STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157643	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAGON HOME HEALTH CARE INC	**3310 HICKORY RD STE B-1A , MISHAWAKA, Indiana, 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). A complaint survey for complaints # 94846 and #98981 was conducted in conjunction with this survey. See Event ID #5FFF4-H1 for survey report. Survey Dates: 6/5/2023, 6/6/2023, 6/7/2023, and 6/8/2023 Facility ID: 012531 Unduplicated Skilled Census for the past 12 months: 203 Current Census: 23 During this survey, 1 Condition of Participation was corrected: Condition of Participation: Skilled Professional Services; 1 Condition of Participation was re-cited: Condition of Participation: Care Planning, Coordination of Services, and Quality of Care; and 1 new Condition of Participation was cited at Condition of Participation: Discharge Planning. Also during this survey, 11 standard level tags were corrected, 13 standard level tags were re-cited, and 1 new standard level tags was 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	G0000		

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

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G0000	Continued from page 1 competency evaluation programs for a period of two years beginning 12/09/22 and continuing through 12/08/24.	G0000		
G0536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure all current medications were reviewed to identify potential drug interactions, side effects, and duplicate drug therapy in 1 of 1 home visit. (Patient #1) The findings include: 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...." Observation of a home visit for Patient #1 was conducted on 6/6/2023, at 2:00 PM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles were reviewed. The following medications were observed, guanfacine (medication to treat high blood pressure and attention deficit hyperactivity disorder), esomeprazole (antacid), tylenol (for pain), venlafaxine (antidepressant), metformin (for blood sugars), and gabapentin (for nerve pain). The patient was not observed to be taking losartan potassium (to lower blood pressure). Person #1 (family member) indicated the patient had not taken losartan potassium for a long time. Clinical record review for Patient #1 was completed on 6/6/2023, for certification period 5/16/2023 - 7/14/2023. Record review evidenced a medication profile	G0536		

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G0536	Continued from page 2 for certification period 5/16/2023 - 7/14/2023, which failed to include the following medications the patient was taking: guanfacine (medication to treat high blood pressure and attention deficit hyperactivity disorder), esomeprazole (antacid), tylenol (for pain), venlafaxine (antidepressant), metformin (for blood sugars), and gabapentin (for nerve pain). The medication profile indicated the patient was taking losartan potassium (to lower blood pressure). Record review failed to evidence all patient's current medications were reviewed for potential drug interactions, side effects, and duplicative drug therapy. During an interview on 6/7/2023, at 12:43 PM, the Clinical Manager indicated they did not know why all the medications the patient was taking were not on the medication profile and reviewed.	G0536		
G0560	Discharge Planning CFR(s): 484.58 Condition of Participation: Discharge planning. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to send all necessary medical information pertaining to the patient's current course of illness and treatment to the receiving health care practitioner to ensure a safe and effective transition of care (see tag G0564). The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.58 Discharge Planning. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the agency failed to ensure its policy was followed for discharge planning in 4 of 4 closed clinical records reviewed. (Patient #8, #9, #10, #11) The findings include: 1. Review of an agency policy revised January 2023,	G0560		

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G0560	Continued from page 3 titled “Discharge Criteria and Planning” stated, “… The patient is informed of discharge plan at least fifteen (15) calendar days before the services are stopped and acknowledges understanding reason. The evaluation of a patient’s discharge needs and discharge plan must be documented in a timely manner. The evaluation must be included in the medical record and discussed with patient or patient representative. All relevant information from the Agency will be incorporated into the discharge plans to avoid delays. … Physician and other care providers will be informed and knowledgeable of discharge. … The patient’s continuing care needs, if any, are assessed at discharge. … Patients will receive verbal or written instructions….” 2. Review of an agency policy revised February 2021, titled “Reassessments/Update of the Comprehensive Assessment” stated, “… Audio only or two-way audio-video telecommunication can be used for updates to the comprehensive if it is part of the patient’s plan of care. … Minimally, the comprehensive assessment must be updated and revised: … discharged from Agency: within 2 calendar days of the discharge/transfer/death date….” 3. Clinical record review on 6/7/2023, for Patient #8, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 3/21/2023-5/19/2023, which indicated the patient’s diagnoses included, but were not limited to, retention of urine, rheumatoid arthritis (a disease causing painful swelling of the joints), and chronic pain syndrome. Review indicated the agency was to provide skilled nursing services 1 time every other week for 8 weeks for foley catheter (a plastic tube inserted into the bladder to drain urine) management. Review indicated the discharge plan included discharge when patient returned to a stable genitourinary status and caregiver was able to perform foley catheter care. Review indicated the patient’s goals included, but were not limited to, the patient’s pain level would be less than 2 with improved activity level due to effective pain control. Review of an agency document titled “Physician Order” dated 5/3/2023, indicated the skilled nurse was to flush the foley catheter as needed for patency and sediment. Review of agency documents titled “LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit” completed by LPN 1 indicated the patient was starting injections at the rheumatology office weekly on document dated 5/3/2023. Review of document dated	G0560		

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G0560	Continued from page 4 5/3/2023, indicated the patient's pain was rated at time of the visit a 5 on a scale of 0-10 [0 being no pain and 10 the most severe] with the worst pain reported during the past week at 7 on a scale of 0-10. Review of document dated 5/12/2023, indicated the patient's worst pain in the past week was a 7 on a scale of 0-10. Review indicated the nurse flushed the foley catheter for mild sediment on documents dated 5/3/2023 and 5/12/2023. Review indicated the patient received discharge notice regarding the plan to discharge to the urologist on document dated 5/3/2023. Review of document dated 5/12/2023, indicated there were no plans to discharge the patient and home care was medically necessary. Review of an agency document titled "Communication Note" completed by LPN 1 and dated 5/12/2023, indicated the patient began new intravenous (administered into the blood stream though a vein) infusions for the treatment of rheumatoid arthritis weekly at the rheumatologist (a physician which treats arthritis and immune-related conditions) office. Review indicated the patient was to undergo a port placement (a medical device implanted under the skin usually in the chest used to draw blood and administer medication) on May 25, 2023. Review indicated the patient had an appointment with the pain physician on June 8, 2023. Review of an agency document titled "Discharge Non-Visit" completed by the Clinical Manager and dated 5/19/2023, and identified to be a comprehensive assessment, failed to evidence the comprehensive assessment was completed in-person. Review of the plan of care for certification period 3/21/2023-5/19/2023, failed to evidence audio or video telecommunication could be used for comprehensive assessments. Review failed to evidence the patient was offered and declined an in-person discharge comprehensive assessment. Review failed to evidence the patient's need for intravenous infusion treatments were assessed. Review indicated the patient had difficulty breathing and failed to evidence an assessment of the patient's respiratory status. Review failed to evidence an assessment of the patient's foley catheter and urinary system to include size of catheter, date last changed, patency, appearance of urine, and any signs and symptoms of infection. Review of an agency document titled "Home Health Discharge Summary" dated 6/1/2023, indicated the agency discharged the patient on 5/19/2023, to the care of the urologist (a physician that specializes in conditions affecting the urinary tract). Review failed to evidence the agency communicated with the urologist prior to	G0560		

