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H 000	INITIAL COMMENTS An annual licensure survey was conducted on 04/19/2023, 04/20/2023, 04/24/2023, 04/25/2023, 04/26/2023, 04/27/2023, and 04/28/2023 to determine compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency provided home care services to 255 patients and employed 440 staff. The findings of the survey were based on the review of administrative records, 20 active patient records, five discharged patient records, 35 personnel records, and a review of the agency's response to complaints and incidents received. The survey findings were also based on the completion of two home visits. Listed below are abbreviations used throughout this report: ADL - Activities of Daily Living CHF - Congestive Heart Failure DON- Director of Nursing HHA - Home Health Aide HCA - Home Care Agency IADL- Instrumental Activities of Daily Living OT - Occupational Therapist PCA - Personal Care Aide POC - Plan of Care	H 000	Please begin typing your responses here:	

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H 000	Continued From page 1 PPD - Purified Protein Derivative PT - Physical Therapist RN - Registered Nurse SN - Skilled Nurse SOC - Start of Care ER – emergency room	H 000		
H 120	3906.1(a) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (a) A description of the services to be provided; This Statute is not met as evidenced by: Based on contract review and interview, the home care agency (HCA) failed to ensure the contractual agreements for physical therapy (PT), and occupational therapy (OT) included a description of services to be provided. (PT #1 and OT #1) Findings included: On 04/19/2023 at 1:35 PM during an interview with the home care agency's leadership, it was identified that the agency utilized a third-party contractor to supplement physical and occupational therapy services.	H 120	The contractual agreement of the Physical Therapist and Occupational Therapist has has been revised to include the description of the services to be provided. Please see attachment #1A&B. The front desk staff and the Human Resource staff have been in-serviced on the new contract form for all new applicants. The Human Resource Manager shall review all new contracts to ensure that the description of services included.	5/25/23 6/21/23

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H 120	Continued From page 2 Review of the third-party contractual agreements on 04/19/2023 at 3:24 PM for services rendered by the contracted physical and occupational therapist showed a description of services to be provided by the therapist, however, lacked evidence of a description of services to be provided specifically by the physical and occupational therapists. The findings were shared with facility leadership at the time of review.	H 120		
H 126	3906.1(g) CONTRACTOR AGREEMENTS If a home care agency offers a service that is provided by a third party or contractor, agreements between the home care agency and the contractor for the provision of home care services shall be in writing and shall include, at a minimum, the following: (g) The duration of the agreement, including provisions for renewal, if applicable; and... This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that the agency's contractual agreements were renewed for one of three contractual agreements reviewed for the agency's physical therapist (PT #1) included in the sample. Findings included: During the entrance conference on 04/19/123 at 10:22 AM, the HCA's director of nursing (DON) stated that the agency obtained contractual agreements for physical therapy (PT),	H 126	The contractual agreement of the Physical Therapist was revised to include the duration of service of the contract and a copy was given to the surveyor. The front desk staff and the Human Resource staff have been in-serviced on the new contract form for all new applicants. The Human Resource Manager shall review all new contracts to ensure that the duration of service is included in each contract.	5/25/23 6/21/23

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H 126	Continued From page 3 occupational therapy (OT) and skilled nursing (SN) services. A review of the facility's personnel records was conducted on 04/19/202 at 3:24 PM revealed the following: The personnel file for the agency's physical therapist (PT#1) showed a contractual agreement that was signed on 05/03/2010. Further review of the agreement revealed that the "agreement would be effective from the signature date, and is renewable every four (4) years." There was no documented evidence that the PT's contractual agreement had been renewed since 2010. During an interview on 04/26/2023 at 10:04 AM, the Administrator stated that she did revise some of the agency's nursing contractual agreements and may have forgotten the therapists. At the time of the survey, the home care agency's Administrator submitted a revised contractual agreement for physical therapist #1 dated 04/26/2023 13 years after the physical therapist signed the original contract.	H 126		
H 147	3907.2(c) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (c) Resume of education, training certificates, skills checklist, and prior employment, and evidence of attendance at orientation and in-service training, workshops or seminars; This Statute is not met as evidenced by: Based on record review and interview, the home	H 147		

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H 147	Continued From page 4 care agency (HCA) failed to maintain accurate personnel records to include employee's participation in orientation for one licensed practical nurse (LPN #1) and the agency's front desk receptionist. Findings included: A review of personnel records on 04/19/2023 at 3:24 PM, revealed the following: The agency's licensed practical nurse (LPN #1) and the front desk receptionist ' s personnel files included dates of hire of 12/20/ 2022 and 01/18/2023 respectively, with no documented evidence that the employees participated in the home care agency's orientation. During an interview with the human resources (HR) division on 04/21/2023 at 3:24 PM, the leadership staff stated that there would be a receipt to evidence that the employee had participated in the agency ' s orientation. It should be noted during the electronic review of the personnel records, there was no documented evidence of receipts for LPN #1 and the front desk receptionist. At the time of the survey, the home care agency failed to ensure that two new employees (LPN #1) participated in orientation proximal to hire and prior to her providing services and the front desk receptionist.	H 147	The orientation of the front desk receptionist has been completed. Please see attachment #2. The LPN# 1 has been terminated from the company. The Human Resource staff shall be in-serviced again to ensure that all newly hired employees are oriented on company policies and procedures and on the assignment for which they are hired to perform. The Human Resource staff shall give the employee an orientation form post orientation to sign for proof of orientation and file it in the employee's record. The Human Resource Manager has been in-serviced to review the new hire checklist to ensure that of all new hire records are up to date before commencement of service to ensure effectiveness.	6/21/23
H 148	3907.2(d) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information:	H 148		

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H 148	Continued From page 5 (d) Documentation of current CPR certification, if required; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to maintain accurate personnel records, which included documentation of current CPR certification, for three home health aides (HHAs) and a registered nurse included in the sample (HHAs #2 and #7 and RN #3). Findings included: Review of the personnel records on 04/19/2023 and 04/27/2023 at 3:24 PM, and 3:01 PM respectively, failed to show current CPR certifications for HHAs 2, #7, and RN #3. During an interview on04/27/2023, the Human Resources Assistant stated that they compile a list of employees to notify at least two weeks prior to the expiration of any documents, however, at the time of the survey, the home care agency failed to ensure that all personnel had current CPR certification.	H 148	The CPR certification cards for citated employees have been renewed. Please see attachment #3A, B, C The Human Resource staff shall be in-serviced to generate the compliance report of all current employees from 1/1/2023 to 7/31/2023, review and contact all those with expired documents and those expiring by June 30th to renew before the end of June. The Human Resource staff starting June 1st, 2023 shall also pull a 60 day in advance compliance report on the first week day of every month and give to the Receptionist and Medical Record staff to contact employees to renew their documents. Those who refused to renew on time should be removed from work one week before the expiration date of the document to ensure compliance. The Human Resource Manager has been in-serviced to pull these monthly reports at the beginning and at the end of the month and review to ensure effectiveness.	6/21/23
H 152	3907.2(h) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (h) Copies of completed annual evaluations; This Statute is not met as evidenced by: Based on record review and interview, the home	H 152		

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H 152	Continued From page 6 care agency (HCA) failed to maintain accurate personnel records to include completed evaluations for one of three contractual agreements included in the sample, the agency ' s occupational therapist (OT #1). Findings included: A review of the facility's personnel records was conducted on 04/19/2023 at 3:24 PM revealed the following: The personnel file for occupational therapist (OT #1) included a date of hire of 11/02/2020. Further review of the file showed no documented evidence of an annual evaluation since the employee's initial one year anniversary. Review of the agency's policy entitled Selection/Hiring of Personnel on 04/28/2023 at 4:20 PM showed "The agency will conduct a performance evaluation of all staff after the first three months of employment and annually thereafter..." During an interview with the Leadership Staff on 04/19/2023 at 3:45 PM revealed that the Administrator conducts the annual evaluations for OT #1; however, at the time of the survey, there was no documented evidence that an annual evaluation had been conducted for OT #1.	H 152	The evaluation of the Occupational Therapist has been done. Please see attachment #4 The Human Resource staff has been in-serviced to generate the compliance report of all current employees from 1/1/2023 to 7/31/2023, sort and summit expired evaluations of nurses and therapists to the Administrator or Assistant Clinical Manager before 6/30/23to conduct evaluations. The Human Resource staff starting June 1st, 2023 shall also pull a 60 day in advance compliance report on the first week day of every month and give to the Administrator or Assistant Clinical Manager to conduct Clinical staff evaluations due Those that fail to do their evaluations should be removed from work one week before the expiration date of the document to ensure compliance. The Human Resource manager has been in-serviced to pull these monthly reports at the beginning and at the end of the month and review to ensure effectiveness.	6/21/23
H 162	3907.6 PERSONNEL At the time of initial employment of each employee, the home care agency shall verify that the employee, within the six months immediately preceding the date of hire, has been screened for and is free of communicable disease.	H 162		

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H 162	Continued From page 7 This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to verify that each employee was free of communicable diseases within the six months immediately preceding the employee's date of hire for four employee's personnel files included in the sample, (Front Desk Receptionist, Staffing Coordinator #1, LPN #1 and home health aide HHA #4). Findings included: A review of the facility's personnel records was conducted on 04/19/2023 at 3:24 PM revealed the following: 1. The personnel file for the agency's Front Desk Receptionist included a hire date of 01/18/2023. Further review of her personnel file showed that she had not been screened since her date of hire. It should be noted that evidence of a purified protein derivative (PPD) was provided for the receptionist during the survey on 04/24/2023. 2.The personnel file for the agency's Staffing Coordinator #1 included a hire date of 01/02/2006. Further review of her personnel file showed that she had not be screened since 4/09/2019. 3. The personnel file for licensed practical (LPN #1) included a hire date of 12/20/2022. Further review of her personnel file showed that she had a purified protein derivative (PPD) dated 02/26/2022, ten months prior to her hire date. 4.The personnel file for home health aide (HHA #4) included a hire date of 03/27/2023. Further review of her personnel file showed that she had	H 162	The receptionist has been screened and she is free of communicable disease. The Human Resource staff responsible for hiring shall be in-serviced to use the employment check list at all times to control all new hire applications to ensure that they have been screened of communicable diseases and to ensure that the screening was done 6 months or earlier before the hired date. Any screening results after 6 months shall be repeated before hiring. The Human Resource Manager shall be in-serviced to review all new hire applications to ensure effectiveness.	6/21/23

