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	05/08/2023

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
G0000	INITIAL COMMENTS This was a Federal Post Condition Revisit survey conducted at Paragon Home Health Care Inc., a deemed home heath agency, by the Indiana Department of Health (IDOH). Survey Dates: 5/3/2023, 5/4/2023, 5/5/2023, and 5/8/2023 Facility ID: 012531 Unduplicated Skilled Census for the past 12 months: 202 Current Census: 38 During this survey, 2 Conditions of Participation were corrected: Condition of Participation: Comprehensive Assessment of Patients, and Condition of participation: Organization and Administration of Services; and	G0000	Initial Comments	

	2 Conditions of Participation were re-cited: Condition of Participation: Care Planning, Coordination of Services, and Quality of Care and Condition of Participation: Skilled Professional Services. Also during this survey, 8 standard level tags were corrected, 13 standard level tags were re-cited, and 10 new standard level tags were cited. This deficiency report also reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Based on the Condition-level deficiencies cited during the 12/09/22 survey, 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, 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. QR completed from 05-18-2023 through 05-22-2023 by A3			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review, and interview, the home health agency failed to ensure comprehensive patient assessments included the patients' current health status in 2 of 2 clinical records reviewed with wounds. (Patient #2, #3) The findings include: Clinical record review on 5/3/2023, for Patient #3, evidenced an agency document	G0528	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical on 05/26/23 importance of doing complete assessment during OASIS visits and also on regular visits. Director of Nursing addressing the importance of identifying patient current and past health conditions, living situations and also caregiver. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be	2023-06-02

	4/30/2023, and identified as the comprehensive assessment. Review indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage III (an open pressure ulcer with full thickness loss of skin) to the right ischium (area of the buttock). Review failed to evidence the comprehensive assessment included an assessment of the wound to the right ischium to include size and appearance. Review of agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" indicated a wound from moisture damage was noted to the area to the upper buttocks/coccyx (area above the buttocks) and the nurse applied zinc ointment on document dated 4/24/2023. Review of document dated 4/25/2023, indicated the wound to the upper buttocks/coccyx had reopened and had minimal watery drainage. Review of documents dated 4/28/2023 and 5/1/2023, indicated the nurse applied zinc ointment to the wound to the upper		conducted at least next 90 days.	

	to evidence the comprehensive assessment completed on 4/30/2023 included an assessment of the wound to the upper buttocks/coccyx. Review of a document from Entity #4 (wound clinic) dated 4/27/2023, indicated the patient had an open wound to the left ischium. Review failed to evidence the comprehensive assessment completed on 4/30/2023 included an assessment of the wound to the left ischium. During an interview on 5/8/2023, at 2:05 PM, the alternate clinical manager indicated the comprehensive assessment should include wound measurements, a photograph of the wound, the dressing in place, if any, and appearance of the wound. 1. Record review evidenced an agency policy revised 02/2022, titled "Initial Assessment/Comprehensive Assessments" which stated, "... Each patient admitted will receive a comprehensive assessment ... The comprehensive assessment will			

	health status ... The comprehensive assessment will identify the patient's need for home care and meet the patient's needs for : ... Medical ...." 2. Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to have a right lower leg wound which was bright red, and had bloody drainage. The patient also had a dressing to the left lower leg, which was not removed by the nurse during the visit. Clinical record review for Patient #2 was completed on 5/8/2023, for certification period 4/18/2023 - 6/16/2023. Record review evidenced a recertification comprehensive assessment dated 4/17/2023, which indicated the patient had a wound to the left leg, with a non-removable dressing, but failed to include an assessment of the right lower leg wound or left lower leg wound, such as wound appearance, measurement of wounds, exact location of wounds, type of wounds, drainage from wounds,			

	or dressing types to be applied to the wounds. During an interview on 5/5/2023, at 2:18 PM, the Alternate Clinical Manager indicated the comprehensive assessments should have included head to toe assessments, including wound assessments.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the home health agency failed to ensure all current medications were reviewed to identify potential drug interactions, side effects, duplicate drug therapy and/or noncompliance with drug therapy in 3 of 5 active clinical records reviewed. (Patient #2, #3, #4) The findings include:	G0536	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical on 05/26/23 importance of reconciling the medication profiles at least every 60 days. Director of Nursing educated the clinicians importance of writing over the counter medications in the medication profile. Director of Nursing addressing the importance of identifying major drug interaction and duplicate medications. Clinical staff will communicate with physician office or with DON if they find any major drug interactions or duplicate therapy. DON will ensure to communicate with physician office if we identify any major drug interactions or duplicate therapy. DON will review all therapy case medication profiles. Director of Nursing is responsible to ensure the compliance is met. Monitoring:	2023-06-02

	3. Clinical record review on 5/3/2023, for Patient #3, evidenced agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" dated 4/14/2023, 4/17/2023, and 4/18/2023, which indicated the nurse applied Nystatin (antifungal medication) to the patient's groin. Review failed to evidence an order for the Nystatin. Review of an agency document titled "Medication Profile" dated 4/18/2023, failed to evidence Nystatin was included in the list of medications reviewed for potential adverse effects, drug reactions, and significant drug interactions. Review of an agency document titled "LPV/LPN Visit" dated 4/25/2023, indicated the physician ordered Ciprofloxacin (antibiotic) and dexamethasone (anti-inflammatory) medications for the ear. Review failed to evidence the medications were reviewed prior to 4/30/2023. During an interview on 5/8/2023, at 2:30 PM, the alternate clinical manager		A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

review Nystatin for potential adverse effects prior to 4/19/2023. At 3:00 PM, the alternate clinical nurse indicated the Ciprofloxacin and dexamethasone were not reviewed until they were added onto the medication profile on 4/30/2023 and indicated they should have been reviewed and added to the medication profile at time the medications were ordered.

4. Clinical record review on 5/4/2023, for Patient #4, evidenced agency documents titled "PTA [physical therapy assistant] Visit" dated 4/6/2023, 4/13/2023, 4/17/2023, 4/19/2023, 4/25/2023, 4/27/2023, and 5/2/2023, which indicated the patient had a lidocaine patch (a patch applied to the skin that contains pain relieving medication) to the left knee for pain.

Review of agency documents titled "Home Health Certification and Plan of Care" for certification periods 2/11/2023-4/11/2023 and 4/12/2023-6/10/2023, and the medication profile failed to evidence the lidocaine patch was included in the patient's

medication.

During an interview on 5/5/2023, at 2:52 PM, the alternate clinical manager indicated the medication could not be reviewed if it was not added to the medication profile.

1. Record review evidenced an agency policy revised 02/2021, titled "Medication Reconciliation" which stated, "... The Agency will reconcile patient's medications at time of admission and on an ongoing basis in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and non-compliance with drug therapy ...."

2. Clinical record review for Patient #2 was completed on 5/8/2023, for certification period 4/18/2023 - 6/16/2023. Record review evidenced skilled nurse visit notes dated 4/14/2023 and 4/18/2023, which indicated the patient was taking aspirin (to prevent stroke

	once daily. Record review evidenced a medication profile dated and signed by the registered nurse on 4/17/2023.The medication profile failed to include the Tylenol (pain medication) or aspirin. During an interview on 5/8/2023, at 12:45 PM, Patient #2 indicated they were taking Tylenol (pain medication) as needed for pain. During an interview on 5/8/2023, at 11:32 AM, the Alternate Clinical Manager indicated all medications the patient was taking should have been included on the medication profile and reviewed for interactions or side effects.			
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	G0570	All tags(G0572, G0574, G0578, G0580, G0586, G0590, G0592, G0602, G0606) were addresses individually Standard Level: Corrective Action:	2023-06-02

	plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review, and interview, the Administrator failed to ensure all patients' needs were met and medical care/treatment provided by agency staff followed a 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 services were provided in conformance with physician orders (Please see tag G0578); failed to ensure services and treatments were administered only as ordered by the physician (Please see tag G0580); failed to review and revise the plans of care (Please see tag G0586); failed to ensure the physician was notified of changed in condition (Please see tag G0590); failed to ensure the revised plans of care included information concerning the patients' progress toward measurable outcomes and		Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff and clerical staff on 05/26/23 importance of identifying patient needs(services) before we admit patients to our services. Monitoring: Director of Nursing will review every intake forms before we admit the patients into our services. A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the intake forms to ensure compliance.	

goals identified on the plan of care (Please see tag G0592); failed to communicate with all physicians involved in the plan of care (Please see tag G0602); and failed to coordinate care (Please see tag G0606).

These practices had the potential to affect all agency patients.

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, Coordination of Services, and Quality of Care.

A standard level deficiency was also cited at this level.

Based on 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 in 3 of 5 active records reviewed. (Patient #1, #3, #4)

The findings include:

3. Clinical record review on 5/3/2023, for Patient #3, evidenced an agency document

	titled "Recertification" dated 4/30/2023, which indicated the patient's diagnoses included Multiple Sclerosis (a progressive disease involving the brain and spinal cord) and quadriplegia (paralysis of all 4 limbs). Review indicated the patient was dependent for personal care and activities of daily living (ADLs) and indicated the patient had caregivers coming in the morning and evening to provide care. Review failed to evidence the agency offered the patient home health aide services to assist with personal care and ADLs. During an interview on 5/8/2023, at 10:20 AM, Licensed Practical Nurse (LPN) #1 indicated the patient received care from caregivers from Entity #2 and the patient lived with a family member who was medically compromised and unable to provide personal care and ADLs for the patient. During an interview on 5/8/2023, at 10:45 AM, Person #3 at Entity #2 indicated the patient received 46 hours a week of attendant care services which were provided 2 times a day, 7 days a week and 11 hours			

	a week of homemaker services. During an interview on 5/8/2023, at 12:50 PM, the alternate clinical manager indicated the patient had a need for total care. The alternate clinical manager indicated there was no documentation the agency offered the patient home health aide services. During an interview on 5/8/2023, at 12:50 PM, the administrator indicated the agency did not offer home health aide services because the agency had another caregiver in the home and the agency can not duplicate services. The administrator indicated the agency did not offer home health aide services to the patient because the patient would have to pay for home health aide services privately and the agency did not accept private pay as payor source. 4. Clinical record review on 5/4/2023, for Patient #4, evidenced an agency document titled “Start of Care” dated 2/11/2023, and identified as the initial comprehensive assessment which indicated the			

patient's primary diagnosis was quadriplegia. Review indicated the patient required assistance with dressing, grooming, bathing, and transferring and indicated the patient was chairfast.

Review evidenced an agency document titled "Consent For Service" signed and dated by the patient's caregiver and the physical therapist on 2/11/2023, indicated the agency was to provide physical therapy and home health aide (HHA) services 2 times a week.

Review of an agency document titled "Physician Order" dated 3/7/2023, indicated the agency was to hold home health aide services per patient request until 4/3/2023. Review failed to evidence communication with the patient/caregiver regarding the request to hold home health aide services. Review indicated home health aide services were not provided until 4/12/2023 and review failed to evidence the agency met the patient's needs for home health aide services for personal care.

During an interview on 5/5/2023, at 8:56 AM, the

patient's caregiver indicated the patient nor the caregiver requested for the home health aide services to be on hold. The patient's caregiver indicated their previous home health aide quit and the agency needed to find a new home health aide. The patient's caregiver indicated the previous home health aide was Person #8 (previously employed HHA).

During an interview on 5/5/2023, at 2:22 PM, the alternate clinical manager indicated he was unsure why home health aide services were placed on hold and indicated there should have been documented communication with the patient/caregiver for the reason why services were placed on hold. No additional information was provided.

During an interview on 5/8/2023, at 3:20 PM, the administrator indicated Person #8 was a previously employed home health aide and the last day worked was 2/28/2023.

1. Record review evidenced an agency policy revised 01/2023, titled "Patient Admission

	Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the Agency in the patient's place of residence ... Patients will be accepted for care only if Agency can meet a patient's identified needs ...." 2. Clinical record review for Patient #1 was completed on 5/5/2023, for certification period 4/5/2023 - 6/3/2023. Record review evidenced a referral order dated 4/4/2023, which indicated the patient was to receive home physical therapy and nursing services. Record review evidenced a start of care assessment dated 4/5/2023, which indicated the patient was able to take medication at the correct time if individual doses were prepared in advance by another person. The start of care assessment indicated the patient was not able to take medications at the correct times unless prepared by another person. The assessment indicated the patient lived with a family member who had dementia			

	and memory loss), who was not able to assist with care. The start of care assessment failed to evidence any med setup was performed, taught, or demonstrated during the visit. Record review evidenced a plan of care for certification period 4/5/2023 - 6/3/2023, which indicated the patient was to receive physical therapy once weekly for 1 week, and twice weekly for 2 weeks. The plan of care indicated the patient was only ordered 1 skilled nurse visit, during the start of care, to evaluate the patient's needs. Record review failed to evidence the patient received skilled nursing services for medication setup as identified on the referral order and the start of care assessment. During an interview on 5/5/2023, at 10:00 AM, the Alternate Administrator indicated the agency should have provided the patient with medication box setup by a skilled nurse or education on medication box setup.			
G0572	Plan of care	G0572	Corrective Action:	2023-06-02

	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 the patients received an individualized plan of care, and/or received the services ordered in the plan of care in 5 of 5 active clinical records reviewed. (Patient #1, #2, #3, #4, #5) The findings include: 1. Clinical record review on 5/3/2023, for Patient #3, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/1/2023-6/29/2023, which indicated the patient had a foley catheter (a tube inserted		Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of creating individualized plan of care for all patients. Director of Nursing educated the clinicians on importance of identifying the patient needs and providing appropriate skilled services accordingly. Director of Nursing also in-serviced the clinical staff the importance of contacting the physicians as needed to provide appropriate care for the patients. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

	place with a small, inflated balloon to drain urine from the body) which the skilled nurse was to change monthly using a 18 French (size of the catheter) and a 30 cc (cubic centimeters, unit of measure for the balloon size) catheter. Review indicated the skilled nurse was to administer Copaxone (an injectable medication used to treat multiple sclerosis a progressive disease involving the brain and spinal cord) every Monday, Wednesday, and Friday. Review of agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" indicated the nurse changed the foley catheter using a 10 cc balloon on 4/6/2023. Review failed to evidence the nurse followed the plan of care as directed. Review of document dated 4/10/2023 (Monday), 4/14/2023 (Friday), and 4/19/2023 (Monday) failed to evidence the nurse administered Copaxone as directed. During an interview on 5/8/2023, at 12:26 PM, the alternate clinical manager			

	of care should be followed. The alternate clinical manager indicated if the nurse administered the Copaxone injection, it should be documented in the nurse visit note. 2. Clinical record review on 5/4/2023, for Patient #4, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification periods 2/11/2023-4/11/2023 and 4/12/2023-6/10/2023, which indicated the physical therapist was to educate the patient on fall prevention and safety. Review of agency documents titled "PTA [physical therapy assistant] Visit" dated 4/6/2023, 4/13/2023, 4/17/2023, 4/19/2023, 4/25/2023, 4/27/2023, and 5/2/2023, failed to evidence the PTA educated the patient on fall prevention and safety. During an interview on 5/5/2023, at 2:49 PM, the alternate clinical manager indicated the PTA should have educated on fall prevention and safety because safety was a priority.			

