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PROFESSIONAL HEALTHCARE RESOURCES	501 SCHOOL STREET, SW SUITE 200 WASHINGTON, DC 20024

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H 000	INITIAL COMMENTS An annual licensure survey was conducted on 08/21/2023, 08/22/2023, 08/23/2023, and 08/24/2023 to determine compliance with Title 22 B DCMR, Chapter 39 (Home Care Agency Regulations). The Home Care Agency provided home care services to 98 patients and employed 87 staff. The findings of the survey were based on the review of administrative records, nine active patient records, three discharged patient records, 12 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 three home visits. Listed below are abbreviations used throughout this report: ADL - Activities of Daily Living 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 PT - Physical Therapist RN - Registered Nurse SN - Skilled Nurse	H 000		

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H 000	Continued From page 1 SOC - Start of Care	H 000		
H 054	3903.2(c)(2) GOVERNING BODY The governing body shall do the following: (c) Review and evaluate, on an annual basis, all policies governing the operation of the agency to determine the extent to which services promote patient care that is appropriate, adequate, effective and efficient. This review and evaluation must include the following: (2) The evaluation shall include a review of all complaints made or referred to the agency, including the nature of each complaint and the agency's response thereto. This Statute is not met as evidenced by: Based on record review and interview, the Governing Body failed to evaluate and review complaints made or referred to the agency, including the nature of each complaint and the agency's response. Findings included: Review of the agency's complaint log on 08/21/2023 at 12:01 PM showed the nature and response of complaints recorded for seven complaints from 09/2022 through 06/2023, however, there was no evidence that the Governing Body evaluated or reviewed the seven documented complaints. Review of the agency's Governing Body's minutes on 08/23/2023 at 11:30 AM showed that several meetings were held between 09/2022 through 08/2023. Further	H 054	**What corrective action(s) will be accomplished to address the identified deficient practice?** Director of QA and Education will instruct the Branch Quality Assurance Process Improvement team to ensure that during their monthly review of the data from the Complaint Log that details of the complaints as far as what happened, how was it investigated, how was it resolved and whether the appropriate people such as the PCP and the patient and/or family members were notified of how the complaint was resolved. Director of QA and Education and Clinical Manager will review the process with the staff and will ensure that the process of handling complaints is done on all the complaints. The Branch Quality Assurance Process Improvement team will collate all these complaints documentation on a quarterly basis for submission to the VP of Clinical Operations, Regulatory and Compliance for review prior to submitting the report to the Board of Directors. BOD will review on a quarterly basis the Complaint Reports submitted by the branch Quality Assurance Process Improvement team. The BOD will ensure that the process identified on handling complaints are followed and that resolutions were completed including proper notification and documentation of the handling of complaints were properly executed. BOD provides feedback to the branch Quality Assurance Process Improvement on any further action to be taken to prevent recurrence of the complaint. **What measures will be put in place or what systemic changes you will make to ensure the deficient practice does not recur:** The VP of Clinical Operations and Regulatory and Compliance and the Director of Quality Assurance Process Improvement and Education will review with the Clinical Manager all complaints filed on a monthly basis as well as at the end of the quarter prior to submitting Quality Assurance Process Improvement reports to the BOD to ensure 100% of all complaints were handled, processed and resolved according to the procedure. **How the corrective action will be monitored to ensure the deficient practice will not recur, i.e. quality assurance program will be implemented.**	10/31/23 10/31/23 and on-going 10/31/23

