

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/15/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 167051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2021
NAME OF PROVIDER OR SUPPLIER FLOYD COUNTY PUBLIC HEALTH/ HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1003 GILBERT STREET CHARLES CITY, IA 50616		
(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
G 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was conducted by the Department of Inspections and Appeals in conjunction with the recertification survey from 1/4/21 through 1/11/21. The recertification survey found the following: During the survey, the surveyors identified an Immediate Jeopardy situation. The agency failed to promptly alert the physician if the patient's plan of care should be altered (Refer to G0590). The Immediate Jeopardy was abated on 1/11/21 at 11:43 AM. The survey found the agency was operating out of compliance with the following Conditions of Participation: 1) Condition of Participation 42 CFR 484.50 Patient Rights (G406 and G458) 2) Condition of Participation 42 CFR 484.60 Care Planning, Coordination and Quality of Care (G570, G572, G574, G576, G580, G590, and G602) 3) Condition of Participation 42 CFR 484.100 Compliance with Federal, State and Local Law (G848) and 4) Condition of Participation 42 CFR 484.105 Organization and Administration of Services (G940 and G942) The survey also found the agency operating out of compliance with multiple other standard level regulatory requirements.	G 000	<i>POC accepted on 1/26/21 with date of correction 1/31/21 - B. Raomussew</i>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature]

Admin

1-26-2021

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 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.

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G 000	Continued From page 1 The agency was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. As a result of the agency's noncompliance with the Medicare Conditions of Participation for home health agencies, the home health agency and its registered nurses are prohibited from providing basic skills competency training, and prohibited from providing evaluation of home health aide written basic skills testing and evaluation of demonstrated competency of the hands on basic skills for the agency's home health aides for 2 years, beginning on 1/11/21 and ending on 1/11/23.	G 000			
G 406	Patient rights CFR(s): 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. This CONDITION is not met as evidenced by: Based on agency policy review, clinical record review, agency staff interview and patient/caregiver interview, the agency failed to ensure patients were not discharged without just cause (G458). The systemic practice resulted in the failure to ensure the organizational framework of the agency promoted and supported coordination of safe and effective delivery of care to the agency's 98 patients.	G 406	G406: 1. Education was provided on 1/8/21 for all nursing staff, to ensure all were aware it is NOT the agency's policy to discharge due to COVID-19. If the patient/family requests a "hold" due to their own concerns re: COVID-19, the agency could also offer remote visits until in-person visits are resumed. The discharge policy was reviewed with all staff for reasons that we can discharge, per the COPs. All discharged must be communicated with the physician/ordering provider to ensure continuity of care. 2. Compliance will be ensured by the review of 100% of discharges/planned discharges on a weekly basis during the nurse team meeting. Clinical manager will continue monitor and ensure compliance with quarterly chart audits. 3. Clinical manager will ensure compliance by 1/22/21.		
G 458	Outcomes/goals have been achieved	G 458			

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G 458	Continued From page 2 CFR(s): 484.50(d)(3) The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved, and the HHA and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services; This ELEMENT is not met as evidenced by: Based on agency policy review, clinical record review, agency staff interview and patient/caregiver interview, the agency failed to ensure the physician responsible for the patient's home health services and the agency agree on the appropriateness of patient discharge for 2 of 2 sampled patients discharged from agency services (Patients #6 and #7). The agency reported a census of 98 patients at the time of the survey. The agency reported discharging 72 patients in the previous 6 months. Failure to ensure both parties are in agreement with the appropriateness of the discharge from home health placed patients at risk for inadequate care to meet the patient's needs at the time of and after discharge. Findings include, According to agency policy, titled Plan of Treatment and dated 6/2005, patient services will be under the direct supervision of a physician and maintained by periodic conferences between the physician and nursing personnel as the patient's condition warrants. Verbal orders received should be written, sent for signature and kept in	G 458	Per the Patient Rights Condition, and the standard G458, the interventions remain the same: 1. Education was provided on 1/8/21 for all nursing staff, to ensure all were aware it is NOT the agency's policy to discharge due to COVID-19. If the patient/family requests a "hold" due to their own concerns re: COVID-19, the agency could also offer remote visits until in-person visits are resumed. The discharge policy was reviewed with all staff for reasons that we can discharge, per the Conditions of Participation. All discharged must be communicated with the physician/ordering provider to ensure continuity of care. 2. Compliance will be ensured by the review of 100% of discharges/planned discharges on a weekly basis during the nurse team meeting. This is a permanent agenda item for the weekly meetings beginning 1/18/21. 3. Clinical manager will ensure compliance by 1/22/21. Ongoing compliance will be assured by clinical manager with quarterly chart audits.		

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G 458	Continued From page 3 the patient's clinical record. According to the agency policy, titled Skilled Nursing Policy and dated 6/2014, the patient will be discharged from skilled nursing service when all goals are met, the patient moves to a higher level of care outside of their home or when the home is unsafe for the patient or staff. According to the agency's undated policy, titled Comprehensive Assessment Policy, the comprehensive assessment determines the patient's problems, needs and strengths; the patient's continuing need for home health care; the patient's continuing eligibility for payment; goals and progress toward or lack of progress toward; and the ability of the agency to adequately meet the needs of the patient's medical, nursing, rehabilitation, social services and discharge planning needs. According to the agency's undated policy, titled Transfer/Discharge Criteria Policy, patients may be discharged from home care in accordance with the following criteria: 1. goals have been achieved 2. goals have been evaluated and determined the agency can not feasibly meet the established goals 3. patient is no longer under the care of a physician 4. at the request of the patient, family or physician 5. inability to locate the patient 6. lack of cooperation 7. patient moves out of geographic service area 8. patient dies 9. in an inpatient facility and Plan of Care orders expire 10. agency closes. Pre-planning for termination of services will include consultation with agency, patient, family and physician. Care will not be diminished or discontinued by the agency due to lack of a	G 458			

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G 458	Continued From page 4 reimbursement source. Final visit will be made to determine progress toward or lack of progress toward goals, planning for referrals to meet the patient's needs and provide instruction to the patient/family. Communication with the physician about discharge and further service that may be needed. 1. Patient #7 had a start of care date of 7/30/2020 and was discharged from agency services on 11/13/2020. The agency included patient #7 to it's list of discharged patients in the previous 6 months, indicating the patient was discharged with all goals met. Clinical record review and associated agency staff interviews reveal the following: a. The Plan of Care, dated 10/23/2020 to 12/23/2020, documented the wound care nurse had been ordering dressing changes twice weekly and the patient had no wounds on the legs at the time of the initiation of the Plan of Care. The Plan continued to identify a goal "have wounds healed by 12/23/2020" on the Plan. b. The update to the comprehensive assessment at the time of discharge, dated 11/13/2020, documented the registered nurse (RN), during the physical assessment, noted blisters that had opened up on the patient's right leg; noted additional new "small blisters forming on the right leg"; noted "two open areas on the left leg by the knee. One 0.8 centimeters by 0.5 centimeters and one 1.0 centimeter by 1.0 centimeter closer to the left ankle". The patient "has small blisters on the right leg" and two new "open wounds one by the knee 1.5 centimeters by 1.0 centimeters and one on the calf 1.3 centimeters by 0.6 centimeters." The RN documented the wounds	G 458			

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G 458	Continued From page 5 were draining a scant amount of clear drainage; the wound beds were red with surrounding tissue pink. The wound status was found with early to partial granulation. The assessment documented the patient asked about going to the local wound clinic and the nurse told the patient that if the spouse did not feel comfortable with taking care of the wounds, then yes, the patient should set up services with the local wound clinic. The nurse documented she "changed the dressing" and documented teaching the spouse "how to do the dressing change and on what to do if certain circumstances come up and the spouse voiced understanding". (Please refer to G580 and G590 as the clinical record did not include any communication with the physician about the wounds and did not include any orders from a physician or physician designee to treat the wounds.) The assessment documented the patient was discharged to the community without formal services and goals met. c. The clinical record lacked any documentation of physician communication to determine agreement that the patient no longer needed home health services and could be safely discharged. d. The discharge summary, dated 11/13/2020 and sent to the physician, did not report the new wounds identified during the discharge comprehensive assessment. e. During agency staff interview on 1/6/2021 at 8:40 AM, Staff D, RN, verified she had identified	G 458			

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G 458	Continued From page 6 new wounds on both of the patient's legs when performing the discharge comprehensive assessment. The RN verified she had not contacted the physician to report the new wounds or obtain direction/orders on how to treat the new wounds. Staff D, RN, reported she discharged the patient from services because Medicare "stopped paying". "We usually keep patients on Medicare for 2 months- if needed, we can extend and we had already extended the patient's (Medicare episode) once." "they didn't want to pay privately for services' so the RN reported teaching the spouse wound care specifics and discharged the patient. Staff D, RN, verified Patient #7 was homebound at the time of the discharge. The RN reported she typically did not report new wounds to the physician signing the new Plan as the spouse usually kept the physician notified. f. The surveyor made multiple attempts to contact the patient/patient's spouse with no success. Multiple message left to return surveyor's telephone calls. The patient was homebound, had new wounds identified on the day of discharge, continued to have a skilled need for home health services yet the agency discharged the patient without physician consultation to determine appropriateness of the discharge. 2) Patient #6 was admitted to the agency on 9/30/2020 and transferred to an inpatient facility on 11/28/2020. Clinical record review revealed: a. The patient transferred to an inpatient facility	G 458			

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G 458	Continued From page 7 on 11/28/2020 and an OASIS assessment was completed on 12/8/2020 with reason for the assessment as transferred to inpatient facility-patient not discharged from agency. b. A fax referral, received by the agency 12/1/2020, for resumption of care post hospitalization. c. An interim physician's order, received 12/2/2020 and completed 12/10/2020, included orders for patient discharge and included comments the patient needed to be discharged from Medicare due to admission to the hospital when the certification period for Medicare was due and the patient was diagnosed with COVID-19 and under quarantine for 14 days so agency staff unable to see the patient until out of isolation. The comment further stated the agency plans to readmit the patient after the 14 day period. d. The discharge summary, completed 12/10/2020, documented discharge date of 11/28/2020. e. An initial comprehensive assessment at start of care was performed on 12/10/2020 and documented the patient was readmitted to the agency on 12/10/2020. Phone interview with Patient #6 on 1/5/21 at 6:59 PM revealed the patient was discharged from the hospital on 12/1/2020 and the patient stated it was the agency's decision to not provide care until isolation period was over. The patient was discharged without proper cause due to being in quarantine after positive	G 458			

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G 458	Continued From page 8 COVID-19 test and hospitalization.	G 458			
G 536	The above findings for Patients #6 and #7 were reviewed with agency Administrator/Clinical Manager. The agency provided no further information prior to the end of the survey. 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 agency policy review, clinical record review and agency staff interview, the agency failed to complete a drug regimen review within the required time frames as part of the update to the comprehensive assessment at the time of resumption of care or discharge for 4 of 4 sampled patients requiring resumption of care or discharge from agency services (Patients #3, #4, #6 and #7). The agency reported a current patient census of 98 patients. The agency reported completing 10 resumption of care comprehensive assessments and 72 discharge assessments in the previous 6 months. Failure to ensure medications reviewed at the time of each drug regimen review are current and accurate and failure to identify actual/ potential concerns increased the potential for unidentified medication interactions and side effect risks to the patient at the time of each comprehensive	G 536	G536: 1. All nurses were educated on 1/14/21 regarding the need to ensure all elements of the Drug regimen review, including: potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy are reviewed and documented with each comprehensive assessment and comprehensive assessment updates. This includes Start of Care, Resumption of Care, Other Follow up, Recertification and Discharge. All records are reviewed by the case managers to ensure current assessments contain documentation of a complete Drug regimen review. 2. Compliance will be maintained by reviewing 100% of all comprehensive assessments/updates until compliance is maintained 3. Clinical manager will ensure compliance by 1/22/21. Clinical manager will ensure ongoing compliance with quarterly chart audits.		

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G 536	Continued From page 9 assessment. Findings Include: According to the agency policy, titled Drug Regimen Review Procedure and dated 5/2012, the drug regimen review as part of the comprehensive assessment will be completed at admission and updated with any major significant change in the patient's condition, at least every 60 days with recertification, within 48 hours of a patient's return home from a qualifying inpatient facility stay and at discharge. During agency staff interview on 1/4/2021 at 3:55 PM, the Administrator/Clinical Manager reported the clinicians assess all medications at the time of admission and with each recertification, enter the medications into the patient's electronic medical record, reconcile all of the medications and document the drug regimen review on the Plan of Care (485 form). 1. Patient #3 had a start of care date of 2/18/2020. Clinical record review revealed the following: a. The patient's clinical record included hospital discharge documentation, dated 3/24/2020, and dated as received by the agency by facsimile on 3/24/2020. The hospital documentation indicated the patient was admitted to the inpatient facility on 3/21/2020 after suffering an episode of bradycardia (abnormally low heart rate) resulting in a fall. The patient remained hospitalized and was discharged to home with home health resumption of care on 3/24/2020. The clinical record lacked documentation of an	G 536			

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G 536	Continued From page 10 update to the comprehensive assessment and lacked documentation of the nurse's assessment of the patient's medications or completion of the required drug regimen review at the time of the resumption of care. b. The patient's clinical record included documentation of a transfer assessment, dated 6/9/2020, documenting the patient's hospital inpatient admission on 6/6/2020 with a diagnosis of pneumonia. The patient's clinical record included an update to the comprehensive assessment at the time of resumption of care, dated 6/10/2020, documenting the patient returned home from the inpatient stay on 6/9/2020. The update lacked documentation of a drug regimen review. 2. Patient #7 had a start of care date of 7/30/2020 and was discharged from agency services on 11/13/2020. Clinical record review revealed the following: a. The patient's clinical record included documentation of a transfer assessment, dated 8/10/2020, documenting the patient's hospital inpatient admission on 8/10/2020. Communication notes, dated 8/10/2020, documented the hospitalization occurred due to high potassium levels in the patient's blood. The patient's clinical record included an update to the comprehensive assessment at the time of resumption of care, dated 8/12/2020, documenting the patient returned home from the inpatient stay on 8/11/2020. The update lacked documentation of a drug regimen review.	G 536			

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G 536	Continued From page 11 b. The patient's clinical record included documentation of an update to the comprehensive assessment at the time of discharge, dated 11/13/2020. The update lacked documentation of a drug regimen review. During staff interview on 1/6/2021 at 8:40 AM, Staff D, Registered Nurse (RN), reported she did not complete the drug regimen reviews as she was new to the agency in the previous 6 months and "am still learning the ropes". 4. Patient #4 had a start of care date of 1/16/15. Patient #4 administered his/her own medications independently, but needed individual doses prepared in advance by another person. The skilled nurse set up the patient's medications every other week. Clinical record review revealed: a. An update to the comprehensive assessment for resumption of care, dated 9/8/2020, failed to include a Drug Regimen Review (DRR). The agency failed to complete a review of all medications the patient is using as part of every comprehensive assessment. 5. Patient #6 had a start of care date of 9/30/2020 and was discharged from the agency on 11/28/2020. Patient #6 administered his/her own medications independently, but needed reminders to take the medications at appropriate times. The skilled nurse visited weekly to assist with weekly medication set up and monitor compliance. Clinical record review revealed:	G 536			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 167051	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/11/2021
NAME OF PROVIDER OR SUPPLIER FLOYD COUNTY PUBLIC HEALTH/ HOME HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1003 GILBERT STREET CHARLES CITY, IA 50616		
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G 536	Continued From page 12 a. An update to the comprehensive assessment for transfer to inpatient facility, dated 11/28/2020, failed to include a Drug Regimen Review. b. The patient's Discharge Summary, included date of discharge of 11/28/2020, failed to include a DRR. The agency failed to complete a review of all medications the patient is using as part of every comprehensive assessment. The above findings for Patients #3, #4, #6 and #7 were reviewed with agency Administrator/Clinical Manager. The agency provided no further information prior to the end of the survey.	G 536			
G 546	Last 5 days of every 60 days unless: CFR(s): 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. This ELEMENT is not met as evidenced by: Based on clinical record review and agency policy review, the agency failed to ensure accurate completion of all required components of the recertification comprehensive assessments between day 56 and 60 of each 60 day certification period for 3 of 6 sampled patients requiring a recertification assessment (Patients #2, #5 and #8). The agency reported a census of 98 patients at the time of the survey. Failure to accurately and thoroughly complete	G 546	G546: 1. Education of all nurses provided on 1/14/21 regarding the timepoints in which the comprehensive assessment needs updated. The recertification was discussed specifically as being day 56-60. If, due to circumstances outside the agency control (such as patient absent or refusal), the physician will be notified of the missed visit, and the assessment will be completed at the first available time/date for the patient. The RN will document why the assessment was late. A report of all recertifications and dates due was pulled. Upon review, no recertification assessments are pending as late currently. 2. Compliance will be ensured by the review of 100% of recertifications on a weekly basis during the nurse team meeting. This is a permanent agenda item for the weekly meetings beginning 1/18/21. 100% of all recertification assessment documentation will also be reviewed for timeliness and completion 3. Clinical manager will ensure compliance by 1/22/21 and ongoing compliance with quarterly chart audits.		