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G0560	Continued from page 5 discharge on what care the urologist was to provide and how often the urologist would provide care. Review failed to evidence the physician responsible for the plan of care was informed of the plan for discharge to the care of the urologist prior to the date of discharge. Review failed to evidence communication regarding the plans of discharge with the rheumatologist and pain physician. Review failed to evidence discharge planning was conducted related to the plan for care for the patient's upcoming port placement, monitoring of the intravenous infusion treatments, and the patient's unmet pain goal. During an interview on 6/8/2023, at 3:16 PM, the Clinical Manager indicated the patient's pain some days was "really bad". At 3:20 PM, the Clinical Manager indicated Person #6 (urologist) was the physician assuming the care for the patient at time of discharge and indicated the agency did not send the discharge summary to the urologist, rheumatologist, and pain physician. At 3:28 PM, the Clinical Manager indicated she completed the discharge assessment based on what she knew of the patient because she was in India and there was no other registered nurse available to do the assessment. At 3:24 PM, the Clinical Manager indicated the discharge assessment was not completed in person because the Clinical Manager was in India at time of discharge and the discharge assessment was completed based on what she knew of the patient. The Clinical Manager indicated she was not aware of the patient's intravenous infusion treatments nor about the plan to have a port placed so she did not educate the patient on the signs and symptoms of adverse reactions to the infusion treatments and did not include the infusion treatments in the discharge assessment. The Clinical Manager indicated the assessment of the breath sounds heard in all four lobes must have been a carry-over since the assessment was not completed in person and lung sounds were not assessed. The Clinical Manager indicated the assessment of the foley catheter and urinary system should be included in a comprehensive assessment. 4. Clinical record review on 6/8/2023, for Patient #9, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/18/2023-6/16/2023, which indicated the agency was to provide skilled nursing services 4 times a week for 9 weeks for wound care to both lower extremities. Review indicated the patient was treated at the wound clinic 1 time weekly for wound care. Review indicated the discharge plans included the patient would be discharged when the patient was able to provide care per self and when wounds were healed. Review indicated	G0560		

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G0560	Continued from page 6 the patient's rehabilitative potential was fair. Review of agency documents identified as nurse visit notes dated 4/5/2023, 4/6/2023, 4/7/2023, 4/11/2023, 4/12/2023, 4/13/2023, 4/14/2023, and 4/18/2023, indicated discharge was not considered due to lymphedema (tissue swelling), wounds, lack of caregiver support, and patient unable to perform wound care per self. Review of an agency document titled "Recertification" completed by the Clinical Manager and dated 4/17/2023, and identified as the comprehensive assessment, indicated the patient was non-compliant and had been "making up stories about the nurses and reporting to the wound clinic", but review failed to evidence communication with the patient and physician regarding the non-compliance and failed to evidence the patient and physician were notified of change in discharge plans if non-compliance and behaviors continued. Review evidenced an agency document titled "Communication Note" completed by LPN 1 and dated 4/19/2023, which indicated the patient touched the nurse inappropriately with his feet, looked increasingly disheveled, and was noncompliant with medications. Review of an agency document titled "Physician Order" dated 4/19/2023, indicated the patient was discharged from the agency for noncompliance with care. Review failed to evidence any coordination with the physician and the wound clinic prior to the date of discharge regarding the plans to discharge. Review failed to evidence the agency provided a 15 day notice prior to discharge. Review of an agency document titled "Discharge Non-Visit" completed by the Clinical Manager and dated 4/19/2023, and identified to be a comprehensive assessment, failed to evidence the comprehensive assessment was completed in-person. Review of the plan of care for certification period 4/18/2023-6/16/2023 failed to evidence audio or video telecommunication could be used for comprehensive assessments. Review failed to evidence the patient was offered and declined an in-person discharge comprehensive assessment. Review failed to evidence the agency assessed the patient's wounds at time of discharge. Review indicated the patient had complaints with the home care nurses leading to the wound clinic questioning the wound care provided by the home care nurses. Review failed to evidence coordination of care with the wound clinic regarding the patient's complaints and wound clinic's	G0560		

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G0560	Continued from page 7 concerns with the wound care provided by the agency staff. Review indicated the Clinical Manager spoke with the nurse at the office of the physician responsible for the plan of care regarding the patient's behavior and no nurse willing to make visits to the patient. Review failed to evidence coordination with the wound clinic on the frequency of the wound clinic visits for wound care and failed to evidence the patient was instructed on how often to follow up with the wound clinic. During an interview on 6/8/2023, at 4:09 PM, the Clinical Manager indicated she never did speak with the physician responsible for the plan of care but spoke with the nurse at the physician's office who indicated it was fine for the patient to follow-up with the wound clinic and be discharged from the home care agency. The Clinical Manager indicated she did not get a verbal order from the physician for discharge but wrote the order and sent it to the physician for signature. The Clinical Manager indicated the discharge comprehensive assessment was not completed in person because no one from the agency wanted to go, and indicated wounds should be included in a comprehensive assessment. The Clinical Manager indicated she was unsure how many times the patient would be seen at the wound care clinic for wound care. The Clinical Manager indicated there were reports from other nurses regarding the patient's behavior, but there were no plans for discharge discussed with the patient and the physician if the reported behavior continued. The Clinical Manager indicated the agency did not provide the patient a notice prior to discharge and indicated she sent the patient a text message the day of discharge informing the patient the wound clinic would be providing his wound care from now on. The Clinical Manager indicated she did not provide any other discharge instructions to the patient. 5. Clinical record review on 6/7/2023, for Patient #10, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/19/2023-6/17/2023, which indicated the patient's goals included, but were not limited to, patient's pain would attain effective pain management and have pain less than 3 on a scale of 0-10. Review indicated the discharge plan included, but was not limited to, when patient goals were met. Review indicated the certifying physician was Person #9 (practitioner at the wound clinic) and Person #7 was the primary care physician responsible for the plan of care. Review of agency documents titled "PTA [physical	G0560		