	3. Clinical record review on 5/4/2023, for Patient #5, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification periods 2/18/2023-4/18/2023 and 4/19/2023-6/17/2023, which indicated the agency was to provide physical therapy services 2 times a week. Review failed to evidence the agency provided physical therapy services during the week of 4/2/2023 and the week of 4/16/2023. Review of the plan of care for certification period 2/18/2023-4/18/2023, indicated the patient was to receive continuous oxygen at 2 liters per minute (lpm) and the physical therapist was to provide balance training. Review of the plan of care for certification period 4/19/2023-6/17/2023, indicated the patient was to receive continuous oxygen at 3.5 lpm. Review of an agency document titled "Recertification" completed by the physical therapist and dated 4/15/2023, indicated the patient received oxygen at 3.5 lpm. Review failed to evidence the physical therapist provided oxygen as			

	directed in the plan of care. Review of agency documents titled "PTA Visit" indicated the PTA did not provide balance training on document dated 4/11/2023. Review of documents dated 4/26/2023 and 4/28/2023, indicated the patient received oxygen at 2 lpm. Review failed to evidence the PTA provided oxygen as directed in the plan of care. During an interview on 5/5/2023, at 1:38 PM, the alternate clinical manager indicated services should be provided as directed in the plan of care. At 2:00 PM, the alternate clinical manager indicated any deviation from the plan of care should have been clarified by a physician order and indicated there was not an order to change the patient's oxygen flow rate. During an interview on 5/5/2023, at 2:03 PM, the alternate administrator indicated the clinicians should provide the interventions listed in the plan of care. 1. Record review evidenced an			

	agency policy revised 02/2022, titled "Plan of Care - CMS and Physician/Practitioner Orders" which stated, "... Skilled nursing and other home health services will be in accordance with a Plan of Care based on the patient's diagnosis and assessment of immediate and long-range needs and resources ... Each patient must receive an individualized plan of care, including any revisions or additions ...." 2. Clinical record review for Patient #1 was completed on 5/5/2023, for certification period 4/5/2023 - 6/3/2023. Record review evidenced a start of care assessment dated 4/5/2023, which indicated the patient required medication setup to take medications at the proper time, and also indicated the patient had no willing or able caregiver available to assist with medications.			

	Record review evidenced a plan of care for certification period 4/5/2023 - 6/3/2023, which failed to be individualized to include the required medication setup services which were identified on the start of care assessment. Record review evidenced a physical therapy plan of care for certification period 4/5/2023 - 6/3/2023, which indicated the physical therapist or assistant was to perform the following during home visits twice weekly: functional mobility training, teach fall prevention/safety, proprioceptive training, bed mobility training, establish/upgrade home exercise program, postural control training, and teach safe stair climbing skills. Record review evidenced physical therapy visit notes dated 4/11/2023, 4/13/2023, 4/18/2023, 4/20/2023, and 4/25/2023, which all failed to indicate the physical therapy assistant performed functional mobility training, teach fall prevention/safety, proprioceptive training, bed mobility training,			

exercise program, postural control training, and teach safe stair climbing skills as ordered on the plan of care.

During an interview on 5/5/2023, at 9:47 AM, the Alternate Administrator indicated the services included on the plan of care should have been based on the patient's needs identified on the start of care assessment, and should have included medication setup or education on medication set up. At 10:13 AM, the Alternate Administrator indicated the physical therapy assistant wasn't required to perform every task ordered on the plan of care, and were only expected to address the main problems.

3. Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse was observed performing the following wound care to the patient's right lower leg wound: cleansed with normal saline, applied hydrofera blue (antibacterial/absorbent wound dressing), wrapped with kerlix (gauze wrap), and applied

	stockinette). The skilled nurse failed to apply an ABD pad (absorbent pad) to the wound. Clinical record review for Patient #2 was completed on 5/8/2023. Record review evidenced a document dated 3/28/2023, from Entity #1 (wound clinic), which indicated the patient had appointments at the wound clinic every other week on Tuesday. This document indicated the home health agency was to see the patient only 1 time a week every other week, when the patient went to the wound clinic. This document indicated the home health agency was to perform wound care as follows to a right leg wound: cleanse with normal saline, apply adaptic (non-adherent wound dressing), apply hydrofera blue, cover with ABD pad, wrap with kerlix, and apply tubigrips. Record review evidenced a plan of care for certification period 2/17/2023 - 4/17/2023, which indicated the skilled nurse was to visit twice weekly and perform wound care to a left lower leg wound as follows: cleanse with normal saline, apply hydrofera blue, cover with			

	ABD pad, and secure with kerlix and tubigrip. The plan of care failed to be individualized to include the correct frequency of visits: 1 time weekly every other week due to wound clinic appointments, and twice weekly every other week. The plan of care failed to be individualized to include the correct right leg wound, and failed to be individualized to include the orders for adaptic to be applied to the wound. Record review evidenced a missed visit note dated 4/11/2023, which indicated the visit was missed because the patient had a wound clinic appointment. Record review evidenced a plan of care for certification period 4/18/2023 - 6/16/2023, which indicated the skilled nurse was to visit twice weekly and perform wound care to a right lower leg wound as follows: cleanse with normal saline, apply hydrofera blue, cover with ABD pad, and secure with kerlix and tubigrip. The plan of care failed to be individualized to include the correct frequency of visits: 1 time weekly every other week due to wound clinic			

	appointments, and twice weekly every other week. The plan of care failed to be individualized to include the orders for adaptic to be applied to the wound. Record review evidenced a missed visit note dated 4/25/2023, which indicated the visit was missed because the patient had a wound clinic appointment. During an interview on 5/8/2023, at 11:37 AM, the Alternate Clinical Manager indicated wound care should have been provided as was ordered on the plan of care. At 11:40 AM, the Alternate Clinical Manager indicated they did not know why the plan of care didn't have the correct frequency of visits as ordered by the wound clinic physician. At 11:46 AM, the Alternate Clinical Manager indicated the plan of care had the wrong leg, and should have included adaptic orders.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include	G0574	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies.	2023-06-02

	the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the home health agency failed to ensure the individualized plan of care included all the required elements in 3 of 5 active clinical records reviewed. (Patient #1, #3, #4)		Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of gathering all the clinical details from the patient and generating the plan of care accordingly. Plan of care should be individualized for each patient. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

The findings include:

1. Clinical record review on 5/3/2023, for Patient #3, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/1/2023-6/29/2023, which indicated the patient had a foley catheter (a plastic tube inserted into the bladder to drain urine from the body) and indicated the patient's medications included, but were not limited to, Renacidin (a medicated solution used to prevent clogs in urinary catheters), Biofreeze (a topical pain reliever) for pain in joints, and Nystatin (antifungal medication) to reddened areas. Review indicated the medication should be inserted into the bladder via the catheter and released intrathecally (through the spinal column). Review failed to indicate to which joints the Biofreeze was to be applied and to what reddened areas the Nystatin was to be applied.

During an interview on 5/8/2023, at 12:22 PM, the alternate clinical manager

should have indicated the Renacidin should have been released through the catheter. The alternate clinical manager indicated the specific joints to where the Biofreeze was to be applied and Nystatin to the groin should have been included in the plan of care.

Record review of an agency document titled "LVN/LPN [licensed vocational nurse] Visit" completed by LPN #1 and dated 4/17/2023, indicated the patient had off-loading boots to the feet. Review failed to evidence the plan of care included the boots.

During an interview on 5/8/2023, at 2:32 PM, the alternate clinical manager indicated the boots should have been included in the individualized plan of care.

2. Clinical record review on 5/4/2023, for Patient #4, evidenced an agency document titled "Recertification" dated 4/10/2023, and identified as the comprehensive assessment completed by the physical therapist. Review indicated the patient's primary diagnosis was

patient was chairfast.

Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/12/2023-6/10/2023, which indicated the patient's medications included, but were not limited to, Biokult (dietary supplement), Omega fish oil (dietary supplement), Vitamin K2 (dietary supplement), Aleve (pain reliever) as needed, Lisipro (an injectable medication used to treat high blood sugar), and Lantus (an injectable medication used to treat high blood sugar). Review failed to evidence the dosage of Biokult, Omega fish oil, and Vitamin K2. Review failed to evidence the frequency and indications for use as needed for Aleve. Review failed to evidence the type of injection for Lisipro and Lantus. Review indicated the patient was to receive physical therapy services to include minimizing the risk for hospitalization due to problems with physical limitations, instruct patient on energy conservation techniques, instruct patient on gait (walking), and perform therapeutic exercises. Review failed to evidence the plan of

	care was individualized to include what interventions would be provided to minimize the risk for hospitalization, what energy conservation techniques would be taught, what therapeutic exercises would be performed and to what part of the body, and failed to evidence the plan of care was individualized to meet the patient's inability to walk. During an interview on 5/5/2023, at 2:27 PM, the alternate clinical manager indicated all medications should include a dosage, and the Aleve was for pain and should include the frequency of administration. The alternate clinical manager indicated the Lisipro and Lantus were to be administered by subcutaneous (into the tissue under the skin) injection. At 2:30 PM, the alternate clinical manager indicated the physical therapy plan of care was more comprehensive but was not completed for this patient, and the alternate clinical manager indicated he would instruct the physical therapists to begin completing the physical therapy plan of care. 1. Record review evidenced an			

	agency policy revised 02/2022, titled "Plan of Care - CMS #485 Physician/Practitioner Orders" which stated, "... The individualized plan o fcare must include the following: ... All pertinent diagnoses ... Types of services, supplies, and equipment required ... Frequency and duration of visits to be made ... Rehabilitation potential ... Functional limitations ... Activities permitted ... Nutritional requirements ... All medication and treatments ... Safety measures to protect against injury ... 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 ... Patient and caregiver education and training to facilitate timely discharge ... Patient-specific interventions and education, measurable outcomes and goals identified by the Agency and the patient ...." 2. Clinical record review for Patient #1 was completed on 5/5/2023, for certification period 4/5/2023 - 6/3/2023. Record review evidenced a start			

	4/5/2023, which identified the following risks for hospitalization: currently taking 5 or more medications and other risks not listed. Record review evidenced a plan of care for certification period 4/5/2023 - 6/3/2023, which failed to include the risks for hospitalization or interventions to address the risks for hospitalizations which were identified during the start of care assessment. The plan of care indicated the patient was taking Xarelto (blood thinner), but failed to include bleeding precautions. The plan of care failed to include any patient or caregiver education. During an interview on 5/5/2023, at 9:54 AM, the Alternate Administrator indicated the plan of care should have included all the risks for hospitalization identified on the comprehensive assessment. At 9:57 AM, the Alternate Administrator indicated they were not sure if bleeding precautions should have been included on the plan of care. At 10:03 AM, the Alternate Administrator indicated the patient's plan of			

	care should have included education on medication management, diet, and any important nursing needs.			
G0578	Conformance with physician orders 484.60(b) Standard: Conformance with physician or allowed practitioner orders. Based on record review and interview, the agency failed to ensure services were performed in conformance with physician orders in 1 of 2 clinical records reviewed with wounds. (Patient #3) The findings include: Review of an agency policy revised February 2022, titled "Plan of Care – CMS #485 and Physician/Practitioners Orders" stated, "... Care and services provided will be provided according to physician/practitioner orders...." Clinical record review on 5/3/2023, for Patient #3, evidenced a document from Entity #4 (wound clinic) titled "Physician Orders Details" from Person #5 (wound clinic	G0578	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of following physician orders and provide appropriate care as per physicians instructions. A detailed physician order has to be written if there is change in care and also coordinate with physician to add additional care as per patients needs. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

	physician) dated 4/27/2023, which indicated the patient had an open area to the left ischium (area of the buttock) with a wound order of a mepilex dressing (a type of wound treatment) to be changed every 2-3 days. Review of agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" between 4/28/2023 and 5/3/2023, failed to evidence the nurse changed a treatment to an open area to the left ischium per physician orders. During an interview on 5/8/2023, at 2:07 PM, the Alternate Clinical Manager indicated the wound clinic managed the patient's wounds and the physician's orders should be followed.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the agency failed to	G0580	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff	2023-06-02

	provide services as only ordered by a physician in 1 of 2 clinical records reviewed with wounds. (Patient #3) The findings include: Review of an agency policy revised February 2022, titled "Plan of Care - CMS and Physician/Practitioner Orders" stated, "... Drug, services and treatments are administered by staff only as ordered by physician/practitioner...." Clinical record review on 5/3/2023, for Patient #3, evidenced an agency document titled "Physician Order" dated 3/27/2023, which indicated the nurse was to apply a duoderm (an occlusive dressing) to the pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage 1 (a wound with nonblanching reddened, intact skin) to the coccyx (the area above the buttocks) as needed.		on 05/26/23 importance of communicating with physicians after initiating the care and also communicating with physicians when ever there is change in the care. Director of Nursing also educated the importance of writing detailed physician order has to be written if there is change in care and also coordinate with physician to add additional care as per patients needs. Director of Nursing also educated the clinical staff on importance of generating the plan of care as soon as care is initiated. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

	Review of an agency document titled "SN [skilled nurse] Wound Care Visit" dated 4/5/2023, indicated the area to the upper buttocks/coccyx was healed. Review of agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" indicated a wound from moisture damage was noted to the area to the upper buttocks/coccyx and the nurse applied zinc ointment (medicated wound ointment) on 4/24/2023. Document dated 4/25/2023, the nurse indicated the wound to the upper buttocks/coccyx had reopened and had minimal watery drainage. Document dated 4/26/2023, indicated the nurse applied zinc ointment to the upper buttocks/coccyx wound. Review failed to evidence an order for zinc ointment. During an interview on 5/8/2023, at 2:58 PM, the alternate clinical manager indicated there was not an order for the zinc ointment. Review of agency documents titled "LVN/LPN Visit" dated 4/14/2023, 4/17/2023,			