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G 546	Continued From page 13 recertification comprehensive assessments in a timely manner increased the potential that patients might not receive services in a manner to meet individualized patient needs. Findings include: According to the undated agency policy, titled Comprehensive Assessment Policy, a comprehensive assessment for recertification will be completed within the last five days of every 60 day episode, beginning with the start of care. The comprehensive assessment for each patient must be completed in its entirety by the same clinician. According to the undated agency policy, titled Drug Regimen Review Procedure, the comprehensive assessment must include a review of all medications the patient is currently using. 1. Patient #2 had a start of care date of 3/31/2020. Clinical record revealed: a. An update to the comprehensive assessment for recertification, dated as initiated on 7/27/2020 but was not electronically signed as completed until 8/13/2020, day 16 into the new certification period. The assessment was not completed by day 60 as required by regulation and agency policy, which was 16 days late. b. An update to the comprehensive assessment for recertification, dated as initiated on 11/23/2020 but was not electronically signed as completed until 11/30/2020, day 5 into the new	G 546			

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G 546	Continued From page 14 certification period. The assessment was not completed by day 60 as required by regulation and agency policy, which was 5 days late. The agency failed to update the comprehensive assessment in the last 5 days of the 60 day episode. 2. Patient #5 had a start of care date of 10/2/2020. Clinical record revealed: a. An update to the comprehensive assessment for recertification, dated as initiated on 11/25/2020 but was not electronically signed as completed until 12/2/2020, day 2 into the new certification period. The assessment was not completed by day 60 as required by regulation and agency policy, which was 2 days late. The agency failed to update the comprehensive assessment in the last 5 days of the 60 day episode. 3. Patient #8 had a start of care date of 10/17/2019. Clinical record review revealed the following: a. The Plans of Care, dated 4/14/2020 to 6/12/2020 and 6/13/2020 to 8/11/2020, included physician orders for home health aide visits once weekly and completion of a comprehensive assessment and aide supervision every 60 days by a registered nurse. The update to the comprehensive assessment at the time of recertification, dated 6/9/2020 was not completed until 6/18/2020, 6 days after the end of	G 546			

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G 546	Continued From page 15 the certification period, making the assessment 6 days late. b. The Plans of Care, dated 8/12/2020 to 10/10/2020 and 10/11/2020 to 12/19/2020, included physician orders for home health aide visits once weekly and completion of a comprehensive assessment and aide supervision every 60 days by a registered nurse. The update to the comprehensive assessment at the time of recertification, dated 10/6/2020, was not completed until 10/12/2020, 2 days after the end of the certification period, making the assessment 2 days late. The findings for Patient #2, #5 and #8 were reviewed with the Administrator/Clinical Manager. The agency provided no additional information prior to the end of the survey.	G 546			
G 548	Within 48 hours of the patient's return CFR(s): 484.55(d)(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician-ordered resumption date; This ELEMENT is not met as evidenced by: Based on agency policy review, clinical record review and agency staff interview, the agency failed to ensure completion of the update to the comprehensive assessment within 48 hours of the agency's knowledge of return home from an inpatient facility for 1 of 3 sampled patients requiring a resumption of care assessment (Patient #3). The agency provided services to 98 patients at	G 548	G548 1. Education of all nurses provided on 1/14/21 regarding the timepoints in which the comprehensive assessment needs updated. The Resumption of Care was discussed specifically, within 48 hours of the patient's return home from an inpatient stay, or within 48 hours of the agency's knowledge of the patient's return home. The physician could also order a specific date to resume care. If, due to circumstances outside the agency control (such as patient absent or refusal), the physician will be notified of the missed visit, and the assessment will be completed at the first available time/date for the patient. The RN will document why the assessment was late. All current resumptions were reviewed at the team meeting on 1/18/2 and upon review, no Resumption of Care assessments are pending as late currently. 2. Compliance will be ensured by the review of 100% of Resumptions of Cares on a weekly basis during the nurse team meeting. This is a permanent agenda item for the weekly meetings beginning 1/18/21. 100% of all Resumptions of Care assessment documentation will also be reviewed for timeliness and completion. 3. Clinical manager will ensure compliance by 1/22/21 and ensure continued compliance with quarterly chart audits		

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G 548	Continued From page 16 the time of the survey and performed 10 resumption of care assessments in the previous 6 months. Failure to complete resumption of care comprehensive assessment in a timely manner increased the potential that patients might not receive services in a manner to meet individualized patient needs. Findings include: According to the agency's undated policy, titled Comprehensive Assessment Policy, a patient specific comprehensive assessment must be performed within 48 hours of the patient's return home from a 24 hour hospital admission for admission other than diagnostic testing. Patient #3 had a start of care date of 2/18/2020. Clinical record review revealed the following: a. The patient's clinical record included hospital discharge documentation, dated 3/24/2020, and dated as received by the agency by facsimile on 3/24/2020. The hospital documentation indicated the patient was admitted to the inpatient facility on 3/21/2020 after suffering an episode of bradycardia (abnormally low heart rate) resulting in a fall. The patient remained hospitalized and was discharged to home with home health resumption of care on 3/24/2020. The clinical record lacked documentation of an update to the comprehensive assessment at the time of the resumption of care. During agency staff interview on 1/5/2021 at 10:00 AM, the Administrator/Clinical Manager	G 548			

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G 548	Continued From page 17 provided documentation from the hospital verifying the patient was admitted to inpatient care on 3/21/2020 and discharged on 3/24/2020. The Administrator/Clinical Manager reported the nurse found out about the hospital discharge after the patient was home so did not complete the transfer assessment or the resumption of care assessment. A facsimile transmittal, dated 3/25/2020, was filled out by the nurse and sent to the physician questioning med changes made during the hospitalization. The transmittal was stapled to the above stated discharge information that was sent to the agency from the hospital via facsimile on 3/24/2020. The nurse became knowledgeable of the patient's transfer to the hospital and the patient's return home on 3/24/2020. The transfer to inpatient facility and update to the comprehensive assessment for resumption of care should have been completed by 3/26/2020, 48 hours after the nurse's knowledge of both. The above stated findings for Patient #3 were reviewed with the Administrator/Clinical Manager. The agency provided no additional information prior to the end of the survey.	G 548	G570 1.) All changes in plans of care were immediately reported to the ordering provider(s) for those examples found during survey, when the patient is still on service. These contacts were documented in the clinical record. 2.) All current patients were reviewed by the Administrator and/or Clinical Manager with each case manager, to ensure compliance with the ordered plan of care. If the plan has been altered, the ordering provider(s) were contacted immediately, if it has not already been done, and documented. 3.) Created a Policy "Monitoring Patient's Response/Reporting to the Physician/Provider" to clearly define when communication should occur with the ordering provider. 4.) Education with all clinicians was provided on 1/8/21 regarding the new policy and reinforce expectations of the need to communicate with the ordering provider(s) when there are changes in the plan of care or patient condition. The examples found during the survey were covered as part of this education. 5.) The Administrator, or her designee, will ensure weekly communication with each case manager to ensure compliance with the plan of care as ordered, or altered		
G 570	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.	G 570			

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G 570	Continued From page 18 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 standards of practice. This CONDITION is not met as evidenced by: Based on clinical record review, agency policy review and agency staff interview, the agency: 1) failed to ensure each patient received services that were established by a doctor of medicine, osteopathy or podiatry (G572); 2) failed to ensure all supplies/equipment/medications/treatments required by the patient to meet his/her needs were included on each patient's Plan of Care (G574); 3) failed to ensure all patient care orders, including verbal orders, must be recorded in the plan of care (G576); 4) failed to provide medications, treatments and services only as ordered by a physician (G580); 5) failed to promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or the plan of care should be	G 570	based on patient needs or condition changes, per physician/provider orders. 6.) Audits will be completed every quarter and will incorporate the notification of physician(s)/providers in any condition or plan of care change, as one of the specific metrics reviewed. Weekly meetings will also be held to ensure compliance is maintained. 7.) The Administrator was responsible to ensure compliance, obtained by 1/31/21.		

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G 570	Continued From page 19 altered (G590); and 6) failed to assure communication with all physicians involved in the Plan of Care (G602). The cumulative systemic practices resulted in the failure to ensure the organizational framework of the agency promoted and supported the coordination of safe and effective delivery of care to the agency's 98 patients.	G 570			
G 572	Plan of care CFR(s): 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 refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. This STANDARD is not met as evidenced by: Based on agency policy review, clinical record review and agency staff interview, the agency failed to follow a Plan of Care established and periodically reviewed by a physician or notify the physician of the need to vary frequency of visits or inability to perform treatments/services as originally ordered on the Plan for Care for 4 of 7 sampled patients (Patients #3, #5, #6 and #7). The agency reported a census of 98 patients at the time of the survey. Failure to follow a Plan of Care established by a	G 572	G572: This deficiency is also directly related to the lack of documentation of any communications with the patient's physician/ordering provider when there were changes in frequency, as well as the interventions that were not completed or documented in the record, per the plan of care. Therefore, some of the interventions/plan of correction mirrors G570 (Condition). 1.) All changes in plans of care/missed visits were immediately reported to the ordering provider(s) for those examples found during survey, when the patient is still on service. These contacts were documented in the clinical record.		

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G 572	Continued From page 20 physician placed patients at risk of not receiving safe, individualized and consistent care designed to meet each patient's health care needs. Findings include: According to the agency policy, titled Skilled Nursing Service Policy and dated 6/2014, the skilled nurse will regularly reevaluate the Plan of Care and the patient's needs; coordinate all services; and notify the physician if changes may be needed to the Plan of Care. During agency staff interview on 1/4/2021 at 3:43 PM, the Administrator/Clinical Manager reported if the frequency of visits if varied from the Plan of Care, the nurse will include a summary of the missed visits for the previous 60 days in the next Plan of Care. 1. Patient #3 had a start of care date of 2/18/2020. Clinical record review and associated agency staff interviews revealed the following: a. The Plan of Care, dated 2/18/2020 to 4/17/2020, included physician orders for skilled nursing visits 1-2 times every other week for 8 weeks to assess the patient's ability to function at home, monitor compliance with medications, assess pain management, monitor and report temperatures greater than 100.4 and teach safety factors and signs/symptoms of infection to report. The skilled nurse visit notes, dated 3/3,18,26,31/2020, lacked assessment of the patient's temperature as ordered by the physician. The skilled nurse visit note, dated 3/26/2020,	G 572	2.) All current patients were reviewed by the Administrator and/or Clinical Manager with each case manager, to ensure compliance with the ordered plan of care. If the plan has been altered, the ordering provider(s) were contacted immediately, if it has not already been done, and documented. 3.) Created a Policy "Monitoring Patient's Response/Reporting to the Physician/Provider" to clearly define when communication should occur with the ordering provider. 4.) Education with all clinicians was provided on 1/8/21 regarding the new policy and reinforce expectations of the need to communicate with the ordering provider(s) when there are changes in the plan of care or patient condition. The examples found during the survey were covered as part of this education. Instruction was also provided that all visits and visit documentation must be reflective of the ordered Plan of Care, and omitted interventions would also warrant a physician notification. .		

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G 572	Continued From page 21 lacked assessment of the patient's ability to function at home as ordered by the physician. The skilled nurse visit note, dated 3/26/2020, lacked assessment of the patient's pain management needs. The clinical record lacked any documentation of physician notification for the variance in the tasks ordered on the Plan of Care. b. The Plan of Care, dated 6/17/2020 to 8/15/2020, included physician orders for skilled nursing visits 1-2 times every other week for 8 weeks to assess the patient's ability to function at home, monitor compliance with medications, assess pain management and teach safety factors and signs/symptoms of infection to report. The skilled nurse visit notes, dated 7/7,21/2020 and 8/4/2020, lacked assessment of the patient's ability to function at home as ordered by the physician. The skilled nurse visit note, dated 7/21/2020 and 8/4/2020, lacked assessment of the patient's pain management needs. The clinical record lacked any documentation of physician notification for the variance in the tasks ordered on the Plan of Care. c. The Plan of Care, dated 10/15/2020 to 12/13/2020, included physician orders for skilled nursing visits 1-2 times every other week for 8 weeks to assess the patient's ability to function at home, monitor compliance with medications, assess pain management and teach safety factors and signs/symptoms of infection to report.	G 572	5.) The Administrator, or her designee, will ensure weekly communication with each case manager to ensure compliance with the plan of care as ordered, or altered based on patient needs or condition changes, per physician/provider orders. 6.) Audits will be completed every quarter and will incorporate the notification of physician(s)/providers in any condition or plan of care change, as well as a review to ensure the visit documentation reflects the ordered interventions, as one of the specific metrics reviewed. Weekly meetings will be held by the Clinical manager to ensure compliance is maintained by 1/31/2021 and will ensure continued compliance. The Administrator was responsible to ensure compliance.		

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G 572	Continued From page 22 The skilled nurse visit notes, dated 10/27/2020, lacked assessment of the patient's ability to function at home as ordered by the physician. The skilled nurse visit note, dated 10/27/2020, lacked assessment of the patient's pain management needs. The clinical record lacked any documentation of physician notification for the variance in the tasks ordered on the Plan of Care. 2. Patient #7 had a start of care date of 7/30/2020 and was discharged from agency services on 11/13/2020. Clinical record review revealed the following: a. The Plan of Care, dated 7/30/2020 to 9/27/2020, included physician orders for occupational therapy visits 3 times weekly beginning on 8/3/2020. The clinical record included documentation of only 2 occupational therapy visits during the week of 8/1-7/2020. The clinical record lacked documentation of communication with the physician to discuss that inability to follow the Plan of Care. The clinical record included documentation of only 1 occupational therapy visit during the week of 8/8-14/2020. The clinical record lacked documentation of communication with the physician to discuss that inability to follow the Plan of Care. The Plan of Care, dated 9/28/2020 to 10/23/2020 or 10/23/2020 to 12/23/2020, lacked a summary	G 572			

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G 572	Continued From page 23 reporting the any missed occupational therapy visits. b. The Plan of Care, dated 7/30/2020 to 9/27/2020, included physician orders for home health aide visits 2 times weekly. The clinical record included documentation of only 1 home health aide visit during the week of 9/19-25/2020. The clinical record lacked documentation of communication with the physician to discuss that inability to follow the Plan of Care. The Plan of Care, dated 9/28/2020 to 10/23/2020 or 10/23/2020 to 12/23/2020, lacked a summary reporting the any missed home health aide visits. c. The Plan of Care, dated dated 9/28/2020 to 10/23/2020, included physician orders for home health aide visits 2 times weekly. The clinical record included documentation of only 1 home health aide visit during the weeks of 10/3-9/2020 and 10/10-16/2020. The clinical record lacked documentation of communication with the physician to discuss that inability to follow the Plan of Care. The Plan of Care, or 10/23/2020 to 12/23/2020, lacked a summary reporting the any missed occupational therapy visits. 3. Patient #5 had a start of care date of 10/2/2020. The patient's Plans of Care, dated 10/2/2020 to 11/30/2020 and 12/1/2020 to 1/29/2021, included orders for skilled nursing services every other week to set up the patient's medications in a weekly medication planner and	G 572			

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G 572	Continued From page 24 home health aide visits two times per week for skin care to lower legs. Clinical record review revealed: a. Only one home health aide visit occurred the week of 11/21/2020, 12/12/20 and 12/22/20. b. No home health aide visits occurred the weeks of 12/12/2020. The agency failed to consult the physician to approve modifications to the original plan. 4. Patient #6 had a start of care date of 9/30/2020 and was discharged from agency on 11/28/2020. The patient's Plan of Care, 9/30/2020 to 11/28/2020, included orders for skilled nursing services 1-2 times per week to set up the patient's medications in a weekly medication planner and home health aide visits two times per week for personal care assistance. Clinical record review revealed: a. Only one home health aide visit occurred the week of 12/7/2020, 12/14/2020. c. No home health aide visits occurred the weeks of 12/21/2020. d. The skilled nursing visit note, dated 11/10/2020, documented the nurse assessed the patient had severe pain in the right heel area, where the patient had a wound and the patient was taking extra strength Tylenol every 4 to 6 hours for pain, but medication was not working. The nurse further documented the patient would need to contact the doctor to get stronger pain	G 572			

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G 572	Continued From page 25 medications. The agency failed to consult the physician to approve modifications to the original plan. The above findings for Patients #3, #5, #6, and #7 were reviewed with agency Administrator/Clinical Manager. The agency provided no further information prior to the end of the survey.	G 572			
G 574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (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;	G 574	G574: 1. All nurses were educated on 1/14/21 regarding the need to ensure all elements of the Plan of Care are thorough and accurate, per the Conditions of Participation, including areas found upon survey, such as specificity of Durable Medical Equipment/Supplies, medications and all as needed medications are qualified with reason, as well as advanced directives. All current records are to be reviewed by the case managers to ensure current Plan of Cares contain all mandated documentation. Clarification orders and a "care plan" may be used to update/correct any Plans of Cares found to be incomplete or non-compliant. 2. Compliance will be maintained by reviewing 100% of all comprehensive assessments/updates until compliance is met and maintained. Clinical manager will ensure ongoing compliance with quarterly chart audits 3. Clinical manager will ensure compliance by 1/31/21.		