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G0560	Continued from page 8 therapy assistant] Visit" completed by the PTA, indicated the patient reported pain of 5 on a scale of 0-10 on documents dated 4/28/2023, and 4/29/2023, 7 on a scale of 0-10 on document dated 5/2/2023, and 6 on a scale of 0-10 on document dated 5/3/2023. Review of document dated 5/3/2023, indicated the PTA discussed discharge for the following week with the patient but failed to evidence the PTA discussed with the physician the need for pain management as evidenced by the report of increased pain by the patient. Review failed to evidence coordination with the pain clinic regarding the patient's increased pain. Review indicated the visit on 5/3/2023, was the last visit prior to patient discharge on 5/11/2023. Review of an agency document titled "Order for Discharge" dated 5/11/2023, indicated the patient was discharged from the agency effective 5/11/2023, due to the patient reached maximum potential. Review failed to evidence the agency communicated the unmet goals to the physician responsible for the plan of care and the practitioner at the wound clinic to the patient's increasing pain. During an interview on 4/8/2023, at 2:01 PM, the patient's caregiver indicated the patient was being treated by Person #9 at a pain clinic and was still having "quite a bit of pain" that affected the patient's mood, sleep, movement, and activities. The patient's caregiver indicated Person #9 was the practitioner that referred to home health care for physical therapy for pain management. During an interview on 6/8/2023, at 3:40 PM, the Clinical Manager indicated there was no coordination with the pain clinic and there was no documentation in the clinical record regarding the patient's pain management need prior to discharge. 6. Clinical record review on 6/8/2023, for Patient #11, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/4/2023-6/2/2023, which indicated the agency was to provide skilled nursing services 2 times a week for 9 weeks for wound care to the left buttock. Review indicated the patient lived at an assisted living facility and had a power of attorney. Review indicated the discharge plans included discharging the patient when the wound healed and indicated the rehabilitative potential was good. Review indicated the wound healed on 5/2/2023. Review of an agency document titled "Order for Discharge" dated 5/5/2023, indicated the agency	G0560		

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G0560	Continued from page 9 transferred the patient to Entity 8 (hospice agency). Review failed to evidence coordination with the assisted living facility and Entity 8 on the reason for the transfer to hospice. Review failed to evidence communication with the patient and power of attorney regarding the transfer to hospice. Review of an agency document titled “Transfer Summary” and an agency document titled “Transfer Discharge” completed by the Alternate Clinical Manager and dated 5/5/2023, failed to evidence the care was coordinated with the hospice and the assisted living facility. During an interview on 6/8/2023, at 12:05 PM, the Alternate Clinical Manager indicated he was notified by the assisted living facility the patient was transferred to hospice care. The Alternate Clinical Manager indicated he believed the decision to transfer to hospice was made by the patient’s power of attorney and was unsure why the patient was transferred to hospice. During an interview on 6/8/2023, at 3:45 PM, the Clinical Manager indicated there was no documented communication with the assisted living facility and the hospice agency regarding the plans to transfer to hospice. The Clinical Manager indicated she believed the hospice referral came from the assisted living facility. The Clinical Manager indicated there was no documented communication with the patient’s power of attorney regarding the transfer to hospice.	G0560		
G0570	Care planning, coordination, quality of care CFR(s): 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted	G0570		

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G0570	Continued from page 10 standards of practice. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency 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 all orders were recorded in the plan of care (Please see tag G0576); failed to ensure services were provided in conformance with physician orders (Please see tag G0578); failed to review and revise the plans of care (Please see tag G0586); 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); and failed to coordinate care (Please see tag G0606). 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 deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the agency failed to meet the patient's needs prior to discharge in 2 of 4 closed record reviews. (Patient #8. #9) The findings include: 1. 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 … Ensure that each patient, and his or her caregiver(s), where applicable, receives ongoing education and training by the Agency, as appropriate, regarding the care and services identified in the plan of care. The Agency must provide training, as necessary, to ensure a timely discharge…." 2. Review of an agency policy revised February 2021, titled "Plan of Care – CMS #485 and Physician/Practitioners Orders" stated, "… Skilled nursing and other home health services will be in accordance with a Plan of Care … Patients are accepted for treatment on the reasonable expectation that Agency	G0570		

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G0570	Continued from page 11 can meet the patient's medical, nursing, rehabilitative and social needs in his or her place of residence...." 3. Clinical record review on 6/7/2023, for Patient #8, start of care 11/30/2021, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 3/21/2023-5/19/2023, which indicated the patient's diagnoses included, but were not limited to, retention of urine, rheumatoid arthritis (a disease causing painful swelling of the joints), and chronic pain syndrome. Review indicated the agency was to provide skilled nursing services 1 time every other week for 8 weeks for foley catheter (a plastic tube inserted into the bladder to drain urine) management. Review indicated the discharge plan included discharge when patient returned to a stable genitourinary status and caregiver was able to perform foley catheter care. Review indicated the patient's goals included, but were not limited to, the patient's pain level would be less than 2 with improved activity level due to effective pain control. Review of an agency document titled "Recertification" dated 3/20/2023, and identified as the comprehensive assessment, indicated the patient was alert and oriented and lived alone in a senior living community and had attendant care for personal care 3 times a week. Review of agency documents titled "LVN/LPN [licensed vocational nurse/licensed practical nurse] Visit" completed by LPN 1 indicated the patient was starting injections at the rheumatology office weekly on document dated 5/3/2023. Review of document dated 5/3/2023 indicated the patient's pain was rated at time of the visit a 5 on a scale of 0-10 with the worst pain reported during the past week at 7 on a scale of 0-10. Review of document dated 5/12/2023, indicated the patient's worst pain in the past week was a 7 on a scale of 0-10. Review indicated the nurse flushed the foley catheter for mild sediment on documents dated 5/3/2023 and 5/12/2023. Review indicated a new medication order for protonix (a medication used to treat acid reflux) and failed to evidence the nurse educated the patient on the new medication. Review of an agency document titled "Physician Order" dated 5/3/2023, indicated the agency increased the frequency of the skilled nursing visits to 1 time a week through the end of the certification period due to "increased health issues; respiratory; rheumatology; pain doctor". Review indicated an order to flush the foley catheter as needed for patency and sediment.	G0570		