	4/21/2023, indicated the nurse applied Nystatin (antifungal medication) to the patient's groin. Review failed to evidence an order for Nystatin. During an interview on 5/8/2023, at 2:30 PM, the alternate clinical manager indicated there was not an order for Nystatin. Review of an agency document titled "LVN/LPN Visit" dated 4/25/2023, indicated the patient had increased, thick, mustard-yellow secretions from the right ear after a procedure on 4/19/2023 for ear tube placement. Review indicated the nurse suctioned secretions from the right ear using a bulb syringe (a suction device). Review failed to evidence an order for ear suction. During an interview on 5/8/2023, at 11:23 AM, Person #7 at the office of Person #6 (EENT physician) indicated the ear is self-cleaning after tube placement and a bulb syringe should not be used. Person #7 indicated there was not an order to suction the ear. During an interview on 5/8/2023, at 2:47 PM, the			

	alternate clinical manager indicated ear suction was considered an invasive procedure and required an order. The alternate clinical manager indicated there was not an order to suction the ear.			
G0586	Review and revision of the plan of care 484.60(c) Standard: Review and revision of the plan of care. Based on observation, record review, and interview, the home health agency failed to ensure the plans of care were revised and reviewed in 3 of 5 active clinical records reviewed. (Patient #2, #3, #4) The findings include: 1. Clinical record review on 5/3/2023, for Patient #3, evidenced an agency document titled "Physician Order" dated 3/27/2023, which indicated the nurse was to apply a duoderm (an occlusive dressing) to the pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged	G0586	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of following care plan for all the patients. Clinicians has to ensure all the physician orders has to be incorporated into the current plan of care. Dynamic plan of care has to be generated for all the patients and each care plan has to be individualized based on patient needs. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

	pressure to the skin) stage 1 (a wound with nonblanching reddened, intact skin) to the coccyx (the area above the buttocks) as needed. Review of an agency document titled "SN [skilled nurse] Wound Care Visit" dated 4/5/2023, indicated the area to the upper buttocks/coccyx was healed. Review of agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" indicated a wound from moisture damage was noted to the area to the upper buttocks/coccyx and the nurse applied zinc ointment on 4/24/2023. Review of document dated 4/25/2023, indicated the wound to the upper buttocks/coccyx had reopened and had minimal watery drainage. Review of documents dated 4/26/2023 and 4/28/2023, indicated the nurse applied zinc ointment to the wound to the upper buttocks/coccyx. Review evidenced a document from Entity #4 (wound clinic) titled "Physician Orders Details" dated 4/27/2023, which indicated the patient had an			

	open area to the left ischium (area of the buttock) requiring a wound treatment of a mepilex dressing (a type of wound treatment) to be changed every 2-3 days. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 3/3/2023-5/1/2023, failed to evidence the plan of care was revised by the agency and reviewed by the physician to include the wounds and treatment to the left ischium and to the upper buttocks/coccyx. During an interview on 5/8/2023, at 2:07 PM, the alternate clinical manager indicated the plan of care should have been revised to include the wound treatment to the left ischium and upper buttocks/coccyx. Review of agency documents titled "LVN/LPN Visit" indicated the patient started on a new medication, ofloxacin (an antibiotic), to both ears for 7 days on 4/20/2023. Review failed to evidence the plan of care was updated to include the			

patient's new medication. Review of the document dated 4/25/2023, indicated the physician ordered new medications: Ciprofloxacin (antibiotic) and dexamethasone (anti-inflammatory) medications for the ear. Review failed to evidence the plan of care was updated to include the patient's new medication.

During an interview on 5/8/2023, at 2:35 PM, the alternate clinical manager indicated the plan of care should have been updated by contacting the physician responsible for the plan of care to confirm the medication and writing an order to amend the plan of care. The alternate clinical manager indicated there was no order written for the medication and no update to the plan of care.

2. Clinical record review on 5/4/2023, for Patient #4, evidenced agency documents titled "PTA [physical therapy assistant] Visit" dated 4/6/2023, 4/13/2023, 4/17/2023, 4/19/2023, 4/25/2023, 4/27/2023, and 5/2/2023, which indicated the patient had a lidocaine patch (a patch applied

	to the skin that contains pain relieving medication) to the left knee for pain. Review of agency documents titled “Home Health Certification and Plan of Care” for certification periods 2/11/2023-4/11/2023 and 4/12/2023-6/10/2023, failed to evidence the plan of care was updated to include the patient’s use of a lidocaine patch. During an interview on 5/5/2023, at 2:52 PM, the alternate clinical manager indicated the medication should have been clarified with the physician, a supplemental order for the medication written, and then medication should have been added to the plan of care. 1. Record review evidenced an agency policy revised 02/2022, titled "Plan of Care - CMS #485 and Physician/Practitioner Orders" which stated, "... All patient care orders, including verbal orders, must be recorded in the plan of care. The plan will be revised to reflect any verbal order received during the 60-day certification period so that all Agency staff are working from a current plan ...."			

	2. Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to have a wound on their right lower leg, for which the nurse provided wound care. The patient was observed to have a left leg which was wrapped in kerlix and tubigrips. The left leg wound dressing was not removed during the visit. Clinical record review for Patient #2 was completed on 5/8/2023, for certification periods 2/17/2023 - 4/17/2023, and 4/18/2023 - 6/16/2023. Record review evidenced physician orders from Entity #1 (wound clinic), dated 3/28/2023, which indicated the skilled nurse was to apply adaptic (non-adherent wound dressing) to a right lower leg wound. The wound clinic orders indicated the skilled nurse was to visit and perform wound care once weekly every other week, and twice weekly every other week. Record review evidenced a plan of care for certification period 2/17/2023 - 4/17/2023, which			

	to be performed on a left leg wound, and failed to include wound treatment orders for a right lower leg wound. The plan of care failed to be revised to include the application of adaptic.The plan of care indicated the skilled nurse was to visit twice weekly, and failed to be revised to reflect the wound clinic orders for alternating visits twice weekly and once weekly. Record review evidenced a plan of care for certification period 4/18/2023 - 6/16/2023, which failed to be revised to include the orders for adaptic to be applied to the right lower leg. The plan of care indicated the skilled nurse was to visit twice weekly, and failed to be revised to reflect the wound clinic orders for alternating visits twice weekly and once weekly.			

	Record review evidenced a skilled nurse visit note dated 4/14/2023, which indicated on 4/10/2023, the patient developed a new left lower extremity wound, which required 7 sutures. The plan of care failed to be revised to reflect any orders for treatment of left lower leg wound. During an interview on 5/8/2023, at 11:46 AM, the Alternate Clinical Manager indicated the plans of care should have been revised to reflect the correct leg, adaptic, and the correct frequency of nursing visits. At 11:51 AM, the Alternate Clinical Manager indicated the plan of care should have been revised to reflect treatment orders for the new wound.			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to	G0590	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians after initiating the care and also communicating with physicians when ever	2023-06-02

	ensure the physician responsible for the plan of care was notified of a new wound in 1 of 2 active clinical records reviewed with wounds. (Patient #3) The findings include: Review of an agency policy revised February 2021, titled "Coordination of Patient Care" stated, "... The Agency must: ... Assure communication with all physicians/practitioners involved in the plan of care ... Staff provides the physician/practitioner with patient information on an ongoing basis regarding: ... Current condition and changes in condition ...." Clinical record review on 5/3/2023, for Patient #3, evidenced a document from Entity #4 (wound clinic) titled "Physician Orders Details" from Person #5 (wound clinic physician) dated 4/27/2023, which indicated the patient had an open wound to the left ischium (area of the buttock) with a wound order of a mepilex dressing (a type of wound treatment) to be changed every 2-3 days. Review		there is change in the care. Director of Nursing also educated the importance of writing detailed physician order has to be written if there is change in care and also coordinate with physician to add additional care as per patients needs. Director of Nursing also educated the clinical staff on importance of generating the plan of care as soon as care is initiated. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

	failed to evidence the physician responsible for the plan of care was notified of the new wound and wound treatment ordered by the wound clinic physician. During an interview on 5/8/2023, at 2:07 PM, the alternate clinical manager indicated the physician responsible for the plan of care should have been notified of the new wound and treatment orders but had not been notified by the agency.			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care.	G0592	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 how to write goals during assessment and also during evaluations. Director of Nursing also educated the clinical staff those goals has to be measurable goals. Director of Nursing also educated the clinical staff on incorporating the progress towards the goals in the recertification plan of cares. All goals has to be measurable. Director of Nursing is responsible to ensure the compliance is met. Monitoring:	2023-06-02

	Based on record review and interview, the home health agency failed to ensure revised plans of care included the patient's progress towards measurable outcomes and goals in 3 of 4 clinical records reviewed which received services longer than 60 days. (Patient #2, #3, #4) The findings include: 3. Clinical record review on 5/3/2023, for Patient #3, start of care 3/3/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/1/2023-6/29/2023, which failed to be revised to include the patient's progress towards measurable outcomes and goals. 4. Clinical record review on 5/4/2023, for Patient #4, start of care 2/11/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/12/2023-6/10/2023, which failed to be revised to include the patient's progress towards measurable outcomes and goals.3. Clinical record review		A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

start of care 2/18/2023, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/19/2023-6/17/2023, which failed to be revised to include the patient’s progress towards measurable outcomes and goals.

5. During an interview on 5/5/2023, at 2:53 PM, the alternate clinical manager indicated the revised plan of care did not contain progress to goals, and indicated the agency put the progress to goals on the 60 day summary instead.

1. Record review evidenced an agency policy revised 02/2022, titled "Plan of Care - CMS #485 and Physician/Practitioner Orders" which stated, "... A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the Agency and patient in the plan of care ...."

2. Clinical record review for

	Patient #2 was completed on 5/8/2023. Record review evidenced a revised plan of care for certification period 4/18/2023 - 6/16/2023, which failed to include any information regarding the patient's progress towards the measurable outcomes and goals identified on the plan of care. During an interview on 5/8/2023, at 2:10 PM, the Alternate Clinical Manager indicated they did not normally include progress towards goal on the plans of care.			
G0602	Communication with all physicians 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. Based on record review and interview, the agency failed to communicate with all physicians involved in the plan of care in 1 of 1 clinical record reviewed with an EENT physician (physician that deals with conditions of the eyes, ears, nose, and throat). (#3) The findings include:	G0602	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians after initiating the care and also communicating with physicians when ever there is change in the care. Director of Nursing also educated the importance of writing detailed physician order has to be written if there is change in care and also coordinate with physician to add additional care as per patients needs. Director of Nursing also educated the clinical staff on importance	2023-06-02

	Review of an agency policy revised February 2021, titled "Coordination of Patient Care" stated, "... The Agency must: Assure communication with all physicians/practitioners involved in the plan of care...." Clinical record review on 5/3/2023, for Patient #3, evidenced agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" indicated the patient had an appointment with the EENT physician that day due to the patient's complaint of clogged ears on document dated 4/19/2023. Document dated 4/20/2023, indicated the patient started on ofloxacin (antibiotic) drops to both ears for 7 days. Review of document completed by LPN #3 and dated 4/24/2023, indicated the patient had yellow drainage from the right ear tube and the patient reported the EENT physician was supposed to be notified of any drainage. Review of the document dated 4/25/2023, indicated the patient had ear tubes placed on 4/19/2023 and the patient had thick, mustard-yellow, cloudy,		of generating the plan of care as soon as care is initiated. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

	malodorous drainage from the right ear. Review indicated the EENT physician was notified of drainage on 4/25/2023, and the patient was ordered Ciprofloxacin (antibiotic) and dexamethasone (anti-inflammatory) medications for the ear. Review failed to evidence the name of the EENT physician and contact information. Review failed to evidence the agency communicated with the EENT physician prior to 4/25/2023 to obtain post-procedure instructions regarding the ear tube placement. During an interview on 5/8/2023, at 10:58 AM, LPN #3 indicated he/she was unaware of who the EENT physician was.			

	During an interview on 5/8/2023, at 2:58 PM, the alternate clinical manager indicated there was not a name and contact information for the EENT physician in the clinical record. The alternate clinical manager indicated the agency should have communicated with the EENT physician regarding the instructions for the care of the ear tube placement.			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to ensure the coordination of care with all disciplines and agencies providing services to the patient in 2 of 5 active clinical records reviewed. (Patient #3, #5) The findings include: 1. Review of an agency policy revised February 2021, titled	G0606	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians and other agencies involved in patient care after initiating the care and also communicating with appropriate concern people/agencies when ever there is change in the care. Director of Nursing also educated the importance of writing detailed documentation about the communication clinicians had with other agencies. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing	2023-06-02

	"Coordination of Patient Care" stated, "... The Agency must ... Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines...."		will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

	2. Clinical record review on 5/3/2023, for Patient #3, evidenced an agency document titled "Recertification" dated 4/30/2023, which indicated the patient's diagnoses included Multiple Sclerosis (a progressive disease involving the brain and spinal cord) and quadriplegia (paralysis of all 4 limbs). Review indicated the patient was dependent for personal care and activities of daily living, had a foley catheter (a tube inserted into the bladder to drain urine), and had a wound. Review indicated the patient had caregivers coming in the morning and evening to provide care. Review failed to evidence the name of the agency providing the caregivers, the care they were to provide, and the duration of the visits provided. During an interview on 5/8/2023, at 10:20 AM, Licensed Practical Nurse (LPN) #1 indicated the patient was cared for by caregivers from Entity #2. During an interview on 5/8/2023, at 10:45 AM, Person #3 at Entity #2 indicated the patient received 46 hours a			

which were provided 2 times a day, 7 days a week and 11 hours a week of homemaker services. Person #3 indicated staff provided from Entity #2 were not allowed to administer any medications or provide wound care. Person #3 indicated she had difficulties with the home care agency nurses instructing the attendants to perform wound care in the absence of the nurse.

During an interview on 5/8/2023, at 12:45 PM, the alternate clinical manager indicated he was unaware what agency provided the caregivers and did not know the type of care the patient received from another agency. The alternate clinical manager indicated there was no care coordination with another agency providing services to the patient in the home.

Record review of an agency document titled "LVN/LPN [licensed vocational nurse] Visit" completed by LPN #1 and dated 4/17/2023, indicated the morning attendant did not arrive to the patient's home as scheduled and the LPN had to assist the patient with personal

	care. Review indicated the patient was going to search for a new attendant care agency due to the reliability issues with the current agency. Review failed to evidence the agency coordinated care with Entity #2 (attendant care agency) regarding the reliability concerns. During an interview on 5/8/2023, at 2:32 PM, the alternate clinical manager indicated the agency should have coordinated care with Entity #2 (attendant care agency) regarding the reliability issues. Review of documents from Entity #4 (wound clinic) indicated the wound to the patient's right ischium (area of the buttock) measured 0.4 centimeters (cm) in length, 0.6 cm in width, and 1.3 cm in depth on document dated 4/20/2023. Review of document dated 4/27/2023 indicated the wound to the right ischium measured 0.2 cm in length, 0.2 cm in width, and 0.1 cm in depth. Review of agency documents			

	4/5/2023 through 5/5/2023, indicated the wound to the right ischium measured 1.4 cm in length, 0.6 cm in width, and 0.4 cm in depth. Review failed to evidence coordination with the wound clinic regarding the discrepancy between wound measurements. During an interview on 5/8/2023, at 2:40 PM, the alternate clinical manager indicated there was no coordination of care with the wound clinic other than the wound clinic's visit notes regarding the wound measurements. 3. Clinical record review on 5/4/2023, for Patient #5, evidenced agency documents titled "Missed Visit" dated 4/6/2023, 4/19/2023, and 4/21/2023, which indicated the physical therapy assistant (PTA) was unable to provide the visit. Review of document dated 4/6/2023, indicated the patient was treated in the emergency room. Review failed to evidence the PTA coordinated care with the physical therapist regarding the patient's emergency room visit. Review of documents dated 4/19/2023 and			

	4/21/2023, failed to evidence the PTA coordinated care regarding the missed visits and the failure to meet the ordered frequency as directed in the plan of care. During an interview on 5/5/2023, at 1:40 PM, the alternate clinical manager indicated staff was educated they should communicate missed visits to the supervising discipline for each patient. The alternate clinical manager indicated there was no documentation the PTA notified the physical therapist. During an interview on 5/5/2023, at 1:53 PM, the alternate administrator indicated the PTA should have notified everyone involved in the patient's care of the emergency room visit. The alternate administrator indicated the agency was unaware of the emergency visit.			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of	G0682	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies.	2023-06-02

	practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the home health agency failed to ensure clinicians followed standard precautions in 1 of 1 home visit observed. (Patient #2) The findings include: Record review evidenced an agency policy revised 07/2021, titled "Standard Precautions" which stated, "... Perform hand hygiene after removing gloves ...."		Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 on OSHA and also hand washing techniques. Director of Nursing educated the clinical staff on safe practices for both patients and clinical staff. Director of Nursing is responsible to ensure the compliance is met. Monitoring: Clinical staff will have OAHA training at least once a year. Director of Nursing will perform home visits along with clinicians at least once a quarter with each clinician for next 2 quarters to ensure clinicians follow protocols. This will be monitored by Director of Nursing.	

	Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, at 12:10 PM, Licensed Practical Nurse #1 was observed removing tubigrips (compression stockinette) from patient's right leg, removed gloves, and donned new gloves, without performing hand hygiene in between. At 12:12 PM, Licensed Practical Nurse #1 was observed cleansing the patient's wound with gauze and normal saline, removing gloves, and donning new gloves without performing hand hygiene in between. During an interview on 5/8/2023, at 11:41 AM, the Alternate Clinical Manager indicated the nurse ideally would have performed hand hygiene between glove changes.			
G0700	Skilled professional services 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy,	G0700	All tags(G0714, G0716, G0718, G0726, G0728) were addresses individually	2023-06-02

	speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. Based on observation, record review, and interview, the home health agency failed to ensure skilled professionals provided patient and caregiver education (Please see tag G0714); failed to ensure registered nurses completed clinical notes in a timely and/or accurate manner (Please see tag G0716); failed to ensure the Registered Nurse (RN) communicated with all physicians involved in the patient's plan of care (Please see tag G0718); failed to supervise nursing services (Please see tag G0726); and failed to ensure supervision of therapy services (Please see tag G0728). This practice had the potential to affect all patients serviced by the agency. The Findings include:			
G0714	Patient and caregiver education 484.75(b)(5)	G0714	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies.	2023-06-02

	Patient and caregiver education; Based on observation, record review, and interview, the home health agency failed to ensure skilled professionals performed patient education in 4 of 5 active clinical records reviewed. (Patient #1, #2, #3, #5) The findings include: 4. Clinical record review on 5/3/2023, for Patient #3, agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" dated 4/6/2023 and 4/20/2023, indicated the patient required total care for all personal care and activities of daily living (ADLs) and had left sided weakness and right sided paralysis. Review indicated the skilled nurse educated the patient to cleanse the foley catheter (a tube inserted into the bladder to drain urine from the body) and empty the catheter bag once it was half full. Review failed to evidence the nurse educated the caregiver responsible for providing care to the patient for foley catheter care and catheter bag emptying. Review of document dated 4/20/2023,		Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of educating the patients on their clinical issues and also educating the patients on their disease process and also on medications, their importance and side effects. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

	a new medication, ofloxacin (an antibiotic), to both ears for 7 days. Review indicated the nurse educated the patient on the medication and the caregiver was not present at the time of the visit. Review failed to evidence the nurse provided education to the caregiver responsible for the administration of the ear medication. During an interview on 5/8/2023, at 10:20 AM, Licensed Practical Nurse (LPN) #1 indicated the patient was cared for by caregivers from Entity #2. LPN #1 indicated the patient lived with a family member who was medically compromised and who was not able to provide personal care, wound care, and catheter care. During an interview on 5/8/2023, at 10:45 AM, Person #3 at Entity #2 indicated the patient received 46 hours a week of attendant care services which were provided 2 times a day, 7 days a week. Person #3 indicated staff provided from Entity #2 were not allowed to administer any medications or provide foley or wound care.			

	difficulties with the home care agency nurses instructing the attendants to perform wound care in the absence of the nurse. During an interview on 5/8/2023, at 12:26 PM, the alternate clinical manager indicated the patient is not capable of performing foley catheter care but is knowledgeable about what care should be completed, and indicated the patient would instruct the caregiver. At 2:48 PM, the alternate clinical manager indicated he was unsure who was to administer the patient's ear medication and the nurse should have determined that and then educated the caregiver on the administration of the ear medication. 5. Clinical record review on 5/4/2023, for Patient #5, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification periods 2/18/2023-4/18/2023, which indicated the patient was to receive continuous oxygen at 2 liters per minute (lpm), and for certification period			

	4/19/2023-6/17/2023, which indicated the patient was to receive continuous oxygen at 3.5 lpm and indicated the physical therapist was to educate the patient on fall prevention and safety. Review of an agency document titled "Recertification" completed by the physical therapist and dated 4/15/2023, indicated the patient received oxygen at 3.5 lpm. Review failed to evidence the physical therapist educated the patient to administering oxygen as ordered. Review of agency documents titled "PTA [physical therapy assistant] Visit" dated 4/26/2023 and 4/28/2023, indicated the patient received oxygen at 2 lpm. Review failed to evidence the PTA educated the patient to administering oxygen as ordered. Review failed to evidence the PTA educated the patient to fall prevention and safety. During an interview on 5/5/2023, at 2:00 PM, the alternate clinical manager indicated the clinician should have educated the patient to			

following the physician orders for the oxygen flow rate. At 2:02 PM, the alternate clinical manager indicated fall prevention is a priority.

During an interview on 5/5/2023, at 2:02 PM, the alternate administrator indicated clinicians did not need to teach on every topic at every visit but rather focus the teaching on the major things first.

1. Record review evidenced an agency policy revised 02/2021, titled "Skilled Professional Services" which stated, "... Skilled professional serrvices include skilled nursing services, physical therapy, speech language pathology services, occupational therapy, physician and medical social work services ... Skilled professionals must assume responsibility for, but not be restricted to the following: ... Patient and caregiver education ...."

2. Clinical record review for Patient #1 was completed on 5/5/2023, Record review

	evidenced a plan of care for certification period 4/5/2023 - 6/3/2023, which indicated the patient was to receive physical therapy visits once weekly for 1 week, and twice weekly for 4 weeks. The plan of care indicated the physical therapists and assistants were to perform patient/caregiver education every visit. Record review evidenced a physical therapy visit notes dated and signed by Physical Therapy Assistant #1 on 4/11/2023, 4/13/2023, 4/18/2023, 4/20/2023, and 4/25/2023, which failed to include any education performed. During an interview on 5/5/2023, at 10:13 AM, the Alternate Administrator indicated the physical therapy assistants should have educated the patient on the root cause of their diagnoses and issues. 3. Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse failed to perform education on			

	importance of wound care, disease process, signs and symptoms of worsening disease process, notification of the physician, incision care to prevent infection, self management of pacemaker, fall prevention, storage of wound supplies, wound care, and standard precautions. Clinical record review for Patient #2 was completed on 5/8/2023. Record review evidenced a plan of care for certification period 2/17/2023 - 4/17/2023, which indicated the skilled nurse was to visit twice weekly, and educate the patient on possible drug interactions, importance of wound care, disease process, signs and symptoms of worsening disease process, notification of the physician, wound care to prevent infection, anticoagulant management, fall prevention, storage of wound supplies, wound care, and standard precautions. Record review evidenced a skilled nurse visit note dated 4/14/2023, which indicated the nurse educated the patient on high blood pressure, but failed to educate the patient about			

	possible drug interactions, importance of wound care, disease process, signs and symptoms of worsening disease process, notification of the physician, wound care to prevent infection, anticoagulant management, fall prevention, storage of wound supplies, wound care, and standard precautions, as ordered on the plan of care. Record review evidenced a plan of care for certification period 4/18/2023 - 6/16/2023, which indicated the skilled nurse was to visit twice weekly, and educate the patient on possible drug interactions, importance of wound care, disease process, signs and symptoms of worsening disease process, notification of the physician, incision care to prevent infection, self management of pacemaker, fall prevention, storage of wound supplies, wound care, and standard precautions. Record review evidenced a skilled nurse visit note dated 4/18/2023, which failed to indicate the nurse educated the patient on possible drug interactions, importance of			

	wound care, disease process, signs and symptoms of worsening disease process, notification of the physician, incision care to prevent infection, self management of pacemaker, fall prevention, storage of wound supplies, wound care, and standard precautions, as ordered on the plan of care. Record review evidenced a skilled nurse visit note dated 4/21/2023, which failed to indicate the nurse educated the patient on possible drug interactions, importance of wound care, disease process, signs and symptoms of worsening disease process, notification of the physician, incision care to prevent infection, self management of pacemaker, fall prevention, storage of wound supplies, wound care, and standard precautions, as ordered on the plan of care. Record review evidenced a skilled nurse visit note dated 4/28/2023, which failed to indicate the nurse educated the patient on possible drug interactions, importance of			

	signs and symptoms of worsening disease process, notification of the physician, incision care to prevent infection, self management of pacemaker, fall prevention, storage of wound supplies, wound care, and standard precautions, as ordered on the plan of care. During an interview on 5/8/2023, at 11:32 AM, the Alternate Clinical Manager indicated the nurse should have educated on diagnosis, medications, fall precautions, an signs and symptoms of exacerbation. The Alternate Clinical Manager indicated the clinician was not expected to perform all the education ordered on the plan of care each visit.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on observation, record review, and interview, the home health agency failed to ensure skilled professionals accurately and completely documented	G0716	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence:	2023-06-02

	patient assessments and clinical notes in 4 of 5 active clinical records reviewed. (Patient #1, #2, #3, #5) The findings include: 4. Clinical record review on 5/3/2023, for Patient #3, evidenced agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" dated 4/13/2023 and 4/27/2023, and completed by LPN #1, which indicated the patient went to the wound clinic earlier in the day and indicated the nurse performed wound care at the skilled nurse visit. Nurse visits dated 4/5/2023, 4/6/2023, 4/7/2023, 4/11/2023, 4/12/2023, 4/13/2023, 4/14/2023, 4/18/2023, 4/19/2023, 4/20/2023, 4/21/2023, 4/25/2023, 4/26/2023, 4/27/2023, and 5/3/2023 (not Mondays) indicated the wound to the right ischium (area on the buttock) measured 1.4 centimeters (cm) in length, 0.6 cm in width, and 0.4 cm in depth. During an interview on		Director of Nursing in-serviced all clinical staff on 05/26/23 importance of submitting the patient documentation timely. Director of Nursing educated the clinicians on importance of writing detailed physician order(person they spoke with, time they spoke with the person) when they communicate with physician office. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. DON will QA all the clinical records to identify if clinicians are following care plan or not and also make sure clinicians are following up with physicians when there is change in patients care. These chart audits will be conducted at least next 90 days.	

	indicated he/she did not perform wound care at the visits provided on the same day the patient went to the wound clinic. LPN #1 indicated the documentation of the wound treatment performed at the visit must have been a carry-over from a previous note. LPN #1 indicated he/she measured the wound weekly on Mondays and the wound measurements documented on the nurse visit notes from days other than Mondays must have been a carry-over from a previous note. During an interview on 5/8/2023, at 2:04 PM, the alternate clinical manager indicated documentation should not auto-populate on the nurse visit notes and indicated the nurse probably did not know to change the documentation that was auto-populated on the note. Review of agency documents titled "LVN/LPN Visit" indicated the patient started a new medication, ofloxacin (antibiotic), to both ears for 7 days on document dated 4/20/2023. Review of document dated 4/25/2023, indicated the patient was ordered 2 new			

	medications to be administered via the ears, Ciprofloxacin (antibiotic) and dexamethasone (steroid to reduce inflammation). Review of agency documents titled "LVN/LPN Visit" completed by LPN #3 and dated 4/24/2023 and 4/27/2023, failed to evidence the LPN documented the administration of the ear medication. During an interview on 5/8/2023, at 10:58 AM, LPN #3 indicated she applied the ear medication during the nurse visits on 4/24/2023 and 4/27/2023 but did not document the medication administration. During an interview on 5/8/2023, at 2:13 PM, the alternate clinical manager indicated the nurse should document the administration of medication in the nurse visit note to include the name of the medication, dose, route, and patient reaction. 5. Clinical record review on 5/5/2023, for Patient #5, evidenced an agency document			

	Certification and Plan of Care" for certification period 4/19/2023-6/17/2023, which indicated the agency was to provide physical therapy services 2 times a week. Review failed to evidence a physical therapy visit note since 4/28/2023. Review evidenced a physical therapy assistant (PTA) visit was scheduled for 5/3/2023, and indicated the visit note was not yet started. During an interview on 5/5/2023, at 2:10 PM, the alternate clinical manager indicated the PTA completed the visit on 5/3/2023, and the documentation should have been completed the same day. 1. Record review evidenced an agency policy revised 02/2021, titled "Skilled Professional Services" which stated, "... Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, occupational therapy, physician and medical social work services ... Skilled professionals must assume responsibility for, but not be			

	restricted to the following: ... assessment of the patient ... Preparing clinical notes ...." 2. Clinical record review for Patient #1 was completed on 5/5/2023. Record review evidenced a plan of care for certification period 4/5/2023 - 6/3/2023, which indicated the patient was to receive physical therapy visits once weekly for 1 week, and twice weekly for 4 weeks. Record review evidenced a physical therapy missed visit note dated 4/27/2023 and signed by Physical Therapy Assistant #1, which indicated the patient had a missed visit. This visit note indicated a physician office was notified, but failed to document which physician was notified, how the physician was notified, results of the communication or on what day or time the physician was notified. During an interview on 5/5/2023, at 10:06 AM, the Administrator indicated the visit note indicated the physician was notified. The Alternate Administrator indicated they did not know how to verify the			

	skilled professional called the physician, since it wasn't documented. 3. Observation of a home visit for Patient #2 was completed on 5/5/2023, at 12:00 PM, to observe a routine skilled nursing visit. During the visit, the skilled nurse did not measure the patient's right lower leg wound. During the visit, the nurse did not discuss discharge planning, and did not remove the left lower leg dressing or assess the left lower leg. Clinical record review for Patient #2 was completed on 5/8/2023, for certification periods 2/17/2023 - 4/17/2023, and 4/18/2023 - 6/16/2023. Record review evidenced skilled nurse visit notes dated 4/14/2023, 4/18/2023, 4/21/2023, and 4/25/2023, which indicated the patient had 3 wounds, right lower leg, left upper chest, and left lower leg. These visit notes indicated wound care was performed, but failed to include which wound(s) were treated with wound care. Record review evidenced missed visit notes dated			