Health Regulation & Licensing Administration

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H 162	Continued From page 8 a purified protein derivative (PPD) dated 06/16/2022, nine months prior to her hire date. Review of the policy on 04/28/2023 entitled Selection/Hiring of Personnel showed no documented evidence that the employees were required to be screened within six months prior to their hire. During the Exit Interview on 04/28/2023, the Administrative Staff acknowledged the findings and were referred to Title 22 DCMR Chapter 39 for Home Care Agency's regulations that required the HCA to verify that each employee has been screened for and free of communicable disease within six months immediately preceding the date of hire.	H 162		
H 163	3907.7 PERSONNEL Each employee shall be screened for communicable disease annually, according to the guidelines issued by the federal Centers for Disease Control, and shall be certified free of communicable disease. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to verify that each employee was screened and certified free of communicable disease annually for three of 23 home health aides HHA ' s personnel records sampled, (HHAs #10, 14, and #15). Findings included: A review of the facility's personnel records was conducted on 04/20/2023 at 12:03 PM revealed	H 163	1)The Physicals and PPD of HHA #10 expired on 3/2/23 and she stopped work on 2/20/23. The Human Resource staff shall be in-serviced to verify and show surveyors the last date of service of terminated employees on the software. The Human Resource Manager shall be in-serviced to ensure that any field staff who has not served for more than 60 days should be terminated in the software.	6/21/23

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H 163	Continued From page 9 the following: 1. The personnel file for home health aide (HHA #10) included a hire date of 08/25/2021. Further review of the file showed that HHA #10 was last screened for communicable diseases on 03/02/2022. 2. The personnel file for home health aide (HHA #14) included a hire date of 07/25/2019. Further review of the file showed that she was seen by a physician on 02/25/2023; however, he failed to document evidence that the employee was screened and free of communicable diseases. 3. The personnel file for home health aide (HHA #15) included a hire date of 07/08/2022. Further review of the file showed that HHA #15 was last screened for communicable diseases on 03/11/2022. During the Exit Interview on 04/28/2023, the Administrative Staff acknowledged the findings.	H 163	2 The Physicals of HHA #14 expires on 3/25/24 and CXR expires on 10/5/23 however, the TB annual symptom screening was not done because the employee used the wrong physical form. The Human Resource staff shall be in-serviced to give and accept the Agency's physical form only which has the TB symptoms listed and ensures that these symptoms are checked when each employee is screened of communicable disease. The HR Manager shall generate the compliance report every month and randomly review 10% of physical forms to ensure compliance 3) The Physicals and PPD of HHA #15 expired on 3/11/23 and she stopped work on 1/15/23. The Human Resource staff shall be in-serviced to verify and show surveyors the last date of service of terminated employees on the software. The Human Resource Manager shall be in-serviced to ensure that any field staff who has not served for more than 60 days should be terminated in the software.	6/21/23
H 277	3911.2(q) CLINICAL RECORDS Each clinical record shall include the following information related to the patient: (q) Communications between the agency and all health care professionals involved in the patient's care; This Statute is not met as evidenced by: Based on interview and record review, the home care agency (HCA) failed to ensure communications between the agency and all health care professionals involved in the patient's	H 277		

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H 277	Continued From page 10 care was documented for one of 20 active patients in the sample (Patient #9). Findings included: On 04/20/2023 at 1:28 pm, review of Patient #9's clinical record showed plans of care (POCs) with duration periods of 01/18/2023 through 03/18/2023 and 03/19/2023 through 05/17/2023, for skilled nursing services two to three times a week for wound care, personal care aide (PCA) services 14 hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Also, the patient was ordered physical therapy (PT) services two to three times a week for eight weeks and occupational therapy (OT) services one to two times a week for eight weeks to evaluate for OT services and establish a plan of treatment, rehabilitation goals, and home environment for accessibility and safety. The patient's diagnoses included stage three sacral pressure ulcer, right great toe wound and suprapubic wound, obstructive and reflux uropathy, type II diabetes mellitus, protein-calorie malnutrition, hypertension, malignant neoplasm of prostate, hyperlipidemia, and hyperkalemia. On 04/25/2023 at 11:06 am, a scheduled visit was conducted at Patient #9's home. The concerns below were identified: 1. Stage III sacral pressure ulcer was being treated two to three times a week between the licensed practical nurse and the supervisory registered nurse (RN). However, the wound dressing was not staying in place. According to the aide, the patient was having regular bowel movements and each time the dressing would be soiled. She would clean it with a wound cleanser and cover it with gauze. In addition, the clinical	H 277	1.Adhesive dressing has been purchased and used to cover the sacral wound and the dressing is intact with each bowel movement change. A new PCP from House Call has been consulted and has seen the client and gave a new order for treatment. The Assistant Clinical Manager who manages skilled patient charts has been assigned to take over the weekly field wound measurements and supervision of the LPNs while a new LPN has been assigned to the client and the wound is improving. All clinicians and intake staff shall be in-serviced on care coordination with the interdisciplinary team and PCP. The field Quality Assurance(QA) nurses shall visit skilled admissions one week post the beginning of service and then monthly until discharged and once for PCA admissions to ensure that services are provided as ordered and give any recommendations to the office nursing team to improve the quality of care. The Administrator/QA nurse shall review 100% of skilled client records every quarter to ensure compliance. 2.The PCAs have been trained on the use of the Hoyer lift. The new house call PCP has re-order the Occupational Therapist services on 5/26/23 and re-evaluation shall be conducted this week. Client has been re-educated to comply with the instructions of the care team and allow the PCA to turn and reposition him. All clinicians shall be in-services on patient Mobility and environmental safety.	5/10/23 5/17/23 5/5/23 6/21/23 6/21/23

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H 277	Continued From page 11 record reviewed lacked evidence of wound improvement and modification of wound care treatment. The wound characteristics were unchanged since January 2023. There was no evidence of wound consultation post hospitalization x 2. 2. Mobility was a big concern. The patient was confined in his second-floor bedroom and was bed bound. He was non-compliant with the aide's attempts at turning and repositioning. He expressed his preference to stay in bed, laying down on his back despite the sacral wound. Per aide, he did not like the wedge and would remove it when applied. Also, there was a Hoyer lift in the room that was not being used. Nevertheless, he was getting physical therapy twice a week for therapeutic and range of motion exercises. Also, he was ordered occupational therapy that was not being provided. 3. Type II diabetes was poorly managed. The patient's blood sugar was not being checked three times a day as ordered. His daughter was coming twice a week to perform the blood sugar and give Insulin based on the established doctor's parameters. The nurses would check the blood sugar once during their visits. 4. Nutrition was inadequate and not consistent with the ordered "diabetic diet." The patient and aide on duty reported a poor nutritional intake. During the visit, patient was observed eating a glazed donut. There were a few other donuts in the kitchen and different types of sausages in the fridge as well as Ensure drinks, which the aide reported he liked drinking once a day, since he did not like the home health aide's cooking. He enjoyed eating mashed potatoes.	H 277	3.The new PCP has changed the frequency of blood sugar monitoring to daily in AM with sliding scale. The office and field nurses are currently monitoring the blood sugar Monday through Friday and daughter to do the weekend monitoring. The PCP was contacted on 5/26/23 for a glucometer sensor and when approved and supplied, the PCA shall be educated to read the glucometer results and communicate the daily results to the office and the office nurse will go and administer the insulin if needed. All clinicians and intake staff shall be in-serviced to ensure that all existing diabetic clients are able to monitor their own blood sugar and administer insulin and all medications or they have a representative who is willing to monitor and administer insulin and all medications. Field nurses should evaluate these abilities and report findings to the office nursing team for further interventions for clients who need assistance with blood sugar monitoring, insulin and other medication administration. The Administrator/QA nurse shall review 100% of skilled client records and diabetics to ensure compliance. 4.The daughter and nurse shall meet with the client and prepare a list of preferred diabetic diet options and placed it on the refrigerator. The PCA shall be educate on how to cook the food items and patient to comply with diabetic diet. Clinicians shall be in-serviced to educate clients, PCAs and family on diet and document in their notes and notify the PCP of any patient non-compliance behavior. Office nursing team shall verify dietary education during clinical documentation review.	6/21/23 6/21/23

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H 277	Continued From page 12 5. Patient #9 was lacking the oversight of a physician as he was confined on the second floor and required an ambulance for transportation. He attempted to follow- up with his primary care physician on 03/16/2023 and was rerouted to the emergency room for shortness of breath. He was discharged on 03/18/2023 and had not been able to follow-up with the doctor. On 04/26/2023 at 12:40 pm, the Administrator, DON, and physical therapist were interviewed and made aware of the findings. The DON and admission nurse indicated that the patient's daughter had stated on admission that she was living with the patient and would be checking the blood sugar. It was a month later, that the nurse "found out that she was not living in the house." Also, it was revealed that the patient did not have a case manager. In addition, the assistant director of nursing (ADON), who was in charge of the skilled services, was not aware that OT was not providing the services. At the time of survey, the home care agency's clinicians failed to show evidence of documented communications between the agency and all health care professionals involved in Patient #9's care.	H 277	5.A house call PCP has accepted and seen the client at his home. Client also has refused to live on the first floor per PCP and nursing recommendation. Clinicians shall be in-serviced to assess all clients home environment under their care and report any safety concerns to the office nursing team via email for proper follow up. The field Quality Assurance(QA) nurses shall visit skilled admissions one week post the beginning of service and then monthly until discharged and once for PCA admissions to assess the home environment and give any recommendations to the office nursing team to improve the quality of care. The Administrator/QA nurse shall review 100% of skilled client records every quarter to ensure compliance	5/17/23 6/21/23
H 300	3912.2(d) PATIENT RIGHTS & RESPONSIBILITIES Each home care agency shall develop policies to ensure that each patient who receives home care services has the following rights: (d) To receive treatment, care and services consistent with the agency/patient agreement and	H 300		

Health Regulation & Licensing Administration

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H 300	Continued From page 13 with the patient's plan of care; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency (HCA) failed to ensure that services were provided in accordance with the plan of care (POC) for seven of 20 active patients sampled (Patients #2, 3, 5, 6, 11, 15, and #16). Findings included: 1. On 4/19/2023 at 12:08 pm, review of Patient #2's clinical record showed a plan of care (POC) with a duration period of 9/16/2022 through 05/31/2023, for skilled nurse (SN) visits once every 30 days and as needed to conduct skilled assessments of body systems, home health aide supervision, evaluate co-morbid conditions, and intervene to minimize complications. Also, the patient had orders for personal care services 12 hours x seven days a week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Her diagnoses included heart failure, chronic respiratory failure, anxiety disorder, hypertension, depression, acid reflux, obesity, and migraine. Continued review of Patient #2's clinical record showed that personal care services were not provided on 10/01/2022, 10/02/2022, 10/08/2022, 10/09/2022, 10/15/2022, 10/16/2022, 10/22/2022, 10/23/2022, 10/29/2022, 10/30/2022, 11/05/2022, 11/06/2022, 12/04/2022, 12/09/2022 through 12/15/2022, 12/18/2022, 12/24/2022, 12/25/2022, and 12/31/2022. 2. On 04/19/2023 at 02:29 pm, review of Patient #3's clinical record showed a POC with a duration period of 02/01/2023 through 01/31/2024. The POC included a physician's order for skilled nurse	H 300	1.The shortage of staff caused by COVID-19 pandemic affected clients' PCA services especially weekend services. For clients that the Agency was unable to completely staff, government rules prohibited Agencies from discharging clients during the pandemic because no Agency was accepting transfer cases and fair hearings were suspended. The intake coordinator was instructed to work with scheduling and only accept new referrals with scheduling approval. The Intake and Staffing Coordinators shall be re-educated to timely notify the office nursing team of patients with staffing difficulties with no short -term solutions to the issue for possible transfer and discharge and continue to work together for new intakes. The staffing coordinators shall be re-educated to timely complete their on-hold forms to justify the reason services were not provided on certain days. The Clinical Manager and QA shall review at least 2% of PCA records every quarter to ensure compliance. 2.Please see H300 (1)	6/21/23