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H 054	Continued From page 2 review of the minutes revealed that an acknowledgement of the complaints was presented; however, the minutes failed to include the nature of each complaint referred to the agency and the agency's evaluation and review. During an exit interview on 08/24/2023 at 1:31 PM, the agency leadership staff verified that the number of complaints were compiled and included in the Governing Body minutes, but the nature and resolution were not included.	H 054	The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will review 100% all complaints received by the branch to ensure that the process is being followed. This review will be done for at least 3 quarters threshold set at 100% and if threshold is not met, the Clinical Manager will be retrained and will be reminded each time the Director of QA and Education determines that the complaint process is not being followed 100%. Findings both positive and corrective will be discussed at the Branch Quality Assurance Process Improvement monthly meetings so that recurrence of non-compliance will be identified and corrected.	10/31/23 and on-going for at least 3 quarters Random audits will continue quarterly to ensure compliance is sustained.
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 care agency (HCA) failed to maintain accurate personnel records to include employee's participation in orientation for one of two registered nurses included in the sample (RN #2). Findings included: A review of personnel records on 08/21/2023 at 2:11 PM, revealed the following: The agency's registered nurse ' s (RN #2 ' s) personnel file included date of hire of 09/26/ 2022. It should be noted that although there was	H 147	**What corrective actions will be accomplished to address the identified deficient practice?** The Director of HR and the Director of QA and Clinical Education will meet with recruiters to discuss/review the on-boarding process and the required orientation program. The Recruiters will be re-educated in the process and the importance of ensuring that new employees are given orientation prior to starting work in the company. The orientation checklist must be completed and are filed in the personnel files of the employees. The recruiters will be required to ensure and provide documentation that the new employees beginning October 1, 2023, will undergo orientation prior to start of work. The HR Director will review all orientation checklist beginning October 1, 2023, to ensure new employees were given orientation prior to start of work. **What measures will be put in place or what systemic changes you will make to ensure deficient practice does not recur?** The recruiters will ensure that the orientation checklists for all new employees are completed 100% of the time and filed in their personnel files. The HR Director or designee (Infinit-O HR team) will conduct a monthly audit using the worker productivity report to ensure all new hired employees were given orientation and the orientation were properly recorded in their orientation checklist and filed in the employee personnel files.	10/31/23 10/31/23 and on-going

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H 147	Continued From page 3 no documented evidence that the employee participated in the home care agency's orientation, he has been providing patient services for 11 months. During an interview with the office manager on 08/21/2023 at 3:24 PM, revealed that she was a new employee hired on 03/17/2023. Due to her hire date, the office manager stated she had no knowledge why RN #2 had not participated in the agency ' s orientation. At the time of the survey, the home care agency failed to ensure that RN #2 participated in orientation proximal to hire and prior to her providing services.	H 147	**How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The Director of QA and Clinical Education in collaboration with the Director of HR will meet quarterly to review the audit results presented by the Infinit-o HR team. The review will be done for at least 3 quarters. The Threshold is set for 100% and if the threshold is not met, the Director of HR will counsel the recruiters and remind them of the goal of 100% compliance.	10/31/23 and on-going 10/31/23 and on-going
H 151	3907.2(g) PERSONNEL Each home care agency shall maintain accurate personnel records, which shall include the following information: (g) Documentation of reference checks; 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 to include documentation of reference checks for two of 12 personnel files sampled (RN #2 and the agency ' s Clinical Educator/ Director /Quality Assurance). Findings included: A review of personnel records conducted on 08/21/2023 at 2:11 PM revealed the following:	H 151	**What corrective actions will be accomplished to address the identified deficient practice?** The Director of QA and Education in collaboration with the Director of HR will conduct a meeting with the Recruiters and HR Generalist to discuss and re-educate on the process of onboarding new employees. The process of obtaining the references such as one reference from previous employers and one reference for personal and/or professional reference will be reviewed. The recruiters will immediately implement the process on the hires for the month of October 2023. The HR Director or designee will check all of the hires in October 2023 to ensure that the 2 references have been obtained for 100% of the October hires. **What measures will be put in place or what systemic changes you will make to ensure deficient practice does not recur?** The recruiters will ensure that the On-boarding checklist is used for all of the hires, all completed and that the required documents are all obtained before the new hire starts work. The recruiters will ensure that all hires 100% will have the two references required prior to start of work.	10/31/23 10/31/23