	4/11/2023, and 4/25/2023, which indicated the patient had missed visits, but failed to document which physician was notified, how the physician was notified, results of the communication or on what day or time the physician was notified. Record review evidenced a visit note dated 3/28/2023, from Entity #1 (wound clinic) which indicated the patient's right lower leg wound measured 7cm (centimeters) x 6.5 cm x 0.1 cm. Record review evidenced skilled nursing visit notes dated 4/14/2023, 4/18/2023, and 4/21/2023, which all indicated the patient's right lower leg wound measured 7cm (centimeters) x 6.5cm x 0.1cm. Record review evidenced a visit note dated 4/25, from Entity #1 (wound clinic), which indicated the patient's right lower leg wound measured 4cm x 3.2cm x 0.1cm. Record review evidenced skilled nursing visit notes dated 4/28/2023, 5/2/2023, and 5/5/2023, which all indicated the patient's right lower leg			

	0.1cm. Record review evidenced a skilled nurse visit note dated 5/5/2023, which indicated the nurse discussed discharge planning with the patient, and indicated the left lower leg had 7 sutures, and was clean, dry, and intact. During an interview on 5/8/2023, at 11:47 AM, the Alternate Clinical Manager indicated the visit notes didn't specify which wound was treated with wound care. At 11:52 AM, the Alternate Clinical Manager indicated the missed visit notes should have included which physician was notified, what day and time they were notified, and results of the notification. At 12:02 PM, the Alternate Clinical Manager indicated the wound measurements automatically populated in the visit notes, and wounds were only measured on the first visit of the week. At 12:10 PM, the Alternate Clinical Manager indicated they were not sure why the nurse documented on the 5/5/2023 visit note that they performed discharge planning and left			

	wasn't performed. During an interview on 5/8/2023, at 3:17 PM, Licensed Practical Nurse #2 indicated they had been seeing Patient #2, and would use the wound clinic measurements for documentation if they were close to the actual measurements they obtained during the visit.			
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on observation, record review, and interview, the home health agency failed to ensure skilled professionals communicated with all physicians regarding the current plan of care in 3 of 5 active clinical records reviewed. (Patient #2, #3, #5) The findings include: 3. Clinical record review on 5/3/2023, for Patient #3, evidenced an agency document	G0718	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians and appropriate parties involving in patient care. All clinicians should communicate with physicians office as soon as they initiated the care also when their is a change in care provided to the patient. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

	titled "Physician Order" dated 3/27/2023, which indicated the nurse was to apply a duoderm (an occlusive dressing) to the pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage 1 (a wound with nonblanching reddened, intact skin) to the coccyx (the area above the buttocks) as needed. Review of an agency document titled "SN [skilled nurse] Wound Care Visit" dated 4/5/2023, indicated the area to the upper buttocks/coccyx was healed. Review of agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" indicated a wound from moisture damage was noted to the area to the upper buttocks/coccyx and the nurse applied zinc ointment on 4/24/2023. Review of document dated 4/25/2023, indicated the wound to the upper buttocks/coccyx had reopened and had minimal watery drainage. Review failed to evidence the physician responsible for the plan of care was notified of the reopened			

	buttocks/coccyx. Review of document dated 4/24/2023, indicated the patient had yellow liquid draining from a tube placed in the right ear and the patient informed the nurse the EENT physician (physician that treats conditions of the eye, ear, nose, and throat) was supposed to be notified of any drainage. Review failed to evidence the nurse informed the EENT physician of the drainage. Review of the document dated 4/25/2023, indicated the patient had ear tubes placed on 4/19/2023 and the patient had thick, mustard-yellow, cloudy, malodorous drainage from the right ear. Review indicated the EENT physician was notified of drainage on 4/25/2023, and the patient was ordered Ciprofloxacin (antibiotic) and dexamethasone (anti-inflammatory) medications for the ear and failed to evidence the physician responsible for the plan of care was notified of the drainage from the ear and of the new medications. During an interview on 5/8/2023, at 2:53 PM, the alternate clinical manager			

	called the EENT physician. At 2:58 PM, the alternate clinical manager indicated the nurse should have notified the physician responsible for the plan of care of the reopened area, the ear drainage, and the new medications. 4. Clinical record review on 5/4/2023, for Patient #5, evidenced an agency document titled "Missed Visit" completed by physical therapy assistant (PTA) #2 and dated 4/6/2023, which indicated the patient was treated in the emergency room. Review evidenced the document stated, "... Physician Office Notified: Yes ...." Review failed to evidence the name of the physician notified. During an interview on 5/5/2023, at 1:23 PM, PTA #2 indicated they did not call the physician for a missed visit and for the emergency room visit and was unaware the visit note had a section for physician notification and did not check "yes". During an interview on 5/5/2023, at 1:53 PM, the alternate clinical manager			

	documentation the physician was notified of the emergency room visit. 1. Record review evidenced an agency policy revised 02/2021, titled "Coordination of Patient Care" which stated, "... The Agency must: ... Assure communication with all physicians/practitioners involved in the plan of care ... Staff provides the physician/practitioner with patient information on an ongoing basis regarding: ... Current condition and changes in condition ... Outcomes of care and services ...." 2. Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse was observed performing the following wound care to the patient's right lower leg wound: cleansed with normal saline, applied hydrofera blue (antibacterial/absorbent wound dressing), wrapped with kerlix (gauze wrap), and applied tubigrip (compression stockinette). The skilled nurse			

	failed to apply an ABD pad (absorbent pad) to the wound. Licensed Practical Nurse #1 indicated they didn't apply the ABD pad because it would put too much pressure on the wound. Licensed Practical Nurse #1 failed to notify the physician of the change in treatment provided. Clinical record review for Patient #2 was completed on 5/8/2023. Record review evidenced a plan of care for certification period 4/18/2023 - 6/16/2023, which indicated the skilled nurse was to visit twice weekly and perform wound care as follows: cleanse with normal saline, apply hydrofera blue, cover with ABD pad, and secure with kerlix and tubigrip. Record review evidenced a skilled nurse visit note dated 4/14/2023, which indicated the patient had developed a new left lower extremity wound on 4/10/2023, which had been treated in the emergency room with 7 sutures. Record review failed to evidence the physician listed on the plan of care was notified of			

	extremity wound. Record review evidenced a skilled nurse visit note dated 5/5/2023, which failed to evidence the physician was notified that the ABD pad was not applied during the visit. During an interview on 5/8/2023, at 11:37 AM, the Alternate Clinical Manager indicated the physician should have been notified that the ABD pad wasn't applied and the need for new orders. At 11:51 AM, the Alternate Clinical Manager indicated the physician on the plan of care should have been notified of the new wound to the left lower leg.			
G0726	Nursing services supervised by RN 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). Based on observation, record review, and interview, the home health agency failed to ensure licensed practical nurses were supervised by registered nurses in 2 of 2 clinical records	G0726	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence:	2023-06-02

	reviewed, which received services from licensed practical nurses. (Patient #2, #3) The findings include: 4. Clinical record review on 5/3/2023, for Patient #3, evidenced agency documents titled "LVN/LPN Visit" dated 4/17/20223, 4/18/2023, and 4/19/2023 which indicated the LPN applied nystatin (an antifungal medication) to the patient's groin area. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 3/3/2023-5/1/2023, failed to evidence nystatin was included in the patient's medication orders. Review failed to evidence the RN provided supervision of the LPN to ensure the LPN was providing care as directed by the plan of care. During an interview on 5/3/2023, at 12:54 PM, the alternate clinical manager indicated there were no supervision visits of the LPN and indicated the RN should		Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians and appropriate parties involving in patient care. All clinicians should communicate with physicians office as soon as they initiated the care. LPN's/PTA's, COTA, HHA should communicate with their supervisors for any changes in the care. All supervisors should oversee the care provided to all the patients under their care. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. DON will monitor the scheduled supervisory visits for LPN and all other disciplines to make sure all supervisory visits were done accordingly. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

	the LPN every 30 days. 1. Record review evidenced an agency policy revised 03/2018, titled "Supervision of Staff" which stated, "... The skilled nursing and other therapeutic services furnished will be under the supervision and direction of a physician or RN [registered nurse] ...." 2. Record review evidenced an undated agency policy obtained on 5/8/2023, titled "Wound Care Policy" which stated, "... Clinicians must obtain new wound care orders from MD [physician] if wound care orders are not followed according to plan of care or most recent MD order ... Clinicians are responsible for wound measurements every seven days ...." 2. Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit the licensed practical nurse performed wound care to a right lower leg wound as follows: cleansed with normal saline, applied hydrofera blue			

	(antibacterial absorbent dressing), applied 4x4 gauze, wrapped with kerlix (gauze wrap), and applied tubigrips (compression stockinette). During the visit, the licensed practical nurse indicated the ABD (absorbent dressing) was not applied because it would put too much pressure on the wound. Clinical record review for Patient #2 was completed on 5/8/2023. Record review evidenced a plan of care for certification period 4/18/2023 - 6/16/2023, which included the following wound care to the right lower leg: cleanse with normal saline, apply hydrofera blue, apply ABD (absorbent dressing), wrap with kerlix, and apply tubigrips. Record review evidenced a licensed practical nurse visit note dated 5/5/2023, which failed to indicate the physician or clinical manager was notified of the ABD not being applied during the visit. Record review evidenced a licensed practical nurse supervisory visit completed by the registered nurse on 4/17/2023, which indicated the			

	licensed practical nurse was following the plan of care for tasks assigned, reporting changes in patient's needs and condition, and no changes to the plan of care were required. Record review evidenced a plan of care for certification period 2/17/2023 - 4/17/2023, which indicated the skilled nurse was to visit twice weekly, and educate the patient on possible drug interactions, importance of wound care, disease process, signs and symptoms of worsening disease process, notification of the physician, wound care to prevent infection, anticoagulant management, fall prevention, storage of wound supplies, wound care, and standard precautions.			

	Record review evidenced missed licensed practical nurse visit notes dated 4/11/2023, and 4/25/2023, which indicated the patient had missed visits, but failed to document which physician was notified, how the physician was notified, results of the communication or on what day or time the physician was notified.			

Record review evidenced a skilled nurse visit note dated 4/14/2023, which indicated the licensed practical nurse educated the patient on high blood pressure, but failed to educate the patient about possible drug interactions, importance of wound care, disease process, signs and symptoms of worsening disease process, notification of the physician, wound care to prevent infection, anticoagulant management, fall prevention, storage of wound supplies, wound care, and standard precautions, as ordered on the plan of care. This visit note indicated the patient had developed a new wound to the left leg, but failed to include care coordination with the registered nurse or physician.

Record review evidenced licensed practical nurse visit notes dated 4/14/2023, 4/18/2023, 4/21/2023, and 4/25/2023, which indicated the patient had 3 wounds, right lower leg, left upper chest, and left lower leg. These visit notes indicated wound care was performed, but failed to include which wound(s) were treated

	with wound care. Record review evidenced a visit note dated 3/28/2023, from Entity #1 (wound clinic) which indicated the patient's right lower leg wound measured 7cm (centimeters) x 6.5 cm x 0.1 cm. Record review evidenced licensed practical nurse visit notes dated 4/14/2023, 4/18/2023, and 4/21/2023, which all indicated the patient's right lower leg wound measured 7cm (centimeters) x 6.5cm x 0.1cm. Record review evidenced a visit note dated 4/25, from Entity #1 (wound clinic), which indicated the patient's right lower leg wound measured 4cm x 3.2cm x 0.1cm. Record review evidenced licensed practical nurse visit notes dated 4/28/2023, 5/2/2023, and 5/5/2023, which all indicated the patient's right lower leg wound measured 4cm x 3.2cm x 0.1cm.			

	5/3/2023, at 11:23 AM, the Clinical Manager indicated that licensed practical nurses were supervised during supervisory visits every 30 days. During an interview on 5/5/2023, at 2:07 PM, the Alternate Clinical Manager indicated that the registered nurse should have been supervising the licensed practical nurses by reviewing the visit notes. During an interview on 5/8/2023, at 11:47 AM, the Alternate Clinical Manager indicated the visit notes didn't specify which wound was treated with wound care. At 11:52 AM, the Alternate Clinical Manager indicated the missed visit notes should have included which physician was notified, what day and time they were notified, and results of the notification. At 12:02 PM, the Alternate Clinical Manager indicated the wound measurements automatically populated in the visit notes, and wounds were only measured on the first visit of the week. The Alternate Clinical Manager indicated the care performed			

	should have been as ordered on the plan of care. During an interview on 5/8/2023, at 3:17 PM, Licensed Practical Nurse #2 indicated they had been seeing Patient #2, and would use the wound clinic measurements for documentation if they were close to the actual measurements they obtained during the visit.			
G0728	Rehab services supervised by PT, OT 484.75(c)(2) Rehabilitative therapy services are provided under the supervision of an occupational therapist or physical therapist that meets the requirements of §484.115(f) or (h), respectively. Based on record review and interview, the physical therapist failed to provide supervision to the physical therapy assistant (PTA) in 1 of 3 active clinical records reviewed with services provided by a PTA. (Patient #5) The findings include: Review of an agency policy revised March 2018 titled "Supervision of Physical Therapy	G0728	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians and appropriate parties involving in patient care. All clinicians should communicate with physicians office as soon as they initiated the care. LPN's/PTA's,COTA,HHA should communicate with their supervisors for any changes in the care. All supervisors should oversee the care provided to all the patients under their care. Director of Nursing is responsible to ensure the compliance is met. Monitoring:	2023-06-02

	Assistants and Occupational Therapy Assistants" stated, "... Services furnished by a Physical Therapy Assistant or Occupational Therapy Assistant will be furnished under the supervision of a qualified Physical or Occupational Therapist. Supervisory visits will occur every 30 days ...." Clinical record review on 5/4/2023, for Patient #5, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification periods 2/18/2023-4/18/2023 and 4/19/2023-6/17/2023, which indicated the agency was to provide physical therapy services 2 times a week. Review of the plan of care for certification period 2/18/2023-4/18/2023, indicated the patient was to receive continuous oxygen at 2 liters per minute (lpm) and the physical therapist was to provide balance training. Review of the plan of care for certification period 4/19/2023-6/17/2023, indicated the patient was to receive continuous oxygen at 3.5 lpm. Review of an agency document		A chart audit tool has been developed to monitor the compliance. DON will monitor the scheduled supervisory visits for PTA and all other disciplines to make sure all supervisory visits were done accordingly. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

	titled "Recertification" completed by the physical therapist and dated 4/15/2023, indicated the patient received oxygen at 3.5 lpm. Review failed to evidence the physical therapist provided oxygen as directed in the plan of care. Review of agency documents titled "PTA Visit" indicated the PTA did not provide balance training on document dated 4/11/2023. Review of documents dated 4/26/2023 and 4/28/2023, indicated the patient received oxygen at 2 lpm. Review failed to evidence the PTA provided oxygen as directed in the plan of care. Review evidenced an agency document titled "Missed Visit" completed by PTA #2 and dated 4/6/2023, which indicated the patient was treated in the emergency room. Review failed to evidence the PTA notified the supervisor of the change in patient's condition which led to the treatment in the emergency room. Review of an agency document titled "PTA Supervisory Visit" completed by the physical			

	indicated the PTA informed the supervisor of the patient's change in condition leading to an emergency room visit and indicated the PTA followed the plan of care for completion of tasks. Review failed to evidence the physical therapist provided supervision of the PTA to include ensuring the PTA informed the supervisor of patient changes and provided services as directed in the plan of care. During an interview on 5/5/2023, at 2:09 PM, the alternate clinical manager indicated the physical therapist should review the PTA visit notes but indicated they probably did not review the notes as they should have.			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties.	G0798	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of completing plan of care with appropriate patient needs, Plan of cares should include but not limited to all skilled need and also non skilled needs as per	2023-06-02

	Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the agency failed to ensure the home health aide (HHA) had complete, patient-specific written patient care instructions to be performed by the home health aide in 1 of 1 clinical record reviewed with home health aide services. (Patient #4) The findings include: Review of an agency policy revised February 2021, titled "Care Planning Process" stated, "... Home Health Aide assignment sheet ... The assignment sheet/plan of care will include: ... Nutritional requirements ... Allergies ...." Clinical record review on 5/4/2023, for Patient #4, evidenced an agency document titled "HHA Care Plan" dated 4/10/2023 for episode 4/12/2023-6/10/2023, which failed to evidence the patient's diet. During an interview on		patient needs. Clinicians should communicate with supervisors and physicians if there is any change in care plan. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. DON will audit all HHA care plans and their visits to ensure HHA are following care plan for all the patients. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

	5/5/2023, at 2:41 PM, the alternate clinical manager indicated the HHA care plan should be completed to include the diet.			
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 agency failed to ensure the home health aide (HHA) provided services as directed in the aide care plan in 1 of 1 clinical record reviewed with HHA services. (Patient #4) The findings include: Review of an agency policy revised February 2022, titled "Home Health Aide Supervision" stated, "... Home Health Aide supervision must ensure that aides ... following the patient's	G0800	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of following the plan of care. Director of Nursing educated the clinical staff on preparing individualized plan of cares and incorporate all the components which are pertained for the patients care. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. DON will audit all HHA care plans and their visits to ensure HHA are following care plan for all the patients. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

	tasks assigned to a Home Health Aide ...." Clinical record review on 5/4/2023, for Patient #4, evidenced an agency document titled "HHA Care Plan" dated 4/10/2023 for episode 4/12/2023-6/10/2023, indicated the home health aide was assigned to obtain the patient's temperature and record last bowel movement at every visit. Review of agency documents titled "HHA Visit" indicated the home health aide did not obtain the patient's temperature as directed on document dated 4/10/2023. Review failed to evidence the home health aide recorded the bowel movement on documents dated 4/10/2023, 4/12/2023, 4/14/2023, 4/18/2023, 4/23/2023, 4/24/2023, 4/27/2023, and 5/3/2023. During an interview on 5/5/2023, at 2:43 PM, the alternate clinical manager indicated the home health aides are not supposed to do vital signs including temperature and indicated the bowel movement should have been recorded in			

	note.			
G0818	HH aide supervision elements 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on record review and interview, the agency failed to ensure the home health aide (HHA) was supervised to ensure the aide furnished care that followed the patient's plan of care in 1 of 1 clinical record reviewed with home health aide services. (Patient #4) The findings include: Review of an agency policy	G0818	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of following the plan of care. Director of Nursing educated the clinical staff on preparing individualized plan of cares and incorporate all the components which are pertained for the patients care. Director of Nursing also educated the clinicians in importance of following care plan. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. DON will audit all HHA care plans and their visits to ensure HHA are following care plan for all the patients. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

	"Home Health Aide Supervision" stated, "... Home Health Aide supervision must ensure that aides ... following the patient's plan of care for completion of tasks assigned to a Home Health Aide ...." Clinical record review on 5/4/2023, for Patient #4, evidenced an agency document titled "HHA Care Plan" dated 4/10/2023 for episode 4/12/2023-6/10/2023, indicated the home health aide was assigned to obtain the patient's temperature and record last bowel movement at every visit. Review of agency documents titled "HHA Visit" indicated the home health aide did not obtain the patient's temperature as directed on document dated 4/10/2023. Review failed to evidence the home health aide recorded the bowel movement on documents dated 4/10/2023, 4/12/2023, 4/14/2023, 4/18/2023, 4/23/2023, and 4/24/2023. Review of an agency document titled "HHA Supervisory Visit" dated 4/26/2023, indicated the HHA followed the patient' plan of care for completion of tasks			

	as assigned. Review failed to evidence the agency provided home health aide supervision to ensure the home health aide followed the aide care plan as directed. During an interview on 5/5/2023, at 2:45 PM, the alternate clinical manager indicated the supervising staff should review the HHA visit notes and should follow-up with the HHA to provide education if the HHA did not complete the care as directed.			
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; Based on observation, record review, and interview, the administrator failed to be responsible for the day-to-day operations of the agency. The findings include: The Administrator failed to ensure the RN conducted a review of all medications, and/or major drug-drug interactions and/or failed to	G0948	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Administrator initiated the meeting with DON and clerical staff on 05/26/2023 to discuss all the tags(G0536,G0572,G0574,G0580,G0586, G0592,G0606,G0682,G0714, G0716, G0718, 8). All the tags were addresses and developed process to assure no recurrence. Processes were individualized as specified in each tag. Monitoring: A chart audit tool has been developed for all tags and will monitor for compliance.	2023-06-02

	ensure the interactions were reported to the physician. Please see tag G0536. The Administrator 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 individualized. Please see tag G0572. The Administrator failed to ensure all patients' plans of care included all required elements. Please see tag G0574. The Administrator failed to ensure services and treatments were administered only as ordered by the physician. Please see tag G0580. The administrator failed to ensure the plans of care were updated and revised. Please see tag G0586. The Administrator failed to ensure the revised plans of care included information concerning the patients' progress toward measurable outcomes and goals identified on the plan of care. Please see tag G0592.		Governing body will monitor the job duties of administrator and ensure all the deficiencies were addressed.	

	The administrator failed to ensure services were integrated. Please see tag G0606. 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 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 registered nurses completed clinical notes in an accurate manner. Please see tag G0716. The administrator failed to ensure skilled professionals communicated with all physicians on the plan of care. Please see tag G0718. During an interview on 5/5/2023 at 3:00 PM, Registered Nurse #1 indicated they had stepped down from the position of Alternate Clinical Manager because the quality review staff			

	Registered Nurse #1 indicated competencies for new staff were not observed as was indicated on the paperwork, but they just were signed off on in the agency. Registered Nurse #1 indicated they had never seen the Alternate Administrator or the Alternate Clinical Manager before the survey being conducted. Registered Nurse #1 indicated the Administrator was never in the office.			
G0958	Clinical manager 484.105(c) 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 observation, record review, and interview, the home health agency failed to ensure the clinical manager or designated alternate provided oversight of all patient care services and personnel in 1 of 5 active clinical records reviewed. (Patient #2) The findings include: 1. Record review evidenced an	G0958	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing conducted in-service with clerical staff and educated them to communicate with Director of Nursing when there is change in scheduling or anything related to patient care. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed for all deficiencies. Administrator will monitor all the audit tools on daily basis to ensure DON and ADON are addressing and fixing all the deficiencies. These chart audits will be conducted at least next 90 days.	2023-06-02

	agency policy revised 02/2022, titled "Clinical Manager Job Description" which stated, "... The Clinical Manager is available at all times during operating hours [or appoints a similarly qualified alternate] and participates in all activities relevant to professional services furnished, including the development of qualifications and assignment of personnel ...." 2. Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit Licensed Practical Nurse #1 was observed providing care to the patient. Clinical record review for Patient #2 was completed on 5/8/2023, for certification period 4/18/2023 - 6/16/2023. Review of the electronic medical record on 5/4/2023, indicated Licensed Practical Nurse #2 was scheduled to perform a home visit with Patient #2 on 5/5/2023. During an interview on 5/8/2023, at 11:31 AM, the Alternate Clinical Manager indicated they did not know			

	why Licensed Practical Nurse #1 performed the home visit instead of Licensed Practical Nurse #2.			
G0968	Assure implementation of plan of care 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. Based on observation, record review, and interview, the clinical manager failed to ensure the plans of care were updated and revised in 1 of 5 clinical records reviewed. (Patient #2) The findings include: 1. Record review evidenced an agency policy revised 02/2022, titled "Clinical Manager Job Description" which stated, "... Assures the development, implementation, and updates of the individualized patient plans of care ...." 2. Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to have a wound	G0968	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians after initiating the care and also communicating with physicians when ever there is change in the care. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. If DON is the case manager then ADON will audit those charts and make sure charts are in compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

which the nurse provided wound care. The patient was observed to have a left leg which was wrapped in kerlix and tubigrips. The left leg wound dressing was not removed during the visit.

Clinical record review for Patient #2 was completed on 5/8/2023, for certification periods 2/17/2023 - 4/17/2023, and 4/18/2023 - 6/16/2023. Record review evidenced physician orders from Entity #1 (wound clinic), dated 3/28/2023, which indicated the skilled nurse was to apply adaptic (non-adherent wound dressing) to a right lower leg wound. The wound clinic orders indicated the skilled nurse was to visit and perform wound care once weekly every other week, and twice weekly every other week.

Record review evidenced a plan of care for certification period 2/17/2023 - 4/17/2023, which indicated the wound care was to be performed on a left leg wound, and failed to include wound treatment orders for a right lower leg wound. The Clinical Manager failed to ensure the plan of care was revised to include the

	application of adaptic.The Clinical Manager failed to ensure the plan of care was revised to include the wound clinic orders for alternating visits twice weekly and once weekly. Record review evidenced a plan of care for certification period 4/18/2023 - 6/16/2023, which failed to be revised to include the orders for adaptic to be applied to the right lower leg. The plan of care indicated skilled nursing was to visit twice weekly, and the Clinical Manager failed to ensure the plan of care was revised to include the wound clinic orders for alternating visits twice weekly and once weekly. Record review evidenced a skilled nurse visit note dated 4/14/2023, which indicated on 4/10/2023, the patient developed a new left lower extremity wound, which required 7 sutures. The Clinical Manager failed to ensure the plan of care was revised to reflect any orders for treatment of left lower leg wound. During an interview on 5/8/2023, at 11:46 AM, the			

	Alternate Clinical Manager indicated the plans of care should have been revised to reflect the correct leg, adaptic, and the correct frequency of nursing visits. At 11:51 AM, the Alternate Clinical Manager indicated the plan of care should have been revised to reflect treatment orders for the new wound. The Alternate Clinical Manager indicated the Clinical Manager should have ensured updates to the plan of care were completed by performing quality review of the charts.			
N0000	Initial Comments This was a follow-up visit for a State re-licensure survey and federal post condition revisit survey conducted at Paragon Home Health Care Inc., a deemed home heath agency, by the Indiana Department of Health (IDOH). Survey Dates: 5/3/2023, 5/4/2023, 5/5/2023, and 5/8/2023.	N0000	Initial Comments	

	Facility ID: 012531 Unduplicated Skilled Census for the past 12 months: 202 Current Census: 38			
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 administrator failed to be responsible for the day-to-day operations of the agency. The findings include:	N0444	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Administrator initiated the meeting with DON and clerical staff on 05/26/2023 to discuss all the tags G0528,G0536,G0570,G0572,G0574,G0578,G0580,G0586,G0590,G0592,G0602,G0606,G0682,G0714, G0716,G0718,G0726,G0728,G0798,G0800,G0818,G0940,G0948,G0958,G0968). All the tags were addresses and developed process to assure no recurrence. Processes were individualized as specified in each tag. Monitoring: A chart audit tool were developed for all deficiencies, administrator will monitor all the deficiencies. Governing body will oversee the administrator.	2023-06-02

	The Administrator failed to ensure the RN conducted a review of all medications, and/or major drug-drug interactions and/or failed to ensure the interactions were reported to the physician. Please see tag N0527. The Administrator 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 individualized. Please see tag N0522. The Administrator failed to ensure all patients' plans of care included all required elements. Please see tag N0524. The administrator failed to ensure services were coordinated. Please see tag N0486. The Administrator failed to ensure agency personnel followed infection control precautions for the prevention/control of infection/communicable disease. Please see tag N0470.			

	The Administrator failed to ensure registered nurses completed clinical notes in an accurate manner. Please see tag N0544. The administrator failed to ensure skilled professionals communicated with all physicians on the plan of care. Please see tag N0546. During an interview on 5/5/2023 at 3:00 PM, Registered Nurse #1 indicated they had stepped down from the position of Alternate Clinical Manager because the quality review staff were falsifying documentation. Registered Nurse #1 indicated competencies for new staff were not observed as was indicated on the paperwork, but they just were signed off on in the agency. Registered Nurse #1 indicated they had never seen the Alternate Administrator or the Alternate Clinical Manager before the survey being conducted. Registered Nurse #1 indicated the Administrator was never in the office.			
N0447	Home health agency administration/management	N0447	Corrective Action:	2023-05-26

	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. The findings include: Review of an agency policy revised February 2022, titled "Administrator: Defined" stated, "... The Administrator of the Agency has the following responsibilities: ... Ensuring the accuracy of the public information materials ...." Review of agency information from CMS indicated the alternate clinical manager was registered nurse #1. Review indicated the alternate administrator was registered nurse #2.		Administrator identified the issue and made necessary changes to comply with state policies. Measure to Assure No Recurrence: Administrator send the necessary documents to Indiana state. Monitoring: Governing body will monitor administrator to ensure administrator is addressing and fixing all the deficiencies. Administrator will report to GB after all the forms were submitted to state.	

