/22 (week 3), a missed visit during the week of 10/23/22 (week 4), and a missed visit during the week of 11/13/22 (week 7). A document dated 9/15/22, titled "Progress Note Details", evidenced Entity #12 (a wound clinic) ordered wound care to be performed every 2 days. A document dated 9/30/22, titled "Physician Orders Details", evidenced Entity #12 ordered wound care to be performed every 2 days. A document dated 10/28/22, titled "Physician Orders Details" evidenced Entity #12 ordered wound care to be performed every 2 days. A document dated 12/06/22, titled "Physician Orders Details" evidenced Entity #12 ordered wound care to be performed every 2 days. A home visit was observed with Patient #6 and the Clinical Manager on 12/05/22, from 11:00 AM - 12:05 PM. The patient indicated she was concerned that her blood pressure was high. The Clinical Manager indicated she would			

have another agency nurse bring out a log to record blood pressures.

A document dated 12/05/22, titled "Skilled Visit Note" failed to evidence the Clinical Manager coordinated care with another agency nurse to ensure the patient received a blood pressure log, and failed to evidence coordination with the patient's certifying physician (Person #11) for recertification of home care services.

During an interview on 12/08/22 at 1:10 PM, the Clinical Manager indicated the home visit for patient #6 on 12/05/22 was a comprehensive reassessment for recertification of home care services, the wound care wasn't performed every 2 days because they don't work weekends, she didn't coordinate with entity #12 to inform them the wounds were not changed every 2 days, and there was no coordination with Person #11 for recertification of home care services. When queried if coordination occurred with the physician for missed visits, the Clinical Manager indicated the EMR should automatically generate an

	order.			
G0964	Coordinate referrals; 484.105(c)(3) Coordinating referrals, Based on record review and interview, the home health agency failed to ensure the Clinical Manager evaluated each patient referral to determine the appropriateness for home care. Findings include: 1. An agency policy with revised date February 2021, titled "Patient Admission Criteria", stated, "... When a telephone referral is received by the agency, a referral form is completed by a [sic] RN ... Each referral is evaluated by the Clinical Manager ... to determine the appropriateness of home care ...." 2. An agency job description signed by Employee #7 (Referral/Intake Supervisor/Office Manager) and the Administrator on 9/10/18, titled "Referral/Intake	G0964	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy9.3.1 titled "Patient Admission Criteria". During this management meeting on 1/27/23,deficiencies cited in clinical records under G-0964 were reviewed and discussedin detail. The Director of Clinical Services has completed re-orientationof agency's policy pertaining to the requirement. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff including contracted staff. During the meeting, the Director of ClinicalServices discussed agency policy 9.3.1 titled "Patient Admission Criteria" andthe importance of the requirement that the Clinical Manager evaluates eachpatient referral to determine the appropriateness for home care	2023-02-02

	Supervisor", stated "... Responsible for managing all aspects of the patient intake process ... Essential Job Functions ... Ensures seamless transition of patients to home care by providing direct oversight of patient education and preparation of home care, plan of care initiation, and coordination of care with multiple service providers ... Position Qualifications ... 1. Registered Nurse with current licensure ... 2. Bachelor's degree in Nursing ...." The document evidenced the position qualifications "1. Registered Nurse with current licensure [and] 2. Bachelor's degree in Nursing" were crossed out and initialed by the Administrator. 3. During an interview on 12/05/22 at 3:00 PM, The Clinical Manager indicated she was not involved with referrals or the intake process, she never saw any paperwork about new referrals until after Employee #7 processed the paperwork, Employee #7 decided if the patients were accepted for care or not, Employee #7 did all the "leg work", Employee #7 told her (the Clinical Manager) when to admit the patient, and the		anddocumentation must be present in the clinical record. Citations listed in therecord reviews were addressed with all office and field staff. The Director of ClinicalServices re-educated all staff on the importance of this requirement. All staffunderstood and acknowledged the agency policy 9.3.1 titled “Patient AdmissionCriteria” and the requirement that the Clinical Manager evaluates each patientreferral to determine the appropriateness for home care and documentation mustbe present in the clinical record. All new staff will be oriented of thisrequirement at the time of hire. This corrective action will be implementedeffective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize achart audit tool to ensure that the Clinical Manager evaluated each patientreferral to determine the appropriateness for home care	

	patients were almost always admitted well after the referral dates. When queried if Employee #7 was an RN or licensed practical nurse (LPN), the Clinical Supervisor stated "... No ..." 4. During an interview on 12/06/22 at 11:25 AM, when queried to describe the referral/home care admission process, Employee #7 indicated when she received a referral, she decided if they (the agency) could accept it or not based on the service area and what type of insurance the patient had, and she would let the referring entity/person know if the agency could accept the patient or not; she (Employee #7) would verify the insurance, make sure the agency had all required paperwork, such as the history and physical (H&P), wound orders, or anything like that, and then after that, she entered the referral into the system (electronic medical record [EMR], notified the RN, called the patient, and set up a time to do the admission for home care services. 5. During an interview on 12/06/22 at 1:37 PM, the		present in the clinical record. This process of utilizing chart audit toolwill help us identify any discrepancies in clinical records and take correctivemeasures accordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all dischargedpatients on a weekly basis to ensure that all transferred or discharged patientclinical records show evidence that the Clinical Manager evaluated each patientreferral to determine the appropriateness for home care and documentation mustbe present in the clinical record. Weekly reports will be generated and resultswill be compiled and sent to the Administrator to ensure that processes haveimproved. This process will continue for each week for the next 30 days until100% compliance is achieved and to maintain this	

	Administrator indicated they (agency) didn't need an RN to do the patient "intake part", they had a Clinical Manager that Employee #7 could consult if she needed anything, and Employee #7 processed all referrals. The Clinical Manager indicated she was made aware of patient referrals after everything was ready and insurance was cleared, Employee #7 would sent her the patient's information, and then she (the Clinical Manager) would call the patient to schedule the initial/admission visit. The Clinical Supervisor indicated she did not decide if patients were accepted for services, Employee #7 did. 6. During an interview on 12/09/22 at 12:12 PM, Employee #5 (Marketer) indicated Employee #7 was the Intake Coordinator, and Employee #6 (Office Staff) was starting to do that job as well. When queried who decided if a patient was accepted for care, Employee #5 indicated Employee #7 decided. When queried if either Employee #6 or #7 was a nurse, Employee #5 stated "No."		level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no	

			recurrence and monitoringof this deficiency.	
G0966	Assure patient needs are continually assessed 484.105(c)(4) Assuring that patient needs are continually assessed, and Based on observation, record review, and interview, the Clinical Manager failed to ensure the patients' needs were assessed, for 2 of 2 home visits observed with a Registered Nurse (RN) (#2, 6). Findings include: 1. An agency job description received on 12/06/22, revised date February 2022, titled "Director of Clinical Services [Clinical Manager]", stated, "... Assures ongoing assessment of patient/family needs ...." 2. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care", evidenced the patient's primary	G0966	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy 9.13.1titled “Coordination of Patient Care” and Director of Clinical Services Jobdescription. During this management meeting on 1/27/23, deficiencies cited inclinical records under G-0966 were reviewed and discussed in detail. The Director of Clinical Services has completedre-orientation of agency’s policy and Director of Clinical Services jobdescription pertaining to the requirement. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff including contracted staff. During the meeting, the Director of ClinicalServices discussed agency policy 9.13.1 titled “Coordination of Patient Care” andthe importance of the requirement that the patients'	2023-02-02