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G 574	Continued From page 26 (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include. This ELEMENT is not met as evidenced by: Based on clinical record review, home visit observation, patient interview and agency staff interview, the agency failed to ensure the accurate completion of all components comprising the Plan of Care, including all supplies/equipment used by the patient and accurate medication orders for 5 of 7 sampled patients (Patients #1, #2, #3, #4, and #5). The agency reported a current census of 98 patients at the time of the survey. Failure to maintain complete and accurate Plans of Care with current orders placed the patients at risk to not receive services, medications and/or treatments according to assessed needs and physician orders. Findings include: 1. Patient #2 had a start of care date of 3/31/2020 and received skilled nursing services from the agency. The Plans of Care, dated 11/26/2020 to 1/24/2021, documented a primary diagnosis of diabetes mellitus and secondary diagnoses of chronic kidney disease. Clinical record review revealed: a. The Plans of Care, dated 7/29/2020 to 9/26/2020, 9/27/2020 to 11/25/2020, and 11/26/2020 to 1/24/2021, included orders for Carboxymethylcellulose sodium drops 0.5% and ordered one drop to both eyes five times per day.	G 574			

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G 574	Continued From page 27 During a home visit observation on 1/4/21 at 2:52 PM, with Staff B, Registered Nurse (RN), the surveyor observed the nurse performing weekly medication set up. The surveyor reviewed additional medications that were not set up by the RN with the patient. The patient reported only using the drops three times a day for a long time. The patient stated a long time was "at least a few months". The Plan of Care, failed to reflect the correct frequency of Carboxymethylcellulosesodium drops used by the patient. b. The Plans of Care, dated 7/29/2020 to 9/26/2020, 9/27/2020 to 11/25/2020, and 11/26/2020 to 1/24/2021, included orders for Symbicort Inhaler 160 micrograms peractuation (mcg/act) twice daily. During the same home visit observation on 1/4/21, the patient stated has not been using the Symbicort inhaler since early fall as patient was having problems with the nasal sprays, so stopped the Symbicort. The Plan of Care, failed to reflect the correct frequency of Symbicort used by the patient. c. The Plans of Care, dated 7/29/2020 to 9/26/2020, 9/27/2020 to 11/25/2020, and 11/26/2020 to 1/24/2021, listed the following equipment/supplies used to meet the patient's needs: cane, grab bars, home blood glucose monitor, lifeline, ramp, shower chair, toilet riser, walker, wheelchair, hand held shower, and medication planner. During the same home visit on 1/4/21, the	G 574			

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G 574	Continued From page 28 surveyor reviewed medical supplies and equipment used by the patient. The patient reported use of incontinence supplies for years since the patient had colon cancer. The Plan of Cares, dated 7/29/2020 to 9/26/2020, 9/27/2020 to 11/25/2020, and 11/26/2020 to 1/24/2021, failed to include incontinence supplies as supplies needed to meet the patients needs. 2. Patient #4 had a start of care date of 1/16/15 and received skilled nursing and home health aide services from the agency. The Plans of Care, dated 8/22/20 to 10/2020, 10/21/2020 to 12/19/2020, and 12/20/2020 to 2/17/2021, documented a primary diagnosis of diabetes mellitus and secondary diagnoses of macular degeneration. Clinical record review revealed: a. The Plans of Care, dated 8/22/20 to 10/2020, 10/21/2020 to 12/19/2020, and 12/20/2020 to 2/17/2021, documented living will as patient's advance directives. b. Agency admission form, titled Consent for Services and Release of Information, initial date 7/20/17, and reviewed dates of 7/26/18 and 7/25/19, documented the patient had a living will and durable power of attorney. The Plans of Care failed to identify the patient had a durable power of attorney as advanced directives. 3. Patient #5 had a start of care date of 10/2/2020 and received skilled nursing and home health	G 574			

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G 574	Continued From page 29 aide services from the agency. The Plans of Care, dated 10/2/2020 to 11/30/2020 and 12/1/2020 to 1/29/2021, documented a primary diagnosis of congestive heart failure Clinical record review revealed: a. The Plans of Care, dated 8/22/20 to 10/2020, 10/21/2020 to 12/19/2020, and 12/20/2020 to 2/17/2021, documented a living will as patient's advance directives. b. Agency admission form, titled Consent for Services and Release of information, initial date 10/2/2020, documented the patient had a living will and durable power of attorney. The Plans of Care failed to identify the patient had a durable power of attorney as advanced directives. 4. Patient #1 had a start of care date of 11/25/2020. Clinical record review revealed the following: The Plan of Care, dated 11/25/2020 to 1/23/2021, included physician orders for skilled nursing visits 1-2 times per week for one week, then once weekly thereafter. The same Plan included physician orders for 2 PRN (as needed) visits; however, the Plan failed to identify the physician pre-approved reason to make the skilled nurse visits on an as needed basis. 5. Patient #3 had a start of care date of 2/18/2020. Home visit observation by the surveyor, clinical record review and accompanying interviews revealed the following:	G 574			

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G 574	Continued From page 30 a. On 1/5/2021 at 1:30 PM, the surveyor accompanied Staff C, Registered Nurse (RN) to Patient #3's home. During the home visit the surveyor noted the patient had a ramp leading up over the stairs from the outside of the front entrance of the home inside. The surveyor noted the patient ambulated using an electric scooter. Patient #3 reported being unable to stand for long periods of time or ambulate; therefore used the electric scooter for all mobility outside the home. The patient verified use of the ramp for multiple years. The Plans of Care, dated 6/17/2020 to 8/15/2020, 8/16/2020 to 10/14/2020, 10/15/2020 to 12/13/2020 and 12/14/2020 to 2/11/2021, lacked identification of the ramp as equipment used to meet the mobility needs of the patient. b. During the same home visit, the surveyor noted the bathroom used by the patient for bathing had grab bars at the entrance of the shower and a shower chair was located inside the shower. Patient #3 reported performing all bathing/showering independently but used the grab bars for safety when entering and exiting the shower and sat on the shower chair during the entire shower due to an inability to stand for long periods of time. The Plans of Care, dated 6/17/2020 to 8/15/2020, 8/16/2020 to 10/14/2020, 10/15/2020 to 12/13/2020 and 12/14/2020 to 2/11/2021, lacked identification of the grab bars and shower chair as equipment used to meet the safety and bathing needs of the patient. c. The patient's clinical record included hospital discharge information sent to the agency by	G 574			

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G 574	Continued From page 31 facsimile on 3/24/2020. The documentation reported the patient was hospitalized for a fall on 3/21/2020 with a discharge date of 3/24/2020. During the same home visit, the surveyor noted the patient wore a black cord around the neck. The surveyor inquired what the cord was for and the patient removed the cord from under the shirt, exposing an emergency response pendant worn to assist with seeking medical assistance during a fall or a emergent medical event. The Plans of Care, dated 6/17/2020 to 8/15/2020, 8/16/2020 to 10/14/2020, 10/15/2020 to 12/13/2020 and 12/14/2020 to 2/11/2021, documented history of falls as a diagnosis. The Plans lacked identification of the emergency response system as equipment used to meet the safety needs of the patient. d. The initial comprehensive assessment, dated 2/18/2020, and the updates to the comprehensive assessment at the time of recertification, dated 6/16/2020, 8/14/2020, 10/13/2020 and 12/11/2020, documented Patient #3 experienced urinary incontinence. During the same home visit, the surveyor noted Patient #3 wore incontinence briefs. During agency staff interview while still in the patient 's home, Staff C, RN, verified knowledge the patient wore incontinence briefs at all times. The Plans of Care, dated 6/17/2020 to 8/15/2020, 8/16/2020 to 10/14/2020, 10/15/2020 to 12/13/2020 and 12/14/2020 to 2/11/2021, lacked identification of the incontinence briefs as supplies used to meet the urinary incontinence needs of the patient.	G 574			

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G 574	Continued From page 32 e. The patient's clinical record included hospital discharge information sent to the agency by facsimile on 3/24/2020. The documentation reported the patient was hospitalized for a fall on 3/21/2020 with a discharge date of 3/24/2020. Direction on the discharge document required the patient to monitor blood sugars three times daily and as needed. During the same home visit, Staff C, RN, reported the patient did not own a glucometer; therefore, did not monitor his/her blood sugars as recommended by the physician. During patient interview while still in the patient's home, the patient reported he/she did own a glucometer and monitored the blood sugar once or twice weekly and as needed if not feeling good. "I have been diabetic for 20 years so I know when to check it." The surveyor observed the glucometer, stored in the bag with the patient's medications. Staff C, RN, had removed multiple medications out of the bag during the home visit to set up the patient's medications in a weekly planner. The Plans of Care, dated 4/18/2020 to 6/16/2020, 6/17/2020 to 8/15/2020, 8/16/2020 to 10/14/2020, 10/15/2020 to 12/13/2020 and 12/14/2020 to 2/11/2021, lacked identification of the glucometer as equipment used to meet the diabetic monitoring needs of the patient. f. The Plans of Care, dated 8/16/2020 to 10/14/2020, 10/15/2020 to 12/13/2020 and 12/14/2020 to 2/11/2021, included an order for hydromorphone taken on an as needed basis	G 574			

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G 574	Continued From page 33 (PRN). The Plan failed to identify the physician's pre-approved reason for taking the hydromorphone.	G 574			
G 576	The findings for Patients #1, #2, #3, #4, and #5 were reviewed with the Administrator/Clinical Manager. The agency provided no additional information prior to the end of the survey. 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 agency policy review, clinical record review and agency staff interview, the agency failed to maintain a working Plan of Care for patients and update the working Plans of Care with any new verbal/interim physician orders for 6 of 7 sampled patients. (Patients #1, #2, #3, #5, #6 and #7) The agency reported a current census of 98 patients at the time of the survey. Failure to update the Plan of Care increased the potential for medication errors in administration or inaccurate provision of care. Findings include: According to agency policy, titled Plan of Treatment, dated 6/2005, upon taking verbal orders from an attending physician for skilled nursing service or personal care of a patient, written medical confirmation will be obtained by the nurse. A verbal order sheet will be sent to the physician for signature on date of receiving a verbal order and should be in the clinical record within 14 days. Renewed Plans of Treatment and	G 576	G576: 1. All nurses were educated on 1/08 and 1/14/21 regarding the need to ensure all additional orders will be incorporated into the plan of care, to ensure a complete and accurate Plan of Care at all times. This is done by ensuring that all orders are documented in the "Verbal order" format (even if obtained written by physician), and then complete the action in the software called the "485 Update" to incorporate the additional orders into the Plan of Care. 2. Compliance will be maintained by reviewing 100% of all comprehensive assessments/updates timepoints until 100% compliance is met and maintained. 3. Clinical manager will ensure compliance by 1/31/21. Clinical manager will also ensure ongoing compliance with quarterly chart audits.		

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G 576	Continued From page 34 updates should be sent to the physician prior to the 60 day expiration date so it can be signed, dated and returned to the agency and incorporated into the record without lapse of coverage. During agency staff interview on 1/4/21 beginning at 3:55 PM, the Administrator reported the agency electronic health record system had the ability to incorporate interim physician orders to the Plan of Care whenever new orders or changes to the plan occur. The electronic health record system will show this under the Orders section and say "485 Update". 1. Patient #2 had a start of care date of 3/31/2020. Clinical record review revealed: a A faxed physician order, dated 4/21/2020, ordered Cephalexin 500 milligrams (mg) three times a day for 10 days for patient's cellulitis to left lower leg. c. An interim physician order, dated 5/12/2020, ordered an increase in the estradiol patch 0.1 mg per 24 hours with instructions to use one patch twice weekly with the 0.05 mg per 24 hour patches and to apply on Tuesday and Friday mornings. The initial Plan of Care, dated 3/31/2020 to 5/29/2020, failed to include an update with the changes of the added/changed medication orders. The agency failed to ensure the Plan of Care was updated to include all patient care orders.	G 576			

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G 576	Continued From page 35 2. Patient #5 had a start of care date of 10/2/2020. Clinical record review revealed: a An interim physician order, dated 12/9/2020, ordered gabapentin 300 mg daily in the evening for left foot pain. b. An interim physician order, dated 12/18/2020, ordered furosemide 40 mg tablets and instructed the patient to take 1/2 tablet (20 mg) daily in the morning and ordered pantoprazole 40 mg daily. c. An interim physician order, dated 5/12/2020, ordered an increase in the estradiol patch 0.1 mg per 24 hours with instructions to use one patch twice weekly and to apply on Tuesday and Friday mornings. The order also included orders to discontinue furosemide 80 mg as needed for increased fluid and weight increase by 3 pounds in 24 hours or 5 pounds in one week, discontinue furosemide 40 mg daily, discontinue spironolactone 25 mg daily, discontinue warfarin 5 mg tablets with instruction to take 1.5 tablets for a total of 7.5 mg on Mondays, Wednesdays, and Fridays, and discontinue warfarin 5 mg on Sundays, Tuesdays, and Saturdays. d. An interim physician order, dated 12/28/2020, included an order for warfarin 5 mg daily. The Plan of Care, dated 12/1/2020 to 1/29/2021, failed to include an update with the changes of the added/changed medication orders. The agency failed to ensure the Plan of Care was updated to include all patient care orders.	G 576			

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G 576	Continued From page 36 3. Patient #6 had a start of care date of 9/30/2020 and was discharged from the agency on 11/28/2020. Clinical record review revealed a faxed physician's order from the wound clinic, dated 11/18/2020, ordered a change in wound care as follows: apply medihoney to the right heel wound bed, cover with gauze and secure with tape and change daily and apply betadine twice a day to the right great toe and keep the toe dry. The Plan of Care, dated 9/30/2020 to 11/28/2020, failed to include an update with the changes of the wound care orders. The agency failed to ensure the Plan of Care was updated to include all patient care orders. 4. Patient #1 had a start of care date of 11/25/2020. Clinical record review revealed the following: The Plan of Care, dated 11/25/2020 to 1/23/2021, included physician orders for physical therapy evaluation and treat 12 times in one month as pre-approved by the patient's insurance company and orders for occupational therapy evaluation and treat 12 times in one month as pre-approved by the patient's insurance company. a. The clinical record included a physician's Interim order, dated 11/27/2020, ordering physical therapy twice weekly for 5 weeks. The Plan was not updated with the new interim order.	G 576			

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G 576	Continued From page 37 b. The clinical record included a physician's interim order, dated 11/30/2020, ordering occupational therapy twice weekly for 1 week and 3 times weekly for an additional 3 weeks. The Plan was not updated with the new interim order. 5. Patient #3 had a start of care date of 2/18/2020. Clinical record review revealed the following: a. The Plan of Care, dated 4/18/2020 to 6/16/2020, included a physician's order for metoprolol extended release 25 milligrams daily. The clinical record included a physician's interim order, dated 4/28/2020, increasing the dose of metoprolol to 100 milligrams daily. The Plan was not updated with the new interim order for the increased metoprolol dosage. b. The Plan of Care, dated 6/17/2020 to 8/15/2020, included a physician's order for morphine 30 milligrams twice daily. The clinical record included a physician's interim order, dated 6/23/2020, changing the frequency of administration from twice daily to three times daily. The Plan was not updated with the new interim order for the increased frequency of morphine administration. 6. Patient #7 had a start of care date of 7/30/2020 and was discharged from home health on 11/13/2020. Clinical record review revealed	G 576			

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G 576	Continued From page 38 the following: a. The Plan of Care, dated 7/30/2020 to 9/27/2020, included physician orders for a physical therapy evaluation and treat 3 times per week for 4 weeks. The clinical record included a physician's interim order, dated 8/27/2020, ordering continued physical therapy visits twice weekly for one week and then 3 times weekly for 3 additional weeks. The Plan was not updated with the new interim order for additional therapy visits. The above stated findings for Patients #1, #2, #3, #5, #6 and #7 were reviewed with the Administrator/Clinical Manager. The agency provided no additional information prior to the end of the survey.	G 576			
G 580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician. This ELEMENT is not met as evidenced by: Based on agency policy review, clinical record review and agency staff interview, the agency failed to provide medications, treatments or services only as ordered by the physician for 5 of 8 sampled patients (Patients #3, #5, #6, #7 and #8). The agency reported a current patient census of 98 patients. Failure to ensure staff obtain physician orders for administration of medications, treatments or services provided by agency staff placed agency patients at risk for inconsistent care/treatment	G 580	G580: 1. All nurses were educated on 1/08 and 1/14/21 regarding the need to ensure all all care is completed per orders, and complete orders are to be obtained by the community physician(s) for all identified needs found during the assessments/ visits. The orders must be very specific to ensure appropriate care for examples such as wound care, medications, and oxygen. As the patient needs are assessed to be changing, the physician must be notified and orders must be obtained for the appropriate treatment changes. The agency can not solely determine these changes, but must obtain orders.		

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G 580	Continued From page 39 and possible harm. Findings include: According to agency policy, titled Plan of Treatment and dated 6/2005, patient services will be under the direct supervision of a physician and maintained by periodic conferences between the physician and nursing personnel as the patient's condition warrants. Verbal orders received should be written, sent for signature and kept in the patient's clinical record. According to the agency policy, titled Wound Care and dated 11/2012, the home health agency will follow recommendations made by the WOCN (certified wound ostomy nurse) "unless contraindicated by the physician (not ordered)". Orders for wound care will contain specifics for the care of the wound and incision care. Wound orders will include medications used, dressing protocol and frequency of care. 1. Patient #3 had a start of care date of 2/18/2020. Review of the clinical record and associated agency staff and patient interviews revealed the following: a. The Plans of Care, dated 6/17/2020 to 8/15/2020, 8/16/2020 to 10/14/2020, 10/15/2020 to 12/13/2020 and 12/14/2020 to 2/11/2021, documented in the summary section that Patient #3 used oxygen at night and as needed (PRN) during the day. The Plans lacked any orders for oxygen, amount or mode of administration. b. On 1/5/2021 at 1:30 PM, the surveyor accompanied Staff C, Registered Nurse (RN) to Patient #3's home. During the home visit, the	G 580	2. Compliance will be maintained by reviewing 100% of all comprehensive assessments/updates timepoints until 100% compliance is met and maintained. Clinical manager will ensure ongoing compliance with quarterly chart audits. 3. Clinical manager will ensure compliance by 1/31/21.		