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G0570	Continued from page 12 Review evidenced an agency document titled "Communication Note" completed by the skilled nurse and dated 5/12/2023, which indicated the patient began new intravenous (administered into the blood stream though a vein) infusions for the treatment of rheumatoid arthritis administered weekly at the office of the rheumatologist (a physician which treats arthritis and immune-related conditions). Review indicated the patient was to undergo a port placement (a medical device implanted under the skin usually in the chest used to draw blood and administer medication) on May 25, 2023. Review indicated the patient had an appointment with the pain physician on June 8, 2023. Review of an agency document titled "Discharge Non-Visit" completed by the Clinical Manager and dated 5/19/2023, was identified to be the comprehensive assessment. Review indicated the patient had pain that occasionally affected sleep and day-to-day activities. Review of an agency document titled "Home Health Discharge Summary" dated 6/1/2023, indicated the agency discharged the patient on 5/19/2023. Review indicated the agency discharged the patient to the care of the urologist (a physician that specializes in conditions affecting the urinary tract). Review failed to evidence coordination with the urologist prior to discharge regarding the frequency of catheter care/change to be provided and the catheter flush as needed. Review failed to evidence the patient's pain goal was met and no coordination with the physicians regarding the patient's pain was documented. Review failed to evidence coordination regarding the patient's port placement and monitoring of the intravenous infusion treatments was documented. During an interview on 6/8/2023, at 2:16 PM, Patient #8 indicated she was unaware she had been discharged by the agency. Patient #8 indicated she spoke to the clinical manager the day prior regarding the clinical manager was in India when recertification was due so the clinical manager would come to the patient's home next week. Patient #8 indicated she was to visit the urologist every 6 months and as needed. Patient #8 indicated she had an appointment with the urologist on 6/2/2023 who instructed her to continue with home health for catheter changes. Patient #8 indicated she can not change or flush the catheter per self and indicated the personal care attendants did not provide catheter care. Patient #8 indicated she did not receive discharge instructions from the agency because she had never been told by the agency she was discharged. During an interview initiated on 6/8/2023, at 12:58 PM,	G0570		

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G0570	Continued from page 13 LPN 1 indicated he/she did not ever give the patient discharge notice and the Clinical Manager did not ever discuss plans for patient discharge with LPN 1. LPN 1 indicated the patient was not appropriate for discharge because the patient needed home care for foley care and monitoring of new intravenous infusion treatments for rheumatoid arthritis. During an interview on 6/8/2023, at 3:24 PM, the Clinical Manager indicated the discharge assessment was not completed in person because the Clinical Manager was in India at time of discharge and the discharge assessment was completed based on what she knew of the patient. The Clinical Manager indicated she was not aware of the patient's intravenous infusion treatments nor about the plan to have a port placed so she did not educate the patient on the signs and symptoms of adverse reactions to the infusion treatments. The Clinical Manager indicated the agency could have continued skilled services to monitor the soon-to-be-placed port for signs and symptoms of infection, but the Clinical Manager was unaware of the plan to place a port and of the intravenous infusion treatments. At 3:26 PM, the Clinical Manager indicated she did not know the LPN was flushing the patient's catheter, so she did not educate the patient at time of discharge on the catheter flush and did not know who would provide the catheter flush if needed. The Clinical Manager indicated the patient was not able to flush the foley catheter due to the abnormality of the patient's fingers due to the rheumatoid arthritis and indicated the caregiver responsible for the catheter care at time of discharge was the urologist. The Clinical Manager indicated she did not speak to the patient about discharge prior to date of discharge and indicated the patient called this week asking about the next catheter change. The Clinical Manager indicated she informed the patient she would complete a start of care assessment next week after contacting the physician. When queried why the Clinical Manager would get a physician order to admit the patient to home care and conduct an initial assessment next week if urology was to manage the patient's foley catheter, the Clinical Manager remained silent. 4. Clinical record review on 6/8/2023, for Patient #9, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 4/18/2023-6/16/2023, which indicated the agency was to provide skilled nursing services 4 times a week for 9 weeks for wound care to both lower extremities. Review of agency documents identified as nurse visit notes dated 4/5/2023, 4/6/2023, 4/7/2023, 4/11/2023,	G0570		

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G0570	Continued from page 14 4/12/2023, 4/13/2023, 4/14/2023, and 4/18/2023, indicated discharge was not considered due to lymphedema (tissue swelling), wounds, lack of caregiver support, and patient unable to perform wound care per self. Review indicated 2 wounds to the right lower extremity and 2 wound to the left lower extremity, all with heavy drainage. Review of document dated 4/14/2023, indicated the nurse noted medications not filled in the patient's Medi-planner and documented the patient reported that was all the medications the patient could afford and indicated the patient demonstrated inappropriate behavior with the nurse. Review of document dated 4/18/2023, indicated the patient demonstrated inappropriate behaviors with the nurse and was noncompliant with many medications due to the patient's report of inability to pay for all medications. Review of document dated 4/19/2023, indicated the patient demonstrated inappropriate behaviors with the nurse and appeared disheveled and over sedated. Review of an agency document titled "Recertification" completed by the Clinical Manager and dated 4/17/2023, and identified as the comprehensive assessment, indicated the patient was non-compliant and had been "making up stories about the nurses and reporting to the wound clinic", but review failed to evidence communication with the patient and physician regarding the non-compliance. Review failed to evidence the agency referred the patient for social work services regarding the inability to pay for medication. Review failed to evidence the agency initiated a behavior plan as part of the plan of care related to the patient's demonstration of inappropriate behavior with the staff. During an interview on 6/8/2023, at 4:05 PM, the Clinical Manager indicated the agency probably should have included the patient's behaviors in the plan of care. The Clinical Manager indicated the wound clinic that provided care to the patient 1 time a week informed the Clinical Manager that the patient had a history of behaviors, and the Clinical Manager stated, "To me, he was a sweet old man." The Clinical Manager indicated the agency did not provide social work services but should have made a referral if the patient was having difficulty paying for medication.	G0570		
G0572	Plan of care CFR(s): 484.60(a)(1) Each patient must receive the home health services that	G0572		