	additional diagnoses included chronic non-pressure ulcer to the right ankle, and unspecified systolic (congestive) heart failure (impairment of the left side of the heart). Skilled nursing orders included observation and evaluation (assessment) of the patient. A home visit was observed with Patient #2 and the Clinical Manager on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Manager indicated the patient had 1 wound on the right lateral (outside) ankle, to which she provided wound care/treatment. Observed the patient's left foot was swollen, dark red/purple in color (indicative of impaired circulation), had several small raised blisters on the 2nd toe, and 2 dark purple areas on the ball (bottom, where the toes attach to the foot) of the left foot, by the great and 5th toe joints. The Clinical Manager indicated the left foot was like that for the last couple of weeks. The Clinical Manager failed to assess for presence of pedal pulses (throbbing of arteries on the top of the foot, to assess blood flow), or perform a diabetic foot exam		needs must be assessed anddocumentation must be present in the clinical record. Citations listed in therecord reviews were addressed with all office and field staff. The Director of ClinicalServices re-educated all staff on the importance of this requirement. All staffunderstood and acknowledged the agency policy 9.13.1 titled "Coordination ofPatient Care" and the requirement that the patients' needs must be assessed anddocumentation must be present in the clinical record. All new staff will beoriented of this requirement at the time of hire. This corrective action willbe implemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize achart audit tool to ensure that the patients' needs must be assessed and documentationmust be present in the clinical record. This process of utilizing chart	

	(assess if the patient had sensation, adequate blood flow, inspect between toes, assess for ingrown toenails). During an interview on 12/08/22 at 12:03 PM, the Clinical Manager indicated the home visit for patient #2 on 12/05/22, was a comprehensive reassessment for recertification of home care services. The Clinical Manager stated, "... No, I did not check the pedal pulses ... I checked them the first time I saw him ....", and indicated she did not assess the left foot blisters on the 2nd toe, or the 2 dark purple areas on the ball of the left foot. When queried if she performed a complete comprehensive reassessment on the patient during the home visit on 12/05/22, the Clinical Manager indicated she did not. 3. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date 10/07/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced diagnoses included chronic venous hypertension (a condition that results from weakened lower extremity veins		any discrepancies in clinical records and takecorrective measures accordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all dischargedpatients on a weekly basis to ensure that all transferred or discharged patientclinical records show evidence that the patients' needs must be assessed anddocumentation must be present in the clinical record. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each week for thenext 30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance	

	that have lost their ability to return blood to the heart, which causes high blood pressure in the legs), and chronic non-pressure ulcers (wounds caused by insufficient blood flow, or poor circulation) to both lower legs. Skilled nursing orders included observation and evaluation of the patient, and measure wounds weekly (wound measurements are assessed and documented as length, then width, then depth). A home visit was observed with Patient #6 and the Clinical Manager on 12/05/22, from 11:00 AM - 12:05 PM. The Clinical Manager performed wound care to each lower extremity, measured the wound on the front of the left lower leg (length, 7.5 cm [centimeters], width 13.0 cm), and a wound on the inside of the left lower leg (2.0 cm x 2.0 cm). Both of the patient's lower legs were swollen. The Clinical Manager failed to measure the depth of either wound, or assess for presence of pedal pulses. During an interview on 12/08/22 at 1:10 PM, the Clinical Manager indicated the		is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	12/05/22, was a comprehensive reassessment for recertification of home care services, and confirmed she didn't measure the depths of the wounds, or assess pedal pulses. When queried if she performed a complete comprehensive reassessment on the patient during the home visit on 12/05/22, the Clinical Manager indicated she did not, she couldn't do some of the assessments required during a comprehensive assessment/reassessment because she had a bad elbow, and she just asked the patients questions instead of actually assessing them. 4. During an interview on 12/09/22 at 2:00 PM, the Administrator indicated he expected the nurse to assess everything.			
G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on observation, record	G0984	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy 9.7.1titled "Reassessments/Update of the	2023-02-02

	review, and interview, the Clinical Manager failed to ensure clinical services were provided in accordance with current clinical practice guidelines and accepted professional standards of practice, for 2 of 2 home visits observed (#2, 6). Findings include: 1. An agency policy with revised date February 2021, titled "Reassessments ....", stated, "... Staff will additionally reassess each patient with each home visit on an ongoing basis ...." 2. An agency job description received on 12/06/22, revised date February 2022, titled "Director of Clinical Services [Clinical Manager]", stated, "... Assures ongoing assessment of patient/family needs and implementation of ... plan of care ... fulfills job requirements ...." 3. Review on 12/5/22 of a National Library of Medicine web-based reference, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4144247/, cite: Nair B. Compression therapy for venous leg ulcers. Indian		Comprehensive Assessment". During thismanagement meeting on 1/27/23, deficiencies cited in clinical records under G-0984were reviewed and discussed in detail. The Director of Clinical Services has completedre-orientation of agency's policy pertaining to the requirement. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff including contracted staff. During the meeting, the Director of ClinicalServices discussed agency policy 9.7.1 titled "Reassessments/Update of theComprehensive Assessment" and the importance of the requirement that the clinicalservices are provided in accordance with current clinical practice guidelinesand accepted professional standards of practice and documentation must bepresent in the clinical record. Citations listed in the record reviews will beaddressed with all office and field staff. The Director of Clinical Services re-educatedall staff on the importance of this requirement. All staff understood	

	Jul;5(3):378-82. doi: 10.4103/2229-5178.137822. PMID: 25165679; PMCID: PMC4144247, titled "Compression therapy for venous leg ulcers", stated "... Bandages should generally be applied toe to knee at 50% stretch and with 50% overlap ...." 4. Clinical record review for Patient #2 was completed on 12/08/22 (start of care date 8/08/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced the patient's primary diagnosis was diabetes, and an additional diagnosis of a chronic non-pressure ulcer to the right ankle, and unspecified systolic (congestive) heart failure (impairment of the left side of the heart); skilled nursing orders included to teach disease process and diet, provide wound care to the right ankle, and evaluate wound for healing. A home visit was observed with Patient #2 and the Clinical Manager on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Manager indicated the patient		andacknowledged the agency policy 9.7.1 titled "Reassessments/Update of theComprehensive Assessment" and the requirement that the clinical services are providedin accordance with current clinical practice guidelines and acceptedprofessional standards of practice and documentation must be present in theclinical record. All new staff will be oriented of this requirement at the timeof hire. This corrective action will be implemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize achart audit tool to ensure that the clinical services are provided inaccordance with current clinical practice guidelines and accepted professionalstandards of practice and documentation must be present in the clinical record.This process of utilizing chart audit tool will help us identify anydiscrepancies in clinical records and take	