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G 580	Continued From page 40 patient reported using oxygen via nasal cannula at night and sometime during the day. c. During the home visit, Staff C, RN, reported the oxygen was administered by nasal cannula at 2 liters at night and as needed during the day. d. The clinical record did not include any physician orders for oxygen. 2. Patient #7 had a start of care date of 7/30/2020 and was discharged from agency services on 11/13/2020. Clinical record review and associated agency staff interviews revealed the following: a. The home health aide assignments for August, September, October and November 2020 included direction to the home health aide to monitor the patient's weight and record. b. The Plans of Care, dated 7/30/2020 to 9/27/2020, 9/28/2020 to 10/23/2020 and 10/23/2020 to 12/23/2020, included physician orders for home health aide visits 1-2 times weekly to assist with bathing and personal care. The Plans lacked approval from the physician for the home health aides to monitor the patient's weight. c. The Plan of Care, dated 7/30/2020 to 9/27/2020, did not include a diagnosis of open wounds. The Plan lacked any direction to the nurse to perform wound care of any kind. The Plan lacked any specific wound care orders. d. The skilled nurse visit note, dated 8/12/2020, documented identification of a blister on the back of the patient's right calf. The nurse documented	G 580			

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G 580	Continued From page 41 performing a dressing change to the right calf with plan to dress daily- nurse 3 times per week and spouse to dress the legs when no nurse visit. An ace wrap was applied to the patient's right leg by the nurse for compression. The clinical record lacked documentation of any physician's order to treat the right leg and lacked an order to apply an ace wrap to the right leg for compression. e. The skilled nurse visit notes, dated 8/13, 8/14, 8/15, 8/21, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/8, 9/9, 9/11 and 9/14/2020, documented "dressing change done" to right calf with ace wraps applied during the skilled nurse visits; however, the nurse did not document what type of dressing change was completed. f. The skilled nurse visit note, dated 9/16/2020, documented identification of 3 open wounds to the right leg, one on the right shin, one on the upper calf and one on the lower calf. "dressing was done" to all open wounds on the right leg. The clinical record lacked documentation of any interim orders giving direction to the nurse on the treatment of the wounds. g. The skilled nurse visit note, dated 9/21/2020, documented dressing change was performed to all three wounds on the patient's right leg. h. The update to the comprehensive assessment at the time of recertification, dated 9/23/2020, documented the patient saw a wound ostomy nurse (WOCN) the previous day. The WOCN debrided some wounds and opened up blisters. The patient now had a dime sized wound on the left leg and 3 open wounds on the right leg. The note described direction received from the WOCN to cleanse the wounds, apply Aquacel AG	G 580			

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G 580	Continued From page 42 one layer to all open areas, cover and apply Surepress compression bandage from toes to knees. (No interim order was found in the patient's clinical record.) i. The Plan of Care, dated 9/28/2020 to 10/23/2020, included orders for the nurse to perform "wound care" but no specific wound care orders were found on the Plan of Care. j. The skilled nurse visit note, dated 9/28/2020, documented identification of two new blisters on the left shin that were open and 4 open areas on the right leg. The nurse performed dressing change following the WOCN orders documented in the 9/23/2020 assessment despite having no new orders for the 3 new open wounds. k. The WOCN provided written interim orders, dated 10/1/2020, for the remaining wounds. l. The WOCN provided written interim orders, dated 10/7/2020, changing the treatment to the remaining open wounds. m. The skilled nurse visit note, dated 10/9/2020, documented a new blister opened on the right leg, leaving one on the upper leg, one on the middle leg and one on the lower leg. The nurse documented treating the new blistered area using the WOCN orders for the other two open areas. No documentation of new orders for the new blister were found. n. The skilled nurse visit note, dated 10/14/2020, documented a new blister opened on the left leg. The nurse documented treating the new wound with Aquacel, an ABD pad and tubigrip to hold in place. The patient's clinical record lacked	G 580			

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G 580	Continued From page 43 documentation of any orders to treat the new wound. o. The skilled nurse visit notes, dated 10/16,19/2020, documented the nurse continued to treat the new areas on the right leg and left leg despite having no orders to do so. p. The Plan of Care, dated 10/23/2020 to 12/23/2020, lacked specific orders for wound care. q. The skilled nurse visit note, dated 10/26/2020, documented all wounds scabbed and considered healed. r. The skilled nurse visit note, dated 11/2/2020, identified a small open wound on the middle of the left shin and a small open wound below the right knee. The patient's clinical record lacked any orders for treatment of either of the new wounds yet the nurse documented "dressing done" to treat the wounds. s. The update to the comprehensive assessment at the time of discharge, dated 11/13/2020, documented the nurse noted an open area to the left leg by the knee and one closer to the left ankle. The nurse noted small blisters on the right leg and two open areas- one by the right knee and one on the right calf. The clinical record lacked documentation of any wound care orders to treat the new wounds, yet the nurse documented "dressing done" to treat the wounds. (Please see G458 for associated information) t. During agency staff interview on 1/6/2021 at 8:40 AM, Staff D, RN, reported all wound care orders for Patient #7 came from the WOCN. She	G 580			

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G 580	Continued From page 44 verified she never got any wound care orders from the physician signing the Plan of Care. 3. Patient #8 had a start of care date of 10/17/2019. Clinical record review revealed the following: a. The home health aide visit note, dated 11/24/2020, documented the aide applied triple antibiotic ointment to the patient's reddened right groin. b. The home health aide assignment did not include application of the triple antibiotic ointment. c. The Plan of Care, dated 10/11/2020 to 12/9/2020, did not include physician orders for the use of triple antibiotic ointment. The Plan lacked any orders for the home health aide to apply any topical creams when caring for Patient #8. d. During agency staff interview on 1/5/2021 at 9:15 AM, Staff E, RN, reported she was unaware the home health aide applied triple antibiotic ointment to the patient's groin. 4. Patient #5 had a start of care date of 10/2/2020. Clinical record review revealed: a. Home health aide visit notes, dated 11/3/2020, 11/17/2020, and 12/22/2020, included documentation the home health aide performed the task of shaving the patient. The Plans of Care, dated 10/2/2020 to 11/30/2020 and 12/1/2020 to 1/29/21, failed to include orders of physician approval for the aide	G 580			

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G 580	Continued From page 45 to perform shaving. b. Home health aide visit notes, dated 11/10/2020 and 12/29/2020, included documentation the home health aide performed the task of applying a Band-Aid to a callous on the left foot for cushioning. The Plans of Care, dated 10/2/2020 to 11/30/2020 and 12/1/2020 to 1/29/21, failed to include orders of physician approval for the aide to perform a simple dressing change. The aide provided services that were not ordered by the physician. 5. Patient #6 had a start of care date of 9/30/2020 and was discharged from the agency on 11/28/2020. Clinical record review revealed: a. The skilled nursing visit note, dated 11/10/2020, included documentation the nurse performed wound care to the right heel with new wound care orders for use of Aquacel AG, cover with gauze or abdominal pad (ABD) dressing and then secure with Kerlix wrap and apply ACE bandage over the whole ankle and foot. Interview with the Administrator on 1/6/2020, revealed the order was taken off of Patient Discharged Instructions as the patient had surgery to remove the thick eschar of the right heel wound. The agency failed to contact the physician to verify approval of the patient's discharge instructions. The Plan of Care, dated 9/30/2020 to 11/28/2020,	G 580			

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G 580	Continued From page 46 failed to include a physician order for the change in wound care.	G 580			
G 590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(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: Based on agency policy review, clinical record review, agency staff interview and patient/caregiver interview, the agency failed to report changes in patient clinical findings or changes in patient needs to the physician for 6 of 8 sampled patients (Patients #1, #3, #4, #6, #7 and #8). The agency provided services to 98 patients at the time of the survey. Failure to communicate the patient's status with the physician placed agency patients at risk for unidentified worsening of conditions, inappropriate treatments, or unmet home health care needs. Findings include: According to the agency's undated policy, titled Record Retention, documentation shall establish effective interchange, reporting and coordination of patient care.	G 590	G590: 1. All changes in plans of care were immediately reported to the ordering provider(s) for those examples found during survey, when the patient is still on service. These contacts were documented in the clinical record. 2. All current patients were reviewed by the Administrator and/or Clinical Manager with each case manager, to ensure compliance with the ordered plan of care. If the plan has been altered, the ordering provider(s) were contacted immediately, if it has not already been done, and documented. 3. Created a Policy "Monitoring Patient's Response/Reporting to the Physician/Provider" to clearly define when communication should occur with the ordering provider.		

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G 590	Continued From page 47 According to the agency's undated policy, titled Transfer/Discharge Criteria Policy, clinician's must communicate with the physician about discharge and further service that may be needed. According to the agency policy, titled Skilled Nursing Service Policy and dated 6/2014, the registered nurse (RN) coordinates all services for holistic patient care; notifies the physician of changes in patient condition; and updates the physician of the patient's condition at least every 60 days. According to the agency policy, titled Wound Care and dated 11/2012, the home health agency will follow recommendations made by the WOCN (certified wound ostomy nurse) "unless contraindicated by the physician (not ordered)". Orders for wound care will contain specifics for the care of the wound and incision care. Wound orders will include medications used, dressing protocol and frequency of care. According to the agency policy, titled Plan of Treatment and dated 6/2005, the patient's services will be under the direct supervision of a physician and maintained by periodic conferences between the physician and nursing personnel as the patient's condition warrants or at least every 60 days. During agency staff interview on 1/4/2021 at 3:55 PM, the Administrator/Clinical Manager reported all agency staff document contact with patient physicians in the communication notes. 1. Patient #1 had a start of care date of	G 590	4. Education with all clinicians was provided on 1/8/21 and weekly through 1/31/2021 by the agency administrator or designee regarding the new policy and reinforce expectations of the need to communicate with the ordering provider(s) when there are changes in the plan of care or patient condition. The examples found during the survey were covered as part of this education to emphasize the impact of a lack of communication and that this can truly impact quality of patient care. 5. The Administrator, or her designee, will ensure weekly communication with each case manager to ensure compliance with the plan of care as ordered, or altered based on patient needs or condition changes, per physician/provider orders. 6. Audits will be completed every quarter and will incorporate the notification of physician(s)/providers in any condition or plan of care change, as one of the specific metrics reviewed. 7. The Administrator was responsible to ensure compliance, obtained by 1/31/21. Audit will be completed by agency administrator or designee to ensure compliance met and ongoing compliance.		

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G 590	Continued From page 48 11/25/2020. Clinical record review revealed the following: a. The Plan of Care, dated 11/25/2020 to 1/23/2021, included the diagnosis of hemiplegia secondary to massive multiple strokes; identified the patient required all food and medication administration via a gastrostomy tube (a tube directly entering the patient's stomach through an opening in the abdomen); and identified the need for skilled nursing for teaching of use of the gastrostomy tube and medical assessment and physical, occupational and speech therapy evaluations. The individual therapy evaluations identified need for continued services to address non-ambulatory status, inability to speak and inability to sit/stand unassisted. b. The initial comprehensive assessment at the time of admission, dated 11/25/2021, documented Patient #1 experienced multiple major strokes in the summer of 2020. The patient was admitted for skilled rehabilitative care immediately following the discharge from the hospital and was admitted directly from the rehabilitative facility, returning home with a plan for the spouse and multiple adult children to care for the patient. c. The Plan of Care, dated 11/25/2020 to 1/23/2021, ordered skilled nursing services 1-2 times weekly for 1 week then once weekly thereafter. The skilled nurse visited the patient on 11/25/2020 for admission and did not return to the patient's home until 12/11/2020, 16 days later. The communication note, dated 12/2/2020, documented contact with Patient #1's spouse, who reported an adult daughter staying in the	G 590			

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G 590	Continued From page 49 home had tested positive for COVID 19 "so we will delay treatments and visits until out of quarantine." d. The physical therapy evaluation/plan of care, dated 11/27/2020, ordered physical therapy services 2 times weekly for 5 weeks. The therapist saw the patient on 11/27/2020 and 12/1/2020. The communication note, dated 12/2/2020, documented the physical therapist contacted the RN to report "they will be putting client on hold temporarily due to the client's (adult child) testing positive for COVID 19 and is in the home and quarantining." The therapist reported a plan to wait and see if the patient had any symptoms of the virus and, if not, would resume services. The therapy addendum note, dated 12/3/2020, documented the patient's physical therapist "had discussion with nursing staff and the occupational therapist, resulting in the patient's services being placed on hold until at least the next Wednesday due to Covid 19 exposure." The RN noted acknowledgement of the note on 12/4/2020. The next physical therapy visit occurred on 12/10/2020, 9 days later. e. The occupational therapy evaluation/plan of care, dated 11/30/2020, ordered occupational therapy services 2 times for 1 week, then 3 times weekly for 3 additional weeks. The therapy addendum note, dated 12/2/2020, documented the patient's occupational therapy services were "being placed on hold due to close exposure to COVID positive person (adult child	G 590			

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G 590	Continued From page 50 living with the patient)". The RN noted acknowledgement of the note on 12/4/2020. The communication note, dated 12/2/2020, documented the occupational therapist contacted the RN to report "they will be putting client on hold temporarily due to the client's (adult child) testing positive for COVID 19 and is in the home and quarantining." The therapist reported a plan to wait and see if the patient had any symptoms of the virus and, if not, would resume services. The occupational therapist saw the patient on 11/30/2020 and not again until 12/11/2020, 11 days later. The occupational therapy visit note addendum, dated 12/11/2020 but completed on 12/14/2020, documented the occupational therapist only saw the patient once during the week of 12/5- 11/2020 "as the patient's services were on hold due to close exposure to the corona virus". The RN noted acknowledgement of the note on 12/31/2020. f. The Plan of Care, dated 11/25/2020 to 1/23/2021, ordered speech therapy evaluation with services 8 times in 1 month. The communication note, dated 12/1/2020, documented the Administrator left the nurse a note, informing the nurse the speech therapist could not complete the evaluation visit for Patient #1 until 12/7/2020 as the speech therapist had been exposed to COVID 19. Upon review of the patient's paper clinical record on 1/4/2021, the surveyor found no speech therapy visit notes present.	G 590			

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G 590	Continued From page 51 During agency staff interview on 1/4/2021 at 2:45 PM, the Administrator/Clinical Manager reported the speech therapist, a contracted employee, had most likely not sent the notes to the home health agency. She reported a plan to call and get the notes for surveyor review. After receiving the speech therapy visit notes, the surveyor noted the speech therapist did not complete the ordered evaluation until 12/15/2020, 20 days after the patient's admission to service. The evaluation documented the delay in initiation of the speech therapy evaluation occurred due to the "family being quarantined after having COVID 19". Agency staff interviews revealed the following: g. On 1/4/2021 at 2:00 PM, the Administrator/Clinical Manager stated "if the therapy has a policy to not see COVID patient they have to follow it." On 1/5/2021 at 10:35 AM, the Administrator/Clinical Manager reported if a patient or family member does not want our presence due to COVID 19 "we have to abide- that is what we have done". When questioned about physician communication related to holding services, she replied "Oh, I'm sure we have lots of communication with the physician." h. On 1/6/2021 at 8:55 AM, Staff B, Admission RN, reported she took a phone call from the occupational therapist indicating Patient #1's adult child living temporarily in the home had tested positive for COVID 19 and was quarantining in the home in the basement. "They	G 590			

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G 590	Continued From page 52 had been around each other, if patient's or someone in the home tests positive or has been exposed, the agency typically holds services for 10 days per Iowa Department of Public Health recommendations then restarts services". Staff B, Admission RN, reported this was the typical agency practice. "I though the occupational therapist didn't want exposed and to my knowledge I thought it was okay with the family. Don't go in unless there is dire medical need like wound care or IV that no one was available to perform." The Admission RN verified she had not contacted the patient's physician to discuss the holding of services but she had notified Staff E, RN and patient's primary nurse, and believed she would have contacted the physician. i. On 1/6/2021 at 9:15 AM, Staff E, RN, reported she was the primary nurse for Patient #1. The nurse reported Staff B, Admission RN, received a call from the occupational therapist reporting the patient's exposure to COVID 19. Staff B, Admission RN, reported the call to Staff E, RN. Staff E, RN, reported she contacted speech, physical and occupational therapies to notify them all services for Patient #1 were on hold as the family and patient had to quarantine. Staff E, RN, reported she had discussed this with the Administrator/Clinical Manager and the Administrator/Clinical Manager placed the patient's services on hold for 10 days as this was the protocol for quarantining due to exposure mandated by the Governor and the Iowa Department of Public Health. Staff E, RN, verified she had not contacted the patient's physician to discuss the plan to place services on hold and did not notify the physician	G 590			

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G 590	Continued From page 53 of the delay in skilled nursing or any of the therapy visits. Care was resumed 10 days later. The RN verified the patient's insurance had only approved a certain amount of visits and the patient missed out on almost 2 weeks of services so the agency did seek approval for an additional 30 days of service. Caregiver/family interview revealed the following: j. On 1/5/2021 at 7:00 PM, Patient #1's spouse reported the patient's adult child who was temporarily residing in the home to assist with the care of the patient upon recent return home from a rehabilitative inpatient facility tested positive for COVID 19. The spouse reported the child immediately quarantined in the basement and had no further contact with the patient or other family members. The spouse reported the patient had COVID 19 while in the inpatient facility in September 2020 and the rest of the family who were around the patient wore masks at all times when unable to socially distance. No other family member experienced symptoms or tested positive for the virus. The spouse reported she did let the agency staff know of the situation and "I understood the protocol was that we were all quarantined and they couldn't come until after the quarantine period. It was really too bad because insurance allotted certain number of visits and all of our deductible and out of pocket maximums were met for the year (2020). Now we can't get all of the missed visits back and, after the first of the year (2021), everything (financially with the insurance) starts over again beginning 1/1/2021."	G 590			

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G 590	Continued From page 54 2. Patient #3 had a start of care date of 2/18/2020. Clinical record review revealed the following: a. The Plan of Care, dated 4/18/2020 to 6/16/2020, included documentation of diabetes as an active diagnosis for Patient #3; however, did not include any interventions to monitor or assess diabetes effects. The Plan included orders for skilled nursing visits 1-2 times every other week to set up the patient's medications, monitor for medication compliance and monitor for safety in the home. b. The initial comprehensive assessment completed at the time of admission, documented diabetes was an active diagnosis, indicating that it was associated with the home health episode of care. c. The patient's clinical record included hospital discharge information sent to the agency by facsimile on 3/24/2020. The documentation reported the patient was hospitalized for a fall on 3/21/2020 with a discharge date of 3/24/2020. During the hospitalization, the patient's Hgb A1C tested 11.5%. Direction on the discharge document required the patient to monitor blood sugars three times daily and as needed. d. The clinical record lacked documentation of communication with the physician to obtain any further instructions related to the high A1C test. e. The Plans of Care, dated 6/17/2020 to 8/15/2020, 8/16/2020 to 10/14/2020, 10/15/2020 to 12/13/2020 and 12/14/2020 to 2/11/2021, continued to include documentation of diabetes as an active diagnosis for Patient #3; however,	G 590			