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G0572	Continued from page 15 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. This STANDARD is NOT MET as evidenced by: Based on 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 4 of 6 active clinical records reviewed. (Patient #3, 4, 5, 7) The findings include: 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 #3 was completed on 6/6/2023. Record review evidenced a plan of care for certification period 5/4/2023 - 7/2/2023, which indicated the physical therapist was to visit twice weekly and educate the patient on infection control, pain, and energy conservation measures. Record review evidenced a physical therapy visit note dated 6/2/2023, which failed to indicate the therapist educated the patient on infection control measures, pain, and energy conservation, as was ordered on the plan of care. Record review evidenced a physical therapy visit note dated 6/6/2023, which failed to indicate the therapist educated the patient on infection control or pain, as was ordered on the plan of care.	G0572		

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G0572	Continued from page 16 During an interview on 6/7/2023, at 11:19 AM, the Clinical Manager indicated the therapist should have performed the tasks from the plan of care. 3. Clinical record review for Patient #4 was completed on 6/6/2023. Record review evidenced a plan of care for certification period 4/21/2023 - 6/19/2023, which indicated the skilled nurse was to visit twice weekly, and indicated the nurse may apply pressure bandages to the patient's legs as needed for edema (swelling) management. The plan of care failed to be individualized to specify the patient's baseline level of edema or level of edema which required pressure bandaging. Record review evidenced a recertification comprehensive assessment dated 4/20/2023, which indicated the patient had non pitting edema (swelling which does not cause a skin indentation when pressure is applied) to bilateral lower extremities. Record review evidenced a skilled nurse visit note dated 6/2/2023, which indicated the patient had 2+ pitting edema (3-4 millimeters of indentation in skin which lasts less than 15 seconds when pressure is applied), but failed to indicate the patient's legs were wrapped as ordered for edema management. During an interview on 6/7/2023, at 12:25 PM, the Clinical Manager indicated the nurses should have been wrapping the patient's legs for any swelling, but that the plan of care should have specified the amount of swelling to wrap the legs. At 12:29 PM, the Clinical Manager indicated the patient's legs should have been wrapped with pressure bandages for 2+ pitting edema. 4. Clinical record review for Patient #5 was completed on 6/6/2023. Record review evidenced a plan of care for certification period 4/16/2023 - 6/14/2023, which indicated the nurse was to notify the physician for a blood pressure less than 95/50. The plan of care indicated the nurse was to notify the physician of any significant skin changes. Record review evidenced a skilled nurse visit note dated 6/2/2023, which indicated the patient's blood pressure was 70/50, and the patient had developed a new reddened area to the left heel.	G0572		

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G0572	Continued from page 17 Record review failed to evidence the physician was notified of this blood pressure outside of parameters or the new reddened area to the left heel, as ordered in the plan of care. During an interview on 6/7/2023, at 12:56 PM, the Clinical Manager indicated the physician should have been notified of the blood pressure outside of parameters and the new reddened area to the left heel. 5. Clinical record review on 6/8/2023, for Patient #7, evidenced an agency document titled “Recertification” dated 5/10/2023, and identified as the comprehensive assessment. This document indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage IV (full thickness skin loss with possible involvement of bone, muscle, or tendon) to the coccyx (lower back above the buttocks). Review of documents from Entity #5 (wound clinic) dated 4/28/2023, indicated the treatment for the wound to the coccyx was to apply prisma (wound dressing), Cuticerin (a lubricant-infused gauze) to the exposed bone, aquacel (wound dressing), Qwick (wound dressing), and a border dressing every 3 days. During an interview on 6/8/2023, at 4:34 PM, the Alternate Clinical Manager indicated the patient still had a wound to the coccyx and he had provided wound care treatment most recently on 6/7/2023. Review of an agency document titled “Home Health Certification and Plan of Care” for certification period 5/12/2023-7/10/2023, failed to evidence the plan of care included the wound treatment to the coccyx wound. During an interview on 6/8/2023, at 4:20 PM, the clinical manager indicated the plan of care did not include the wound care orders but the agency nurses followed the wound care clinic’s orders. The clinical manager indicated the nurse that developed the plan of care was new and probably overlooked including the wound care orders.	G0572		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi)	G0574		

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G0574	Continued from page 18 The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the individualized plan of care included all the required elements in 5 of 6 active clinical records reviewed. (Patient #1, 2, 3, 5, 7) The findings include:	G0574		

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G0574	Continued from page 19 1. Record review evidenced an agency policy revised 02/2022, titled "Plan of Care - CMS #485 Physician/Practitioner Orders" which stated, "... The individualized plan of care 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. Observation of a home visit for Patient #1 was conducted on 6/6/2023, at 2:00 PM, to observe a routine skilled nurse visit. During the visit, the following equipment was observed: neck brace, hospital bed, and walker. During the visit, the nurse checked the patient's glucometer for the blood glucose reading obtained previously that day. Clinical record review for Patient #1 was completed on 6/6/2023, for certification period 5/16/2023 - 7/14/2023. Record review evidenced a recertification comprehensive assessment dated 5/12/2023, which indicated the patient had the following risks for hospitalization: history of falls, and currently taking 5 or more medications. Record review evidenced a plan of care for certification period 5/16/2023 - 7/14/2023, which failed to identify the history of falls as a hospitalization risk, and failed to include interventions to address any hospitalization risks identified in the comprehensive assessment. The plan of care failed to include the neck brace, hospital bed, and walker. The plan of care indicated the patient was diabetic (had problem regulating blood sugars), but failed to include orders for the nurses to assess or document the blood glucose readings during visits. During an interview on 6/7/2023, at 12:38 PM, the Clinical Manager indicated the plans of care should have included the risks for hospitalizations and interventions to address the risks. The Clinical Manager indicated the equipment was not on the plan of care because the plan of care wasn't updated to include	G0574		