	had 1 wound on the right lateral (outside) ankle, to which she provided wound care/treatment. Observed the patient's left foot was swollen, dark red/purple in color (indicative of impaired circulation), had several small raised blisters on the 2nd toe, and 2 dark purple areas on the ball (bottom, where the toes attach to the foot) of the left foot, by the great and 5th toe joints. The Clinical Manager indicated the left foot was like that for the last couple of weeks. The patient indicated he needed his toenails trimmed, and asked the Clinical Manager to trim them. The Clinical Manager indicated she couldn't trim them, but she'd have another agency nurse do it. The Clinical Manager failed to trim the patient's toenails per the patient's request. During an interview on 12/08/22 at 12:03 PM, when queried why she failed to trim the patient's toenails, the Clinical Manager indicated she made someone bleed before while cutting their toenails, so she won't do it anymore. When queried if she arranged to ensure the patient's toenails		accordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all dischargedpatients on a weekly basis to ensure that all transferred or discharged patientclinical records show evidence that the clinical services are provided inaccordance with current clinical practice guidelines and accepted professionalstandards of practice and documentation must be present in the clinical record.Weekly reports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each week for the next 30 days until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is	

	were trimmed, the Clinical Manager indicated she didn't. 5. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date 10/07/22). A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced diagnoses included chronic venous hypertension (a condition that results from weakened lower extremity veins that have lost their ability to return blood to the heart, which causes high blood pressure in the legs), and chronic non-pressure ulcers (wounds caused by insufficient blood flow, or poor circulation) to both lower legs. A home visit was observed with Patient #6 and the Clinical Manager on 12/05/22, from 11:00 AM - 12:05 PM. The Clinical Supervisor performed wound care to each lower extremity. Both of the patient's lower legs were swollen. The Clinical Manager applied elastic compression wraps to each of the patient's lower legs, started each wrap from just below the knee and wrapped downward to the toes. The Clinical		not achieved at thedesired target of 100% compliance and any deficiencies are identified within 30days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	Manager failed to correctly apply the elastic compression bandages in accordance with accepted professional practices. During an interview on 12/08/22 at 1:10 PM, the Clinical Manager indicated she applied the patient's elastic compression bandages from the top to bottom of the leg/foot, and she didn't know they should be applied from the toes upward to below the knee, to prevent pooling of blood in the feet/toes. During an interview on 12/08/22 at 3:30 PM, the Clinical Manager indicated her personnel record failed to evidence a clinical competency document for the application of elastic compression bandages. During an interview on 12/09/22 at 2:00 PM, when queried to describe the correct application of elastic compression bandages to the lower legs, the alternate Clinical Manager stated, "... I usually start at the top and work my way down ... I haven’t done that very much ...."			

G1008	Clinical records 484.110 Condition of participation: Clinical records. The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically. Based on observation, record review, and interview, the home health agency failed to ensure the patient's clinical record contained the current comprehensive reassessment and updated/revised plan of care (Please see tag G1012); failed to ensure the clinical record evidenced the name/contact information for the patient's primary care physician/practitioner (Please see tag G1020); failed to ensure a transfer and/or discharge summary completed and sent to the appropriate physician/practitioner and/or or receiving facility (Please see tag G1022); failed to retain all	G1008	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy 9.29.1titled “Transfer/Referral Criteria and Planning, 9.30.1 titled, “DischargeCriteria and Planning, 9.31.1 titled, “Discharge summary”, 6.4.1 titled"Patient Confidentiality" and 11.1.1 titled “Medical Record Content”.During this management meeting on 1/27/23, deficiencies cited in clinicalrecords under G-1008 were reviewed and discussed in detail. The Director of Clinical Services has completedre-orientation of agency’s policy pertaining to the requirement. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall staff including contracted staff. During the meeting, the Director of ClinicalServices discussed agency policy 9.29.1 titled “Transfer/Referral Criteria andPlanning, 9.30.1 titled, “Discharge Criteria and	2023-02-02

	State/Federal regulation (Please see tag G1026); and failed to ensure it safeguarded all patients' clinical record information against loss or unauthorized use (Please see tag G1028). This practice had the potential to affect all patients serviced by the agency. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for the Condition of Participation 42 CFR §484.110: Clinical Records. A standard level deficiency was cited as follows: Based on observation, record review, and interview, the Registered nurse (RN) failed to ensure all clinical records were documented accurately, and adhered to current clinical record documentation standards of practice, for 2 of 2 home visits observed with an RN (#2, 6), and 1 of 1 clinical record reviewed with no identified certifying physician (#1). (Tag G1008) Findings include: 1. An agency policy, revised		Planning, 9.31.1 titled,“Discharge summary”, 6.4.1 titled "Patient Confidentiality" and 11.1.1titled “Medical Record Content” and the importance of the requirement that thepatient's clinical record contained the current comprehensive reassessment andupdated/revised plan of care, the clinical record must contain the name/contactinformation for the patient's primary care physician/practitioner, a completed transferand/or discharge summary must be sent to the appropriate physician/practitionerand/or or receiving facility, all patients' clinical records must be retained perState/Federal regulation, the home health agency safeguarded all patients'clinical record information against loss or unauthorized use and documentationmust be present in the clinical record. Citations listed in the record reviews wereaddressed with all office and field staff. The Director of Clinical Services re-educatedall staff on the importance of this requirement. All staff understood andacknowledged	

	date February 2022, titled "Medical Record Content", stated, "... The Agency will initiate and maintain an individual and accurate medical record for each patient ...." 2. An agency policy, revised date February 2022, titled "Professional Standards of Practice", stated, "... The Agency and staff will comply with accepted professional standards and principles ...." 3. An agency policy, revised date February 2022, titled "Plan of Care ... and Physician/Practitioner Orders", stated, "... Verbal orders are accepted only by personnel authorized to do so by applicable state laws and regulations ... put in writing, signed, timed, and dated with the date of receipt ...." 4. An agency document with effective date 2/01/2016, titled, "General Contract for Services", evidenced the home health agency contracted with Entity #8 to provide Quality Assurance/Compliance for preparations of Federal and State re-certification surveys; identify, correct, and help		the agency policy 9.29.1 titled “Transfer/Referral Criteria andPlanning, 9.30.1 titled, “Discharge Criteria and Planning, 9.31.1 titled,“Discharge summary”, 6.4.1 titled "Patient Confidentiality" and 11.1.1titled “Medical Record Content” and the requirement that the patient's clinicalrecord contained the current comprehensive reassessment and updated/revisedplan of care, the clinical record must contain the name/contact information forthe patient's primary care physician/practitioner, a completed transfer and/ordischarge summary must be sent to the appropriate physician/practitioner and/oror receiving facility, all patients' clinical records must be retained perState/Federal regulation, the home health agency safeguarded all patients'clinical record information against loss or unauthorized use and documentationmust be present in the clinical record. and documentation must be present inthe clinical record. All new staff will be oriented of this requirement at thetime of hire.	