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H 300	Continued From page 14 (SN) visits every 30 days and as needed, and PCA services 15 hours a day seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). The patient's diagnoses included congestive heart failure, chronic kidney disease, hypertension, gout, type II diabetes mellitus, history of other venous thrombosis and embolism, and glaucoma. Continued review of Patient #3's clinical record showed that personal care services were not provided on 12/22/2022 through 12/26/2022, 12/31/2022, 01/14/2023 through 01/17/2023, 01/19/2023 and 01/20/2023. 3. On 04/28/2023 at 10:49 am, review of Patient #5's clinical record showed a POC with a duration period of 01/01/2022 through 12/31/2022, for SN visits once every 30 days and as needed to conduct skilled assessments, personal care aide supervision, and evaluation of complications necessitating medical attention. Also, the patient had orders for PCA services eight hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The patient had diagnoses that included cerebral infarction, hypertension, Chronic viral hepatitis C, and schizophrenia. Continued review of Patient #3's clinical record showed that personal care services were not provided on 06/04/2022, 06/05/2022, 06/11/2022, 06/12/2022, 06/21/2022, 10/02/2022, 10/09/2022, 10/18/2022 through 10/21/2022, and 10/24/2022 through 10/31/2022. 4. On 04/27/2023 at 11:57 am, review of Patient #6's clinical record showed a POC with a duration period of 01/26/2023 through 07/31/2023. A review of the POC showed that the patient's diagnoses included spinal stenosis, cervical region, osteoarthritis, left shoulder, Type II	H 300	3. Please see H300 (1) 4 The nurse in question will be given a written warning for failure to notify the PCP and the office nursing team of the Coccyx wound. She will be re-educated to coordinate all abnormal findings on patients to the PCP and office	

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H 300	Continued From page 15 diabetes, hypercholesterolemia, and history of malignant neoplasm of breast. Continued review of the POC showed physician's orders for the skilled nurse to visit the patient every 30 days and as needed for assessments, patient education, and HHA supervision. Also, the patient had orders for home health aide (HHA) services 16 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). On 01/26/2023, the registered nurse admitted Patient #6 and documented a "healing stage II pressure ulcer on the coccyx." There was no evidence of a wound care order or treatment. On 02/05/2023, the nurse visited the patient and documented "pain: Tailbone" and "Patient has pressure ulcer on her tail bone, incontinent of both bowel and urine. Family educated to buy an A&D ointment and apply on the affected areas every change of briefs and make sure this client stays dry at all times. Aide was educated to reposition this patient every 2 hours. Teaching understanding was verbalized." Interview with the weekend HHA #22 on 04/27/2023 at 12:34 PM indicated that the patient was in distress every weekend she worked due to pain, and that her wound was getting worse. She communicated continuously with the patient's daughter. She added that the patient would ask to be repositioned for comfort. She also confirmed that the skilled nurse visited on 02/05/2023 around 06:00 pm for supervisory visit but "did not see the wound because Patient was sleeping." Review of weekday HHA #23's documentation on 02/06/2023 through 02/08/2023 showed that the client was confused and in pain. She documented on each occasion that she notified the supervisory nurse. Interview with HHA #23 on	H 300	Nursing team within 24 hours. All clinicians shall be in-serviced to report all abnormal findings during visits to the interdisciplinary team via email within 24 hours. The field Quality Assurance(QA) nurses shall visit all the active new admissions of 2023 to ensure accuracy, visit skilled admissions one week after start of service and then monthly until discharged and once for PCA admissions to ensure that services are provided as ordered and give any recommendations to the office nursing team. The Administrator/QA nurse shall review 100% of skilled client records every quarter to ensure compliance	6/21/23

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H 300	Continued From page 16	H 300		

04/27/2023 at 01:17 pm revealed that Patient #6's wound was getting worse, opened, and had an odor. She stated that the patient was crying intermittently because of pain. She would notify the daughter who would medicate the mother with Codeine, and that would help for "few hours." She added that one time she called the supervisory nurse "five times" and was instructed to call 911 on 02/08/2023.

Interview with the patient's daughter on 04/27/2023 at 01:22 pm, revealed that patient was admitted on 02/08/2023 to the intensive care unit for sepsis, pneumonia, and urinary tract infection. She indicated that since hospitalization, her mother was on a feeding tube, had a colostomy bag, and two surgical procedures for the wound as it was "so deep." She concluded that her Mom was doing better and was in a rehabilitation facility where she would most likely stay for long term care.

On 04/27/2023 at 03:52 pm, the director of nursing (DON) was made aware of the aforementioned interview with the daughter. She indicated that the nurse should have called the doctor when she discovered the wound to get either a referral for skilled services or wound care orders.
The registered nurse (RN) failed to provide services and treatment that were consistent with the patient agreement and plan of care for Patient #6.

5. On 04/26/2023 at 11:56 am, review of Patient #11's clinical record showed a POC with a duration period of 02/01/2022 through 01/31/2023. The POC included a physician's order for skilled nursing visits every 30 days and as needed, and HHA services ten (10) hours a

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H 300	Continued From page 17 day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). The patient's diagnoses included convulsions, chronic combined systolic and diastolic heart failure, type II diabetes mellitus, stage IV chronic kidney disease, peripheral vascular disease, hyperlipidemia, muscle weakness, anemia, gastro-esophageal reflux disease, ischemic cardiomyopathy, and unsteady gait. Continued review of Patient #11's clinical record showed that personal care services were not provided on 05/18/2022 through 05/20/2022, 06/28/2022 through 06/30/2022, 07/04/2022 through 07/08/2022, and 07/11/2022 through 07/15/2022. 6. On 4/28/23 at 09: 32 am, review of Patient #15's clinical record showed a POC with a duration period of 09/01/2022 through 08/31/2023. The POC included a physician's order for skilled nursing visits every 30 days and as needed, and PCA services eight (8) hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). The patient's diagnoses included abnormalities of gait and mobility, type II diabetes mellitus, glaucoma, hypertension, sarcoidosis of lung, alcohol abuse with intoxication, hyperlipidemia, and Hyperparathyroidism Continued review of Patient #15's clinical record showed that personal care services were not provided on 12/01/2022 through 12/04/2022, 12/10/2022, 12/11/2022, 12/17/2022, 12/18/2022, 12/24/2022, 12/25/2022, 12/31/22, 01/01/2023, 01/07/2023, 01/08/2023, 01/14/ 2023, 01/15/2023, 01/21/2023, 01/22/2023, 01/28/2023 through 01/31/2023, 02/04/ 2023, 02/05/2023, 02/11/2023, 02/12/2023, 02/18/2023, 02/19/2023, 02/25/2023 and 02/26/2023.	H 300	5 Please see H300 (1) 6 Please see H300 (1).	

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H 300	Continued From page 18 7. On 04/24/2023 at 02:23 pm, review of Patient #16's clinical record showed a POC with a duration period of 12/01/2022 through 11/30/2023. The POC included a physician's order for skilled nursing visits every 30 days and as needed, and PCA services 15 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The patient's diagnoses included hypertension, lymphedema, bed confinement status, ototoxic hearing loss, left ear, drug-induced obesity, osteoarthritis, vascular dementia, and depression. Continued review of Patient #16's clinical record showed that the agency provided seven (7) hours instead of the ordered 15 hours per day of personal care services on 08/08/2022 through 08/12/2022, 10/21/2022, and 10/24/2022 through 10/28/2022. On 04/28/2023 at 03:30 pm, the agency Director of Nursing was made aware of the findings. At the time of the survey, the home care agency failed to ensure that home health aide services were provided in accordance with the plan of care for Patients #2, 3, 5, 6, 11, 15, and #16.	H 300	7. Please see H300 (1).	
H 358	3914.3(g) PATIENT PLAN OF CARE The plan of care shall include the following: (g) Physical assessment, including all pertinent diagnoses; This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency (HCA) failed to include a pertinent diagnosis in the plan	H 358		

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H 358	Continued From page 19 of care (POC) for one of 20 active patients included in the sample (Patient #6). Findings included: On 04/27/2023 at 11:57 AM, review of Patient #6's clinical record showed a plan of care (POC) with a duration period of 01/26/2023 through 07/31/2023. A review of the POC showed that the patient had diagnoses that included spinal stenosis, cervical region, osteoarthritis, left shoulder, Type II diabetes, hypercholesterolemia, and history of malignant neoplasm of breast. Continued review of the POC showed physician's orders for the skilled nurse (SN) to visit the patient every 30 days and as needed for assessments, patient education, and PCA supervision. Also, the patient had orders for personal care services 16 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). On 01/26/2023, the registered nurse (RN) admitted Patient #6 and documented a "healing stage II pressure ulcer on the coccyx." There was no evidence of a wound care order or treatment. On 02/05/2023, the nurse visited the patient and documented "pain: Tailbone" and "Patient has pressure ulcer on her tail bone, incontinent of both bowel and urine. Family educated to buy an A&D ointment and apply on the affected areas every change of briefs and make sure this client stays dry at all times. HHA was educated to reposition the patient every 2 hours. Teaching understanding was verbalized." There was no evidence, among the patient's diagnoses listed on the plan of care, that the patient had a pressure ulcer or altered skin	H 358	The office nurse coordinators responsible for reviewing patient assessments and Plan of Cares shall be in-serviced to be thorough during their review process, contact the admitting nurse for all discrepancies identified and ensure that they are corrected before the Plan of Care is faxed to the PCP. All clinicians shall be in-serviced to review their work thoroughly before submission to the office. The Quality Assurance(QA) Coordinator or Clinical Manager shall randomly review 10% of all new admissions every month to ensure compliance.	6/21/23