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G 590	Continued From page 55 did not include any interventions to monitor or assess diabetes effects. The Plan included orders for skilled nursing visits 1-2 times every other week to set up the patient's medications, monitor for medication compliance and monitor for safety in the home. f. The updates to the comprehensive assessment for recertification, dated 4/14/2020, 6/16/2020, 8/14/2020, 10/13/2020 and 12/11/2020, lacked monitoring of the patient's blood sugars and lacked an assessment of the endocrine system. Home visit observation and accompanying interviews revealed the following: g. On 1/5/2021 at 1:30 PM, the surveyor accompanied Staff C, Registered Nurse (RN) to Patient #3's home. During the visit, Staff C, RN, reported the patient did not own a glucometer; therefore, did not monitor his/her blood sugars as recommended by the physician. During patient interview while still in the patient's home, the patient reported he/she did own a glucometer and monitored the blood sugar once or twice weekly and as needed if not feeling good. "I have been diabetic for 20 years so I know when to check it." The surveyor observed the glucometer, stored in the bag with the patient's medications. Staff C, RN, had removed multiple medications out of the bag during the home visit to set up the patient's medications in a weekly planner. 3. Patient #7 had a start of care date of 7/30/2020 and was discharged from agency	G 590			

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G 590	Continued From page 56 services on 11/13/2020. Clinical record review and associated agency staff interviews revealed the following: a. The Plan of Care, dated 7/30/2020 to 9/27/2020, did not include a diagnosis of open wounds. The Plan lacked any direction to the nurse to perform wound care. The Plan lacked any specific wound care orders. b. The skilled nurse visit note, dated 8/12/2020, documented identification of a blister on the back of the patient's right calf. The nurse documented performing a dressing change to the right calf with plan to dress daily- nurse 3 times per week and spouse to dress the legs when no nurse visit. An ace wrap was applied to the patient's right leg by the nurse for compression. The clinical record lacked documentation of any physician's order to treat the right leg and lacked an order to apply an ace wrap to the right leg for compression. Documentation of physician notification of the new wound was not found in the skilled nurse visit note or in a communication note. c. The skilled nurse visit note, dated 9/11/2020, noted drainage from the patient's red, warm left leg. Documentation of physician notification of the new findings was not found in the skilled nurse visit note or in a communication note. d. The skilled nurse visit note, dated 9/16/2020, documented identification of 3 open wounds to the right leg, one on the right shin, one on the upper calf and one on the lower calf. "dressing was done" to all open wounds on the right leg. Documentation of physician notification of the	G 590			

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G 590	Continued From page 57 new wounds was not found in the skilled nurse visit note or in a communication note. e. The update to the comprehensive assessment at the time of recertification, dated 9/23/2020, documented the patient saw a wound ostomy nurse (WOCN) the previous day. The WOCN debrided some wounds and opened up blisters. The patient now had a dime sized wound on the left leg and 3 open wounds on the right leg. Documentation of physician notification of the new wounds was not found in the skilled nurse visit note or in a communication note. f. The Plan of Care, dated 9/28/2020 to 10/23/2020, included orders for the nurse to perform "wound care" but no specific wound care orders were found on the Plan of Care. g. The skilled nurse visit note, dated 9/28/2020, documented identification of two new blisters on the left shin that were open and 4 open areas on the right leg. The nurse performed dressing change following the WOCN orders documented in the 9/23/2020 assessment despite having no new orders for the 3 new open wounds. Documentation of physician notification of the new wounds was not found in the skilled nurse visit note or in a communication note. h. The skilled nurse visit note, dated 10/9/2020, documented a new blister opened on the right leg, leaving one on the upper leg, one on the middle leg and one on the lower leg. The nurse documented treating the new blistered area using the WOCN orders for the other two open areas. No documentation of new orders for the new	G 590			

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G 590	Continued From page 58 blister were found. Documentation of physician notification of the new wound was not found in the skilled nurse visit note or in a communication note. i. The skilled nurse visit note, dated 10/14/2020, documented a new blister opened on the left leg. The nurse documented treating the new wound with Aquacel, an ABD pad and tubigrip to hold in place. The patient's clinical record lacked documentation of any orders to treat the new wound. Documentation of physician notification of the new wound was not found in the skilled nurse visit note or in a communication note. j. The Plan of Care, dated 10/23/2020 to 12/23/2020, lacked specific orders for wound care. k. The skilled nurse visit note, dated 10/26/2020, documented all wounds scabbed and considered healed. l. The skilled nurse visit note, dated 11/2/2020, identified a small open wound on the middle of the left shin and a small open wound below the right knee. The patient's clinical record lacked any orders for treatment of either of the new wounds yet the nurse documented "dressing done" to treat the wounds. Documentation of physician notification of the new wounds was not found in the skilled nurse visit note or in a communication note. m. The skilled nurse visit note, dated 11/9/2020,	G 590			

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G 590	Continued From page 59 documented left leg open wound was healed but 3 blisters were noted. Documentation of physician notification of the new wounds was not found in the skilled nurse visit note or in a communication note. n. The update to the comprehensive assessment at the time of discharge, dated 11/13/2020, documented the nurse noted an open area to the left leg by the knee and one closer to the left ankle. The nurse noted small blisters on the right leg and two open areas- one by the right knee and one on the right calf. The clinical record lacked documentation of any wound care orders to treat the new wounds, yet the nurse documented "dressing done" to treat the wounds. Documentation of physician notification of the new wounds was not found in the skilled nurse visit note or in a communication note. (Please see G458 for associated information) m. The Plans of Care, dated 7/30/2020 to 9/27/2020, 9/28/2020 to 10/23/2020 and 10/24/2020 to 12/23/2020, included orders for skilled nursing services 1-2 times weekly and home health aide services 1-2 times weekly to provide assistance with personal care. The same Plans documented the patient had diagnoses of acute and chronic respiratory failure, heart failure, diabetes, severe obesity and sleep apnea requiring the use of a CPAP (machine to assist with breathing when sleeping). The home health aide assignment for the period of 7/30/2020 through 11/13/2020, directed the following:	G 590			

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G 590	Continued From page 60 "Weigh and record here as requested". The assignment did not give the aide parameters to indicate when the aide should report weight gain or loss to the nurse. The patient had diagnoses of heart failure. Weight gain was a symptom of heart failure exacerbation. The agency's parameters for reporting weight gain to the physician were greater than 3 pound gain in 24 hours and 5 pounds in one week. Skilled nurse visit notes and aide visit notes documented the following: 1. 9/1/2020= 330# 2. 9/2/2020= 333# 3. 9/3/2020= 336# no report to the physician. 4. 9/23/2020= 338# 5. 9/28/2020= 342# no report to the physician 6. 10/26/2020=338# 7. 11/6/2020= 346# no report to the physician The agency failed to notify the physician of Patient # 7's weight gain when greater than 3 pound gain in 24 hours and 5 pounds in one week. 4. Patient #8 had a start of care date of 10/17/2019. Clinical record review revealed the following: a. The Plans of Care, dated 6/13/2020 to 8/11/2020 and 8/12/2020 to 10/10/2020, included physician orders for home health aide visits once weekly and completion of a comprehensive	G 590			

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G 590	Continued From page 61 assessment and aide supervision every 60 days by a registered nurse. The Plans documented the patient had a primary diagnosis of dementia. b. The update to the comprehensive assessment at the time of recertification, dated 8/11/2020, documented the update was performed via telephone with the patient's adult child as the adult child, who resided with the patient, had tested positive for COVID 19. c. The home health aide visit notes for August 2020 included documentation of only one visit on 8/4/2020. The next home health aide visit occurred on 9/1/2020. The notes lacked an explanation for why the visits were not made. d. The Plan of Care, dated 10/11/2020 to 12/9/2020, documented in the summary section that the "home health agency canceled visits" during the previous 60 day period but did not indicate the dates of the canceled visits or the reason for missing the visits. Agency staff interview revealed the following: e. On 1/6/2021 at 9:15 AM, Staff E, RN, reported Patient #8's adult child, who resided in the same home, had a positive COVID 19 test. Since the patient was exposed to the virus, "services were put on hold". "We put services on holdto limit the spread of COVID." Staff E, RN, reported the agency had an unwritten policy that patient services are put on hold if any exposure/positive test is present in the home. "During the quarantine, we are unable to go in the home."	G 590			

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G 590	Continued From page 62 The RN verified she had not notified the physician of the hold on services except to put the missed visits on the next certification period Plan of Care. 5. Patient #4 had a start of care date of 1/16/15. The Plans of Care, dated 9/29/18 to 11/27/18 and 11/28/18 to 1/26/19, documented the patient's diagnoses as diabetes mellitus and macular degeneration. Clinical record review revealed a. The Plan of Care, dated 10/21/2020 to 12/19/2020, included orders for skilled nursing every other week for medication set up and two times per week home health aide visits for assistance with personal cares. b. An update to the comprehensive assessment for recertification, dated 10/19/2020, documented someone must assist the patient to groom self, the patient needed clothing laid out or handed out for dressing, and required the presence of another person throughout the bath for assistance or supervision. c. A skilled nurse visit note, dated 11/23/2020, documented the agency may need to put aide services on hold, since the patient was exposed to someone who had COVID-19. The nurse further documented the nurse set up medications in planners for two weeks and set them up early since the patient was exposed to COVID-19. The patient had an appointment the following day to get tested. d. The patient's clinical record failed to include home visit notes for the weeks of 11/21/2020 and 11/28/2020. The record also did not include	G 590			

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G 590	Continued From page 63 documentation of why the visits did not occur. Interview with Staff Q, Registered Nurse (RN) on 1/7/21 at 8:17 AM, revealed home health aide services were missed the weeks of 11/21/2020 and 11/28/2020 due to the patient having COVID-19. The nurse stated no contact was made to the physician's office and missed visits are always noted on the next Plan of Care for physician notification. Surveyor phone interview with Patient #4 on 1/6/21 at 9:03 AM, revealed the patient was in isolation for 14 days and was admitted overnight for observation the day before Thanksgiving. Patient #4 revealed the patient did not want to expose anyone and further stated, "I don't think they were allowed to come see me anyway when I was in isolation." The agency failed to promptly alert the physician of changes in the patient's condition or needs. 6. Patient #6 had a start of care date of 9/30/2020 and was transferred to and inpatient facility on 11/28/2020. The Plans of Care, dated 9/30/2020 to 11/28/2020, documented the patient's diagnoses as diabetes mellitus with a skin ulcer. Clinical record review revealed a. The Plan of Care, dated 9/30/2020 to 11/28/2020, included orders for skilled nursing one to two times per week for medication setup, monitoring blood sugars/diabetes, assess vital signs and wounds, assist with wound cares as needed, and monitor for infection and respiratory status and two times per week home health aide	G 590			

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G 590	Continued From page 64 visits for assistance with personal cares. b. The initial comprehensive assessment at start of care, dated 9/30/2020, documented the patient has a history of falls and multiple hospitalizations. The assessment also documented grooming utensils must be placed within reach for the patient to groom self, needed clothing laid out or handed to the patient for upper body dressing, needed someone to help put on undergarments, slacks, socks, or shoes, and needed intermittent assistance of another person for bathing or encouragement or reminders, or to get in and out of the shower or tub or to wash difficult areas. c. A skilled nurse visit note, dated 11/23/2020, the patient was exposed to someone who had COVID-19 and would need to be checked when the patient attends dialysis. The patient had no fever, chills, or shortness of breath. The patient did have a dry, nonproductive cough. The patient wore a mask and the nurse wore more Personal Protective Equipment (PPE) when doing the patient's cares. The patient was encouraged to get tested when attends dialysis. d. The patient's clinical record failed to include home visit notes for the weeks of 11/21/2020. The record also did not include documentation of why the visits did not occur. e. A transfer assessment, dated as 11/28/2020 and completed on 12/8/2020, documented the patient was transferred to an inpatient facility and not discharged from the agency. Interview with Staff Q, RN on 1/6/21 at 7:47 AM revealed the agency was aware the patient was exposed to COVID-19 on 11/23/2020. The home	G 590			

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G 590	Continued From page 65 health aide had a high risk child, so knew the aide did not want to go into the patient's home. The nurse revealed the physician was not contacted for the visits that were missed and stated the patient was discharged and the discharge summary contains any missed visits for physician notification. The nurse also stated the physician was not notified of patient's transfer to the inpatient facility as the nurse was not sure how long the patient would be in the hospital. The nurse informed the surveyor the Administrator told the nurse there was an isolation period for COVID-19 positive patients and exposed patients and staff could not go in until the patient was done with isolation. The agency failed to promptly alert the physician of changes in the patient's condition or needs. The above findings for Patients #1, #3, #4, #6, #7 and #8 were reviewed with agency Administrator/Clinical Manager. The agency provided no additional information prior to the end of the survey.	G 590			
G 602	Communication with all physicians CFR(s): 484.60(d)(1) Assure communication with all physicians involved in the plan of care. This ELEMENT is not met as evidenced by: Based on clinical record review and staff interview, the agency failed to assure communication with all physicians involved in the Plan of Care 2 of 2 sampled patients receiving cares from clinical nurse specialists (Patients #6 and #7). The agency reported a census of 98 patients at the time of the survey.	G 602			

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G 602	Continued From page 66 Failure to communicate the patient's status with all physicians involved in the Plan of Care placed agency patients at risk for unidentified worsening of conditions, inappropriate treatments, or unmet home health care needs. Findings include: 1. Patient #6 had a start of care date of 9/30/2020 and discharged from the agency on 11/28/2020. Clinical record review revealed: a. A faxed physician's order received from an Advanced Registered Nurse Practitioner (ARNP), dated 11/18/2020, for a change of wound care orders to the patient's right heel and right great toe. b. The skilled nursing visit note, dated 11/20/2020, documented the nurse provided wound cleansing and wound care with new orders received from the ARNP. The clinical record failed to include documentation of the agency communicating the wound care changes with the Plan of Care physician. 2. Patient #7 had a start of care date of 7/30/2020 and was discharged from agency services on 11/13/2020. Clinical record review and associated agency staff interviews revealed the following: a. The Plan of Care, dated 7/30/2020 to 9/27/2020, did not include a diagnosis of open wounds. The Plan lacked any direction to the	G 602	G602: 1. All nurses were educated on 1/14/21 regarding the need to ensure all patient changes in conditions/treatment or status with the agency must be communicated with all relevant physicians, and the following: It is not necessary to receive multiple orders for the same change, but instead, if a treatment change is ordered, it is the agency responsibility to inform the additional relevant physicians/ordering providers who are providing any additional orders to the agency for the patient's care. If an additional specialist, such as the wound care clinic provides an update for ordered treatments, it is the agency's responsibility to communicate this treatment change to the ordering physician. This provides for safe coordination of care, as well as allows the ordering physician the chance to weigh in on the updated treatment. 2. Compliance will be maintained by reviewing 100% of all orders at the time of the comprehensive assessments/updates until compliance is met and maintained. Clinical manager will ensure ongoing compliance with quarterly chart audits. 3. Clinical manager will ensure compliance by 1/31/21.		

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G 602	Continued From page 67 nurse to perform wound care of any kind. The Plan lacked any specific wound care orders. The update to the comprehensive assessment at the time of recertification, dated 9/23/2020, documented the patient saw a wound ostomy nurse (WOCN) the previous day. The WOCN debrided some wounds and opened up blisters. The patient now had a dime sized wound on the left leg and 3 open wounds on the right leg. The note described direction received from the WOCN to cleanse the wounds, apply Aquacel AG one layer to all open areas, cover and apply Surepress compression bandage from toes to knees. No interim order was found in the patient's clinical record. The clinical record lacked documentation of communication with the physician signing the patient's home health Plan of Care to update the physician of the new orders. b. The Plan of Care, dated 9/28/2020 to 10/23/2020, included orders for the nurse to perform "wound care" but no specific wound care orders were found on the Plan of Care. c. The WOCN provided written interim orders, dated 10/1/2020, directing a 2 layer compression wrap remain on the patient's right lower extremity for one week- the dressing would be removed by the WOCN at that time. The clinical record lacked documentation of communication with the physician signing the patient's home health Plan of Care to update the physician of the new orders.	G 602			

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G 602	Continued From page 68 d. The WOCN provided written interim orders, dated 10/7/2020, changing the treatment to cleanse with wound cleanser, pat dry. Apply Aquacel AG one layer to any open draining wound, apply ABD pad, anchor with Medipore tape, and cover with tubigrip. The clinical record lacked documentation of communication with the physician signing the patient's home health Plan of Care to update the physician of the new orders. (Please see G580 and G590 for associated information) e. During agency staff interview on 1/6/2021 at 8:40 AM, Staff D, RN, reported all wound care orders for Patient #7 came from the WOCN. She verified she never got any wound care orders from the physician signing the Plan of Care. Staff D, RN, also verified had never contacted the physician signing the Plan of Care to report the new wounds or any orders given to the home health agency by the WOCN. The findings for Patients #6 and #7 were reviewed with the Administrator/Clinical Manager. The agency provided no additional information prior to the end of the survey.	G 602			
G 684	Infection control CFR(s): 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance	G 684	G684: (see next page)		

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G 684	Continued From page 69 improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This STANDARD is not met as evidenced by: Based on agency policy review and infection control program review, the agency failed to maintain a coordinated agency-wide program for prevention, control, and investigation of infectious and communicable diseases that is an integral part of the agency's quality assessment and performance improvement (QAPI) program. The agency reported a current census of 98 patients. Failure to maintain a coordinated agency-wide program for prevention, control, and investigation of infectious and communicable diseases that is an integral part of the agency's quality assessment and performance improvement (QAPI) program, may put patients at risk of receiving unsafe care or care that allows the spread of infection. Findings include: The agency policy, titled Quality Improvement/Improvement Plan, identified the purpose of the QAPI program is to maintain an integrative process that links knowledge, structures, processes, and outcomes to enhance quality throughout the agencies programs.	G 684	1.) During the Public Health Emergency, the waiver allows a focus of infection control. All infections were documented for patients and staff. The agency has now reviewed the infection documentation to ensure identification of any trends or concerns related to cross contamination. None were found. 2.) Compliance will be maintained by completing the capturing of data monthly, and holding a Quality Assurance/Performance Improvement meeting quarterly with the Administrator (or designee), Clinical Manager and an outside consultant. 3.) The Clinical Manager will be responsible for compliance, which will be obtained by 1/31/21.		