	implementation process of deficiencies identified in Administrative/Clinical documentation and processes; and any plan of correction following surveys. The contract failed to evidence staff qualifications included current professional licensure to receive/alter physician orders, or other documents which required the author's credentials as a skilled licensed professional. 5. Clinical record review for Patient #1 was completed on 12/06/22. The electronic medical record (EMR) evidenced Person # 7 was the patient's certifying physician. A document dated 10/12/22, titled "Referred for Admission", stated, "... Order read back and verified with physician ....", was last updated by Person #21 (not a licensed skilled professional [RN or licensed practical nurse (LPN]), and failed to evidence the document was signed/authenticated by an RN. A document dated 10/12/22, titled "Admission Order ....", evidenced the document was a verbal order, which stated, "...		This corrective action will be implemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize anAdministration audit tool and chart audit tool to ensure that the patient'sclinical record contained the current comprehensive reassessment and updated/revisedplan of care, the clinical record contained the name/contact information forthe patient's primary care physician/practitioner, a completed transfer and/ordischarge summary is sent to the appropriate physician/practitioner and/or orreceiving facility, all patients' clinical records are retained perState/Federal regulation, the home health agency is safeguarding all patients'clinical record information against loss or unauthorized use and documentationmust be present in the clinical record. This process of utilizing chart audittool will help us identify	

	Order read back and verified with physician ...." A document dated 10/14/22, titled "Transfer ....", evidenced the document was a verbal order, which stated, "... Order read back and verified with physician ...." The document failed to evidence the document was signed/authenticated, dated or timed by an RN. A document dated 10/14/22, titled "Resumption of Care ... 8:42 PM", evidenced the document was an incomplete verbal order, which stated, "... Order read back and verified with physician ...." The document failed to evidence the document was signed/authenticated, dated or timed by an RN. A document dated 11/28/22, titled "Discharge from Agency ....", evidenced the document was blank verbal order, which stated, "... Order read back and verified with physician ...." The document evidenced it was last updated by Employee #7, and failed to evidence the document was signed/authenticated, dated or timed by an RN. During an interview on		any discrepancies in clinical records and takecorrective measures accordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize an Administration audit tool and chart audit tool andaudit 100% of all discharged patients on a weekly basis to ensure that all transferredor discharged patient clinical records show evidence that the patient'sclinical record contained the current comprehensive reassessment andupdated/revised plan of care, the clinical record contained the name/contactinformation for the patient's primary care physician/practitioner, a completed transferand/or discharge summary is sent to the appropriate physician/practitionerand/or or receiving facility, all patients' clinical records are retained perState/Federal regulation, the home health agency is	

	12/06/22 at 1:47 PM, the Administrator indicated Person #21 was a quality assurance person he contracted with (Entity #8) to provide assistance with clinical record compliance and accuracy, and this person was not a licensed skilled professional. During an interview on 12/08/22 at 12:12 PM, the Clinical Manager indicated people with administrative privileges in the EMR can create/alter/delete documents which also included orders, Person #21 was "Quality Assurance", and Employee #7 (Referral/Intake Supervisor) and Person #21 both had those privileges, neither of which was a licensed skilled professional. During an interview on 12/09/22 at 12:12 PM, Employee #5 (Marketer) indicated Employee #7 was not a nurse. During an interview on 12/06/22 at 1:47 PM - 3:10 PM, Employee #6 (Office staff) indicated Person #7 sent back all of the orders the agency sent to him for signature, and indicated he wasn't Patient #1's		safeguarding all patients'clinical record information against loss or unauthorized use and documentationmust be present in the clinical record. Weekly reports will be generated andresults will be compiled and sent to the Administrator to ensure that processeshave improved. This process will continue for each week for the next 30 daysuntil 100% compliance is achieved and to maintain this level of compliance allnew employees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to	

	physician. When queried to submit the orders/documents received from Person #7, Employee #6 indicated she shredded them, and the agency did not know who the patient's physician was. When queried, the Administrator indicated the agency had no signed orders for this patient. When queried why the physician orders indicated a clinician “read back and verified” verbal orders, if the physician never gave the verbal orders, the Clinical Manager stated, "... Maybe we’re going by what the patient said ...." The clinical records were falsified to suggest Person #7 gave verbal orders to a licensed skilled professional. When queried why unlicensed skilled professionals created orders in the EMR, the Administrator declined to provide a response. When queried, Employee #7 (not a licensed skilled professional) indicated she created the discharge verbal order, (dated 11/28/22 at 10:14 AM, titled "Discharge from Agency"), but then recanted her statement and indicated it was a "communication note". 6. A home visit was observed		ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	with Patient #2 and the Clinical Manager on 12/05/22 from 2:15 PM - 3:00 PM. The Clinical Manager failed to provide any skilled teaching during the visit, assess pedal pulses (pulses on the tops of the feet to check blood flow), measure any wounds on the left foot/toes, or perform a comprehensive assessment. Clinical record review for Patient #2 was completed on 12/08/22. A document received 12/02/22 at 11:30 AM, dated 9/26/22 at 7:20 PM, titled, "Change Visit Frequency: 9/26/22 ... 7:20 PM" (a verbal order), stated, "... SN [skilled nurse] frequency changed ... new SN frequency ...." The document evidenced it was last updated by Person #21, and stated "... Order read back and verified with physician ...." The document failed to evidence a licensed skilled professional received or signed the order. An additional verbal order document received on 12/08/22, dated 9/26/22 at 7:20 PM, titled, "Change Visit Frequency: 9/26/22 ... 7:20 PM" (a verbal order), stated, "... SN to			

	9/26/2022 ...." The document was signed/authenticated by the Clinical Manager, dated 9/26/2022. This document failed to be evidenced in the EMR on 12/02/22 at 11:30 AM. A document dated 12/05/22, titled "Skilled Nurse Visit", evidenced the Clinical Manager assessed the patient's pedal pulses, provided skilled teaching to the patient/caregiver, which included safety precautions, diabetic monitoring/care, dietary/nutrition requirements, infection control measures, prevention of pressure ulcers (wounds caused by prolonged/unrelieved pressure), proper hand washing techniques, and signs and symptoms of wound infection. The Clinical Manager was not observed providing any skilled teaching or assessment of the patient's pedal pulses during the home visit on 12/05/22. A document dated 12/05/22, titled "Wound Care Worksheet" evidenced the Clinical Manager measured a wound on the patient's left great toe. The Clinical Manager was not observed measuring a wound			

	on the patient's left great toe during the home visit on 12/05/22. During an interview on 12/05/22 at 3:00 PM, the Clinical Manager indicated staff at Entity #8 frequently changed her clinical documents without her consent, and the Administrator was aware of her concern. During an interview on 12/08/22 at 12:03 PM, the Clinical Manager indicated the home visit observed on 12/05/22 with Patient #2 was a recertification visit (comprehensive reassessment). When queried if she performed a comprehensive reassessment on the patient, the Clinical Manager stated, "... No, but it auto-fills most of that anyways ...." When queried about the skilled nursing visit note dated 12/05/22, the Clinical Manager indicated the EMR notes flow over one visit to another (prefills documentation based on previous nursing visits), and stated "... no I did not check pedal pulses ... I checked them the first time I saw him ...." When queried why she documented skilled teaching			