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G0574	Continued from page 20 it all. At 12:46 PM, the Clinical Manager indicated the nurses were expected to inquire about the patient's blood glucose levels on every visit, and indicated this should have been included in the plan of care. 3. Clinical record review for Patient #2 was completed on 6/6/2023, for certification period 5/21/2023 - 7/19/2023. Record review evidenced a recertification comprehensive assessment dated 5/20/2023, which indicated the INR level (blood clotting level) was to be drawn the last week of every month. Record review evidenced a skilled nurse visit note dated 5/31/2023, which indicated the patient was on a high protein diet for wound healing. Record review evidenced a plan of care for certification period 5/21/2023 - 7/19/2023, which indicated the skilled nurse was to visit three times weekly, and obtain an INR level (blood clotting level) monthly as needed. The plan of care failed to include the correct orders for INR level the last week of every month. The plan of care indicated the patient was taking coumadin (blood thinner), but failed to include bleeding precautions. The plan of care failed to include a high protein diet in nutritional information. During an interview on 6/7/2023, at 11:23 AM, the Clinical Manager indicated the actual orders for INR level were to check once monthly, not monthly as needed. The Clinical Manager indicated the plan of care should have included this information. The Clinical Manager indicated bleeding precautions should have been included in the plan of care for patients taking blood thinners. At 11:30 AM, the Clinical Manager indicated the plan of care should have included a high protein diet. 4. Clinical record review for Patient #3 was completed on 6/6/2023, for certification period 5/4/2023 - 7/2/2023. Record review evidenced a recertification comprehensive assessment dated 5/2/2023, which identified the following risks for hospitalization: currently taking 5 or more medications and a history of falling. Record review evidenced a plan of care for certification period 5/4/2023 - 7/2/2023, which indicated the patient was taking eliquis (blood thinner) but failed to include bleeding precautions. The plan of care failed to include interventions to address the hospitalization risks of multiple medications.	G0574		

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G0574	Continued from page 21 During an interview on 6/7/2023, at 11:13 AM, the Clinical Manager indicated bleeding precautions should have been included in the plan of care. At 11:15 AM, the Clinical Manager indicated the plans of care should have included interventions to address all the hospitalization risks. 5. Clinical record review for Patient #5 was completed on 6/6/2023, for certification period 4/16/2023 - 6/14/2023. Record review evidenced a recertification comprehensive assessment dated 4/14/2023, which indicated the patient lived alone and required assistance bathing, dressing, and grooming. This document indicated the patient's family members helped them occasionally. Record review evidenced a plan of care for certification period 4/16/2023 - 6/14/2023, which failed to include psychosocial information such as who the patient's caregiver was, what days or hours they provided services, and what tasks they completed for the patient. The plan of care indicated the patient went to wound clinic, but failed to include the name of the wound clinic, or what days the patient went to wound clinic. During an interview on 6/7/2023, at 12:53 PM, the Alternate Clinical Manager indicated the patient had a paid caregiver who came every day to the patient's home to assist them. The Alternate Clinical Manager indicated this information should have been included in the plan of care. 6. Clinical record review on 6/8/2023, for Patient #7, evidenced documents from Entity #5 (wound clinic) dated 4/28/2023, which indicated the patient was treated at the wound clinic every other week for wound care to the coccyx (lower back above the buttocks). Review indicated the wound clinic orders included Juven (nutritional supplement) was to be consumed twice daily. Review of an agency document titled “Home Health Certification and Plan of Care” for certification period 5/12/2023-7/10/2023, failed to evidence the wound treatment provided at the wound clinic to include the name of the wound clinic and the frequency of the treatment provided by the wound clinic and failed to evidence the nutritional supplement. During an interview on 6/8/2023, at 4:20 PM, the Clinical Manager indicated the nurse that developed the plan of care was new and probably overlooked including the wound clinic.	G0574		

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G0574	Continued from page 22 7. During an interview on 6/7/2023, at 12:53 PM, the Alternate Clinical Manager indicated the plan of care should have included the name of the wound care clinic.	G0574		
G0576	All orders recorded in plan of care CFR(s): 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure all orders were recorded in the plan of care in 3 of 4 active clinical records reviewed with wounds. (Patient #1, 2, 7) The findings include: 1. Record review evidenced an agency policy revised 2/2022, 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...." 2. Clinical record review for Patient #1 was completed on 6/6/2023, for certification period 5/16/2023 - 7/14/2023. Record review evidenced a skilled nurse visit note dated 5/19/2023, which indicated the patient had a new wound to the right upper extremity. Record review evidenced an order for wound care to the right upper extremity, which was entered on 6/5/2023 (18 days later), and back dated to be effective 5/19/2023. Record review failed to evidence an order for wound care was entered prior to 6/5/2023. During an interview on 6/7/2023, at 12:49 PM, the Clinical Manager indicated the nurse received a verbal order on 5/19/2023, but didn't know they had to enter it in the plan of care as an order until later. 3. Clinical record review for Patient #2 was completed on 6/6/2023, for certification period 5/21/2023 - 7/19/2023. Record review evidenced a skilled nurse visit note dated 5/31/2023, which indicated the physician was notified of INR (blood clotting level) level of 4.5, and orders were given to hold the coumadin (blood thinner) 6/1/2023, and 6/2/2023, and resume daily coumadin on 6/3/2023. Record review failed to evidence any orders for holding coumadin were entered until 6/5/2023 (5 days later).	G0576		

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G0576	Continued from page 23 Record review evidenced an order dated 6/5/2023, which indicated effective 6/1/2023, the patient was to hold coumadin on Thursday and Friday, and resume coumadin on Saturday. This order failed to be entered until 6/5/2023. During an interview on 6/7/2023, at 11:28 AM, the Alternate Clinical Manager indicated they received the verbal order to hold coumadin on 5/31/2023, and it was an error that it wasn't entered in the electronic medical record as an order until 6/5/2023. 4. Clinical record review on 6/8/2023, for Patient #7, evidenced documents from Entity #5 (wound clinic) dated 6/5/2023, which indicated the treatment for the wound to the coccyx (lower back above the buttocks) was to apply prisma (wound dressing), aquacel silver (an antimicrobial wound dressing), and cover with a foam dressing every 2-3 days. Review of an agency document titled “Home Health Certification and Plan of Care” for certification period 5/12/2023-7/10/2023, failed to evidence the current plan of care included the wound treatment order from 6/5/2023 from the wound clinic. During an interview on 6/8/2023, at 4:28 PM, the Clinical Manager indicated the wound clinic orders should be included in the plan of care.	G0576		
G0578	Conformance with physician orders CFR(s): 484.60(b) Standard: Conformance with physician or allowed practitioner orders. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure services were performed in conformance with physician orders in 2 of 4 active clinical records reviewed with wounds. (Patient #1, 2) The findings include: 1. 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….”	G0578		