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G 684	Continued From page 70 The agency policy, titled Infection Control, dated 6/2010, identified the Administrator provides time at unit meetings to discuss infection control issues if needed and observes staff and assess that infection control policies are being followed and enforces policies when necessary. Infection control will include employee health, education, and assurance that all standard precautions are used and needed stick injuries are reported. Interview on 1/7/21 at 9:48 AM with the agency Administrator revealed the infection control program is not part of the agency's QAPI program and is separated out. The Administrator reported infection control is reviewed as it impacts patient's care if hospitalization occurs and is tracked in the Electronic Health Record (EHR) program used by the agency. The Administrator stated the data tracked for patient and staff infections will be provided to the surveyor. On 1/7/21 at 11:23 AM, the Administrator provided the surveyor with the following reports: a. An Infection Risk Report from the agency's Electronic Health Record for the time period 1/1/19 to 1/7/21, identified the following potential risks: skin was intact, poor nutrition, Intravenous(IV)/Peripherally Inserted Central Catheter (PICC), number of days on IV therapy, urinary catheter presence and days with urinary catheter, and if medications that can decrease the immune response are taken. b. An Infection Report from the agency's Electronic Health Record for the time period 1/1/19 to 1/7/21, identified the following: patient's name, and treatment performance meds, when the medications were started and ended, patient's	G 684			

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G 684	Continued From page 71 identification number, date of infection, date of onset, date first observed, source, onset type, site, and symptoms. The Administrator revealed to the surveyor that the nurses track these infections for their assigned patients and the nurses run the report, so the Administrator was unsure how to retrieve the report. The Administrator revealed since COVID-19, employee illnesses have been tracked and a sheet is filled out by for each employee and placed in their personnel file. The examples provided to the surveyor by the Administrator included the COVID-19 daily symptom log filled out by each nurse monitoring daily temperature, cough, runny nose, breathing okay, and explanation if not normal. The infection control program included surveillance information, but failed to include an ongoing systematic collection, analysis, interpretation and evaluation of health data closely integrated with the timely dissemination of date to those who need it. The agency failed to track patterns and trends of infections to establish a corrective plan for infection control. The above findings were reviewed with agency Administrator/Clinical Manager. The agency provided no further information prior to the end of the survey.	G 684			
G 798	Home health aide assignments and duties CFR(s): 484.80(g)(1)	G 798	G798: See next page		

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G 798	Continued From page 72 Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written 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). This STANDARD is not met as evidenced by: Based on clinical record review, agency policy review, and agency staff interview, the agency failed to provide individualized and specific written patient care instructions from a registered nurse (RN) to agency home health aides for 3 of 5 sampled patients receiving home health aide services (Patients #4 #7, and #8). The agency reported a census of 98 patients, including 52 who received care provided by a home health aide. Failure to ensure agency registered nurses provided patient specific written instructions directing the care provided by the agency's home health aides for each patient increased the risk agency patient's would receive inappropriate or inconsistent home health aide services. Findings include: According to the undated agency policy, titled Assignment and Supervision of the Home Care Aide, the home care aide is assigned by the scheduler and follows written instructions which are reviewed according to appropriate regulations and guidelines. 1. Patient #4 had a start of date of 1/16/15 and	G 798	1. All nurses were educated on 1/08 and 1/14/21 regarding the need to ensure all elements of the aide care plan are specific and simple, clear directives. It was covered that "Assist with Bathing" is not specific enough, but must say what type of bath- whether shower, tub bath, bed bath, etc. Similarly, all other vague directives, such as "skin care" must be more specific to indicate what is this care- and where is this care to be provided. - All RNs reviewed their current clients charts who have a home health aide to ensure the care plans were updated to ensure this level of detail. 2. Compliance will be maintained by reviewing 100% of all aide care plans at the time of the Start of Care and every comprehensive assessment update (with the exception of Discharge) Clinical manager will ensure ongoing compliance with quarterly chart audits. 3. Clinical manager will ensure compliance by 1/31/21.		

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G 798	Continued From page 73 received every other week skilled nursing services and two times per week home health aide services from the agency. The Plans of Care, dated 10/21/2020 to 12/19/2020 and 12/20/2020 to 2/17/2021, documented a diagnosis of diabetes mellitus type 2 and macular degeneration. The recertification comprehensive assessments, dated 8/21/2020, 10/19/2020, and 12/17/2020, documented the patient required presence of another with bathing and must have clothing or shoes laid out or handed for ability to dress lower body. Clinical record review revealed: The home health aide assignments for the months of October, November, and December directed the aides to perform the task of bath, shampoo 1-2 times per week as requested, perform skin care, and foot care (but no nail trim), and apply antifungal cream to rash areas under the breasts and abdominal folds as requested. b. The RN assigned tasks to the aide of bath, skin care, and foot care, but did not identify the specific type of bath to be performed, or define what type of skin care or foot care was to be completed by the aide. The aide assignment was not specific and individualized to meet the needs of Patient #4. 2. Patient #7 had a start of care date of 7/30/2020 and was discharged from home health services on 11/13/2020. Clinical record review and associated interviews revealed the following: a. The Plans of Care, dated 7/30/2020 to	G 798			

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G 798	Continued From page 74 9/27/2020, 9/28/2020 to 10/23/2020 and 10/24/2020 to 12/23/2020, included orders for skilled nursing services 1-2 times weekly and home health aide services 1-2 times weekly to provide assistance with personal care. The same Plans documented the patient had diagnoses of acute and chronic respiratory failure, heart failure, diabetes, severe obesity and sleep apnea requiring the use of a CPAP (machine to assist with breathing when sleeping). b. The home health aide assignment for the period of 7/30/2020 through 11/13/2020, directed the following: "Foot Care- no nails diabetic". The assignment did not describe what "foot care" meant. The home health aide visit notes, dated 9/1/2020, 11/6/2020 and 11/13/2020, were initialed, indicating foot care was performed; however, the documentation did not indicate the actual task the aide equated to foot care. During agency staff interview on 1/6/2020 at 8:40 AM, Staff D, RN, verified she "probably just meant lotion" when assigning foot care to the home health aides. The home health aide assignment did not give clear, specific directions for the aides to follow when assigning foot care. "Weigh and record here as requested". The assignment did not give the aide parameters to indicate when the aide should report weight gain or loss to the nurse. The patient had diagnoses of heart failure.	G 798			

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G 798	Continued From page 75 Weight gain was a symptom of heart failure exacerbation. The agency's parameters for reporting weight gain to the physician were greater than 3 pound gain in 24 hours and 5 pounds in one week. During agency staff interview on 1/6/2020 at 8:40 AM, Staff D, RN, verified she was tracking the patient's weight due to the diagnosis of heart failure. She reported she assigned the weight check "as requested by the patient". The home health aide assignment did not give clear, specific directions for the aides to follow when assigning monitoring the patient's weight. The aide assignment was not individualized to the patient's needs. 3. Patient #8 had a start of care date of 10/17/2019. Clinical record review revealed the following: Clinical record review and associated interviews revealed the following: The Plans of Care, dated 4/14/2020 to 6/12/2020 and 6/13/2020 to 8/11/2020, included physician orders for home health aide visits once weekly and completion of a comprehensive assessment and aide supervision every 60 days by a registered nurse. The Plans identified the diagnoses of dementia and schizoaffective disorder. The home health aide assignment for the period of 10/17/2019 through 1/11/2021, directed the following:	G 798			

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G 798	Continued From page 76 a. "Nail Care/Foot Care- as needed or requested". The assignment did not describe what "foot care" meant. The nurse directed the aide to perform the task "as needed" thereby requiring the aide to assess the need, which is out of the scope of practice of an aide, or await the patient's request for the task. Patient #8 had the diagnosis of dementia and would have been unable to request the task completion due to the decreased mental capacity. During agency staff interview on 1/6/2020 at 9:15 AM, Staff E, RN, verified she meant apply lotion to the feet when assigning foot care to the home health aides. Staff E concurred the patient did not have the mental competence to request tasks be performed. The home health aide assignment did not give clear, specific directions for the aides to follow when assigning foot care. b. "Skin Care as requested". The assignment did not describe what "skin care" meant. The nurse directed the aide to perform the task "as requested". Patient #8 had the diagnosis of dementia and would have been unable to request the task completion due to the decreased mental capacity. During agency staff interview on 1/6/2020 at 9:15 AM, Staff E, RN, verified she meant apply lotion to the skin when assigning skin care to the home health aides. Staff E concurred the patient did not have the mental competence to request tasks be performed. The home health aide assignment did not give	G 798			

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G 798	Continued From page 77 clear, specific directions for the aides to follow when assigning skin care. The aide assignment was not individualized to the patient's needs. The above findings for Patients #4, #7 and #8 were reviewed with the agency Administrator/Clinical Manager. The agency provided no additional information prior to the end of the survey.	G 798			
G 800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are : (i) Ordered by the physician; (ii) Included in the plan of care; (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: Based on agency policy review, clinical record review and staff interview, the agency failed to ensure home health aides provided care to agency patients only as ordered by the physician, permitted under state law and/or as directed by the skilled professional assigning the home health aide to the patient for 2 of 5 sampled patients receiving home health aide services (Patients #5 and #7). The agency reported a current census of 98 patients at the time of the survey, including 52 who received care provided by a home health aide. Failure to ensure that home health aide services are provided only as ordered by the physician, permitted under state law and/or as directed by the skilled professional assigning the home health	G 800	G800: 1.All aides were educated on 1/20/21 regarding the need to ensure all elements of the Plan of Care are completed exactly as directed. If the patient declines a service on the Plan of Care, the aide must communicate this to the RN Case manager. No additional tasks may be "added" by the aide, but the aide should notify the RN if there are additional identified needs, so the care plan can be updated appropriately. This should also be part of the ongoing coordination of care and supervision provided by the RN. 2. Compliance will be maintained by reviewing 100% of aide documentation to ensure all tasks completed or documented notification of RN is documented. Clinical manager will ensure ongoing compliance with quarterly chart audits. 3. Clinical manager will ensure compliance by 1/31/21.		

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G 800	Continued From page 78 aide to the patient and according to the home health aide care plan increased the risk that patients' personal care needs were not adequately met. Findings including: According to the undated agency policy, titled Assignment and Supervision of the Home Care Aide, the home care aide is assigned by the scheduler and follows written instructions which are reviewed according to appropriate regulations and guidelines. According to the undated agency policy, titled Home Care Aide Duties, general duties include personal hygiene, body positioning/services, measurements, assistance with health care needs (including application of bandages to superficial abrasions/lacerations), emergency measures, preventative applications (including application of protective skin barriers on intact skin (transparent dressing such as Tegaderm or Opsite hydrocolloid such as Duoderm or Replicare). Home Care Aides do not perform and are not assigned by the Registered Nurse to apply debriding ointments and perform dressing changes to wounds beyond a superficial depth. 1. Patient #5 had a start of care date of 10/2/2020. The Plans of Care, dated 10/2/2020 to 11/30/2020 and 12/1/2020 to 1/29/21, included physician orders for skilled nursing services for assessment every other week and home health aide services 2 times per week to assist with personal care. Clinical record review revealed:	G 800			

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G 800	Continued From page 79 a. The Aide Care Plan for the months of October and November included direction to the aide to perform skin care to the lower legs with instructions for the aide to perform the following tasks: cleanse the skin with warm water or SAFCLENS and pat dry gently, apply triamcinalone 0.1% cream to intact reddened/rash skin, from ankle to knee in a very thin layer as needed and per client request, wait 5 minutes and apply a thin layer of Aloe Vesta protective ointment from the foot to the knee (avoiding between the toes), apply tubigrip stocking from the base of the toes to below the knees and hand wash tubagrips and allow to air dry, and report to the nurse any open wounds to bilateral extremities. b. Home health aide visit notes, dated 11/3, 11/6, 11/10, 11/13, 11/17, 11/20, 11/24, 12/1, 12/22 and 12/29/2020, failed to include documentation the aide performed the task of hand wash tubigrips and allow to air dry and failed to document why the task was not performed. c. Home health aide visit notes, dated 12/1/2020 and 12/4/2020, failed to include documentation the aide performed the task of apply tubigrip from base of toes to below the knees and failed to document why the task was not performed. d. Home health aide visit notes, dated 12/4/2020 and 12/8/2020, included documentation the aide applied a silver patch (Aquacel) dressing to the patient's right lower extremity due to the patient requesting the aide to do so. A silver dressing is wound altering and beyond the scope of practice of a home health aide's simple dressing change. The home health aide failed to provide services	G 800			

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G 800	Continued From page 80 that are ordered by the physician, included in the plan of care, permitted under state law, and consistent with home health aide training. 2. Patient #7 had a start of care date of 7/30/2020 and was discharged from home health services on 11/13/2020. Clinical record review and associated interviews revealed the following: a. The Plans of Care, dated 7/30/2020 to 9/27/2020, 9/28/2020 to 10/23/2020 and 10/24/2020 to 12/23/2020, included orders for skilled nursing services 1-2 times weekly and home health aide services 1-2 times weekly to provide assistance with personal care. b. The home health aide assignment for the period of 7/30/2020 through 11/13/2020, directed the home health aides to perform "Foot Care- no nails diabetic" each visit. The home health aide visit notes, dated 8/3, 8/7, 8/13, 8/18, 8/21, 8/28, 9/4, 9/11, 9/25, 9/28 and 10/2, 10/5, 10/16, 10/19, 10/26 and 10/30/2020, lacked documentation the initials of the home health aide verifying completion of the task. The notes lacked identification of the reason for omission of the task. The above findings for Patients #5 and #7 were reviewed with agency Administrator/Clinical Manager. The agency provided no further information prior to the end of the survey.	G 800			
G 814	Non-skilled direct observation every 60 days CFR(s): 484.80(h)(2)	G 814			

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G 814	Continued From page 81 If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care. This ELEMENT is not met as evidenced by: Based on agency policy review and clinical record review, the agency failed to ensure a registered nurse completed home health aide supervision at least every 60 days while observing the home health aide present and providing direct patient care for 1 of 1 sampled patients who received hands on personal care services with no skilled service provision. (Patient #8). The agency reported a current census of 98 patients, including 21 patients who received personal care assistance by a home health aide without any skilled service provision. Failure to supervise home health aide services, at least every 60 days while the aides provided direct patient care, increased the risk that patients received unsatisfactory or inappropriate care from home health aides. Findings include: According to the agency policy, titled 60 Day Supervision of the Home Care Aides and dated 6/05, supervisory visits must be made once every 60 days while the aide is present in the home. Patient #8 had a start of care date of 2/18/2020. Clinical record review revealed the following:	G 814	G814: 1. All nurses were educated on 1/14/21 regarding the need to ensure all all non-skilled clients will have an in-person supervisory visit with the aide present as part of the recertification process to ensure compliance with the standard of supervision every 60 days. 2. Compliance will be maintained by reviewing 100% of all recertifications until compliance is met and maintained. Clinical manager will ensure ongoing compliance with quarterly chart audits. 3. Clinical manager will ensure compliance by 1/31/21.		

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G 814	Continued From page 82 The Plans of Care, dated 6/13/2020 to 8/11/2020 and 8/12/2020 to 10/10/2020, included physician orders for home health aide visits once weekly and completion of a comprehensive assessment and aide supervision every 60 days by a registered nurse. The clinical record included documentation of supervision of the home health aide on 6/9/2020. The update to the comprehensive assessment at the time of recertification, dated 8/11/2020 was completed via telehealth (a visit done by audio or video with audio) without a skilled visit made to the patient's home. The documentation did not include any supervision of the home health aide. The next documentation of home health aide supervision occurred on 10/6/2020, 119 days later. The findings for Patient #8 were reviewed with the Administrator/Clinical Manager. The agency provided no additional information prior to the end of the survey.	G 814			
G 848	Compliance with Federal, State, Local Law CFR(s): 484.100 Condition of participation: Compliance with Federal, State, and local laws and regulations related to the health and safety of patients. The HHA and its staff must operate and furnish services in compliance with all applicable federal, state, and local laws and regulations related to the health and safety of patients. If state or local law provides licensing of HHAs, the HHA must be licensed.	G 848	G848: 1.) Human resource files reviewed and no further deficiencies noted. An HR hire checklist was developed and will be implemented upon any new hire to ensure the appropriate background checks are completed prior to hire/seeing patients. 2.) Compliance will be maintained by initiating a "double check" with both the Administrator and the Clinical Manager "checking off" on the Human Resource checklist. 3.) Administrator is responsible, effective 1/31/21		

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G 848	Continued From page 83 This CONDITION is not met as evidenced by: Based on review of criminal background checks, child abuse and dependent adult abuse record checks, the agency allowed 1 of 5 sampled employees hired or contracted after 3/29/2018 (the date of the last survey conducted by the Department of Inspections and Appeals) without completing the required criminal history, dependent adult abuse and child abuse background checks within 30 days prior to hire (Staff D). The agency hired 7 new employees since 3/29/2018. The systemic practice resulted in the failure to ensure the organizational framework of the agency promoted and supported the adherence to state regulations and coordination of safe and effective delivery of care to the agency's 98 patients. 481 IAC (Iowa Administrative Code) rule 50.9 requires Home Health Agencies complete a criminal background history check, a dependent adult abuse background history check and a child abuse background history check on each prospective employee who will have direct patient contact. The home health agency must complete these record checks prior to the date of hire of a prospective employee. If a positive criminal history, dependent adult abuse history or child abuse history is identified, the agency must seek approval to hire from the Department of Human Services. 481 IAC rule 50.9(4) limits the validity of criminal history, dependent adult abuse history, and child abuse history record checks to a period of 30 days from the date the results of the background checks were received by the agency. Should a	G 848			

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G 848	Continued From page 84 potential employee have a delayed hire date exceeding the allowed 30 days, the agency is required to run the background checks again to search for changes that may have occurred since the last background checks. Failure to complete the required backgrounds checks according to the State of Iowa requirements placed agency patients at risk for potential harm. Findings include: Staff D, Registered Nurse, had a hire date of 6/22/2020. Staff D's personnel file included an initial criminal history check, dependent adult abuse history check and child abuse history check, completed on 4/30/2020. The history background check identified evidence of past criminal history, but found no dependent adult abuse or child abuse history. The identified criminal history had already been identified by a previous employer, evaluated by Department of Human Services (DHS) and DHS approved Staff D to work in health care in the state of Iowa. No new criminal history had occurred since the incident previously identified so the agency was able to hire Staff D. The agency was not able to hire Staff D until 6/22/2020, 53 days after the background checks were run by the agency. Staff D's personnel file lacked documentation of any additional background checks for criminal history, dependent adult abuse history or child abuse history completed after 4/30/2020 and within 30 days of the RN's hire date.	G 848			

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G 848	Continued From page 85 The agency did not rerun the criminal, dependent adult abuse or child abuse history check as required by regulation when identifying Staff D could not start employment until after the 30 day allowed time expired. The findings were reviewed with the Administrator/Clinical Manager. During agency staff interview on 1/6/2020 at 4:20 PM, the Administrator/Clinical Manager, reported a lack of knowledge of the state requirement to repeat the background checks if the employee's hire date was greater than 30 days from the original cleared date for criminal history, dependent adult abuse and child abuse history checks. The Administrator/Clinical Manager immediately requested another background check for all three histories and was awaiting determination of additional criminal history presence after the above stated history that may require contact with DHS. No further information was provided by the agency prior to the end of the survey.	G 848			
G 940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its	G 940	G940: This condition's plan of correction will be reflective of the corresponding standards/elements interventions/corrections to ensure a compliant framework is maintained to support safe, compliant and quality patient care.		