	was performed, the Clinical Manager stated, "... No ... I didn't teach anything during the visit ... That is an automated thing ... I taught him in the past, so I just figured it was fine to leave it there ...." When queried why she documented measurements for the left toe, the Clinical Manager stated, "... That's auto-filled as well ... but I can change it ... those are wound clinic measurements ...." During an interview on 12/08/22 at 12:12 PM, the Clinical Manager indicated someone must have deleted the original order dated 9/26/22 (with orders indicating a frequency change), she didn't delete it, unlicensed staff with administrative privileges could create/alter/delete documents,. and person #21 did quality assurance activities. 7. A home visit was observed with Patient #6 and the Clinical Manager on 12/05/22, from 11:00 AM - 12:05 PM. The patient was a black or African-American female. Observed the Clinical Manager measure a wound on the patient's left lower leg (7.5 centimeters [cm] in length, 13.0 cm in width). The			

	depth of the wound was full thickness (through all layers of skin), and observed as greater than 0.1 cm. The Clinical Manager failed to measure the depth of the wound, assess pedal pulses, or provide any skilled teaching during the visit. Clinical record review for Patient #6 was completed on 12/08/22 (start of care date 10/07/22). A document dated 10/07/22, titled "Start of care ...." (a comprehensive assessment) indicated the patient's was a white male. A document for certification period 10/07/22 - 12/05/22, titled "Home Health Certification and Plan of Care" evidenced skilled nursing orders included to measure wounds weekly (wound measurements are recorded as length, by width, by depth [L x W x D]). A document dated 12/05/22, titled "Skilled Nurse Visit", evidenced the Clinical Manager assessed the patient's pedal pulses, and provided skilled teaching to the patient/caregiver, which included safety precautions,			

	medications, dietary/nutrition requirements, infection control measures, prevention of pressure ulcers, proper hand washing techniques, and signs and symptoms of wound infection. The Clinical Manager was not observed providing any skilled teaching or assessment of the patient's pedal pulses during the home visit on 12/05/22. A document dated 12/05/22, titled "Wound Care Worksheet" evidenced the Clinical Manager inaccurately documented the wound on the patient's left lower leg as 13.0 cm x 7.5 cm x 0.1 cm (the observed measurement during the home visit on 12/05/22 was 7.5 cm x 13.0 cm, with no depth measured). During an interview on 12/08/22 at 1:10 PM, the Clinical Manager indicated the home visit observed on 12/05/22 with Patient #6 was a recertification visit (comprehensive reassessment). When queried if she performed a comprehensive reassessment on the patient, the Clinical Manager stated, "... No ...."			

	comprehensive assessment would be completed, including assessment of OASIS (Outcome and Assessment Information Set) data items, if no comprehensive assessment occurred, the Clinical Manager indicated the document would auto-fill, she didn't complete some of the components required during a comprehensive assessment because she had a bad elbow, and she just asked the patients instead of assessing them. When queried about the skilled nursing visit note dated 12/05/22, the Clinical Manager indicated she didn't assess the patient's pedal pulses, she didn't perform any skilled teaching, and stated "... like I said ... that auto-fills ...." When queried why she documented a depth measurement for the left lower extremity if she did not assess it, the Clinical Manager indicated it was auto-filled, indicated she was unaware wounds were documented as L x W x D, and confirmed they were documented inaccurately (W x L x D) on the "Wound Care Worksheet" (12/05/22). During an interview on			

	Administrator and alternate Clinical Manager confirmed the race/ethnicity on the patient's comprehensive assessment dated 10/07/22 was inaccurate. 8. During an interview on 12/09/22 at 2:00 PM, the Administrator indicated both nursing visits conducted with Patient #2 and Patient #6 were recertification visits (comprehensive reassessment visits), but the Clinical Manager completed routine visit notes ("Skilled Nurse Visit" and "Wound Care Worksheet") because she didn't have time to complete the comprehensive reassessment documents before she left town (evening of 12/08/22), and she would complete comprehensive reassessment documents for Patient #2 and Patient #6 when she returned to work on 12/12/22. The Administrator also indicated the EMR failed to evidence comprehensive reassessment visit notes dated 12/05/22, for Patient #2 or Patient #6.			

G1020	Contact info for primary care practitioner 484.110(a)(5) Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA; and Based on record review and interview, the home health agency failed to ensure the clinical record evidenced the name/contact information for the patient's primary care physician/practitioner, for 1 of 8 clinical records reviewed (#1). Findings include: An agency policy with revised date February 2022, titled "Medical Record Content", stated, "... The Agency will provide an accurate and current medical record for every patient ... will contain the following ... Physician's/Practitioner's name and referral source ...." Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date 10/12/22, discharge date 11/28/22), evidenced a document titled "Home Health Certification and Plan of Care" for certification	G1020	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy11.1.1 titled "Medical Record Content". During this management meeting on 1/27/23,deficiencies cited in clinical records under G-1020 were reviewed and discussedin detail. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall office and field staff. During the meeting, the Director of ClinicalServices discussed agency policy 11.1.1 titled "Medical Record Content" and theimportance of the requirement that the name/contact information for thepatient's primary care physician/practitioner or other health care professionalwho will be responsible for providing care and services to the patient afterdischarge from the HHA must be present in the clinical record. Citations listedin the record reviews were addressed with all office and field staff. TheDirector of Clinical Services re-educated the office and all	2023-02-02

	document indicated Person #7 was the patient's certifying physician. During an interview on 12/06/22, Employee #6 indicated all orders in the patient's record remained unsigned by Person #7. Person #7 informed the agency he was not the patient's physician, and the agency didn't know who the patient's physician was. When queried, Employee #6 indicated she hasn't contacted the patient to find out who the correct physician was, and when queried how long the agency knew the physician information was incorrect, Employee #6 stated, "... I'd say about November [2022] ...."		field staff on theimportance of this requirement. All staff understood and acknowledged theagency policy 11.1.1 titled "Medical Record Content" and the requirement that thename/contact information for the patient's primary care physician/practitioner orother health care professional who will be responsible for providing care andservices to the patient after discharge from the HHA must be present in theclinical record. All new staff will be oriented of this requirement at the timeof hire. This corrective action will be implemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize achart audit tool to ensure that that the name/contact information for thepatient's primary care physician/practitioner or other health care professionalwho will be responsible for providing	

			afterdischarge from the HHA must be present in the clinical record. This process ofutilizing chart audit tool will help us identify any discrepancies in clinicalrecords and take corrective measures accordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, the followingmonitoring process will be put in place, the Director of Clinical Services willutilize a chart audit tool and audit 100% of all discharged patients on aweekly basis to ensure that all transferred or discharged patient clinicalrecords show evidence that the name/contact information for the patient'sprimary care physician/practitioner or other health care professional who willbe responsible for providing care and services to the patient after dischargefrom the HHA must be present in the clinical record. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat	

			processes have improved. This process will continue for each week for thenext 30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations.	