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H 358	Continued From page 20 integrity. On 04/27/2023 at 03:52 PM, the agency Director of Nursing was made aware of the findings. At the time of survey, the home care agency failed to include a pertinent diagnosis in the plan of care for Patient #6.	H 358		
H 364	3914.3(m) PATIENT PLAN OF CARE The plan of care shall include the following: (m) Emergency protocols; and... This Statute is not met as evidenced by: Based on record review and interview, it was determined that the home care agency (HCA) failed to include emergency protocols specific to patient's diagnoses in the Plan of Care (POC) for one of 20 active patients sampled. (Patient #16) Findings included: On 04/24/2023 at 02:23 PM, review of Patient #16's clinical record showed a plan of care (POC) with a duration period of 12/01/2022 through 11/30/2023. The POC included a physician's order for skilled nursing visits every 30 days and as needed, and personal care aide (PCA) services 15 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The patient's diagnoses included hypertension, lymphedema, bed confinement status, ototoxic hearing loss, left ear, drug-induced obesity, osteoarthritis, vascular dementia, and depression.	H 364		

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H 364	Continued From page 21 Continued review of the records showed the skilled nurse (SN) visited the patient on 03/03/2023 and 04/07/2023 and documented that the patient was being non-compliant with care, aggressive, angry or irritated with staff necessitating a high turnover of home health aides. In addition, the nurse's note included on 04/07/2023 the following: "Patient ' s son reports that the client has been hallucinating lately, and her dementia is getting worse, however she continues to deny help. SN contacted the doctor's office and informed the doctor of the client's condition and need for a home visit for follow-up and possibly a psychiatric consult." Further review of the POC lacked evidence of emergency protocols related to the patient's diagnosis of vascular dementia to assist the aides in promoting safety and comfort when the patient was exhibiting signs of behavioral disturbances. On 04/28/2023 at 03:30 pm, the Director of Nursing was made aware of the findings. At the time of survey, the home care agency failed to ensure that the patient's plan of care (POC) included an emergency protocol to properly manage the patient's diagnosis of vascular dementia, and associated behaviors for Patient #16.	H 364	The office nurse coordinators responsible for reviewing patient assessments and Plan of Cares shall be in-serviced to ensure that physical activity, touch and massage, and music are included in the plan of care to manage agitation and aggression for clients with psychological disorders and include the emergency protocol on each Plan of Care. They should contact the admitting nurse for all discrepancies identified and ensure that they are corrected before the Plan of Care is faxed to the PCP. All clinicians shall be in-serviced to review their work thoroughly before submission to the office. The Quality Assurance (QA) Coordinator or Clinical Manager shall randomly review 10% of all new admissions every month and review to ensure compliance.	6/21/23
H 366	3914.4 PATIENT PLAN OF CARE Each plan of care shall be approved and signed by a physician within thirty (30) days of the start of care; provided, however, that a plan of care for personal care aide services only may be approved and signed by an advanced practice registered nurse. If a plan of care is initiated or revised by a telephone order, the telephone order	H 366		

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T & N RELIABLE NURSING CARE	3500 18TH STREET NE WASHINGTON, DC 20018

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H 366	Continued From page 22 shall be immediately reduced to writing, and it shall be signed by the physician within thirty (30) days. This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that each patient's plan of care (POC) was approved and signed by a physician and/or designee, within 30 days of the start of care (SOC) for one of 20 active patients in the sample (Patient #18). Findings included: On 04/24/2023 at 3:49 pm, review of Patient #18's record showed a plan of care (POC) with a duration period of 10/11/2022 through 10/31/2023. The POC included a physician's order for skilled nursing services once monthly to perform multi-systems assessment, vital signs, patient instruction, and personal care aide (PCA) supervision. Also, the POC included an order for personal care services eight hours per day, seven days a week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Further review of the patient's record showed that the POC was signed by the patient's physician on 12/22/2022, greater than 30 days of the start of care. On 04/28/2023 at 03:30 pm, the Director of Nursing was made aware of the findings. At the time of survey, the home care agency failed to ensure that plans of care were signed by physicians within 30 days of the start of care.	H 366	The Care Plan, intake and office nurse Coordinators, and admitting clinicians shall be in-serviced again to ensure that the right PCP's contact information is collected during the intake process and initial assessment to ensure the timely signing of the Plan of Care. The Care Plan Coordinator shall be in-serviced to generate a plan of Care report at the beginning of every 2 weeks for self-audit to ensure all Plan of Cares are being signed within 30days. The Non- Clinical Office Supervisor shall generate the Plan of Care report every month to ensure compliance. Clinical Manager/QA shall randomly review 2% of clinical records every quarter to ensure compliance.	6/21/23

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H 399	Continued From page 23	H 399		
H 399	3915.10(f) HOME HEALTH & PERSONAL CARE AIDE SERVICE Personal care aide duties may include the following: (f) Observing, recording, and reporting the patient's physical condition, behavior, or appearance; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that the home health aide (HHA) recorded and reported the patient's physical condition, behavior, and/or appearance for two of the 20 active patients included in the sample (Patients #10 and #16). Findings included: 1. On 04/20/2023 at 11:04 am, review of Patient #10's clinical record showed a plan of care (POC) with a duration period of 12/01/2021 through 11/30/2022. The patient's diagnoses included history of falling, dependence on wheelchair, type II diabetes mellitus with diabetic neuropathy, and hypertension. The POC contained a physician's order for personal care services 24 hours a day, seven days a week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Continued review of the record showed that the director of nursing (DON) documented the following on 01/14/2022 "writer spoke to Jane Doe (client's daughter) about client's condition due to exposure by PCA on 01/03/2022. Ms. Doe confirmed that client is doing well. She also said the only symptom client is currently showing is coughing. She confirmed that client has tested Positive this morning when	H 399	1.All PCAs shall be in-serviced again to record on the timesheet and report to both the monthly nurse and office nursing team each patient's physical condition, behavior and/or appearance change. The Timesheet Coordinator shall be in-service to verify PCA documentation on the patient's physical condition, behavior and/or appearance for each timesheet and return to PCA for correction if documentation is absent. The timesheet auditor shall audit at least 10% every quarter to ensure compliance. The Clinical Manager/QA Coordinator shall randomly review at least 2% of all records every quarter to ensure compliance	6/30/23

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H 399	Continued From page 24 the Nurse Practitioner visited on 01/14/22. All HHA's have been asked to get tested and pick up personal protective equipment (PPEs) from the office." Further review of the HHA documentation lacked evidence that they observed, recorded, or reported on Patient #10's behavior, physical condition, and or appearance for the period that the patient had been coughing or tested positive for covid-19. 2. On 04/24/2023 at 02:23 pm, review of Patient #16's clinical record showed a plan of care (POC) with a duration period of 12/01/2022 through 11/30/2023. The POC included a physician's order for skilled nursing visits every 30 days and as needed, and personal care aide (PCA) services 15 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). The patient's diagnoses included hypertension, lymphedema, bed confinement status, ototoxic hearing loss, left ear, drug-induced obesity, osteoarthritis, vascular dementia, and depression. Continued review of the records showed that the skilled nurse (SN) visited the patient on 03/03/2023 and 04/07/2023 and documented that the patient was being non-compliant with care, aggressive, angry, or irritated with staff necessitating a high turnover of aides. However, review of the HHA daily documentation lacked evidence that they observed, recorded, or reported on Patient #16's behavior, physical condition, and or appearance. On 04/28/2023 at 03:30 pm, the Director of Nursing was made aware of the findings. At the time of the survey, the agency failed to	H 399	2. Please see H399(1) response.	

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H 399	Continued From page 25 ensure that the home health aide (HHA) recorded assigned tasks for Patients #10 and 16' s physical condition, behavior, and appearance.	H 399		
H 433	3916.2(c) SKILLED SERVICES GENERALLY Each home care agency shall develop written policies for documenting the coordination of the provision of different services. Written policies shall include, at a minimum, the following: (c) Coordinating services with other agencies actively involved in the patient's care, through written communication and/or interdisciplinary conferences, in accordance with the patient's needs; and... This Statute is not met as evidenced by: Based on record review and interview it was determined that the agency failed to document coordination of services with agencies actively involved in the patient's care for five of 20 active patients in the sample. (Patients #3, 11, 13, 14, and #19). Findings included: 1. On 04/19/2023 at 02:29 pm, review of Patient #3's clinical record showed a plan of care (POC) with a duration period of 02/01/2023 through 01/31/2024. The POC included a physician's order for skilled nursing visits every 30 days and as needed, and personal care services 15 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). The patient had diagnoses that included congestive heart failure, chronic kidney disease, hypertension, gout, type	H 433	1.All clinicians shall be in-serviced again to coordinate patient services with case management and other Providers providing other services to our PCA patients. The coordination should be done at least monthly and the clinician should document the subject discussed in their notes. The office nursing team reviewing clinical documentation shall verify evidence of care coordination to ensure effectiveness. The Clinical Director/QA shall review at least 2% of all clinical documentation every quarter.	6/21/23

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H 433	Continued From page 26 II diabetes mellitus, history of other venous thrombosis and embolism, and glaucoma. Continued review of the record showed a nurse assessment dated 03/04/2023 indicating the following: "Client stated that she is receiving physical therapy two times per week from [agency named]." Further review of the records failed to show care coordination with the other provider. On 04/20/2023 at 04:14 pm, the director of nursing (DON) was interviewed. She indicated that the nurses would document care coordination in their clinical notes." However, there was no evidence of coordination of services between the two agencies to ensure safety and continuity of care in the clinical records.	H 433		
	2. On 04/26/2023 at 11:56 am, review of Patient #11's clinical record showed a POC with a duration period of 02/01/2022 through 01/31/2023. The POC included a physician's order for skilled nursing visits every 30 days and as needed, and personal care services ten (10) hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Continued review of the records showed that Patient #11 was hospitalized on 07/22/2022 and discharged on 08/20/2022 with end stage renal disease and on dialysis three times a week. Further review of the records failed to show evidence of coordination of services with the dialysis center to ensure safety and continuity of care.		2. Please see H433(1) Response.	
	3. On 04/24/2023 at 12:37 pm, review of Patient #13's clinical record showed a POC with a duration period of 12/01/2022 through 11/30/2023. The POC included a physician's order for skilled nursing visits every 30 days and as needed, and personal care services eight (8) hours a day, seven days per week to assist with		3. Please see H433(1) Response	

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H 433	Continued From page 27 activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). Also, the POC included the following: "John Doe goes to dialysis on Mondays, Wednesdays, and Fridays. Also, he performs peritoneal dialysis daily at home. Left arm arteriovenous fistula (AV fistula) and abdominal peritoneal dialysis catheter." Continued review of the records failed to show evidence of coordination of services with the dialysis center to ensure safety and continuity of care.	H 433		
	4. On 04/26/2023 at 10:16 am, review of Patient #14's clinical record showed POCs with duration periods of 12/20/2021 through 11/30/2022 and 12/01/2022 through 11/30/2023. The POCs included a physician's order for skilled nursing visits every 30 days and as needed, and personal care services eight hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Also, the POCs included the following: "RN will coordinate client's care with [hospice named] to ensure safety and more effective health outcomes." Continued review of the records showed that the client had a stage II sacral pressure ulcer, and the skilled nurse would document during her monthly visits that wound care was being performed by hospice. Further review of the records failed to show evidence of coordination of services with the Hospice provider as indicated in the POC to ensure safety and continuity of care.		4. Please see H433(1) Response	
	5. On 04/25/23 at 01:31 pm, review of Patient #19's clinical record showed POCs with duration periods of 12/01/2021 through 11/30/2022 and 12/01/2022 through 11/30/2023. The POCs included a physician's order for skilled nursing visits every 30 days and as needed, and personal		5. Please see H433(1) Response	