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G 940	Continued From page 86 organizational structure, including lines of authority, and services furnished. This CONDITION is not met as evidenced by: Based on review of the agency's governing body meeting minutes, the agency failed to involve the governing body in the overall management and operation of the organization resulting in the governing body not being aware the agency was operating out of compliance with several condition level regulations (G942).	G 940			
G 942	The cumulative effects of this systemic practice resulted in the failure of the agency to assure the organizational framework of the agency promoted and supported safe and effective delivery of patient care to its 98 patients. Governing body CFR(s): 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. This STANDARD is not met as evidenced by: Based on review of the agency's governing body meeting minutes, the agency failed to involve the governing body in the overall management and operation of the organization resulting in the governing body not being aware the agency was operating out of compliance with several condition level regulations. The agency reported a census of 98 patients at	G 942	G942: 1.) Notification of the governing body members of the need to ensure that the home health business and operations must be a part of the routine meetings and documented specifically as home health operations, and not just public health. The governing body will document appointment of new Clinical manager and designee by 1/22/21. The governing body also was informed of the specific data and frequency of review for Quality Assurance/Performance Improvement re: infection control on 1/22/21. 2.) Ongoing compliance will be maintained as Home Health has been added as a standard agenda item for the bi-monthly meetings going forward. 3.) Administrator is responsible for compliance by 1/22/21 by reviewing all Board of Health agendas and minutes.		

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G 942	Continued From page 87 the time of the survey. Failure to include the governing body in the overall management and operation of the agency, placed agency patients at risk for inadequate and unsafe care. Findings include: Review of the agency's governing body meeting minutes for the years of 2019 and 2020, demonstrated the quarterly meeting minutes did not reflect discussion of the home health agency's daily operations, focusing mostly on public health issues. The above findings were reviewed with the Administrator/Clinical Manager. The agency provided no further information prior to the end of the survey.	G 942			
G1012	Required items in clinical record CFR(s): 484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician orders; This ELEMENT is not met as evidenced by: Based on agency policy review, clinical record review and staff interview, the agency failed to ensure the clinical record included the patient's current documentation and a complete chart for 6 of 8 sampled patients (Patients #1, #2, #4, #5 #6 and #8). At the time of the survey, the agency reported a current census of 98 patients.	G1012	G1012: 1. All staff were educated on 1/08/21 and 1/14/21 regarding the need to ensure all visit notes are authenticated by a signature, date and credentials in a timely manner. 2. Compliance will be maintained by reviewing for signature and timeliness of signatures of all notes, at the time of all comprehensive assessments/updates until compliance is met and maintained. Clinical manager will ensure ongoing compliance by quarterly chart audits. 3. Clinical manager will ensure compliance by 1/31/21.		

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G1012	Continued From page 88 Failure of the agency to ensure the clinical record included current documentation placed agency patients at risk to receive care or not receive care meeting the needs of the patient. Findings include: According to the undated agency policy, titled Record Retention, required documentation for each service or care provided must be completed on the day the service is rendered and filed in the clinical record within 5 business days. Interview with the Administrator on 1/4/21 at 3:55 PM, revealed the expectation is that all documentation for routine visits, verbal orders, and communication notes will be completed within 5 days according to agency policy. 1. Patient #2 had a start of care date of 3/31/2020. The Plan of Care, dated 11/26/2020 to 1/24/21, included orders for skilled nursing services. Clinical record review revealed a skilled nursing visit note, included documentation the visit occurred on 12/21/2020, with an electronic signature indicating completion on 12/30/2020, 9 days late according to agency policy. 2. Patient #4 had a start of care date of 1/16/15. The Plan of Care, dated 10/21/2020 to 12/19/2020 and 12/20/2020 to 2/17/21, included orders for skilled nursing services and home care aide services. Clinical record review revealed: a. A skilled nursing visit note, included	G1012			

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G1012	Continued From page 89 documentation the visit occurred on 11/12/2020, with an electronic signature indicating completion on 12/4/2020, 22 days late according to agency policy. b. A skilled nursing visit note, included documentation the visit occurred on 11/23/2020, with an electronic signature indicating completion on 12/4/2020, 11 days late according to agency policy. On 1/6/21, the surveyor reviewed the patient's medical chart located at the agency. The chart failed to include December 2020 home care aide documentation. Home care aides document on a monthly care plan sheet and turn in the documentation at the end of each month. Staff R, Office Manager, provided the requested documentation to the home care aide December care plan sheet for surveyor review. The agency failed to follow agency policy of filing all documentation within 5 days of occurrence. 3. Patient #5 had a start of care date of 10/2/2020. The Plans of Care, dated 10/2/2020 and 11/30/2020, 12/1/2020 to 1/29/21, included orders for skilled nursing services and home care aide services. Clinical record review revealed: a. A skilled nursing visit note, included documentation the visit occurred on 10/14/2020, with an electronic signature indicating completion on 10/29/2020, 15 days late according to agency policy. b. A skilled nursing visit note, included	G1012			

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G1012	Continued From page 90 documentation the visit occurred on 12/21/2020, with an electronic signature indicating completion on 12/31/2020, 10 days late according to agency policy. On 1/5/21, the surveyor reviewed the patient's medical chart located at the agency. The chart failed to include November and December 2020 home care aide documentation. Home care aides document on a monthly care plan sheet and turn in the documentation at the end of each month. The agency failed to follow agency policy of filing all documentation within 5 days of occurrence. 4. Patient #6 had a start of care date of 9/30/2020 and was transferred to an inpatient facility on 11/28/2020 and discharged from agency on 12/2/2020. The Plan of Care, dated 9/30/2020 to 11/28/2020, included orders for skilled nursing services and home care aide services. Clinical record review revealed: a. A skilled nursing visit note, included documentation the visit occurred on 10/5/2020, with an electronic signature indicating completion on 10/22/2020, 17 days late according to agency policy. b. A skilled nursing visit note, included documentation the visit occurred on 10/9/2020, with an electronic signature indicating completion on 10/22/2020, 13 days late according to agency policy. c. A skilled nursing visit note, included	G1012			

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G1012	Continued From page 91 documentation the visit occurred on 10/12/2020, with an electronic signature indicating completion on 11/2/2020, 21 days late according to agency policy. d. A skilled nursing visit note, included documentation the visit occurred on 10/16/2020, with an electronic signature indicating completion on 11/2/2020, 17 days late according to agency policy. e. A skilled nursing visit note, included documentation the visit occurred on 10/19/2020, with an electronic signature indicating completion on 11/4/2020, 16 days late according to agency policy. f. A skilled nursing visit note, included documentation the visit occurred on 10/23/2020, with an electronic signature indicating completion on 11/4/2020, 12 days late according to agency policy. g. A skilled nursing visit note, included documentation the visit occurred on 10/26/2020, with an electronic signature indicating completion on 11/5/2020, 10 days late according to agency policy. h. A skilled nursing visit note, included documentation the visit occurred on 11/2/2020, with an electronic signature indicating completion on 11/19/2020, 17 days late according to agency policy. i. A skilled nursing visit note, included documentation the visit occurred on 11/10/2020, with an electronic signature indicating completion on 11/30/2020, 20 days late according to agency	G1012			

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G1012	Continued From page 92 policy. j. A skilled nursing visit note, included documentation the visit occurred on 11/13/2020, with an electronic signature indicating completion on 12/1/2020, 18 days late according to agency policy. k. A skilled nursing visit note, included documentation the visit occurred on 11/16/2020, with an electronic signature indicating completion on 12/4/2020, 18 days late according to agency policy. l. A skilled nursing visit note, included documentation the visit occurred on 11/20/2020, with an electronic signature indicating completion on 12/4/2020, 14 days late according to agency policy. m. A skilled nursing visit note, included documentation the visit occurred on 11/23/2020, with an electronic signature indicating completion on 12/7/2020, 14 days late according to agency policy. On 1/4/21, the surveyor reviewed the patient's medical chart located at the agency. The chart failed to include October and November 2020 home care aide documentation. Home care aides document on a monthly care plan sheet and turn in the documentation at the end of each month. Interview with agency Administrator on 1/4/21 at 4:15 PM, revealed the documentation is somewhere in office and have not been filed yet. The Administrator was able to locate the missing documentation for surveyor review. The agency failed to follow agency policy of filing	G1012			

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G1012	Continued From page 93 all documentation within 5 days of occurrence. 5. Patient #1 had a start of care date of 11/25/2020. Clinical record review with associated agency staff interviews revealed the following: a. The Plan of Care, dated 11/25/2020 to 1/23/2021, included physician orders for skilled nursing services and physical, occupational and speech therapy services. Upon review of the patient's paper clinical record on 1/4/2021, the surveyor found no speech therapy visit notes present. Review of the patient's electronic clinical record on 1/4/2021 revealed no speech therapy notes and no skilled nurse visit notes in the previous two weeks. b. During agency staff interview on 1/4/2021 at 2:45 PM, the Administrator/Clinical Manager reported the speech therapist, a contracted employee, had most likely not sent the notes to the home health agency. She reported a plan to call and get the notes for surveyor review. The Administrator/Clinical Manager reported the skilled nursing visit notes may have just been uploaded to the system so the surveyor would need to run a computer update so the notes would show for review. c. The surveyor ran the update, noting two additional skilled nurse visit notes, dated 12/22/2020 and 12/29/2020, were available for review. Upon review, the surveyor noted the 12/22/2020 visit note was completed on 1/4/2021 at 1:32 PM, 13 days after the visit and after the surveyor had begun to look at the record, and the 12/29/2020 visit note was completed on 1/4/2021	G1012			

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G1012	Continued From page 94 at 1:50 PM, 6 days after the visit and after the surveyor had begun to look at the record. d. On 1/4/2021 at 3:05 PM, the Administrator/Clinical Manager provided a Speech Therapy Evaluation, dated 12/15/2020, and speech therapy routine visit notes, dated 12/18/2020, 12/21/2020, 12/22/2020, 12/28/2020 and 12/29/2020. Documentation of all six visit notes were sent to the agency on 1/4/2021 at 3:02 PM. None of the notes were filed into the patient's clinical record within 5 days of the date of visit as required by agency policy. 6. Patient #8 had a start of care date of 10/17/19. Clinical record review with associated agency staff interviews revealed the following: a. The Plans of Care, dated 10/11/2020 to 12/9/200 and 12/10/2020 to 2/7/2021, included physician orders for home health aide services once weekly and skilled nursing visits for completion of comprehensive assessment and supervision every 60 days. b. Upon review of the patient's paperclinical record on 1/6/2021 at 8:05 AM, the surveyor found no home health aide visit notes for November or December 2020. The surveyor requested the notes for review. c. The Administrator/Clinical Manager presented the November 2020 home health aide visit notes, dated 11/3,20,17,24/2020, on 1/6/2021 at 8:10 AM reporting she found the notes on the nurse's desk.	G1012			

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G1012	Continued From page 95 d. Staff R, Office Manager, presented the December 2020 home health aide visit notes, dated 12/1, 12/8, 12/16, 12/23 and 12/30/2020 on 1/6/2021 at 8:20 AM reporting she found the notes on the nurse's desk. None of the notes were filed into the patient's clinical record within 5 days of the date of visit as required by agency policy. The above findings for Patients #1, #2, #4, #5, #6, and #8 were reviewed with the agency Administrator/Clinical Manager. The agency provided no further information prior to the end of the survey.	G1012			
G1022	Discharge and transfer summaries CFR(s): 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. This ELEMENT is not met as evidenced by: Based on clinical record review and agency staff interview, the agency failed to complete and send a transfer summary to the physician responsible for caring for the patient while in an inpatient	G1022	G1022: 1. All nurses were educated on 1/08 and 1/14/21 regarding the need to ensure all transfers must have a summary sent to the facility to ensure a safe transition of care as soon as possible, but within two business days. All Discharges must have a Discharge summary provided to the attending physician(s) to again ensure a safe hand-off for care. The summary form is found within the Electronic Medical Record. And will be faxed. 2. Compliance will be maintained by reviewing 100% of all transfers/discharge on a weekly basis until compliance is met and maintained. Clinical manager will ensure ongoing compliance with quarterly chart audits. 3. Clinical manager will ensure compliance by 1/31/21.		

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G1022	Continued From page 96 facility within 2 business days of knowledge of the occurrence of the transfer for 3 of 3 sampled patients with transfers to an inpatient facility requiring the transfer summary (Patients #4, #6 and #7). The agency reported a current census of 98 patients. The agency reported 14 patients transferred to an inpatient facility in the previous 6 months. Failure to send the physician and other health care professionals a summary of the patient's care while receiving services from the agency in a timely manner may result in inadequate or inappropriate follow-up after transfer. Findings include: 1. Patient #7 had a start of care date of 7/30/2020 and was discharged from home health services on 11/13/2020. Clinical record review and associated agency staff interviews revealed the following: The update to the comprehensive assessment at the time of transfer to an inpatient facility, dated 8/10/2020, documented the patient was hospitalized on 8/10/2020. The patient remained hospitalized until 8/12/2020, at which time returned to home health care. The clinical record lacked any documentation of completion of a transfer summary. The surveyor requested the Administrator/Clinical Manager identify where the transfer summaries were documented/stored. On 1/5/2021 at 2:48 PM, the	G1022			

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G1022	Continued From page 97 Administrator/Clinical Manager reported she would look for the transfer summary; however, she did not believe the clinicians had been completing and sending transfer summaries. "That will have to be a correction." 2. Patient #4 had a start of care date of 1/16/15 and transferred to an inpatient facility on 9/4/2020. Clinical record review revealed: a. An OASIS assessment for transfer to inpatient facility, completed 9/8/2020, documented the transfer date of 9/4/2020. b. The resumption of care comprehensive assessment, dated 9/8/2020, documented the patient's discharge date from the hospital was 9/6/2020. Interview on 1/7/21 at 9:10 AM with Staff Q, Registered Nurse (RN), revealed the patient transferred to hospital for a procedure on 9/4/2020 and the agency was aware of the transfer ahead of time. The agency failed to complete a transfer summary within 2 business days of a planned transfer. 3. Patient #6 had a start of care date of 9/30/2020 and was transferred to an inpatient facility on 11/28/2020. Clinical record review revealed: a. An OASIS assessment for transfer to inpatient facility-patient not discharged from agency, dated	G1022			

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G1022	Continued From page 98 11/28/2020, was completed on 12/8/2020. b. A fax was received by the agency from the hospital on 12/1/2020, for patient's resumption of care. The agency failed to complete a transfer summary within 2 business days of the patient's care immediately continued in a health care facility. The above findings for Patients #4, #6, and #7 were reviewed with agency Administrator/Clinical Manager. Agency staff provided no further information prior to the end of the survey.	G1022			
G1024	Authentication CFR(s): 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This STANDARD is not met as evidenced by: Based on agency policy review, clinical record review and , the agency failed to ensure authentication of hand written entries made in each patient's clinical record included the employee's signature of the author of the documentation, title of the author, and date/time of the signature for 2 of 2 sampled patients receiving therapy services (Patients #1 and #7). The agency reported a current census of 98 patients at the time of the survey. The agency reported providing therapy services to 8 patients at the time of the survey.	G1024	G1024: 1.All staff were educated on 1/14/21 regarding the need to ensure all visit notes are authenticated by a signature, date and credentials in a timely manner. 2. Compliance will be maintained by reviewing for signature and timeliness of signatures of all notes, at the time of all comprehensive assessments/updates until compliance is met and maintained. Clinical manager will ensure ongoing compliance with quarterly chart audits. 3. Clinical manager will ensure compliance by 1/31/21.		