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H 151	Continued From page 4 1. The personnel file for RN #2 revealed a date of hire of 09/26/ 2022 however, there was no documented evidence of reference checks for RN #2. 2. The personnel file for the agency's Clinical Educator/ Director /Quality Assurance included a hire date of 11/28/2022. Further review of the personnel file showed no documented evidence of reference checks. The findings were confirmed by the agency 's leadership staff.	H 151	**How is the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The Director of HR or designee will review 100% quarterly for 3 quarters all newly hired personnel files which includes the on-boarding checklists to ensure that the files are complete and that there are two references on all of the files. The threshold is 100%. If 100% threshold is not achieved in the first quarter, the HR director will counsel the recruiters to ensure compliance.	10/31/23 and on-going for 3 quarters Random audits will continue quarterly to ensure compliance is sustained.
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 personnel record review and staff interview, the agency failed to ensure annual reviews were completed and located in the personnel record, for two of four physical therapists included in the sample (PTs #2 and #3, and one of two registered nurses included in the sample RN #1). Findings included: A review of the facility's personnel records was conducted on 08/22/2023 at 2:38 PM revealed the following:	H 152	**What corrective Actions will be accomplished to address the identified deficient practice?** The Director of HR and HR Generalist assigned to the branch will work with the Branch Clinical Manager to ensure that the Performance Reviews are done annually for all of the staff starting this performance period. The Director of QA and Education and the Director of HR will send out the performance review calendar in mid-October 2023 for the Clinical Managers to start the performance review for 2022-2023 for all of the staff in the DC Branch. The HR Director or designee will check off from the checklist all of the performance reviews already completed by the CM. The HR Director or designee will ensure that all of the performance reviews for the entire staff is completed before 10/31/23. The completed performance reviews will be filed in personnel files by the HR data Entry Team in Infinit-O. **What measures will be put in place or what systemic changes you will make to ensure deficient practice does not recur?** Annually, by October 1 of each year going forward, the HR Director will issue a memorandum designating the Performance Review period with specific deadlines for the different steps of the review process. The final deadline for completion of all performance reviews for all staff will be completed no later than 12/31 of each year	10/31/23 10/15/23 10/31/23 10/31/23 and on-going

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H 152	Continued From page 5 1. The personnel file for physical therapist (PT # 2) included a date of hire of 04/23/2008. Further review of his personnel file lacked evidence of an annual review since 2017. 2. The personnel file for physical therapist (PT # 3) included a date of hire of 04/6/2020. Further review of the files showed no documented evidence of annual evaluations since the employee's initial one year anniversary or thereafter. 3. The personnel file for registered nurse (RN # 1) included a date of hire of 11/04/2015. Further review of his personnel file lacked evidence of an annual review since 2019. Review of the agency's policy entitled personnel performance on 08/23/2023 at 12:58 PM showed "FT, PT, and PRN employees will receive annual written evaluations on a calendar schedule between November 1 and December 31st of each year." The findings were acknowledged and confirmed at the time of the review.	H 152	The HR Director will review no later that October 31, 2023, and going forward the checklist for all branch personnel to ensure that all of the performance reviews have been completed for this performance review period based on the deadlines in the performance Review Calendar. The HR Data Entry team will conduct a quarterly audit of 100% of all branch personnel files to ensure that all performance reviews were completed and properly filed in the personnel files. **How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The Director of Human Resources or designee will audit quarterly 100% of all the branch personnel files to ensure that the performance reviews have been completed and filed properly. The threshold is 100% so if the 100% was not met during the review, the HR Director and HR Generalist in collaboration with the Branch Clinical Manager will ensure that missing performance reviews are done immediately and filed.	10/31/23 10/31/23 and on-going 10/31/23 and on-going Random audits will continue quarterly to ensure compliance is sustained
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. This Statute is not met as evidenced by: Based on record review and interview, the home	H 162	**What corrective actions will be accomplished to address the identified deficient practice?** The Director of QA and Clinical Education in collaboration with the Director of Human Resources will conduct a meeting with the recruiters and HR generalist to discuss and reeducate on the process of obtaining all renewable requirements prior to start date. Documentation from previous employers for labs showing communicable status should be resulted within 6 months of hire and must be done again post hire within 6 months of start. The reminders will be placed in Homecare Homebase under renewable requirements with a timer to notify Patient Services Coordinators that this person is due for lab to assess communicable disease status and will be a hard stop to scheduling the person to see clients	10/31/23