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H 433	Continued From page 28 care services 12 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily livings (IADLs). Continued review of the records showed a nurse assessment dated 07/06/2022 indicating the following: "Client is on hospice care; [hospice named] is in charge of hospice care." Further review of the records failed to show evidence of coordination of services with the Hospice provider to ensure safety and continuity of care. On 04/28/2023 at 03:30 pm, the DON was made aware of the findings. At the time of the survey, the agency failed to coordinate services with agencies actively involved in providing care for Patients #3, 11, 13, 14, and #19.	H 433		
H 452	3917.2(b) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (b) Coordination of care and referrals; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure that the skilled nurse (SN) coordinated care with the physician's office for four of 20 active patients in the sample (Patients #2, 3, 5, and #14). Findings included: 1.On 4/19/23 at 12:08 pm, review of Patient #2's clinical record showed a plan of care (POC) with a duration period of 9/16/2022 through	H 452		

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H 452	Continued From page 29 05/31/2023, for skilled nurse (SN) visits once every 30 days and as needed to conduct skilled assessments of body systems, personal care aide (PCA) supervision, evaluate co-morbid conditions, and intervene to minimize complications. Also, the patient had orders for personal care services 12 hours x seven days a week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Her diagnoses included heart failure, chronic respiratory failure, anxiety disorder, hypertension, depression, acid reflux, obesity, and migraine. Continued record review showed that the SN visited the patient on 12/17/2022 and documented the following: "Client was discharged from Howard University Hospital on 12/15/2022. The client's husband confirmed that a follow-up appointment was scheduled with client's primary care physician (PCP). Client's husband was instructed to notify PCP and call 911 if there's any change in condition." There was no documented evidence in the clinical record that the SN coordinated care with the physician following the client's hospitalization and overall condition. 2. On 04/19/2023 at 02:29 pm, review of Patient #3's clinical record showed a POC with a duration period of 02/01/2023 through 01/31/2024, for SN visits once every 30 days and as needed to conduct skilled assessments, personal care aide supervision, and evaluation of complications necessitating medical attention. Also, the patient had orders for personal care services 15 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The patient's diagnoses included congestive heart failure (CHF), chronic kidney disease, hypertension, gout, type II diabetes mellitus, glaucoma, history of other venous thrombosis and embolism. Continued	H 452	1.All clinicians shall be in-serviced to coordinate patient care with the PCP post hospitalization, ER visit and any change in condition. If the PCP is not available, leave a message with the PCP's office nurse, ask his/her name, document in your notes and/or on communication note and then inform the office nursing team via email to follow-up with the PCP. This coordination should be done within 72 hours post resumption of care and the clinician should document the subject discussed in their notes. The two field QA nurses responsible for follow up visit post hospitalizations, ER visits and patients with complaints shall verify evidence of care coordination with PCP to ensure effectiveness. The Clinical Director/QA shall review at least 2% of all clinical documentation every quarter to ensure compliance. 2. Please see H452(1)	6/21/23

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H 452	Continued From page 30 record review showed the SN visited the patient on 02/11/2023 and documented the following: "Client was admitted to [hospital named] on 02/03/2023 due to volume overload as a result of CHF exacerbation. Client was treated and discharged home on 02/08/2023." There was no documented evidence in the clinical record that the SN coordinated care with primary provider(s) following the hospitalization and the patient's overall condition. 3. On 04/28/2023 at 10:49 am, review of Patient #5's clinical record showed a POC with a duration period of 01/01/2022 through 12/31/2022, for SN visits once every 30 days and as needed to conduct skilled assessments, personal care aide supervision, and evaluation of complications necessitating medical attention. Also, the patient had orders for personal care services eight hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The patient's diagnoses included cerebral infarction, hypertension, Chronic viral hepatitis C, and schizophrenia. A. Continued record review showed the SN visited the patient on 05/05/2022 and noted the following: "Client was admitted to WHC on 04/27/2022 due to weakness and dizziness. Client was treated and discharged on 05/03/2022." The records lacked evidence that the SN coordinated care with primary provider(s) following the hospitalization and the patient's overall condition. B. Furthermore, the records showed that the SN visited Patient #5 on 06/02/2022 and 06/18/2022 and documented each time the following: "John Doe has been refusing to take his medications	H 452	3A. Please see H452(1)	

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H 452	Continued From page 31 recently... Educated John Doe to take his medications as prescribed and directed. John Doe stated that he does not like to take medications at this time." There was no documented evidence in the clinical record that the SN coordinated care with the providers following Patient #5's continued refusal to take his anti-psychotic medications as prescribed. Please note that the patient was taken to a psychiatric inpatient hospital by the police on 06/24/2022 as he became aggressive and attacked his roommate and staff member. He was later discharged on 09/13/2022 and resumed personal care services with the agency. 4. On 04/26/2023 at 10:16 am, review of Patient #14's clinical record showed a POC with a duration period of 12/20/2021 through 11/30/2022, for SN visits once every 30 days and as needed to conduct skilled assessments, personal care aide supervision, and evaluation of complications necessitating medical attention. Also, the patient had orders for personal care services eight hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The patient's diagnoses included chronic obstructive pulmonary disease, cerebral infarction, stage II pressure ulcer of sacral region, abnormal weight loss, dependence on supplemental oxygen, and severe sepsis with septic shock. Continued record review showed that the SN visited the patient on 06/25/2022 and documented the following: "PRN visit conducted post emergency room (ER) visit following a fall on 6/22/2022... There was no major injury reported. Later, the same day client was taken to the hospital because she was hurting on her hip. Client was discharged home on 6/23/2022 after spending the night in the ER at [a local Hospital]. Scans and x	H 452	3B. All clinicians shall be in-serviced again to coordinate patient care with the PCP following the individualized Plan of Care, non-compliance to medications and services, any change in condition and abnormal vital signs, pain, and blood sugar. If the PCP is not available, leave a message with the PCP's office nurse, ask his/her name, document in your notes and/or communication note in the company's software and then inform the office nursing team via email to follow-up with the PCP. This coordination should be done within 48 hours post the incident and the clinician should document the subject discussed in their notes. The office nursing team reviewing clinical documentation shall verify evidence of care coordination to ensure effectiveness. The Clinical Director/QA shall review at least 2% of all clinical documentation every quarter to ensure effectiveness. 4. Please see H452(1)	6/21/23

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H 452	Continued From page 32 rays were done and no injury or fracture. Client was diagnosed with UTI and prescribed azithromycin, 500mg, one tab daily for five days." There was no documented evidence in the clinical record that the SN coordinated care with primary provider(s) following the hospitalization and the patient's overall condition. On 04/28/2023 at 03:30 pm, the director of nursing (DON) was made aware of the findings. At the time of the survey, the agency failed to ensure that the skilled nurse coordinated care with the physician's office for Patients #2, 3, 5, and #14.	H 452		
H 453	3917.2(c) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (c) Ensuring that patient needs are met in accordance with the plan of care; This Statute is not met as evidenced by: Based on record review and interview, the home care agency (HCA) failed to ensure skilled nursing services were provided in accordance with the patient's plan of care (POC) for eight of 20 active patients sampled (Patients #3, 5, 6, 9, 11, 15, 18, and 19). Findings included: 1. On 04/19/2023 at 02:29 pm, review of Patient #3's clinical record showed plans of care (POCs) with duration periods of 11/14/2022 through	H 453	1. All clinicians shall be in-serviced again to review the orders in each patient's Plan of Care during each home visit to provide care according to the plan of care. Nurses should notify the PCP and then the office nursing team of orders that cannot be implemented via email for recommendations regarding the patient's condition. The office clinicians reviewing clinical documentation shall verify evidence of care intervention and coordination to ensure effectiveness. The Clinical Director/QA shall review at least 2% of all clinical documentation every quarter to ensure effectiveness.	6/21/23

Health Regulation & Licensing Administration

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H 453	Continued From page 33 01/31/2023 and 02/01/2023 through 01/31/2024. The POC included a physician's order for skilled nursing visits every 30 days and as needed, and personal care services 15 hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). Also, the POCs included an order for the skilled nurse (SN) to assess, teach, manage, perform, and evaluate disease management. The patient's diagnoses included congestive heart failure (CHF), chronic kidney disease, hypertension, gout, type II diabetes mellitus, history of other venous thrombosis and embolism, and glaucoma. The nurse was instructed to educate the patient, the aide, and family about daily weights, and to notify the physician of weight increase of two to three pounds in a day or three to five pounds in a week. Continued review of the clinical record showed that the SN assessed the patient's weight of 255 pounds on 11/14/2022 (admission). Further record reviews lacked evidence that the SN assessed the patient's weights during her twice a month consecutive visits from 11/25/2022 through 04/01/2023 except on 12/04/2022 during a recertification assessment. On 04/20/2023 at 4:16pm, the director of nursing (DON) acknowledged the findings. She stated that weight measurement was a challenge as some of the patients could not stand on their feet. She informed the nurses to notify the doctor and ask for other means to check on fluid and amend the plan of care. 2. On 04/28/2023 at 10:49 am, review of Patient #5's clinical record showed a POC with a duration period of 01/01/2022 through 12/31/2022, for SN visits once every 30 days and as needed to conduct skilled assessments, personal care aide	H 453	2.Please see H452(3B)	

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supervision, and evaluation of complications necessitating medical attention. Also, the patient had orders for personal care services eight hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included cerebral infarction, hypertension, Chronic viral hepatitis C, and schizophrenia. Continued review of the record showed that the SN visited Patient #5 on 06/02/2022 and 06/18/2022 and documented each time the following: "John Doe has been refusing to take his medications recently... Educated John Doe to take his medications as prescribed and directed. John Doe stated that he does not like to take medications at this time." There was no documented evidence in the clinical record that the SN coordinated care with primary providers following Patient #5's continued refusal to take anti-psychotic medications as prescribed. The SN failed to ensure that Patient#5's needs were met and in accordance with his POC. Please note that the patient was taken to a psychiatric inpatient hospital by the police on 06/24/2022 as he became aggressive and attacked his roommate and staff member. He was later discharged on 09/13/2022 and resumed personal care services with the agency.