	During an interview at the entrance conference on 5/3/2023, at 10:51 AM, the administrator indicated the alternate administrator was administrative staff #2. The administrator indicated the alternate clinical manager was registered nurse #3. Review of personnel record for administrative staff #2 indicated the hire date as the alternate administrator was 4/14/2023. Review of personnel record for registered nurse #3 indicated the hire date as the alternate clinical manager was 4/17/2023. Review failed to evidence the administrator updated Indiana Department of Health with the correct administrative staff. During an interview on 5/4/2023, at 1:06 PM, the administrator indicated he had not notified the Indiana Department of Health yet of the administrative staff changes.			
N0470	Home health agency administration/management 410 IAC 17-12-1(m)	N0470	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies.	2023-06-02

	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 to ensure clinicians followed standard precautions in 1 of 1 home visit observed. (Patient #2) The findings include: Record review evidenced an agency policy revised 07/2021, titled "Standard Precautions" which stated, "... Perform hand hygiene after removing gloves ...." Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, at 12:10 PM, Licensed Practical Nurse #1 was observed removing tubigrips (compression stockinette) from patient's right leg, removed gloves, and donned new gloves, without performing hand hygiene in between. At 12:12 PM, Licensed Practical Nurse #1 was observed cleansing the patient's wound		Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 on OSHA and also hand washing techniques. Director of Nursing educated the clinical staff on safe practices for both patients and clinical staff. Director of Nursing is responsible to ensure the compliance is met. Monitoring: Clinical staff will have OAHA training at least once a year. DON will make home visits along with clinicians atleast once a quarter to ensure the compliance. This will be monitored by Director of Nursing .	

	with gauze and normal saline, removing gloves, and donning new gloves without performing hand hygiene in between. During an interview on 5/8/2023, at 11:41 AM, the Alternate Clinical Manager indicated the nurse ideally would have performed hand hygiene between glove changes.			
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. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of	N0488	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 on educating all patients about their discharges. Patients will be notified about their discharges 15 days before discharge or last visit before discharge from the clinician. Monitoring: Director of Nursing will ensure the notice of discharge form is given to patients before they discharge. A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

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 the patients received 15 day discharge notice in 2 of 2 discharge records reviewed. (Patient #6, 7)

The findings include:

	1. Record review evidenced an agency policy revised 02/2023, titled "Discharge Planning" which stated, "... The patient is informed of discharge plan at least fifteen calendar days before the services are stopped and acknowledges understanding reason ...." 2. Clinical record review for Patient #6 was completed on 5/8/2023, for certification period 2/23/2023 - 4/20/2023, discharged on 4/20/2023. Record review evidenced a physical therapy visit note dated 4/18/2023, which indicated the patient was notified of discharge 2 days prior to discharge. Record review failed to evidence any previous discharge notice given to the patient. During an interview on 5/8/2023, at 11:30 AM, the Alternate Clinical Manager indicated the patient should have received 15 days discharge notice, and this should have been documented in the visit notes. 3. Clinical record review for Patient #7 was completed on 5/8/2023, for certification			

	period 3/4/2023 - 5/2/2023, discharged on 4/27/2021. Record review evidenced a physical therapy visit note dated 4/26/2023, which indicated the patient was notified of discharge 1 day prior to discharge. Record review failed to evidence any previous discharge notice given to the patient. During an interview on 5/8/2023, at 11:28 AM, the Alternate Clinical Manager indicated the patient should have received 15 day discharge notice, and the notice should have been documented in the visit notes.			
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 record review and interview, the home health agency failed to ensure it only accepted patients for services if the needs of the patient could	N0520	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of following frequencies written while establishing plan of care. Also importance of communicating physicians if there is any change in the patients care. DON will review all the paperwork before accepting patients.	2023-06-02

	be met in * of 5 active records reviewed (Patient #1). The findings include:		Monitoring: Director of Nursing will review all the paperwork before we admit to patient to ensure we can provide appropriate care for all the patients. A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	
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 the patients received an individualized plan of care, and/or received the services ordered in the plan of care in 5 of 5 active clinical records reviewed. (Patient #1, #2, #3, #4, #5) The findings include: 1. Record review evidenced an	N0522	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of creating individualized plan of care of all patients. Director of Nursing also in-serviced the clinical staff the importance of following the plan of care. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

	agency policy revised 02/2022, titled "Plan of Care - CMS and Physician/Practitioner Orders" which stated, "... Skilled nursing and other home health services will be in accordance with a Plan of Care based on the patient's diagnosis and assessment of immediate and long-range needs and resources ... Each patient must receive an individualized plan of care, including any revisions or additions ...." 2. Clinical record review for Patient #1 was completed on 5/5/2023, for certification period 4/5/2023 - 6/3/2023. Record review evidenced a start of care assessment dated 4/5/2023, which indicated the patient required medication setup to take medications at the proper time, and also indicated the patient had no willing or able caregiver available to assist with medications.			

	Record review evidenced a plan of care for certification period 4/5/2023 - 6/3/2023, which failed to be individualized to include the required medication setup services which were identified on the start of care assessment. Record review evidenced a physical therapy plan of care for certification period 4/5/2023 - 6/3/2023, which indicated the physical therapist or assistant was to perform the following during home visits twice weekly: functional mobility training, teach fall prevention/safety, proprioceptive training, bed mobility training, establish/upgrade home exercise program, postural control training, and teach safe stair climbing skills. Record review evidenced physical therapy visit notes dated 4/11/2023, 4/13/2023, 4/18/2023, 4/20/2023, and 4/25/2023, which all failed to indicate the physical therapy assistant performed functional mobility training, teach fall prevention/safety, proprioceptive training, bed mobility training,			

exercise program, postural control training, and teach safe stair climbing skills as ordered on the plan of care.

During an interview on 5/5/2023, at 9:47 AM, the Alternate Administrator indicated the services included on the plan of care should have been based on the patient's needs identified on the start of care assessment, and should have included medication setup or education on medication set up. At 10:13 AM, the Alternate Administrator indicated the physical therapy assistant wasn't required to perform every task ordered on the plan of care, and were only expected to address the main problems.

3. Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse was observed performing the following wound care to the patient's right lower leg wound: cleansed with normal saline, applied hydrofera blue (antibacterial/absorbent wound dressing), wrapped with kerlix (gauze wrap), and applied

	stockinette). The skilled nurse failed to apply an ABD pad (absorbent pad) to the wound. Clinical record review for Patient #2 was completed on 5/8/2023. Record review evidenced a document dated 3/28/2023, from Entity #1 (wound clinic), which indicated the patient had appointments at the wound clinic every other week on Tuesday. This document indicated the home health agency was to see the patient only 1 time a week every other week, when the patient went to the wound clinic. This document indicated the home health agency was to perform wound care as follows to a right leg wound: cleanse with normal saline, apply adaptic (non-adherent wound dressing), apply hydrofera blue, cover with ABD pad, wrap with kerlix, and apply tubigrips. Record review evidenced a plan of care for certification period 2/17/2023 - 4/17/2023, which indicated the skilled nurse was to visit twice weekly and perform wound care to a left lower leg wound as follows: cleanse with normal saline, apply hydrofera blue, cover with			

	ABD pad, and secure with kerlix and tubigrip. The plan of care failed to be individualized to include the correct frequency of visits: 1 time weekly every other week due to wound clinic appointments, and twice weekly every other week. The plan of care failed to be individualized to include the correct right leg wound, and failed to be individualized to include the orders for adaptic to be applied to the wound. Record review evidenced a missed visit note dated 4/11/2023, which indicated the visit was missed because the patient had a wound clinic appointment. Record review evidenced a plan of care for certification period 4/18/2023 - 6/16/2023, which indicated the skilled nurse was to visit twice weekly and perform wound care to a right lower leg wound as follows: cleanse with normal saline, apply hydrofera blue, cover with ABD pad, and secure with kerlix and tubigrip. The plan of care failed to be individualized to include the correct frequency of visits: 1 time weekly every other week due to wound clinic			

	appointments, and twice weekly every other week. The plan of care failed to be individualized to include the orders for adaptic to be applied to the wound. Record review evidenced a missed visit note dated 4/25/2023, which indicated the visit was missed because the patient had a wound clinic appointment. During an interview on 5/8/2023, at 11:37 AM, the Alternate Clinical Manager indicated wound care should have been provided as was ordered on the plan of care. At 11:40 AM, the Alternate Clinical Manager indicated they did not know why the plan of care didn't have the correct frequency of visits as ordered by the wound clinic physician. At 11:46 AM, the Alternate Clinical Manager indicated the plan of care had the wrong leg, and should have included adaptic orders. 4. Clinical record review on 5/3/2023, for Patient #3, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period			

	5/1/2023-6/29/2023, which indicated the patient had a foley catheter (a tube inserted into the bladder and held in place with a small, inflated balloon to drain urine from the body) which the skilled nurse was to change monthly using a 18 French (size of the catheter) and a 30 cc (cubic centimeters, unit of measure for the balloon size) catheter. Review indicated the skilled nurse was to administer Copaxone (an injectable medication used to treat multiple sclerosis a progressive disease involving the brain and spinal cord) every Monday, Wednesday, and Friday. Review of agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" indicated the nurse changed the foley catheter using a 10 cc balloon on 4/6/2023. Review failed to evidence the nurse followed the plan of care as directed. Review of document dated 4/10/2023 (Monday), 4/14/2023 (Friday), and 4/19/2023 (Monday) failed to evidence the nurse administered Copaxone as directed.			

	During an interview on 5/8/2023, at 12:26 PM, the alternate clinical manager indicated the orders in the plan of care should be followed. The alternate clinical manager indicated if the nurse administered the Copaxone injection, it should be documented in the nurse visit note. 5. Clinical record review on 5/4/2023, for Patient #4, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification periods 2/11/2023-4/11/2023 and 4/12/2023-6/10/2023, which indicated the physical therapist was to educate the patient on fall prevention and safety. Review of agency documents titled "PTA [physical therapy assistant] Visit" dated 4/6/2023, 4/13/2023, 4/17/2023, 4/19/2023, 4/25/2023, 4/27/2023, and 5/2/2023, failed to evidence the PTA educated the patient on fall prevention and safety. During an interview on 5/5/2023, at 2:49 PM, the			

	indicated the PTA should have educated on fall prevention and safety because safety was a priority. 6. Clinical record review on 5/4/2023, for Patient #5, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification periods 2/18/2023-4/18/2023 and 4/19/2023-6/17/2023, which indicated the agency was to provide physical therapy services 2 times a week. Review failed to evidence the agency provided physical therapy services during the week of 4/2/2023 and the week of 4/16/2023. Review of the plan of care for certification period 2/18/2023-4/18/2023, indicated the patient was to receive continuous oxygen at 2 liters per minute (lpm) and the physical therapist was to provide balance training. Review of the plan of care for certification period 4/19/2023-6/17/2023, indicated the patient was to receive continuous oxygen at 3.5 lpm. Review of an agency document titled "Recertification" completed by the physical			

	therapist and dated 4/15/2023, indicated the patient received oxygen at 3.5 lpm. Review failed to evidence the physical therapist provided oxygen as directed in the plan of care. Review of agency documents titled "PTA Visit" indicated the PTA did not provide balance training on document dated 4/11/2023. Review of documents dated 4/26/2023 and 4/28/2023, indicated the patient received oxygen at 2 lpm. Review failed to evidence the PTA provided oxygen as directed in the plan of care. During an interview on 5/5/2023, at 1:38 PM, the alternate clinical manager indicated services should be provided as directed in the plan of care. At 2:00 PM, the alternate clinical manager indicated any deviation from the plan of care should have been clarified by a physician order and indicated there was not an order to change the patient's oxygen flow rate. During an interview on 5/5/2023, at 2:03 PM, the alternate administrator			

	provide the interventions listed in the plan of care.			
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.	N0524	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of creating individualized plan of care of all patients. Plan of care should have all the components pertaining to patient care. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

	(xiii) Any other appropriate items. Based on record review and interview, the home health agency failed to ensure the individualized plan of care included all the required elements in 1 of 5 active clinical records reviewed. (Patient #1) The findings include:			
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 home health agency failed to ensure skilled professionals communicated with all physicians regarding the current plan of care in 1 of 5 active clinical records reviewed.	N0527	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff and clerical staff on 05/26/2023 importance on communicating with physicians when there is change in care plan and also faxing the plan of cares and physician orders to physicians and also followup on those orders to get signed. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure	2023-06-02

	(Patient #2) The findings include:		conducted at least next 90 days.	
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 agency failed to ensure the physician received a written summary of the services the agency provided and the patient's status every 60 days in 3 of 5 active clinical records reviewed. (Patients #3, #4, #5) The findings include: 1. Review of an agency policy revised February 2022, titled "Plan of Care – CMS #485 and Physician/Practitioners Orders"	N0529	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of Participation and agency Policies. All disciplines will complete the transfer/discharge summaries according to agency policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 addressing the importance of completing the 60 day summaries on time for better care of patients. All clinical staff has to complete the 60 day summaries appropriately which should include but not limited to care summary, progress towards goals. Clerical staff will fax all the 60 days summaries according to agency policy. Administrator is responsible to ensure the compliance is met. Monitoring: An audit tool has been developed to monitor the compliance. DON will audit all the clinical records to ensure compliance is met. These visit audits will be conducted at least for next 90 days.	2023-06-02

must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the Agency and patient in the plan of care…."

2. Clinical record review on 5/3/2023, for Patient #3 evidenced an agency document titled "Physician Order" dated 4/11/2023, which indicated the patient received antibiotic treatment for 7 days for a urinary tract infection.

Review of an agency document titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" dated 4/24/2023, indicated the patient had ear tubes placed on 4/19/2023 and received antibiotic ear drops.

Review of an agency document titled "Home Health End-of-Episode Summary" dated 5/3/2023, failed to evidence the summary included the infections and the ear procedure.

During an interview on

	alternate clinical manager indicated infections and use of antibiotics should be included in the 60 day summary sent to the physician. 3. Clinical record review on 5/4/2023, for Patient #4 evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 2/11/2023-4/11/2023, which indicated the agency was to provide home health aide services 2 times a week. Review of an agency document titled "Home Health End-of-Episode Summary" dated 4/10/2023, failed to evidence the summary included the home health aide services. During an interview on 5/5/2023, at 2:35 PM, the alternate clinical manager indicated the summary should have included the home health aide services provided.			

	4. Clinical record review on 5/4/2023, for Patient #5 evidenced an agency document titled "Missed Visit" dated 4/6/2023, which indicated the patient was treated in the emergency room. Review of an agency document titled "Home Health End-of-Episode Summary" dated 4/15/2023, failed to evidence the summary included the emergency room treatment. During an interview on 5/5/2023, at 1:57 PM, the alternate clinical manager indicated the emergency room visit should have been included in the 60 day summary. 5. During an interview on 5/5/2023, at 1:57 PM, the alternate clinical manager indicated all care provided during the certification period, any changes, and progress to goals should be included in the 60 day summary to the physician.			
N0532	Patient Care 410 IAC 17-13-1(d)	N0532	Corrective Action:	2023-06-02

	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 observation, record review, and interview, the home health agency failed to ensure clinicians notified the patient's physician of any physical or mental changes in 1 of 5 active clinical records reviewed. (Patient #2) The findings include: 1. Record review evidenced an agency policy revised 02/2021, titled "Coordination of Patient Care" which stated, "... The Agency must: ... Assure communication with all physicians/practitioners involved in the plan of care ... Staff provides the physician/practitioner with patient information on an ongoing basis regarding: ... Current condition and changes in condition ... Outcomes of care and services ...." 2. Observation of a home visit for Patient #2 was conducted		Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians and appropriate parties involving in patient care. All clinicians should communicate with physicians office as soon as they initiated the care. Director of Nursing is responsible to ensure the compliance is met. Monitoring: DOn will review all the clinical records as well as physician orders to ensure plan of care is followed and clinicians notify physicians if there is any change in the care plans. A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

	on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, the nurse was observed performing the following wound care to the patient's right lower leg wound: cleansed with normal saline, applied hydrofera blue (antibacterial/absorbent wound dressing), wrapped with kerlix (gauze wrap), and applied tubigrip (compression stockinette). The skilled nurse failed to apply an ABD pad (absorbent pad) to the wound. Licensed Practical Nurse #1 indicated they didn't apply the ABD pad because it would put too much pressure on the wound. Licensed Practical Nurse #1 failed to notify the physician of the change in treatment provided. Clinical record review for Patient #2 was completed on 5/8/2023. Record review evidenced a plan of care for certification period 4/18/2023 - 6/16/2023, which indicated the skilled nurse was to visit twice weekly and perform wound care as follows: cleanse with normal saline, apply hydrofera blue, cover with ABD pad, and secure with kerlix and tubigrip.			