			The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G1022	Discharge and transfer summaries 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the home health agency failed to ensure a transfer and/or discharge summary was completed and sent to the appropriate physician/practitioner and/or or receiving facility, for 4 of 4 records reviewed with patients who were transferred with	G1022	**Corrective Action:** In order to correct the above deficiency cited, the Administratorand Director of Clinical Services reviewed and discussed the agency policy 9.29.1titled “Transfer/Referral Criteria and Planning, 9.30.1 titled, “DischargeCriteria and Planning, 9.31.1 titled, “Discharge summary” and 11.1.1 titled“Medical Record Content”. During this management meeting on 1/27/23,deficiencies cited in clinical records under G-1022 were reviewed and discussedin detail. Anin-service was conducted by the Director of Clinical Services on 2/2/23 withall office and field staff. During the meeting, the Director of ClinicalServices will discuss agency policy 9.29.1 titled “Transfer/Referral Criteriaand Planning, 9.30.1 titled, “Discharge Criteria and	2023-02-02

	inpatient admission and/or discharged from the agency (#1, 3, 5, 7). Findings include: 1. An agency policy with revised date February 2022, titled "Medical Record Content", stated, "... The Agency will provide an accurate and current medical record for every patient ... will contain the following ... A completed discharge summary when patient is discharged from the agency ...." 2. An agency policy with revised date February 2022, titled "Transfer/Referral Criteria and Planning", stated, "... When a patient's care needs change to require ... specialized services not provided by the agency, the Agency must inform ... the physician/practitioner who is responsible for the patient's home health plan of care ... Appropriate parties will be informed immediately ... This is accomplished by ... A written Transfer Summary ... will be completed ... will be provided ...." 3. Clinical record review for Patient #1 was completed on 12/06/22 (Start of care date		Planning, 9.31.1 titled,“Discharge summary” and 11.1.1 titled “Medical Record Content” and theimportance of the requirement that a completed discharge summary that is sentto the primary care practitioner or other health care professional who will beresponsible for providing care and services to the patient after discharge fromthe HHA (if any) within 5 business days of the patient's discharge, or acompleted transfer summary that is sent within 2 business days of a plannedtransfer, if the patient's care will be immediately continued in a health carefacility or a completed transfer summary that is sent within 2 business days ofbecoming aware of an unplanned transfer, if the patient is still receiving carein a health care facility at the time when the HHA becomes aware of thetransfer. Citations listed in the record reviews were addressed with all officeand field staff. The Director of Clinical Services re-educated the office andall field staff on the importance of this requirement. All staff understood andacknowledged the agency policy 9.29.1 titled	

	10/12/22, discharge date 11/28/22), and evidenced an undated, unsigned document titled "Transferred to an inpatient facility ....". The document indicated the patient was transferred on 10/14/22. The document failed to evidence the certifying physician was notified, and the electronic medical record (EMR) indicated the document was "In Progress". A document dated 10/18/22, titled “Home Discharge Instructions”, indicated the patient was hospitalized for emergent care at Entity #10 (a hospital) from 10/15/22 – 10/18/22, for seizures. A document dated 11/28/22, titled "... Discharge from agency", (a discharge comprehensive assessment) stated "... Status ... In Progress ...." The document failed to be completed, or signed and dated by a clinician. During an interview on 12/06/22 at 2:00 PM, the Clinical Manager indicated the last page of the discharge comprehensive assessment was the discharge summary, they		“Transfer/Referral Criteria andPlanning, 9.30.1 titled, “Discharge Criteria and Planning, 9.31.1 titled,“Discharge summary” and 11.1.1 titled “Medical Record Content” and therequirement of Discharge and transfer summaries. All new staff will be orientedof this requirement at the time of hire. This corrective action will beimplemented effective 2/2/23. **Measures to assure Norecurrence:** In order to ensure that there is norecurrence of this deficiency, the Director of Clinical Services will utilize achart audit tool to ensure that a completed transfer and/or discharge summary isbeing sent to the appropriate physician/practitioner and/or or receivingfacility, for patients who were transferred with inpatient admission and/ordischarged from the agency and evidence must be present in the patient’sclinical record. This process of utilizing chart audit tool will help usidentify any discrepancies in	

	didn't always do a discharge assessment in person, as it depended on the nurse's availability/schedule, and the discharge assessment wasn't completed. When queried to describe the transfer to inpatient facility process, the Clinical Manager indicated they created transfer assessment document within 48 hours, the last page of the assessment was the transfer summary, and it had to be sent to the receiving facility. When queried, the Clinical Manager indicated the EMR did not evidence the transfer summary was sent to the hospital, and the Administrator indicated he would submit the requested information. Upon survey exit, nothing further was submitted for review. During an interview on 12/08/22 at 2:30 PM, the Clinical Manager indicated documents in the EMR marked as "in progress" meant they were not yet completed. 4. Clinical record review for Patient #3 was completed on 12/08/22 (start of care date 1/31/22). A document titled "Transferred to an inpatient		discharge summaries andits submission to physician/practitioner and/or or receiving facility and takecorrective measures accordingly. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Director of ClinicalServices will utilize a chart audit tool and audit 100% of all dischargedpatients on a weekly basis to ensure that all transferred or discharged patientclinical records show evidence that a completed transfer and/or dischargesummary is being sent to the appropriate physician/practitioner and/or orreceiving facility, for patients who were transferred with inpatient admissionand/or discharged from the agency. Weekly reports will be generated and resultswill be compiled and sent to the Administrator to ensure that	

	facility ....", evidenced the patient was transferred to Entity #10 (a hospital) for evaluation. The EMR failed to evidence the certifying nurse practitioner was notified, or a summary was sent. A document received from Entity #1 (a hospital) on 12/02/22, dated 10/17/22, titled "Discharge Summary", indicated the patient required emergent care, and was hospitalized from 10/10/22 – 10/17/22, due to a new infected wound, and osteomyelitis (inflammation of bone caused by infection). During an interview on 12/02/22 at 2:50 PM, Person #17 indicated the patient was hospitalized at Entity #1 (a hospital), not Entity #10 (a hospital). The EMR failed to evidence the correct emergent care facility the patient transferred to, or a summary was sent. During an interview on 12/08/22 at 2:30 PM, the Clinical Manager indicated the EMR didn't evidence the certifying practitioner was notified, or a summary was faxed to the hospital. 5. Clinical record review for		processes haveimproved. This process will continue for each week for the next 30 days until100% compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations.	