3. On 04/27/2023 at 11.57 am, review of Patient #6's clinical record showed a POC with a duration period of 01/26/2023 through 07/31/2023. A review of the POC showed that the patient's diagnoses included spinal stenosis, cervical region, osteoarthritis, left shoulder, Type II diabetes, hypercholesterolemia, and history of malignant neoplasm of breast. Continued review of the POC showed physician' s orders for the skilled nurse to visit the patient every 30 days and as needed for assessments, patient education,

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H 453	Continued From page 35 and HHA supervision. Also, the patient had orders for home health aide (HHA) services 16 hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). A. On 01/26/2023, the registered nurse (RN) admitted Patient #6 and documented a "healing stage II pressure ulcer on the coccyx." There was no evidence of a wound care order or treatment. On 02/05/2023, the nurse visited the patient and documented "pain: Tailbone" and "Patient has pressure ulcer on her tail bone, incontinent of both bowel and urine. The family educated to buy an A&D ointment and apply on the affected areas every change of briefs and make sure this client stays dry at all times. PCA was educated to reposition this patient every 2 hours. Teaching understanding was verbalized." Interview conducted with the weekend HHA #22 on 04/27/2023 at 12:34 pm indicated that the patient was in distress every weekend she worked due to pain, and her wound was getting worse. She communicated continuously with the patient's daughter. She added that the patient would ask to be repositioned for comfort. She confirmed that the skilled nurse visited on 02/05/2023 around 06:00 pm for supervisory visit but "did not see the wound because Patient was sleeping." Review of weekday HHA #23's documentation on 02/06/2023, 02/07/2023, and 02/08/2023 showed that the client was confused and in pain. She documented each time that she had notified the nurse. Interview with HHA #23 on 04/27/2023 at 01:17 pm revealed that the wound was getting worse, opened, and had an odor. She stated that the patient was crying intermittently for pain. She would notify the daughter who would medicate	H 453		

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the mother with Codeine, and that would help for "few hours." She added she once called the nurse "five times" and was instructed to call 911 on 02/08/2023.

Interview with the patient's daughter on 04/27/2023 at 01:22 pm, revealed that Patient #6 was admitted on 02/08/2023 to an intensive care unit for sepsis, pneumonia, and urinary tract infection. She indicated that her mother was on a feeding tube, had a colostomy bag, and two surgical procedures for the wound as it was so deep." She concluded that the patient was doing better and in a rehabilitation facility where she would most likely stay for long term care.

On 04/27/2023 at 03:52 pm, the agency Director of Nursing was made aware. She stated that the nurse should have called the doctor when she discovered the wound and get either a referral for skilled services or wound care orders.

B. The patient was prescribed Metformin 500 mg oral twice a day for Diabetes. The POC showed an order for the SN to assess, teach, manage, evaluate, perform patient/caregiver use of electronic glucose measuring device, signs, and symptoms of hypo/hyperglycemia, and to notify the physician of blood glucose greater than 250 mg/dl or less than 60 mg/dl. On 01/26/2023, the SN documented on the admission assessment "her glucometer had a malfunction, she will be seeing her primary physician the next day and will get a new order for a glucometer." On 01/30/2023, the SN visited the patient and failed to assess Patient #6's blood sugar or follow up regarding the order for a new glucometer. Instead, she noted the following: "blood sugar reading: Not applicable. Type II diabetes mellitus managed at home with medications and diet."

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On 04/28/2023 at 09: 25 am, the DON was informed. She stated that she had spoken with the nurse, who indicated it was an error to document not applicable and she had spoken with the daughter about ordering the glucometer etc. She acknowledged her lack of documentation.
The registered nurse failed to ensure that Patient #6's needs were met and in accordance with the requirements of skilled nursing services.

4. On 04/20/2023 at 1:28 pm, review of Patient #9's clinical record showed plans of care (POCs) with duration periods of 01/18/2023 through 03/18/2023 and 03/19/2023 through 05/17/2023, for skilled nursing services two to three times a week for wound care and monthly for personal care aide (PCA) supervision; and personal care services 14 hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included stage three sacral pressure ulcer, right great toe wound and suprapubic wound, obstructive and reflux uropathy, type II diabetes mellitus, protein-calorie malnutrition, hypertension, malignant neoplasm of prostate, hyperlipidemia, and hyperkalemia. Continued review of the records lacked evidence that skilled nursing services were provided as ordered the week of 03/05/2023, 03/26/2023, and the week of 04/10/2023.

On 04/25/2023 at 11:06 am, a scheduled home visit was conducted to Patient #9's home. The concerns below were identified:

1. Stage III sacral pressure ulcer was treated two to three times a week between the licensed practical nurse and the supervisory registered nurse. However, the wound dressing

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H 453	Continued From page 38 was not staying in place. According to the aide, the patient was having regular bowel movements and each time the dressing would be soiled. The aide reported that she would clean the patient's sacral wound with wound cleanser and cover it with gauze. In addition, the record reviewed lacked evidence of wound improvement and /or modification of wound care treatment. The wound characteristics were unchanged from January 2023. There was no evidence of wound consultation post hospitalization. 2. Functional mobility was a concern. Patient #9 was confined to his second-floor bedroom and was bed bound. He was non-compliant with the aide's attempts of turning and repositioning. He expressed his preference to stay in bed, laying down on his back despite the sacral wound. Per aide, he did not like the positional wedge and would remove it when applied. Also, there was a mechanical lift in the room that was not being used. The patient received physical therapy twice a week for therapeutic and range of motion exercises. Occupational therapy was ordered but not being provided. 3. Type II diabetes management was not consistent with physician orders. The patient's blood sugar was not checked three times a day as ordered. Patient #9's daughter came to his home twice a week to perform blood glucose levels and administer Insulin based on the established parameters. The nurses would check the patient's blood glucose once during their visits; however, glucose levels and insulin was assessed/administered inconsistently and not in accordance with physician orders. 4. Nutrition was not consistent with the ordered "diabetic diet." Patient #9 and the aide on duty	H 453	1. Please see H277(2) Response 2. Please see H277(3) Response 3. Please see H277(4) Response	

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H 453	Continued From page 39 reported a poor nutritional intake. During the home visit, the patient was observed eating a glazed donut. There were additional donuts observed in the kitchen and different types of sausages in the refrigerator as well as Ensure drinks, which the aide reported he liked drinking once a day. The patient reported that he did not like the home health aide's manner of cooking. He enjoyed eating mashed potatoes. The observation of available foods was inconsistent with the prescribed "diabetic diet." 5. Patient #9 was lacking the oversight of a physician as he was confined on the second floor of his home and required an ambulance for transportation. He attempted to follow up with his primary physician on 03/16/2023 and was rerouted to the emergency room for shortness of breath. He was discharged on 03/18/2023 and reported that he had not been able to follow up with the doctor due to lack of transport. The care plan lacked evidence of means of transport for routine medical appointments. On 04/26/2023 at 12:40 pm, the administrator, DON, and physical therapist were interviewed and made aware of the findings. The DON and admission nurse indicated that the patient's daughter had stated at admission that she was living with the patient and would be checking his blood sugar and managing his diabetes. It was a month later that the nurse "found out that she was not living in the house." The agency team failed to ensure that Patient #9's needs were being met and in accordance with the requirements of skilled nursing services, physical and occupational therapy services. As a result of the concerns outlined by the Department of Health survey team, the agency	H 453	5.Please see H277(5) Response	

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H 453	Continued From page 40 initiated an interdisciplinary care conference that was held on 04/27/2023 with the agency leadership team, case manager and daughter to implement measures to ensure that the needs of Patient #9 are met. A level of care reassessment and follow-up meeting was planned and forthcoming. 5. On 04/26/2023 at 11:56 am, review of Patient #11's clinical record showed a POC with a duration period of 02/01/2022 through 01/31/2023, for skilled nursing services every 30 days and as needed for assessments, patient education, and PCA supervision. Also, the patient had orders for home health aide (HHA) services ten (10) hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included convulsions, acute on chronic combined systolic and diastolic heart failure, type II diabetes mellitus, stage IV chronic kidney disease, peripheral vascular disease, hyperlipidemia, muscle weakness, anemia, gastro-esophageal reflux disease, ischemic cardiomyopathy, and unsteady gait. Continued review of the clinical record showed that the patient was hospitalized on 07/22/2022 and discharged on 08/20/2022 with dialysis on Mondays, Wednesdays, and Fridays. On 08/25/2022, a communication note stated the following: "The client was discharged from the Rehabilitation Center of Capital City on 8/20/2022 during the day. The nurse has been notified to do a resumption of care (ROC) assessment, evaluation, education and teaching to the client and aide. The client is home, stable and safe in the community. PCA services are ongoing." Further review of the record showed the skilled nurse performed the resumption of care (ROC) assessment on 09/13/2022 while the aides	H 453		

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resumed the personal care services on 08/24/2022, greater than 2 weeks earlier.

Interview with the DON on 04/26/2023 at 2:38 pm revealed that the nurse would be notified to do a ROC assessment within 48 hours once the agency received a notice that client was being discharged from the hospital.

6. On 4/28/23 at 09: 32 am, review of Patient #15's clinical record showed a POC with a duration period of 09/01/2022 through 08/31/2023. The POC included a physician's order for skilled nursing visits every 30 days and as needed, and personal care services eight (8) hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily livings (IADL). The patient's diagnoses included abnormalities of gait and mobility, type II diabetes mellitus, glaucoma, hypertension, sarcoidosis of lung, alcohol abuse with intoxication, hyperlipidemia, and hyperparathyroidism. Continued review of the clinical record showed that Patient #15 was prescribed Lantus Insulin 100 units/ml subcutaneous 20 units daily and Metformin 100 mg oral, one tablet twice a day. In addition, the POC included an order for the skilled nurse (SN) to report blood sugar results that differed from established parameters: "Assess, teach, manage, evaluate, perform patient/caregiver use of electronic glucose measuring device frequency daily. Notify physician of blood sugar greater than 250 mg/dl or less than 60mg/dl." Continued review of the records showed that the SN visited the patient on 03/02/2023, 03/16/2023, and 04/06/2023 and documented on each visit the following: "Blood Sugar Glucometer: DIDN'T CHECK." Endocrine: Client stated that she checks her blood sugar daily." The skilled nurse