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H 162	Continued From page 6 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 one employee's personnel files included in the sample, (the agency' s Clinical Educator, Director/Quality Assurance). Findings included: A review of the facility's personnel records was conducted on 08/22/2023 at 2:38 PM and revealed the following: The personnel file for the agency ' s Clinical Educator, Director/Quality Assurance included a hire date of 11/28/2022. Further review of her personnel file showed a QuantiFERON Test that was performed on 12/29/2021, eleven months prior to her date of hire. During the Exit Interview on 08/24/2023, 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	The Director of Human Resources will implement this new addition to the policy by 10/31/2023 **What measures will be put into place or what systemic changes you will make to ensure deficient practice does not recur?** The HR Director will review the onboarding process with the recruiters and HR Generalists to ensure that all new hires will have documentation showing that they are free of communicable diseases within six months immediately preceding the employees date of hire . Recruiters will not schedule new hires for orientation unless all required onboarding documents including documents regarding communicable diseases are received. The HR Director or designee will audit all hires for the month of October to ensure all required on boarding documents are obtained and filed on new hires record. **How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The Director of QA and Clinical Education in collaboration with the Director of Human Resources will meet quarterly to discuss audit results presented by the human resource support team. The findings both positive and negative will be discussed at monthly HR meetings ensuring that the team has the opportunity to correct the action in real time. **What corrective actions will be accomplished to address the identified deficient practice?**	10/31/23 10/31/23 and on-going 10/31/23 and on-going for 3 quarters Random audits will continue quarterly to ensure compliance is sustained.
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.	H 163	The Director of QA and Clinical Education in collaboration with the Director of Human Resources will conduct a virtual MS Teams meeting to discuss the new process of completing all annual communicable disease screenings for clinicians at the skills fair in June of each year. The Director of Human Resources will add the screening tool to the annual skills fair packet by 10/31/2023 For each individual who does not have a current screening completed for 2023, Director of QA and Clinical Education will have this completed by October 31, 2023.	10/31/23 10/31/23

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H 163	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 screened and certified free of communicable disease annually for one of two registered nurses (RN #1) included in the sample. Findings included: A review of the facility's personnel records conducted on 08/21/2023 at 2:11 PM revealed the following: The personnel file for registered nurse (RN #1) included a hire date of 11/04/2015. Further review of the file showed that the RN had not been screened for communicable diseases since 2018. During the Exit Interview on 08/24/2023, at 2:30 PM, the Administrative Staff acknowledged the findings.	H 163	**What measures will be put into place or what systemic changes you will make to ensure deficient practice does not recur?** The human resources support (infinite O) team will conduct a monthly audit using the worker productivity report to ensure all clinicians are up to date on annual screenings of communicable diseases. The Director of QA and Clinical Education in collaboration with the Director of Human Resources will meet quarterly to discuss audit results presented by the human resource support team. **How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The Director of QA and Clinical Education in collaboration with the Director of Human Resources will meet quarterly to discuss audit results presented by the human resource support team. This review will be done for at least 3 quarters threshold set at 100% and if the threshold is not met, the human resource support team will be retrained and will be reminded each time the Director of QA and Education and Director of Human Resources determines that the process is not being followed 100%. The findings both positive and negative will be discussed at monthly HR meetings ensuring that the team has the opportunity to correct the action in real time. **What corrective actions will be accomplished to address the identified deficient practice?**	10/31/23 and on-going 10/15/23 and on-going
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 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)	H 300	**The Director of QA and Clinical Education in collaboration with the Director of Human Resources will conduct a staff meeting with the office team including the clinical managers and HR generalist, to educate them on the importance of compliance with enforcing the policy on patient rights and responsibilities.** **The Directors will re-educate the office team on progressive disciplinary action plan that outlines the steps to follow when holding the clinicians responsible for following policies related to patient care. The progression is as follows: verbal warning, written warning, final warning, termination. Depending upon how egregious the act is and the level of harm that would be inflicted upon the patient, immediate termination may be the only step.** **The Director of QA and Clinical Education in collaboration with the Director of Human Resources will conduct a field staff meeting re-educating on the importance of compliance with the following: The goal for a patient is to return to the highest level of function realistically attainable and within the context of the disability with**	10/15/23