	Patient #5 was completed on 12/09/22 (start of care date 9/06/22, discharge date 11/04/22). A document dated 11/04/22, titled "... Discharge from agency", stated "... Status ... In Progress ...." The document was largely blank. The EMR failed to evidence a discharge summary. During an interview on 12/09/22 at 2:26 PM, the alternate Clinical Manager indicated the document titled "... Discharge from agency" was not completed, nor signed and dated by a clinician. The Administrator indicated the EMR didn't evidence the date or time the physician was notified or if a summary was sent, and they (the agency) needed to keep track of this. 6. Clinical record review for patient #7 was completed on 12/09/22 (start of care date 11/09/22). The EMR failed to evidence a discharge assessment (which included the discharge summary) was completed. A document dated 11/28/22, titled "Discharge from Agency ...." evidenced it was a physician		The Director of Clinical Services will be responsible for correctiveaction of this deficiency, measure to assure no recurrence and monitoring ofthis deficiency.	

	order, the document was blank, and was not signed by a clinician or the physician. During an interview on 12/09/22 at 2:30 PM, Employee #6 indicated the plan of care and other orders weren't completed or signed by the clinician or physician. The alternate Clinical Manager indicated the EMR did not include a discharge assessment, and would expect the nurse to conduct a discharge assessment.			
G1026	Retention of records 484.110(c)(1)(2) Standard: Retention of records. (1) Clinical records must be retained for 5 years after the discharge of the patient, unless state law stipulates a longer period of time. (2) The HHA's policies must provide for retention of clinical records even if it discontinues operation. When an HHA discontinues operation, it must inform the state agency where clinical records will be maintained. Based on record review and interview, the home health agency failed to retain all patients' clinical records per State/Federal regulation, for 10 of 10 random patients sampled	G1026	**CorrectiveAction:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/2023, the Governing Body,Administrator and Director of Clinical Services reviewed, discussed the agencypolicy 11.1.1 titled "Medical Record Retention" under Record of Care,Treatment and Services Section. During this meeting, deficiencies cited under G-1026were reviewed, addressed and discussed in detail. The Administrator has	2023-02-02

	without clinical record review (#10, 11, 12, 13, 14, 15, 16, 17, 18, 19), and per the agency's own admission, 1 of 1 active patient records reviewed with missing clinical record documents (#4). Findings include: 1. Indiana Code (IC) 16-39-7-1 stated, "... Maintenance of health records by providers ... "provider" means the following ... (12) A home health agency licensed under IC 16-27 ... (b) A provider shall maintain the original health records or microfilms of the records for at least seven (7) years ...." 2. An agency policy with revised date February 2022, titled "Medical Record Content", stated, "... The Agency will ... maintain an individual and accurate medical record for each patient ... in compliance with all federal/state laws and regulations ...." 3. An agency policy with revised date October 2017, titled "Medical Record Retention", stated, "... patient medical records are retained minimally for five (5) years after the		completedre-orientation of agency’s policies pertaining to Medical Record Retention. TheAdministrator has also updated the Medical Record Retention policy toreflect Indiana'srequirement to retain medical records for 7 years. The Administrator has alsogained access to the previous EMR to ensure availability of medical records. An in-service meeting was conducted by the Governing Body andattended by the Administrator, Director of Clinical Services and all staffincluding contracted personnel on 2/2/23 to discuss the agency policy 11.1.1titled "Medical Record Retention" under Record of Care, Treatment andServices Section During this meeting, deficiencies cited under G-1026 will bereviewed, addressed and discussed in detail with all staff. The Governing Bodywill emphasize on the importance of the requirement that the allpatients' clinical records must be retained for 7 years. All staff understoodand acknowledged the agency’s policy pertaining to medical record retention. Allnew staff will be oriented of	

	state law stipulates a longer period of time ...." 4.. During an interview on 11/30/22 at 11:15 AM, the Clinical Supervisor indicated the home health agency was required to store medical records for 7 years. 5. On 12/09/22 at 1:01 PM, the home health agency's "On-Call Log" was submitted for review. Dates reviewed were 2/06/21 to present, with the newest entry dated 7/10/21. Patients #10, 11, 12, 13, 14, 15, 16, 17, 18, and 19 were documented by name with concerns, but clinical records for patients #10-19 were not evidenced in the agency's electronic medical record (EMR) software. 6. During an interview on 12/06/22 at 1:09 PM, Person #7 (Referral/Intake Supervisor) submitted referral information for Patient #4 (an active patient), and indicated the dates would be wrong, because when they switched from Entity #5 (previous EMR software provider) to Entity #6 (current EMR software provider) within about a year ago, they had to enter Patient #4 as a new admit,		this requirement at the time of hire. This corrective action will be implementedon 2/2/2023. **Measuresto assure No recurrence:** In order to ensure that there is norecurrence of this deficiency, the Governing Body will utilize anAdministration audit tool to ensure that the all patients' clinical records mustbe retained for 7 years as perpolicies and guidelines. This process of utilizing Administration audit toolwill help us identify any discrepancies and implement corrective measures andassess outcomes. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Governing Body willutilize an Administration audit tool and audit 100% of Administration records forthe next 30 days to ensure that all patients' clinical records must beretained for 7	

	and had no older clinical records for Patient #4. Patient #4's referral documents submitted on 12/06/22 evidenced a physician order dated 10/28/21, for home health nursing services. 7. Clinical record review for Patient #4 was completed on 12/09/22. A document dated 1/26/22, titled "Home Health Certification and Plan of Care" evidenced the patient's start of care date was 1/26/22. The EMR failed to include any clinical records prior to 1/26/22. 8. During an interview on 12/06/22 at 1:09 PM, when queried if the agency had access to clinical records stored within Entity #5's software, the Administrator indicated the agency did not, and could only get access to the medical records if he paid additional money. 9. During an interview on 12/09/22 at 2:51 PM, when queried why Patients' #10, 11, 12, 13, 14, 15, 16, 17, 18, and 19's clinical records weren't evidenced in the home health agency's current EMR software, the Administrator indicated he		guidelines and document thefindings in the Administration audit tool. The QAPI Committee willreview audit findings of Administration records. Monthly reports will begenerated and results will be compiled and sent to the Administrator andGoverning Body to ensure that processes have improved. This process willcontinue for each month for the next 3 months until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified withinthe next 3 months, they will continue to be addressed with staff re-trainingand re-education in workshops and in-services and with each individualpersonnel as needed. After 3 months, this process will continue to be monitoredon a quarterly basis and will be included in the quarterly Administration auditreview. Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will	

	had no access to those medical records, as they were from the previous EMR company.		continueto audit 100% of Administration records quarterly to ensure compliance ismaintained. The QAPI Committee will send a written report to the Governing Bodyquarterly for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
G1028	Protection of records 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164. Based on observation, record review, and interview, the home health agency failed to ensure it safeguarded all patients' clinical record information against loss or unauthorized use.	G1028	**CorrectiveAction:** In order to correct the abovedeficiency cited, in Management meeting on 1/27/2023, the Governing Body,Administrator and Director of Clinical Services reviewed, discussed the agencypolicy 6.4.1 titled "Patient Confidentiality" under InformationManagement Section. During this meeting, deficiencies cited under G-1028 werereviewed, addressed and discussed in detail. The Administrator has	2023-02-02