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H 453	Continued From page 42 failed to ensure Patient #15's needs were met and in accordance with the POC. 7. On 04/24/2023 at 3:49 pm, review of Patient #18's record showed a POC with a duration period of 10/11/2022 through 10/31/2023. The POC included a physician's order for skilled nursing services once monthly to perform multi systems assessment, vital signs, patient instruction, and PCA supervision. Also, the POC included an order for personal care services eight hours per day, seven days a week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included type II diabetes mellitus with diabetic neuropathy, chronic kidney disease, absence of right foot, absence of right thumb, hypertension, syncope, and collapse. Also, the nurse was required to "assess, teach, manage, evaluate, perform patient/caregiver use of electronic glucose measuring device frequency daily and to notify physician of blood sugar greater than 250 mg/dl or less than 60mg/dl." Further review of Patient #18's clinical record showed the SN visited the patient on 03/07/2023, 03/18/2023, and 04/07/2023 and documented each time the following: "Blood sugar: declined. Client stated that he checks his blood sugar and blood pressure daily. Educated to report to his primary care physician if his blood sugars are consistently greater than 250 mg/dl or less than 60 mg/dl." There was no documented evidence that the nurse informed the physician of the changes in the patient's condition. Please note Patient #18 was prescribed sliding scale insulin. There was no indication why the client declined nor was there education provided on the risks associated with taking the diabetic medications and not checking the blood sugar levels. The skilled nurse failed to ensure Patient #18's needs were	H 453	7.All clinicians shall be in-serviced again to check patient blood sugar if the visit is conducted before meals. If the visit is after meals, they should check the documented results on the glucometer screen and the composition book where the PCA and client/representative are documenting the daily fasting results. If the patient does not have a book to document the blood sugar results, collect one from the office and instruct patient, PCA and family to document the daily blood sugar and other vital signs for the nurse to review during visits and to take to the PCP during medical appointments. If a patient refuses blood sugar monitoring or any other service from the agency, the nurse should educate the patient and family on the risk associated with the failure to monitor sugar levels or receiving the service. Find out if the non prick glucometer might be helpful and notify the PCP and office nursing team of non-compliance. The office nursing team shall verify evidence of blood sugar monitoring and results for diabetic patients during note review and care coordination for non- compliance. The Clinical Manager/QA shall review at least 2% of all clinical documentation every quarter to ensure effectiveness	6/21/23

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H 453	Continued From page 43 met and in accordance with the POC. 8. On 04/25/23 at 01:31 pm, review of Patient #19's clinical record showed plans of care (POCs) with duration periods of 12/01/2021 through 11/30/2022 and 12/01/2022 through 11/30/2023. The POCs included a physician's order for skilled nursing visits every 30 days and as needed, and personal care services 12 hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily living (IADL). The patient's diagnoses included CHF, chronic obstructive pulmonary disease, chronic kidney disease, Type II diabetes mellitus with hyperglycemia, hypertension, obesity, generalized edema, and shortness of breath. Also, the nurse was required to "assess, teach, manage, evaluate, perform patient/caregiver use of electronic glucose measuring device frequency daily and to notify physician of blood sugar greater than 250 mg/dl or less than 60mg/dl." Further review of Patient #19's clinical record showed the SN visited the patient on 03/01/2023, 03/11/2023, 03/20/2023, 04/01/2023, 04/10/2023, and 04/19/2023 and documented each time the following: "Blood sugar: declined." There was no evidence of physician notification when the patient started "declining" the blood sugar assessments while prescribed multiple insulin regimens for diabetic management. There was no indication why the client declined nor was there education provided on the risks associated with taking the diabetic medications and not checking the blood sugar levels. The skilled nurse failed to ensure Patient #19's needs were met and in accordance with the plan of care. At the time of the survey, the home care agency failed to ensure that skilled nursing services were	H 453	8. Please see H453(7) response	

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H 453	Continued From page 44 provided in accordance with patient's plans of care for Patients #3, 5, 6, 9, 10, 11, 15, 18, and 19.	H 453		
H 458	3917.2(h) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (h) Reporting changes in the patient's condition to the patient's physician; This Statute is not met as evidenced by: Based on record review and interview, the skilled nurse (SN) failed to report changes in the patient's condition to the physician for three of 20 active patients in the sample (Patients #5, 6, 18, and #19). Findings Included: 1. On 04/28/2023 at 10:49 am, review of Patient #5's clinical record showed a POC with a duration period of 01/01/2022 through 12/31/2022, for SN visits once every 30 days and as needed to conduct skilled assessments, personal care aide (PCA) supervision, and evaluation of complications necessitating medical attention. Also, the patient had orders for personal care services eight hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The patient's diagnoses included cerebral infarction, hypertension, Chronic viral Hepatitis C, and schizophrenia. Continued review of the home health aides' (HHA's) documentation from 06/01/2022 to 06/23/2022 showed that the	H 458	1.Patients are currently in compliance with his medication per the management of the Group Home. All clinicians shall be in-serviced again to notify the PCP by phone and the office nursing team via email of any abnormal findings on their patients within 24 hours and/or call 911 if it is an emergency. The office nursing team shall verify evidence of care coordination with PCP and office nurses during monthly documentation review. The Clinical Manager/QA shall review at least 2% of all clinical documentation every quarter to ensure effectiveness	6/21/23

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H 458	Continued From page 45 supervisory nurse was notified that the patient had been aggressive and refused to take his medications. The nurse visited the patient on 06/01/2022 and 06/18/2022 and documented each time the following: "John Doe has been refusing to take his medications recently. No changes in medications or medical conditions reported. Educated John Doe to take his medications as prescribed and directed. John Doe stated that he does not like to take medications at this time." There was no documented evidence that the nurse informed the physician of the changes in the patient' s condition. Please note among the prescribed medications, Patient #5 was on Olanzapine 7.5 mg one tablet twice a day for Schizophrenia. On 06/23/2022, the records showed a note from the staffing coordinator indicating the following "The client had attacked a staff member and his roommate at the housing facility. The police was called, and the client was taken to a psychiatric hospital." 2.On 04/27/2023 at 11:57 am, review of Patient #6's clinical record showed a POC with a duration period of 01/26/2023 through 07/31/2023. A review of the POC showed that the patient's diagnoses included spinal stenosis, cervical region, osteoarthritis, left shoulder, Type II diabetes, hypercholesterolemia, and history of malignant neoplasm of breast. Continued review of the POC showed physician's orders for the skilled nurse to visit the patient every 30 days and as needed for assessments, patient education, and PCA supervision. Also, the patient had orders for PCA services 16 hours a day, seven days per week to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADL). On 01/26/2023, the registered nurse (RN) admitted Patient #6 and documented a "healing	H 458		

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Continued From page 46

stage II pressure ulcer on the coccyx." There was no evidence of a wound care order or treatment. On 02/05/2023, the nurse visited the patient and documented "pain: Tailbone" and "Patient has pressure ulcer on her tail bone, incontinent of both bowel and urine. Family educated to buy an A&D ointment and apply on the affected areas every change of briefs and make sure this client stays dry at all times. PCA was educated to reposition this patient every 2 hours. Teaching understanding was verbalized."

Interview with the weekend HHA #22 on 04/27/2023 at 12:34 pm indicated that the patient was in distress every weekend that she worked due to pain, and her wound was getting worse. She communicated continuously with the patient's daughter. She added that patient would ask to be repositioned for comfort. She confirmed that the skilled nurse visited on 02/05/2023 around 06:00 pm for supervisory visit but "did not see the wound because patient was sleeping." Review of weekday HHA #23's documentation on 02/06/2023, 02/07/2023, and 02/08/2023 showed that the client was confused and in pain. She documented each time that she had notified the nurse. Interview with HHA #23 on 04/27/2023 at 01:17 pm revealed that the wound was getting worse, opened, and had an odor. She stated that patient was crying intermittently for pain. She would notify the daughter who would medicate the mother with Codeine, and that would help for "few hours." She added she once called the nurse "five times" and was instructed to call 911 on 02/08/2023.

Interview with the patient's daughter on 04/27/2023 at 01:22 pm, revealed that Patient was admitted on 02/08/2023 in intensive care unit for sepsis, pneumonia, and urinary tract infection.

Health Regulation & Licensing Administration

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She indicated that the mother was on a feeding tube, had a colostomy bag, and two surgical procedures for the wound as it was so deep." She concluded that the patient was doing better and in a rehabilitation facility where she would most likely stay for long term care.

On 04/27/2023 at 03:52 pm, the DON was made aware. She indicated that the nurse should have called the doctor when she discovered the wound and get either a referral for skilled services or wound care orders.

3. On 04/25/23 at 01:31 pm, review of Patient #19's clinical record showed POCs with duration periods of 12/01/2021 through 11/30/2022 and 12/01/2022 through 11/30/2023. The POCs included a physician's order for skilled nursing visits every 30 days and as needed, and PCA services 12 hours a day, seven days per week to assist with activities of daily living (ADL) and instrumental activities of daily livings (IADL). The patient's diagnoses included congestive heart failure (CHF), chronic obstructive pulmonary disease, chronic kidney disease, Type II diabetes mellitus with hyperglycemia, hypertension, obesity, generalized edema, and shortness of breath. Also, the nurse was required to "assess, teach, manage, evaluate, perform patient/caregiver use of electronic glucose measuring device frequency daily and to notify physician of blood sugar greater than 250 mg/dl or less than 60mg/dl." Further review of Patient #19's clinical record showed the SN visited the patient on 03/01/2023, 03/11/2023, 03/20/2023, 04/01/2023, 04/10/2023, and 04/19/2023 and documented each time the following: "Blood sugar: declined." There was no evidence of a physician notification when the patient started "declining" the blood sugar assessments while

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H 458	Continued From page 48 being prescribed Levemir Insulin 100 units/ml 24 units subcutaneous at bedtime, Novolog Insulin 100 units/ml subcutaneous 10 units three times a day, and Lispro Insulin 100 units/ml 10 units three times a day subcutaneous. On 04/28/2023 at 09: 25 am, the director of nursing was made aware of the findings. At the time of survey, the home care agency's nurses failed to report changes in the patients' condition to the physician for Patients #5, 6, 18, and #19.	H 458		
H 459	3917.2(i) SKILLED NURSING SERVICES Duties of the nurse shall include, at a minimum, the following: (i) Patient instruction, and evalutaion of patient instruction; and This Statute is not met as evidenced by: Based on record review and interview, the skilled nurse failed to document what instructions were given to the patient and what was understood in one of 20 active Patients sampled (Patient #6). Findings included: On 04/27/2023 at 11:57 am, review of Patient #6's clinical record showed a plan of care (POC) with a duration period of 01/26/2023 through 07/31/2023. A review of the POC showed that the patient's diagnoses included spinal stenosis, cervical region, osteoarthritis, left shoulder, Type	H 459	All clinicians shall be in-serviced again to instruct patient/caregiver and PCA on the needs of the patient and evaluate their understanding of instructions every visit. The office nursing team shall verify evidence of patient education and evaluation during monthly documentation review and withhold payment for any notes without patient education and evaluation until it is corrected. The Clinical Manager/QA shall review at least 2% of all clinical documentation every quarter to ensure effectiveness	6/21/23

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II diabetes, hypercholesterolemia, and history of malignant neoplasm of breast. Continued review of the POC showed physician's orders for the skilled nurse to visit the patient every 30 days and as needed for assessments, patient education, and personal care aide (PCA) supervision. Also, the skilled nurse was to assess, teach, manage, evaluate, and perform interventions to monitor and mitigate pain. The patient was prescribed Tylenol-Codeine 300mg-30mg twice a day for pain.

On 04/27/2023 at 12:34 pm, interview with HHA #22 revealed that she was concerned with the patient's sacral wound, and she was crying intermittently with pain. She would notify the daughter, who would give her pain medication. She added, that the "crying would start again after four hours on 02/04/2023 and 02/05/2023."