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G0578	Continued from page 24 2. Observation of a home visit for Patient #1 was conducted on 6/6/2023, at 2:00 PM, to observe a routine skilled nurse visit. During the visit, the patient's right upper extremity wound was observed, and no protective bandage was in place, or applied during the visit. Clinical record review evidenced a physician order dated 6/5/2023, which indicated as of 5/19/2023, the skilled nurse was to apply a protective bandage to the patient's right upper extremity wound twice weekly and as needed. Record review evidenced a skilled nurse visit note dated 6/2/2023, which failed to evidence a protective bandage was applied to the right upper extremity wound. During an interview on 6/7/2023, at 12:49 PM, the Clinical Manager indicated the wound care wasn't provided as ordered probably because the wound was healed. 3. Clinical record review for Patient #2 was completed on 6/6/2023, for certification period 5/21/2023 - 7/19/2023. Record review evidenced a physician order dated 6/2/2023, which indicated the skilled nurse was to perform wound care three times weekly as follows for a right inner thigh wound: cleanse with normal saline, pat dry, leave open to air. Record review evidenced a skilled nurse visit note dated 6/2/2023, which failed to indicate the nurse cleansed the right inner thigh wound with normal saline as was ordered. During an interview on 6/7/2023, at 11:39 AM, the Clinical Manager indicated the nurse had cleansed the wound with normal saline.	G0578		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by:	G0580		

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G0580	Continued from page 25 Corrected 6/8/2023. Corrected 6/8/2023	G0580		
G0586	Review and revision of the plan of care CFR(s): 484.60(c) Standard: Review and revision of the plan of care. This STANDARD is NOT MET as evidenced by: Based on record review, and interview, the home health agency failed to ensure the plans of care were revised and reviewed in 2 of 4 active clinical records reviewed with wounds. (Patient #2, 5) The findings include: 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. Clinical record review for Patient #2 was completed on 6/6/2023, for certification period 5/21/2023 - 7/19/2023. Record review evidenced a recertification comprehensive assessment dated 5/20/2023, which indicated the patient had no issues with pain. This comprehensive assessment indicated the patient had a left shin wound which measured 1.3cm (centimeters) x 1.0cm x 0.1 cm. Record review evidenced a plan of care for certification period 5/21/2023 - 7/19/2023, which did not include any interventions or goals related to pain. Record review evidenced skilled nurse visit notes dated 6/2/2023, and 6/5/2023, which indicated the patient was experiencing pain 7/10 [on a scale with 0 being no pain and 10 the most severe]. Review of the 6/2/2023, skilled nurse visit note evidenced the left shin wound now measured 4.5cm x 2cm x 0.2cm.	G0586		

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G0586	Continued from page 26 Record review failed to evidence the plan of care was revised to reflect the enlarging left shin wound. Record review failed to evidence the plan of care was revised or reviewed to reflect the increase in the patient's pain level. During an interview on 6/7/2023, at 11:33 AM, the Clinical Manager indicated they should have updated the plan of care to reflect the patient's increase in pain. At 11:41 AM, the Clinical Manager indicated the plan of care should have been updated for the worsening left shin wound. 3. Clinical record review for Patient #5 was completed on 6/6/2023, for certification period 4/16/2023 - 6/14/2023. Record review evidenced a recertification comprehensive assessment dated 4/20/2023, which indicated the patient had 1 wound to their coccyx (area at the base of the spine). Record review evidenced a skilled nurse visit note dated 6/2/2023, which indicated the patient had developed a new reddened area to their left heel. Record review evidenced a plan of care for certification period 4/16/2023 - 6/14/2023, which failed to be revised to address the new reddened area to the left heel. During an interview on 6/7/2023, at 1:04 PM, the Clinical Manager indicated the plan of care should have been updated to address the reddened area to the heel.	G0586		
G0590	Promptly alert relevant physician of changes CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Deficiency corrected 06/02/2023	G0590		

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G0590	Continued from page 27 Deficiency corrected 06/02/2023	G0590		
G0592	Revised plan of care CFR(s): 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure revised plans of care included the patient's progress towards measurable outcomes and goals in 6 of 6 clinical records reviewed. (Patient #1, 2, 3, 4, 5, 7) The findings include: 1. Record review evidenced an agency policy revised 02/2022, titled "Plan of Care - CMS #485 and Physician/Practitioner Orders" indicated but was not limited to, "... 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 #1 was completed on 6/6/2023. Record review evidenced an updated plan of care for certification period 5/16/2023 - 7/14/2023, which failed to include the patient's progress towards measurable goals and outcomes. During an interview on 6/7/2023, at 12:44 PM, the Clinical Manager indicated the progress towards goals was included on the recertification assessments, not on the plans of care. 3. Clinical record review for Patient #2 was completed on 6/6/2023. Record review evidenced an updated plan of care for certification period 5/21/2023 - 7/19/2023, which failed to include the patient's progress towards measurable goals and outcomes.	G0592		

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G0592	Continued from page 28 During an interview on 6/7/2023, at 11:28 AM, the Clinical Manager indicated the plan of care should have included progress towards goals. 4. Clinical record review for Patient #3 was completed on 6/6/2023. Record review evidenced an updated plan of care for certification period 5/4/2023 - 7/2/2023, which failed to include the patient's progress towards measurable outcomes and goals. During an interview on 6/7/2023, at 11:16 AM, the Clinical Manager indicated the patient's progress towards goals was documented in the visit notes instead of the plan of care. 5. Clinical record review for Patient #4 was completed on 6/6/2023. Record review evidenced an updated plan of care for certification period 4/21/2023 - 6/19/2023, which failed to include the patient's progress towards measurable goals and outcomes. During an interview on 6/7/2023, at 12:32 PM, the Clinical Manager indicated the progress towards goals should have been included in the plan of care. 6. Clinical record review for Patient #5 was completed on 6/6/2023. Record review evidenced an updated plan of care for certification period 4/16/2023 - 6/14/2023, which failed to include the patient's progress towards measurable goals and outcomes. During an interview on 6/7/2023, at 12:32 PM, the Clinical Manager indicated the progress towards goals should have been included in the plan of care. 7. Clinical record review on 6/8/2023, for Patient #7, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 5/12/2023-7/10/2023, which failed to evidence the current plan of care included the patient’s progress towards measurable goals and outcomes. During an interview on 6/8/2023, at 4:34 PM, the Clinical Manager indicated the current plan of care did not include the patient’s progress to goals.	G0592		
G0606	Integrate all services	G0606		