	Record review evidenced a skilled nurse visit note dated 4/14/2023, which indicated the patient had developed a new left lower extremity wound on 4/10/2023, which had been treated in the emergency room with 7 sutures. Record review failed to evidence the physician listed on the plan of care was notified of the patient's new left lower extremity wound. Record review evidenced a skilled nurse visit note dated 5/5/2023, which failed to evidence the physician was notified that the ABD pad was not applied during the visit. During an interview on 5/8/2023, at 11:37 AM, the Alternate Clinical Manager indicated the physician should have been notified that the ABD pad wasn't applied and the need for new orders. At 11:51 AM, the Alternate Clinical Manager indicated the physician on the plan of care should have been notified of the new wound to the left lower leg.			

N0542	Scope of Services 410 IAC 17-14-1(a)(1)(C) Rule 14 Sec. 1(a) (1)(C) Except where services 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 observation, record review, and interview, the home health agency failed to ensure the plans of care were revised and reviewed in 1 of 5 active clinical records reviewed. (Patient #2) The findings include: 2. Observation of a home visit for Patient #2 was conducted on 5/5/2023, at 12:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to have a wound on their right lower leg, for which the nurse provided wound care. The patient was observed to have a left leg which was wrapped in kerlix and tubigrips. The left leg wound dressing was not removed during the visit. Clinical record review for Patient	N0542	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians and appropriate parties involving in patient care. All clinicians should communicate with physicians and update the plan of cares appropriately. Clinicians will write new orders when there is change in the care. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

	#2 was completed on 5/8/2023, for certification periods 2/17/2023 - 4/17/2023, and 4/18/2023 - 6/16/2023. Record review evidenced physician orders from Entity #1 (wound clinic), dated 3/28/2023, which indicated the skilled nurse was to apply adaptic (non-adherent wound dressing) to a right lower leg wound. The wound clinic orders indicated the skilled nurse was to visit and perform wound care once weekly every other week, and twice weekly every other week. Record review evidenced a plan of care for certification period 2/17/2023 - 4/17/2023, which indicated the wound care was to be performed on a left leg wound, and failed to include wound treatment orders for a right lower leg wound. The plan of care failed to be revised to include the application of adaptic.The plan of care indicated the skilled nurse was to visit twice weekly, and failed to be revised to reflect the wound clinic orders for alternating visits twice weekly and once weekly. Record review evidenced a plan of care for certification period			

	4/18/2023 - 6/16/2023, which failed to be revised to include the orders for adaptic to be applied to the right lower leg. The plan of care indicated the skilled nurse was to visit twice weekly, and failed to be revised to reflect the wound clinic orders for alternating visits twice weekly and once weekly. Record review evidenced a skilled nurse visit note dated 4/14/2023, which indicated on 4/10/2023, the patient developed a new left lower extremity wound, which required 7 sutures. The plan of care failed to be revised to reflect any orders for treatment of left lower leg wound. During an interview on 5/8/2023, at 11:46 AM, the Alternate Clinical Manager indicated the plans of care should have been revised to reflect the correct leg, adaptic, and the correct frequency of nursing visits. At 11:51 AM, the Alternate Clinical Manager indicated the plan of care should have been revised to reflect treatment orders for the new wound.			

N0543	Scope of Services 410 IAC 17-14-1(a)(1)(D) 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 observation, record review, and interview, the home health agency failed to ensure the registered nurses initiated appropriate preventive and rehabilitative procedures in 2 of 5 active clinical records reviewed. (Patient #1, 2) The findings include:	N0543	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of incorporating all the clinical elements in the plan of care. Plan of care should include past all interventions, goals, medications e.t.c. Director of Nursing is responsible to ensure the compliance is met. Monitoring: Director of Nursing will review all oasis(SOC, Recert and ROC) to ensure all the clinical as well as rehab elements were address and included in both OASIS and plan of care. A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02
N0554	Scope of Services 410 IAC 17-14-1(a)(2)(B) Rule 14 Sec. 1(a) (2) (B) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (B) Prepare clinical notes. Based on observation, record review, and interview, the home health agency failed to ensure	N0554	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians and appropriate parties involving in patient care. All clinicians should communicate with physicians office and	2023-06-02

	licensed practical nurses accurately and completely documented patient assessments and clinical notes in 2 of 2 active clinical records reviewed with licensed practical nurse services. (Patient #2, #3) The findings include: 1. Record review evidenced an agency policy revised 02/2021, titled "Skilled Professional Services" which stated, "... Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, occupational therapy, physician and medical social work services ... Skilled professionals must assume responsibility for, but not be restricted to the following: ... assessment of the patient ... Preparing clinical notes ...." 2. Observation of a home visit for Patient #2 was completed on 5/5/2023, at 12:00 PM, to observe a routine skilled nursing visit. During the visit, the licensed practical nurse nurse did not measure the patient's right lower leg wound. During the visit, the nurse did not discuss discharge planning, and did not remove the left		update the plan of cares appropriately. Clinicians will write new orders when there is change in the care. Director of Nursing is responsible to ensure the compliance is met. Monitoring: Director of Nursing will audit all the clinical records for all the patients to ensure clinicians followed care plan and documented accordingly. A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

left lower leg.

Clinical record review for Patient #2 was completed on 5/8/2023, for certification periods 2/17/2023 - 4/17/2023, and 4/18/2023 - 6/16/2023. Record review evidenced skilled nurse visit notes dated 4/14/2023, 4/18/2023, 4/21/2023, and 4/25/2023, which indicated the patient had 3 wounds, right lower leg, left upper chest, and left lower leg. These visit notes indicated wound care was performed, but failed to include which wound(s) were treated with wound care.

Record review evidenced missed visit notes dated 4/11/2023, and 4/25/2023, which indicated the patient had missed visits, but failed to document which physician was notified, how the physician was notified, results of the communication or on what day or time the physician was notified.

Record review evidenced a visit note dated 3/28/2023, from Entity #1 (wound clinic) which indicated the patient's right lower leg wound measured 7cm (centimeters) x 6.5 cm x 0.1 cm.

	Record review evidenced skilled nursing visit notes dated 4/14/2023, 4/18/2023, and 4/21/2023, which all indicated the patient's right lower leg wound measured 7cm (centimeters) x 6.5cm x 0.1cm. Record review evidenced a visit note dated 4/25, from Entity #1 (wound clinic), which indicated the patient's right lower leg wound measured 4cm x 3.2cm x 0.1cm. Record review evidenced skilled nursing visit notes dated 4/28/2023, 5/2/2023, and 5/5/2023, which all indicated the patient's right lower leg wound measured 4cm x 3.2cm x 0.1cm. Record review evidenced a skilled nurse visit note dated 5/5/2023, which indicated the nurse discussed discharge planning with the patient, and indicated the left lower leg had 7 sutures, and was clean, dry, and intact. During an interview on 5/8/2023, at 11:47 AM, the Alternate Clinical Manager indicated the visit notes didn't specify which wound was			

	11:52 AM, the Alternate Clinical Manager indicated the missed visit notes should have included which physician was notified, what day and time they were notified, and results of the notification. At 12:02 PM, the Alternate Clinical Manager indicated the wound measurements automatically populated in the visit notes, and wounds were only measured on the first visit of the week. At 12:10 PM, the Alternate Clinical Manager indicated they were not sure why the nurse documented on the 5/5/2023 visit note that they performed discharge planning and left lower leg assessment, if it wasn't performed. During an interview on 5/8/2023, at 3:17 PM, Licensed Practical Nurse #2 indicated they had been seeing Patient #2, and would use the wound clinic measurements for documentation if they were close to the actual measurements they obtained during the visit. 3. Clinical record review on 5/3/2023, for Patient #3, evidenced agency documents			

	vocational nurse/licensed practical nurse] Visit" dated 4/13/2023 and 4/27/2023, and completed by LPN #1, which indicated the patient went to the wound clinic earlier in the day and indicated the nurse performed wound care at the skilled nurse visit. Nurse visits dated 4/5/2023, 4/6/2023, 4/7/2023, 4/11/2023, 4/12/2023, 4/13/2023, 4/14/2023, 4/18/2023, 4/19/2023, 4/20/2023, 4/21/2023, 4/25/2023, 4/26/2023, 4/27/2023, and 5/3/2023 (not Mondays) indicated the wound to the right ischium (area on the buttock) measured 1.4 centimeters (cm) in length, 0.6 cm in width, and 0.4 cm in depth. During an interview on 5/8/2023, at 10:20 AM, LPN #1 indicated he/she did not perform wound care at the visits provided on the same day the patient went to the wound clinic. LPN #1 indicated the documentation of the wound treatment performed at the visit must have been a carry-over from a previous note. LPN #1 indicated he/she measured the wound weekly on Mondays and			

	the wound measurements documented on the nurse visit notes from days other than Mondays must have been a carry-over from a previous note. During an interview on 5/8/2023, at 2:04 PM, the alternate clinical manager indicated documentation should not auto-populate on the nurse visit notes and indicated the nurse probably did not know to change the documentation that was auto-populated on the note. Review of agency documents titled "LVN/LPN Visit" indicated the patient started a new medication, ofloxacin (antibiotic), to both ears for 7 days on document dated 4/20/2023. Review of document dated 4/25/2023, indicated the patient was ordered 2 new medications to be administered via the ears, Ciprofloxacin (antibiotic) and dexamethasone (steroid to reduce inflammation). Review of agency documents titled "LVN/LPN Visit" completed by LPN #3 and dated 4/24/2023 and 4/27/2023, failed to evidence			

	the LPN documented the administration of the ear medication. During an interview on 5/8/2023, at 10:58 AM, LPN #3 indicated she applied the ear medication during the nurse visits on 4/24/2023 and 4/27/2023 but did not document the medication administration. During an interview on 5/8/2023, at 2:13 PM, the alternate clinical manager indicated the nurse should document the administration of medication in the nurse visit note to include the name of the medication, dose, route, and patient reaction.			
N0566	Scope of Services 410 IAC 17-14-1(c)(5) Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (5) prepare clinical notes; Based on observation, record review, and interview, the home health agency failed to ensure	N0566	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians and appropriate parties involving in patient care. All clinicians should	2023-06-02

	licensed practical nurses accurately and completely documented patient assessments and clinical notes in 2 of 3 active clinical records reviewed with physical therapy assistant services. (Patient #1, #5) The findings include: 1. Record review evidenced an agency policy revised 02/2021, titled "Skilled Professional Services" which stated, "... Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, occupational therapy, physician and medical social work services ... Skilled professionals must assume responsibility for, but not be restricted to the following: ... assessment of the patient ... Preparing clinical notes ...." 2. Clinical record review for Patient #1 was completed on 5/5/2023. Record review evidenced a plan of care for certification period 4/5/2023 - 6/3/2023, which indicated the patient was to receive physical therapy visits once weekly for 1 week, and twice weekly for 4 weeks. Record review evidenced a		communicate with physicians office and write the name of the person who they communicated and time. Director of Nursing is responsible to ensure the compliance is met. Monitoring: Director of Nursing will audit all the clinical records for all the patients to ensure clinicians followed care plan and documented accordingly. A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	

note dated 4/27/2023 and signed by Physical Therapy Assistant #1, which indicated the patient had a missed visit. This visit note indicated a physician office was notified, but failed to document which physician was notified, how the physician was notified, results of the communication or on what day or time the physician was notified.

During an interview on 5/5/2023, at 10:06 AM, the Administrator indicated the visit note indicated the physician was notified. The Alternate Administrator indicated they did not know how to verify the skilled professional called the physician, since it wasn't documented.

3. Clinical record review on 5/5/2023, for Patient #5, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 4/19/2023-6/17/2023, which indicated the agency was to provide physical therapy services 2 times a week. Review failed to evidence a physical therapy visit note since 4/28/2023. Review evidenced a

	physical therapy assistant (PTA) visit was scheduled for 5/3/2023, and indicated the visit note was not yet started. During an interview on 5/5/2023, at 2:10 PM, the alternate clinical manager indicated the PTA completed the visit on 5/3/2023, and the documentation should have been completed the same day.			
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. (6) A discharge summary.	N0608	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 05/26/23 importance of communicating with physicians and appropriate parties involving in patient care. All clinicians should communicate with physicians office and write the name of the person who they communicated and time. Director of Nursing is responsible to ensure the compliance is met. Monitoring: Director of Nursing will audit all the clinical records for all the patients to ensure clinicians followed care plan and documented accordingly. A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be	2023-06-02

	Based on observation, record review, and interview, the home health agency failed to ensure skilled professionals accurately and completely documented patient assessments and clinical notes in 2 of 5 active clinical records reviewed. (Patient #1, 2) The findings include:		conducted at least next 90 days.	
N0610	Clinical Records 410 IAC 17-15-1(a)(7) Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview, the agency failed to ensure entries into the clinical record included the clinician's title and date of the visit in 1 of 1 clinical record reviewed with home health aide (HHA) services. (Patient #4) The findings include: Review of an agency policy	N0610	Corrective Action: Administrator and DON identified the issue and made necessary changes to comply with Condition of participation and agency Policies. Measure to Assure No Recurrence: Director of Nursing in-serviced all clinical staff on 03/24/23 importance of signing the clinical documents with their titles and dates. Director of Nursing is responsible to ensure the compliance is met. Monitoring: A chart audit tool has been developed to monitor the compliance. Director of Nursing will audit 100% of the charts to ensure compliance. These chart audits will be conducted at least next 90 days.	2023-06-02

	"Medical Record Entries and Authentication" stated, "... All entries in patient records will be ... appropriately authenticated, dated ... authenticated by staff signature and title...." Clinical record review on 5/4/2023, for Patient #4, evidenced agency documents titled "HHA Visit" completed by HHA #1 and dated 4/10/2023, 4/12/2023, 4/14/2023, 4/18/2023, 4/23/2023, 4/24/2023, 4/27/2023, and 5/3/2023, which failed to include the clinician's title. Review of the note dated by HHA #1 on 4/24/2023, indicated the visit was performed on 4/25/2023. During an interview on 5/5/2023, at 2:38 PM, the alternate clinical manager indicated visit notes should include the clinician's title and be dated correctly for the date the visit was performed. During an interview on 5/8/2023, at 12:25 PM, the alternate administrator indicated HHA #1 performed the visit on 4/24/2023 documented the date of the visit incorrectly.			

N9999	Final Observations Corrected 4/5/2023	N9999	Final Observations	2023-06-02

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	6/1/2023 4:36:23 PM