Also, HHA #23 confirmed on 04/27/2023 at 01: 17 pm, that the above statement with patient intermittently crying with pain. She stated that the patient's wound had an odor and was looking worse the week of 02/05/2023. She stated she always informed the nurse and the client's daughter of her findings. Further review of the records showed that the SN visited the patient on 02/05/2023 and documented the following "Pain Profile: Primary Site: TAIL BONE."

Continued review of the nurse's note lacked evidence of patient education, evaluation of instruction, and/or interventions to "mitigate the pain" according to the plan of care (POC).

On 04/28/2023 at 09: 25 am, the DON was made aware.

At the time of the survey, the agency failed to

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H 459	Continued From page 50 provide documented evidence that the registered nurse (RN) provided patient instruction and evaluation of instruction for Patient #6.	H 459		
H 550	3922.1 OCCUPATIONAL THERAPY SERVICES If a home care agency provides occupational therapy services, it shall provide those services in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the home care agency (HCA) failed to ensure occupational therapy (OT) services were provided in accordance with the patient's plan of care (POC) for three of 20 active patients in the sample (Patients #7, 9, and #11). Findings included: 1. On 04/28/2023 at 12:21 pm, review of Patient #7's clinical record showed a plan of care (POC) with a duration period of 03/09/2023 through 01/31/2024, for occupational therapy (OT) visits one to two times a week for four weeks to evaluate for OT services and establish a plan of treatment, rehabilitation goals, and home environment for accessibility and safety. The patient's diagnoses included muscular dystrophies, chronic obstructive pulmonary disease, protein-calorie malnutrition, benign prostatic hyperplasia, abnormalities of gait and mobility, pain, and dysphagia. Further review of the records lacked evidence that OT services were provided during the week of April 16, 2023. 2. On 04/20/2023 at 1:28 pm, review of Patient #9's clinical record showed plans of care (POCs)	H 550	Physician orders shall be generated to correct the frequency of care. Occupational Therapist orders are always stated as "evaluate and treat" because Therapists determines the frequency of their visits after their first assessment and not the nurse who did the initial assessment. Admitting clinicians and the office nursing team shall be in-serviced not to indicate the Occupational Therapist frequency on the POC. The Occupational Therapist shall be re-educated to assess all patients assigned to them and if the patient does not need their services, they should coordinate care with the PCP and the office Nursing team, document their assessment decision and complete an Occupational Therapist discharge. For any services not provided after the frequency of the visits has been determined, the Occupational Therapist shall complete a missed visit form to justify the absence of care. The office nursing team shall review all current skilled charts with Occupational Therapy orders to ensure that services are provided according to the plan of care. The office nursing team shall review Occupational Therapy orders and notes every pay period to ensure compliance. The Clinical Manager/QA and the Administrator shall review 100% of skilled charts every month to ensure effectiveness.	6/21/23

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H 550	Continued From page 51 with duration periods of 01/18/2023 through 03/18/2023 and 03/19/2023 through 05/17/2023, for OT visits one to two times a week for eight weeks to evaluate for OT services and establish a plan of treatment, rehabilitation goals, and home environment for accessibility and safety. The patient's diagnoses included stage three sacral pressure ulcer, right great toe wound and suprapubic wound, obstructive and reflux uropathy, type II diabetes mellitus, protein-calorie malnutrition, hypertension, malignant neoplasm of prostate, hyperlipidemia, and hyperkalemia. Further review of the records showed that the OT evaluated the patient on 02/07/2023 when the referral date was 01/18/2023. In addition, there were no OT services provided following the evaluation, when the latter indicated the plan for OT services included one to two sessions per week for 60 days. On 04/24/2023 at 12:05 pm, follow up with the assistant director of nursing (ADON) revealed that the OT indicated that Patient #9 did not need additional OT visits." The OT evaluation and a home visit to the client failed to support that OT visits were not needed. Furthermore, Patient #9 was hospitalized from 03/16/2023 to 03/18/2023 for shortness of breath. The resumption of care orders dated on 03/19/2023 included physical therapy (PT) and Occupational therapy (OT) evaluations and treatments one to two times a week for 60 days. There was no evidence that OT evaluated the patient at the time of survey. 3. On 04/26/2023 at 11:56 am, review of Patient #11's clinical record showed a POC with a duration period of 05/03/2022 through	H 550	Intake, admitting clinicians and the office nursing team shall be in-serviced to review all referrals thoroughly to ensure that only services ordered are included in the Plan of Care and ensure that all disciplines assess patients within 48 hours from the date of the referral from the office nursing team. If the patient does not need the services of each discipline, that discipline's clinician should coordinate care with the PCP and the office Nursing team, document their assessment decision and complete a discharge assessment.. The office nursing team shall review all current skilled charts with Occupational Therapy and other discipline's orders to ensure that services are provided according to the referral and plan of care. The Clinical Manager/QA and the Administrator shall review 100% of skilled charts every month to ensure effectiveness	6/21/23

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H 550	Continued From page 52 07/01/2022, for physical therapy (PT) one to two times a week for 60 days and OT to evaluate and treat for activities of daily livings (ADL) and self-care deficit. The patient's diagnoses included convulsions, acute on chronic combined systolic and diastolic heart failure, type II diabetes mellitus, stage IV chronic kidney disease, peripheral vascular disease, hyperlipidemia, muscle weakness, anemia, gastro-esophageal reflux disease, ischemic cardiomyopathy, and unsteady gait. Continued review of the clinical record lacked evidence that OT evaluated the patient or indicated the reason for the delay. The ADON was interviewed on 04/26/2023 at 03:46 pm regarding the lack of a OT evaluation. He indicated that the OT order was a mistake from the registered nurse (RN) that created the care plan. It was meant for PT only. On 04/28/2023 at 03:30 pm, the DON was made aware of the findings. At the time of the survey, the home care agency failed to provide documented evidence that the occupational therapist provided services in accordance with the plans of care for Patients #7, 9, and #11.	H 550		
H 560	3923.1 PHYSICAL THERAPY SERVICES If physical therapy services are provided, they shall be provided in accordance with the patient's plan of care. This Statute is not met as evidenced by: Based on interview and record review, the home care agency (HCA) failed to ensure physical	H 560		

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H 560	Continued From page 53 therapy (PT) services were provided in accordance with the patient's plan of care (POC) for three of 20 active patients in the sample (Patients #7, 9, and #11). Findings included: 1. On 04/28/2023 at 12:21 pm, review of Patient #7's clinical record showed a plan of care (POC) with a duration period of 03/09/2023 through 01/31/2024, for PT services one to two times a week for seven weeks for strengthening exercises, transfers, balance, stability, endurance, energy conservation, and gait training on level surface. The patient's diagnoses included muscular dystrophies, chronic obstructive pulmonary disease, protein-calorie malnutrition, benign prostatic hyperplasia, abnormalities of gait and mobility, pain, and dysphagia. In addition, the POC included an order for the physical therapist to report vital signs that differed from established parameters: "Notify physician of temperature ranges greater than 99.5 or less than 96.5, systolic blood pressure greater than 150 or less than 90, diastolic blood pressure greater than 90 or less than 60, pulse greater than 100 or less than 60, and respirations greater than 24 or less than 12." Further review of the clinical record showed that the PT visited Patient #7 twice a week from 03/15/2023 through 04/16/2023 with no evidence of assessing the patient's temperature as ordered to determine whether interventions were indicated. 2. On 04/20/2023 at 1:28 pm, review of Patient #9's clinical record showed plans of care (POCs) with duration periods of 01/18/2023 through 03/18/2023 and 03/19/2023 through 05/17/2023, for PT services two to three times a week for eight weeks. The patient's diagnoses included	H 560	The office nursing team shall review all current skilled charts with Physical Therapy orders to ensure that vital signs, pain and blood sugar if applicable are assessed every visit and the Physical Therapist provided interventions on abnormal findings. The Physical Therapist shall be re-educated to assess vital signs, pain and blood sugar if applicable every visit and provide interventions and care coordination if applicable with PCP and Office nursing team. The Assistant Clinical Manager responsible for skilled charts shall be in-serviced to review 100% of Physical Therapy records to ensure effectiveness. The Clinical Manager/QA and the Administrator shall review 100% of skilled charts every month to ensure effectiveness.	6/21/23

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H 560	Continued From page 54 stage three sacral pressure ulcer, right great toe wound and suprapubic wound, obstructive and reflux uropathy, type II diabetes mellitus, protein-calorie malnutrition, hypertension, malignant neoplasm of prostate, hyperlipidemia, and hyperkalemia. The patient was ordered sliding scale Humulin Insulin. In addition, the POC included an order for the physical therapist to report blood sugar results that differed from established parameters: "Assess, teach, manage, evaluate, perform patient/caregiver use of electronic glucose measuring device frequency daily. Notify physician of blood sugar greater than 250 mg/dl or less than 60mg/dl." Further review of the records showed that the PT visited Patient #9 twice a week from 01/31/2023 through 04/19/2023 with no evidence of assessing the patient's blood sugar as ordered to determine whether interventions were indicated. On 04/26/2023 at 12:40 pm, the physical therapist was interviewed in the presence of the administrator and the director of nursing (DON). He indicated that checking blood sugar (BS) was not part of his scope of practice, and it was the responsibility of the skilled nurse. He added that the only time he would check the BS was if the patient refused therapy because of feeling weak. 3. On 04/26/2023 at 11:56 am, review of Patient #11's clinical record showed a POC with a duration period of 05/03/2022 through 07/01/2022, for PT one to two times a week for 60 days and OT to evaluate and treat for activities of daily living (ADL) and self-care deficit. The patient's diagnoses included convulsions, acute on chronic combined systolic and diastolic heart failure, type II diabetes mellitus, stage IV chronic kidney disease, peripheral vascular disease, hyperlipidemia, muscle weakness, anemia, gastro-esophageal reflux disease, ischemic	H 560		

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H 560	Continued From page 55 cardiomyopathy, and unsteady gait. In addition, the POC included an order for the physical therapist to report vital signs that differed from established parameters: "Notify physician of temperature ranges greater than 99.5 or less than 96.5, systolic blood pressure greater than 150 or less than 90, diastolic blood pressure greater than 90 or less than 60, pulse greater than 100 or less than 60, and respirations greater than 24 or less than 12, blood sugar greater than 250 or less than 60 mg/dl." Further review of the clinical record showed that the PT visited Patient #11 twice a week from 05/11/2022 through 06/20/2022 with no evidence of assessing the patient's temperature and blood sugar as ordered to determine whether interventions were indicated. On 04/26/2023 at 12:40 pm, the Administrator and DON were made aware of the findings. At the time of the survey, the home care agency failed to ensure that physical therapy services were provided in accordance with the plans of care for Patients #7, 9, and #11.	H 560		