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G1024	Continued From page 99 Failure to maintain timely, accurate and appropriately authenticated clinical record documentation increased the risk that agency staff provided services without up to date information related to the patient's condition, and decreased the ability of agency staff to communicate effectively in order to coordinate patient care. Findings include: According to the undated agency policy, titled Record Retention, any person who gives client care and who is professionally involved in the management/coordination of patient services may make an entry into the clinical record of the patient. The author of the document must date (month, day, year) and sign the entry, complete with his/her title to authenticate an entry in the clinical record. The agency contracted therapy services. The therapists do not document in the agency's electronic medical record system. The therapy visit notes were completed by the therapists and sent to the home health after completion and incorporated into the patient's paper chart. 1. Patient #1 had a start of care date of 11/25/2020. The Plan of Care, dated 11/25/2020 to 1/23/2021, included physician orders for speech therapy services. Clinical record review revealed the following: a. Upon review of the patient's paper clinical record on 1/4/2021, the surveyor found no speech therapy visit notes present. Review of the	G1024			

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G1024	Continued From page 100 patient's electronic clinical record on 1/4/2021 revealed no speech therapy notes. On 1/4/2021 at 3:05 PM, the Administrator/Clinical Manager provided a Speech Therapy Evaluation, dated 12/15/2020, and speech therapy routine visit notes, dated 12/18/2020, 12/21/2020, 12/22/2020, 12/28/2020 and 12/29/2020. Documentation of all six visit notes were sent to the agency on 1/4/2021 at 3:02 PM. b. The speech therapy visit note, dated as completed on 12/18/2020, was not authenticated electronically or by written signature of the therapist authoring the document. c. The speech therapy visit notes, dated as completed 12/21/2020, 12/22/2020, 12/28/2020 and 12/29/2020, were signed with a handwritten signature of the therapist authoring the document; however, lacked the date/time of the signature. 2. Patient #7 had a start of care date of 7/30/2020 and was discharged from agency services on 11/13/2020. The Plans of Care, dated 7/30/2020 to 9/27/2020, 9/28/2020 to 10/23/2020 and 10/24/2020 to 12/23/2020, included physician orders for physical therapy services. Clinical record review revealed the following: Typed therapy visit notes were present in the chart. The notes documented a typed name of the author with title and the date and time of the visit. The typed visit notes containing the name of a	G1024			

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G1024	Continued From page 101 physical therapy assistant, dated 8/5, 8/7, 8/12, 8/14, 8/17, 8/19, 8/20, 8/24, 8/26, 8/28, 8/31, 9/2, 9/4, 9/8, 9/9, 9/11, 9/14, 9/16, 9/18, 9/21, 9/23, 9/25, 10/7, 10/14, 10/16, 10/19, 10/21, 10/26, 10/28, 10/30, 11/2, 11/4, 11/6, 11/9, 11/11 and 11/13/2020, were not authenticated electronically or by written signature of the therapy assistant authoring the document.	G1024			
E 000	The above stated findings for Patients #1 and #7 were reviewed with the Administrator/Clinical Manager. The agency provided no additional information prior to the end of the survey. Initial Comments	E 000	E017:		
E 017	The recertification survey, conducted from 1/4/21 through 1/11/21, identified the following deficiencies related to emergency preparedness. HHA Comprehensive Assessment in Disaster CFR(s): 484.102(b)(1) [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.] At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55.	E 017	1.All staff were educated on 1/08, and again on 1/14/21 regarding the need to ensure an emergency plan is developed with the patient in case of weather, etc. A form was developed and provided to all staff and placed in admit packs. All case managers developed this Emergency Plan for all of their patients, and will deliver at next planned visit to ensure appropriate teaching occurs with the plan. Instruction also provided that this plan must be updated and reviewed with every comp assessment and as needed. This review will be documented in the narrative of that Comp assessment. Clinical Manager will monitor until compliance is met and maintained. Ongoing chart audits by Clinical Manager will ensure compliance.		

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E 017	Continued From page 102 This STANDARD is not met as evidenced by: Based on review of agency's emergency preparedness plan/policies, review of the agency's admission packet, clinical record review, home visit observation and agency staff interview, the home health agency failed to complete an individualized emergency plan developed as part of the comprehensive assessment, maintaining documentation of the plan in the patient's chart and in the patient's home setting, for 7 of 7 sampled patients (Patients #1, #2, #3, #4, #5, #6 and #7). The agency reported a current census of 98 patients at the time of the survey. Failure to ensure the agency completed an individualized emergency plans developed as part of the comprehensive assessment and failure to ensure the patient has knowledge of the identified Plan placed patients at risk for staff being unaware and unprepared to respond in a timely and effective manner to potential health and safety hazards the patient may encounter. Findings include: According to the agency's undated Emergency Operations Plan, the agency may experience a disruption of services to patients. The home health agency utilized a priority ranking to easily identify and count those patients who would need immediate attention and those that would be more self sufficient or have family available to provide assistance until the agency could resume provision of care. The assessment of priority rankings shall be a part of the comprehensive patient assessment. The patient will be educated on the risks of disasters and the importance of emergency planning.	E 017	(E017 Con't) 2. Compliance will be maintained by reviewing for the Emergency Plan or review of the Emergency Plan, at the time of all comprehensive assessments/updates until compliance is met and maintained 3. Clinical manager will ensure compliance by 1/31/21. Clinical Manager will also ensure ongoing compliance by quarterly chart audits		

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E 017	Continued From page 103 The staff will educate and assist patients on emergency preparedness to the greatest extent possible, at a minimum upon admission, at least every 60 days and in the event of an actual emergency. The staff will encourage patients and their families to follow their personal emergency plans and instructions. Each patient will have a Patient Emergency Preparedness Plan included as part of the comprehensive patient assessment. For evacuation needs, staff will refer to the Patient Emergency Plan in each patient's record for information. According to the agency's undated policy, titled Comprehensive Assessment Policy, each comprehensive assessment must include an evaluation of the home environment and assessment of emergency preparedness of the patient. Review of the agency's admission packet revealed a booklet titled Emergency Preparedness For People Receiving HomeCare. The booklet included general information about ways to prepare for emergencies; general information of different types of potential emergent situations, including fire, storms, extreme cold and earthquakes; and what to do following an emergency event. The last thing in the booklet was a place for specific telephone numbers the patient should use to contact emergency services, poison help, hospital, health care provider, neighbors and family members. The admission packet also included a document titled Client's Emergency Plan. The document	E 017			

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E 017	Continued From page 104 included a section for emergency telephone number section and a section that addressed medical emergencies and when to contact medical personnel. Document instructions were to circle those intervention directions specific to the patient. During agency staff interview on 1/5/2021 at 10:00 AM, the Administrator/Clinical Manager, reported the agency assesses the patient's priority ranking and documents in the communication notes, completes a medical emergency plan to keep in the chart with a copy given to the patient, verbally reviews emergency plans specific to the patient in the home but the specific plan is not put into writing, and provides each patient a booklet on emergency preparedness to keep in the home. 1. Patient #1 had a start of care date of 11/25/2020. Clinical record review revealed the following: a. The Plan of Care, dated 11/25/2020 to 1/23/2021, included the diagnosis of hemiplegia secondary to massive multiple strokes; identified the patient required all food and medication administration via a gastrostomy tube (a tube directly entering the patient's stomach through an opening in the abdomen); and identified the need for skilled nursing for teaching of use of the gastrostomy tube and medical assessment and physical, occupational and speech therapy evaluations. The individual therapy evaluations identified need for continued services to address non-ambulatory status, inability to speak and inability to sit/stand unassisted. b. The patient's initial comprehensive	E 017			

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E 017	Continued From page 105 assessment at start of care, dated 11/25/2020, lacked documentation of a safety assessment to determine the individualized needs of the patient during a disaster or emergency. c. The communication notes, dated 11/25/2020, included identification of the patient's priority ranking to determine need for services if the agency services were disrupted, identifying the patient as a medium priority ranking as the patient had family available to assist until services could be resumed. d. The patient's clinical record included only the completed form with emergency contact information and guidance on what to do in a medical emergency, including when to contact the physician. The clinical record lacked documentation of an individualized written emergency preparedness plan specific to the patient/family needs in the event of a disaster or other emergency, such as fire, tornado, winter storms, loss of electricity, floods, etc. Surveyor observation revealed the following: e. On 1/4/2021 at 12:30 PM , the surveyor accompanied Staff O, Occupational Therapist (OT), to the patient's home. During the home visit, the surveyor noted no posted individualized emergency preparedness plan. The folder provided by the agency contained only the booklet on emergency preparedness. The back page in the booklet available to document individualized contact information with phone numbers was left blank. The folder included a copy of the medical emergency form but lacked any other written plan for other environmental emergencies or disasters.	E 017			

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E 017	Continued From page 106 2. Patient #3 had a start of care date of 2/18/2020. Clinical record review revealed the following: a. The Plans of Care, dated 2/18/2020 to 4/17/2020, 4/18/2020 to 6/16/2020, 6/17/2020 to 8/15/2020, 8/16/2020 to 10/14/2020, 10/15/2020 to 12/13/2020 and 12/14/2020 to 2/11/2021, included the diagnoses of chronic respiratory failure with hypoxia, hypertensive heart disease, chronic obstructive pulmonary disease requiring the use of oxygen at night, diabetes, severe obesity and a history of falls; identified the patient used an electric wheelchair/scooter for all mobility. b. The patient's initial comprehensive assessment at start of care, dated 11/25/2020, lacked documentation of a safety assessment to determine the individualized needs of the patient during a disaster or emergency. c. The updates to the comprehensive assessment at the time of recertification, dated 4/14/2020, 6/16/2020, 8/14/2020, 10/13/2020 and 12/11/2020, lacked documentation of a safety assessment to determine the individualized needs of the patient during a disaster or emergency. d. The update to the comprehensive assessment at the time of resumption of care following hospitalization, dated 6/10/2020, lacked documentation of a safety assessment to determine the individualized needs of the patient during a disaster or emergency. e. The communication notes lacked	E 017			

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E 017	Continued From page 107 documentation of the identification of the patient's priority ranking to determine need for services if the agency services were disrupted at admission or anytime thereafter. f. The patient's clinical record included only the form with emergency contact information filled out. The section for guidance on what to do in a medical emergency, including when to contact the physician, was left blank. The clinical record lacked documentation of an individualized written emergency preparedness plan specific to the patient/family needs in the event of a disaster or other emergency, such as fire, tornado, winter storms, loss of electricity, floods, etc. Surveyor observation and associated staff interviews revealed: g. On 1/5/2021 at 1:30 PM, the surveyor accompanied Staff C, Registered Nurse (RN), to the patient's home. During the home visit, the surveyor noted no posted individualized emergency preparedness plan. The folder provided by the agency had been discarded by the patient prior to the surveyors visit. h. During the home visit, Staff C, RN, reported she had only discussed the emergency plan with the patient. She had never completed a written emergency preparedness plan for the patient's chart or home. 3. Patient #7 had a start of care date of 7/30/2020 and a discharge date of 11/13/2020. Clinical record review revealed the following: a. The Plans of Care, dated 7/30/2020 to 9/27/2020, 9/28/2020 to 10/23/2020 and	E 017			

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E 017	Continued From page 108 10/24/2020 to 12/23/2020, Included the diagnoses of acute and chronic respiratory failure, heart failure, severe obesity and sleep apnea requiring the use of a CPAP (machine to assist with breathing when sleeping). b. The patient's initial comprehensive assessment at start of care, dated 7/30/2020, lacked documentation of a safety assessment to determine the individualized needs of the patient during a disaster or emergency. c. The update to the comprehensive assessment at the time of recertification, dated 9/23/2020, lacked documentation of a safety assessment to determine the individualized needs of the patient during a disaster or emergency. d. The update to the comprehensive assessment at the time of discharge, dated 11/13/2020, lacked documentation of a safety assessment to determine the individualized needs of the patient during a disaster or emergency. e. The communication notes included documentation of the identification of the patient's priority ranking to determine need for services If the agency services were disrupted, identifying the patient as a medium priority ranking as the patient had family available to assist until services could be resumed. f. The patient's clinical record included only the completed form with emergency contact information and guidance on what to do in a medical emergency, including when to contact the physician. The clinical record lacked documentation of an individualized written emergency preparedness plan specific to the	E 017			

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E 017	Continued From page 109 patient/family needs in the event of a disaster or other emergency, such as fire, tornado, winter storms, loss of electricity, floods, etc. 4. Patient #2 had a start of care date of 3/31/2020. Clinical record review revealed: a. The initial comprehensive assessment completed at start of care, dated 3/31/2020, included documentation emergency plan and in home care plans were developed and reviewed with the patient and spouse. b. The updates to the comprehensive assessment completed for recertification, dated 7/27/2020, 9/22/2020, 11/23/2020, included documentation the emergency plan was reviewed. On 1/4/21 at 2:50 PM, during a home visit observation with Staff A, Registered Nurse (RN), the patient reported unable to locate the folder provided at admission with the emergency plan. c. The agency form, titled Client's Emergency Plan was located in the hard chart at the agency, dated 3/31/2020, and included instructions for medical problems or emergencies. The medical record lacked a copy of the patient's individualized emergency preparedness plan. The agency failed to provide the patient with a completed emergency preparedness plan individualized for the patient. 5. Patient #4 had a start of care date of 1/16/15.	E 017			

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E 017	Continued From page 110 Clinical record review revealed: a. The updates to the comprehensive assessment completed for recertification, dated 8/21/2020, 10/19/2020, and 12/17/2020, failed to include documentation of review of the emergency plan. b. The update to the comprehensive assessment completed for resumption of care, dated 9/8/2020, failed to include documentation of review of the emergency plan. c. The agency form, titled Client's Emergency Plan, located in the hard chart at the agency, dated initially 7/26/18 and reviewed on 7/25/19, included instructions for medical problems or emergencies. The medical record lacked a copy of the patient's individualized emergency preparedness plan. The agency failed to provide the patient with a completed emergency preparedness plan individualized for the patient. 6. Patient #5 had a start of care date of 10/2/2020. Clinical record review revealed: a. The initial comprehensive assessment completed at start of care, dated 10/2/2020, failed to include documentation an emergency plan was developed and reviewed at start of care.. b. The update to the comprehensive assessment completed for recertification, dated 11/25/2020, failed to include documentation the emergency plan was reviewed.	E 017			

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E 017	Continued From page 111 c. The agency form, titled Client's Emergency Plan, located in the hard chart at the agency, dated 10/2/2020, included instructions for medical problems or emergencies. The medical record lacked a copy of the patient's individualized emergency preparedness plan. The agency failed to provide the patient with a completed emergency preparedness plan individualized for the patient 7. Patient #6 had a start of care date of 9/30/2020 and was transferred to inpatient facility and discharged from the agency on 11/28/2020. Clinical record review revealed: a. The initial comprehensive assessment completed at start of care, dated 9/30/2020, included documentation emergency plan and in home care plans were written and reviewed with the patient and family. b. The agency form, titled Client's Emergency Plan, located in the hard chart at the agency, dated 10/2/2020, included instructions for medical problems or emergencies. The medical record lacked a copy of the patient's individualized emergency preparedness plan. The agency failed to provide the patient with a completed emergency preparedness plan individualized for the patient. The above findings for Patients #1, #2, #3, #4, #5, #6, and #7 were reviewed with agency Administrator/Clinical Manager. Agency staff provided no further information prior to the end of	E 017			

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E 017	Continued From page 112 the survey.	E 017			
E 037	EP Training Program CFR(s): 484.102(d)(1) *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its	E 037	E037: 1.) All staff and contracted team members have been, or will be trained on the emergency plan. This training occurred on the 14th, 20th and will ensure all contractors will also have appropriate training and documentation of these trainings by 1/31/21. 2.) Compliance will be maintained by the addition of the Emergency Operations Plan as a component of orientation (to be added to the Human Resources file), as well as adding to the calendar for January for bi-annual compliance. Evidence of the training for all new hires after this date will also be ensured during audit of HR chart for all new hires with the "Double check" of the checklist by Administrator and Clinical Manager. 3.) Administrator is responsible for ongoing compliance and will have shown compliance by 1/31/21.		

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E 037	Continued From page 113 emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role.	E 037			

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E 037	Continued From page 114 (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):] (1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster	E 037			

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E 037	Continued From page 115 authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on review of the agency's emergency preparedness plan/policies, review of agency emergency preparedness training and agency staff interview, the agency failed to ensure training in emergency preparedness to all existing staff consistent with their expected roles at the time of orientation and every other year thereafter for 11 of 11 sampled employees (Staff D, G, H, I, J, K, L, M, N, O and P). Lack of emergency preparedness training for staff puts patients at risk should an emergency situation arise and staff would be needed to	E 037			

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E 037	Continued From page 116 assist patients to ensure patient safety. Findings include: According to the agency's undated Emergency Operations Plan, all current staff will be trained on the agency's emergency preparedness plan within 45 days of hire and annually thereafter. Documentation of the training will be maintained by the administrator. Knowledge of the training will be demonstrated by staff participation in the full-scale community-based exercise or table top exercises. Review of the agency's emergency preparedness training revealed the following: 1. Staff D, Registered Nurse (RN), had a hire date of 6/22/2020. The agency was unable to provide documentation of any emergency preparedness training. 2. Staff G, Data Entry/Secretary, had a hire date of 11/30/2020. The agency was unable to provide documentation of any emergency preparedness training. 3. Staff H, Home Health Aide, had a hire date of 4/16/2019. The agency was unable to provide documentation of any emergency preparedness training. 4. Staff I, Home Health Aide, had a hire date of 6/8/2020. The agency was unable to provide documentation of any emergency preparedness training. 5. Staff J, Home Health Aide, had a hire date of 4/30/2018. The agency was unable to provide	E 037			

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E 037	Continued From page 117 documentation of any emergency preparedness training. 6. Staff K, Home Health Aide, had a hire date of 7/9/18. The agency was unable to provide documentation of any emergency preparedness training. 7. Staff L, Scheduler/Secretary, had a hire date of 9/10/2018. The agency was unable to provide documentation of any emergency preparedness training. 8. Staff M, Home Health Aide, had a hire date of 4/23/2018. The agency was unable to provide documentation of any emergency preparedness training. 9. Staff N, Home Health Aide, had a hire date of 8/27/2018 and resigned on 9/16/2019. The agency was unable to provide documentation of any emergency preparedness training. 10. Staff O, Occupational Therapist, had a hire date of 12/13/2005 and worked for the agency as a contracted employee. The agency was unable to provide documentation of any of emergency preparedness training. 11. Staff P, Physical Therapist, had a hire date of 6/26/2020 and worked for the agency as a contracted employee. The agency was unable to provide documentation of any emergency preparedness training. The agency failed to ensure all staff completed initial and annual training in emergency preparedness as required by agency policy and/or initially and at least biannually as required	E 037			

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E 037	Continued From page 118 by regulation. The above stated findings were reviewed with the Administrator/Clinical Manager. During staff interview on 1/7/2021 at 9:00 AM, the Administrator/Clinical Manager reported all staff test for emergency preparedness by participating in the exercises. She believed a verbal discussion occurred with the staff during orientation but did not document evidence of training completion. The Administrator/Clinical Manager was unable to provide any documentation indicating staff annual or biannual emergency preparedness training occurred. The agency provided no further information prior to the end of the survey.	E 037			