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G0606	Continued from page 29 CFR(s): 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. This ELEMENT is NOT MET as evidenced by: 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 6 active clinical records reviewed. (Patient #4, 5) The findings include: 1. Review of an agency policy revised February 2021, titled “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….” 2. Clinical record review for Patient #4 was completed on 6/6/2023, for certification period 4/21/2023 - 6/19/2023. Record review evidenced a recertification assessment dated 4/20/2023, which indicated the patient lived alone, and required assistance with grooming, dressing, and bathing. Record review evidenced a plan of care for certification period 4/21/2023 - 6/19/2023, which indicated the patient had a caregiver available throughout the morning, but failed to include any coordination of care or information regarding what days, hours, or tasks the caregiver performed, or who the caregiver was. During an interview on 6/7/2023, at 12:22 PM, the Clinical Manager indicated if the patient had a caregiver, care should have been coordinated with them. The Clinical Manager was not sure who the caregiver or caregivers were for Patient #4, and was not sure the hours or days they were available to assist the patient. 3. Clinical record review for Patient #5 was completed	G0606		

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G0606	Continued from page 30 on 6/6/2023, for certification period 4/16/2023 - 6/14/2023. Record review evidenced a recertification comprehensive assessment dated 4/14/2023, which indicated the patient lived alone and required assistance bathing, dressing, and grooming. This document indicated the patient's family members helped them occasionally. Record review evidenced a plan of care for certification period 4/16/2023 - 6/14/2023, which failed to include information such as who the patient's caregiver was, what days or hours they provided services, and what tasks they completed for the patient. Record review failed to evidence any care coordination between the home health agency and the private duty caregivers. During an interview on 6/7/2023, at 12:53 PM, the Alternate Clinical Manager indicated the patient had a paid caregiver who came every day to the patient's home to assist them. The Alternate Clinical Manager indicated care should have been coordinated with the private duty caregivers by sharing plans of care and documenting which hours and days the caregiver provided services, and which tasks they performed. 410 IAC 17-12-2(h)	G0606		
G0714	Patient and caregiver education CFR(s): 484.75(b)(5) Patient and caregiver education; This ELEMENT is NOT MET as evidenced by: Deficiency corrected 06/02/2023 Deficiency corrected 06/02/2023	G0714		
G0716	Preparing clinical notes CFR(s): 484.75(b)(6) Preparing clinical notes; This ELEMENT is NOT MET as evidenced by: Based on record review, and interview, the home health agency failed to ensure skilled professionals accurately and completely documented patient assessments and clinical notes in 4 of 6 active clinical records reviewed. (Patient #1, 2, 4, 5)	G0716		

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G0716	Continued from page 31 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 6/6/2023, for certification period 5/16/2023 - 7/14/2023. Record review evidenced a skilled nurse visit note dated 6/2/2023, which indicated the patient had a right upper extremity wound which measured 3.5cm (centimeters) x 2cm. This skilled nurse visit note also indicated the right upper extremity wound was healed. During an interview on 6/7/2023, at 12:49 PM, the Clinical Manager indicated the right upper extremity wound was healed, and was not sure why there were measurements included in the note. 3. Clinical record review for Patient #2 was completed on 6/6/2023. Record review evidenced a plan of care for certification period 5/21/2023 - 7/19/2023, which indicated Person #2 (physician) was the patient's physician. Record review evidenced a skilled nurse visit note dated 6/2/2023, which indicated Person #3 (wound clinic physician) was contacted, but failed to include any documentation of what the physician was contacted about, or results of the communication. This visit note indicated the patient had a wound to the right inner thigh, left inner lateral shin, and 2 wounds to the right medial posterior upper calf. Record review evidenced a skilled nurse visit note dated 6/5/2023, which indicated the patient now had a wound to the right superior calf, left inner lateral shin, and 2 wounds to the right medial posterior upper calf. During an interview on 6/7/2023, at 11:34 AM, the Clinical Manager indicated the nurse should have	G0716		

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G0716	Continued from page 32 documented any relevant information about the phone call such as any orders the physician gave and what the communication was about. At 11:55 AM, the Alternate Clinical Manager indicated the 6/5/2023, visit note was documented incorrectly and should have included the right thigh wound. 4. Clinical record review for Patient #4 was completed on 6/6/2023, for certification period 4/21/2023 - 6/19/2023. Record review evidenced a recertification comprehensive assessment dated 4/20/2023, which indicated the patient had non pitting edema (swelling which does not make an indentation when pressure is applied) to bilateral lower extremities. Record review evidenced skilled nurse visit notes dated 6/2/2023, and 6/6/2023, which indicated the patient's baseline level of edema was 2+ pitting edema (indentation of 3 - 4 millimeters, which lasts less than 15 seconds when pressure is applied). This visit note indicated Person #4 (physician) was called about a medication dosage change, but failed to include information as to what medication, what dosage changed, and what the results of the communication were. During an interview on 6/7/2023, at 12:29 PM, the Clinical Manager indicated the patient's baseline level of edema was 1+, and did not know why the nurse documented 2+ was the baseline. The Clinical Manager indicated the nurse should have documented the communication, and results of the communication with the physician. 5. Clinical record review for Patient #5 was completed on 6/6/2023, for certification period 4/16/2023 - 6/14/2023. Record review evidenced a skilled nurse visit note dated 6/6/2023, which indicated no wound care was performed to the patient's coccyx (area at base of spine) wound, but also included wound measurements. During an interview on 6/7/2023, at 1:03 PM, the Alternate Clinical Manager indicated the wound measurements included in the 6/6/2023, visit note were carried over from the day before, and no measurements were obtained during the 6/6/2023, visit. 410 IAC 17-14-1(a)(1)(E)	G0716		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157643	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G0716 G0726	Nursing services supervised by RN CFR(s): 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure licensed practical nurses were supervised by registered nurses in 1 of 4 clinical records reviewed, which received services from licensed practical nurses. (Patient #4) The findings include: 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]...." Clinical record review for Patient #4 was completed on 6/6/2023, for certification period 4/21/2023 - 6/19/2023. Review of the electronic medical record on 6/5/2023, evidenced scheduled licensed practical nurse supervisory visits scheduled 5/18/2023, and 6/1/2023, which were not completed. Record review evidenced the supervisory visits failed to be completed and documented until 6/6/2023. During an interview on 6/7/2023, at 12:20 PM, the Alternate Clinical Manager indicated the supervisory visits were supposed to be done every 15 days, and documented. 410 IAC 17-14-1(a)(1)(J)	G0716 G0726		
G0800	Services provided by HH aide CFR(s): 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;	G0800		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157643	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/08/2023

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G0800	Continued from page 34 (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is NOT MET as evidenced by: Deficiency corrected 06/02/2023 Deficiency corrected 06/02/2023	G0800		