	Findings include: An agency policy with revised date March 2018, titled "Patient Confidentiality", stated, "... Home care records will not be left in unattended areas in the office, e.g., the reception area. All home care records will be kept stored in metal file cabinets to minimize the possibility of damage from fire and water. Charts will be protected against unauthorized corruption, damage, and/or intrusion ... all home care records will be maintained in metal locked filing cabinets or locked file room ...." On 11/30/22, 12/01, 12/05, 12/06, 12/07, 12/08, and 12/09 (2022), observed 3 bankers boxes stacked on the floor next to the wall in the main reception area of the home health agency. The boxes were not secured in locked cabinets. On 12/09/22 at 2:50 PM, when queried of the 3 bankers boxes contents, the Administrator lifted the lid of the topmost box. The box contained file folders with patient names and clinical documents. The		agency's policies pertaining to Patient Confidentiality. TheAdministrator has placed all clinical records in metal locked filing cabinets.	

	boxes contained old patient discharged records, and he needed to put them away.		An in-service meeting was conducted by the Governing Body andattended by the Administrator, Director of Clinical Services and all staffincluding contracted personnel on 2/2/23 to discuss the agency policy 6.4.1titled "Patient Confidentiality" under Information Management Section.During this meeting, deficiencies cited under G-1028 were reviewed, addressedand discussed in detail with all staff. The Governing Body emphasized on theimportance that the clinical records, its contents, and the information containedtherein must be safeguarded against loss or unauthorized use. All staff understoodand acknowledged the agency's policy pertaining to safeguarding all patients' clinicalrecord information against loss or unauthorized use. All new staff willbe oriented of this requirement at the time of hire. This corrective action will be implementedon 2/2/2023. **Measuresto assure No recurrence:** In order to ensure that there is	

			norecurrence of this deficiency, the Governing Body will utilize anAdministration audit tool to ensure that the clinical records, its contents, andthe information contained therein must be safeguarded against loss or unauthorizeduse. as per policies and guidelines. This processof utilizing Administration audit tool will help us identify any discrepanciesand implement corrective measures and assess outcomes. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Governing Body willutilize an Administration audit tool and audit 100% of Administration records forthe next 30 days to ensure that the clinical records, its contents, and theinformation contained therein must be safeguarded against loss or unauthorizeduse as per policy and guidelines and document the findings in theAdministration audit tool. The QAPI Committee will review	

			audit findingsof Administration records. Monthly reports will be generated and results willbe compiled and sent to the Administrator and Governing Body to ensure thatprocesses have improved. This process will continue for each month for the next3 months until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within the next 3 months, theywill continue to be addressed with staff re-training and re-education inworkshops and in-services and with each individual personnel as needed. After 3months, this process will continue to be monitored on a quarterly basis andwill be included in the quarterly Administration audit review. Quarterly auditsresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the QAPI Committee will continue to audit 100% of Administrationrecords quarterly to ensure compliance is maintained. The QAPI	

			Committee willsend a written report to the Governing Body quarterly for theirrecommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N9999	Final Observations Review of Indiana Code 16-27-2.5 stated "... Sec. 1. (a) After giving a job applicant written notice of the home health agency's drug testing policy, a home health agency shall require a job applicant who is seeking employment with the home health agency for a position that will have direct contact with a patient to be tested for the illegal use of a controlled substance. ... (c) If a job applicant is hired by the	N9999	**Corrective Action:** In order to correct the abovedeficiency cited, the Administrator and Director of Clinical Services held amanagement meeting on 1/27/2023 and reviewed, discussed the drug testing policy.During this meeting, deficiencies cited under N-9999 were reviewed, addressedand discussed in detail. The Administrator and the Director of ClinicalServices developed and implemented home health agency's drug testingpolicy as per Indiana Code 16-27-2.5. This policy will be effective 2/2/23. An in-service meeting was	2023-02-17

	home health agency before the job applicant's results of the drug test are received, the hired individual may not have any contact with patients until the home health agency obtains results of the drug test that indicate that the individual tested negative on the drug test...." Based on record review and interview, the agency failed to provide all unlicensed staff with notice of the home health agency's drug testing policy; or ensured unlicensed employees tested negative on the drug test before having direct contact with patients, for 2 of 2 personnel records reviewed of unlicensed staff with direct patient contact (Home Health Aide [HHA]#1, HHA #2). Findings include: On 11/30/22 at 1:30 PM, request was made to the Clinical Supervisor to submit the agency's drug testing policy for review. On 12/01/22 at 11:35 AM, second request was made to the Clinical Supervisor to submit the agency's drug testing policy		Administratorand attended by all staff including contracted personnel on 2/2/23 to discuss"Drug Testing Policy". The Administrator emphasized on testing required,affected employees, notice to affected employees, sample size determination,frequency of testing, required home health agency actions for a positive testresult and demonstration of compliance. All staff understood and acknowledgedthe requirement. Deficiencies cited under N-9999 were reviewed, addressed anddiscussed in detail with staff. All new staff will be oriented of thisrequirement at the time of hire. This corrective action will beimplemented on 2/17/23. **Measures to assure Norecurrence:** In order to ensure that there is no recurrence of thisdeficiency, the HR Manager will utilize a HR audit tool to track and document onan annual basis, that the home health agency randomly tests at least fifty (50)percent of the agency's employees who provides direct	

for review.

On 12/01/22 at 11:55 AM, Person #6 (Office Staff) indicated the agency had no drug screen policy.

Personnel record review for HHA #1 (Date of hire 1/06/21, first patient contact 1/08/21) was completed on 12/01/22. The record failed to evidence HHA #1 received written notice of the home health agency's drug testing policy, or any drug testing was performed.

Personnel record review for HHA #2 (Date of hire 9/06/22, first patient contact 9/07/22) was completed on 12/01/22. The record failed to evidence HHA #2 received written notice of the home health agency's drug testing policy, or any drug testing was performed.

During an interview on 12/01/22 at 12:20 PM, the Clinical Supervisor indicated HHA #1 and HHA #2 were not drug tested.

with a patient; and is not licensed by a board or commissionunder Ind. Code § 25. [Ind. Code § 16-27-2.5-2(b)(1)]. This process of utilizing HR audit tool forstaff will help us track and identify any discrepancies in the personnel filerecords and enforce all staff to have their files completed and up to datebefore providing care to our patients or services to our agency.

Monitoring:

Inorder to ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizea HR audit tool and audit 100% of all personnel file records on a monthly basisto ensure that applicable active personnel file records show evidence of drugtesting as per policy. The Office Manager will review HR Manager’s auditfindings of all active personnel file records. Monthly reports will begenerated and results will be compiled and sent to the

			processes have improved. This process will continue for each month for thenext 3 months until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within the next 3 months, theywill continue to be addressed with staff re-training and re-education inworkshops and in-services and with each individual personnel as needed. After 3months, this process will continue to be monitored on a quarterly basis andwill be included in the quarterly HR audit review. Quarterly audits resultswill be compiled and sent to the QAPI Committee for review. Once threshold ismet, the QAPI Committee will continue to audit 100% of personnel file recordsquarterly to ensure compliance is maintained. The Administrator and QAPICommittee will send a written report to the Governing Body quarterly for theirrecommendations.	

			The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Muhammad Chaudhry	Administrator	2/3/2023 4:16:56 PM