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H 300	Continued From page 8 failed to ensure that services were provided in accordance with the plan of care (POC) as evidenced by missed home health aide (HHA) visits for two of nine active patients in the sample (Patients #5 and #7). Findings included: 1. On 08/23/2023 at 10:32 am, review of Patient #5's plan of care (POC) showed a duration period of 07/16/2023 through 09/13/2023. The patient's diagnoses included type II diabetes mellitus, congestive heart failure, muscle weakness, abnormalities of gait and mobility, glaucoma, dementia, long term use of insulin, history of falling, and wheelchair dependent. The POC indicated skilled nursing services, physical therapy services, occupational therapy services, and home health aide services, two times a week for eight weeks, and once, one time a week for one week to assist with personal care, hygiene, and activities of daily living (ADLs). Continued review of Patient #5's clinical record showed that home health aide (HHA) services were not provided as ordered the week of 07/16/2023. 2. On 08/22/2023 at 02:30 am, review of Patient #7's plan of care (POC) showed a duration period of 07/03/2023 through 08/31/2023. The patient's diagnoses included stage II sacral pressure ulcer, pressure induced deep tissue damage right heel, chronic respiratory failure with hypoxia, hypertension, muscle weakness, spinal stenosis, lymphedema, osteoarthritis, bipolar disorder, anxiety disorder, obstructive sleep apnea, hypothyroidism, dependence on supplemental oxygen, history of pulmonary embolism, history of falling, and long-term use of anticoagulants. The POC indicated skilled nursing services, physical therapy services, occupational therapy services,	H 300	home health services. All clinician visits outlined in the frequency on the plan of care should be completed as ordered. Patients/Caregivers should be contacted a minimum of 24 hours before the appointment and provided a date and time frame of arrival for the appointment. This date and time will be adhered to by the discipline ordered. If the appointment is missed due to changes in the patient's schedule or any other patient-related reasons, the discipline must submit a missed visit note, contact the physician or provider and the clinical manager alerting them of the missed visit reason, notification of the physician or provider, and what day the appointment will be rescheduled to. The Director of QA and Clinical Education in collaboration with the Director of Human Resources will provide each clinician with a link to access the regulatory policies of the District of Columbia for home care providers, specifically speaking on the Health Occupations Revision Act HORA | doh. **What measures will be put into place or what systemic changes you will make to ensure deficient practice does not recur?** Compliance with the completion of the following interventions will be monitored monthly by the VP of Clinical Operations and Director of QA and Clinical Education. If interventions are not completed or not noted in the clinical records, the clinical manager will reach out to the clinician one-on-one to discuss the importance of following the plan of care and completing the frequency as ordered in the plan of care, progressing to disciplinary action as outlined in the policy. Compliance with this intervention will be 100%. The VP of Clinical Operations, Director of QA, and Clinical Education in collaboration with the Director of Human Resources will discuss all audits related to following the plan of care monthly in a separate leadership meeting, determining whether policies are being followed and updating policies and procedures as necessary to maintain the integrity of the patient rights and responsibility policy. **How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The VP of Clinical Operations, Director of QA, and Clinical Education in collaboration with the Director of Human Resources will discuss all audits related to following the plan of care monthly in a separate leadership meeting, determining whether policies are being followed and updating policies and procedures as necessary to maintain the integrity of the patient rights and responsibility policy.	10/31/23 10/31/23 and monthly on-going 10/31/23 and monthly on-going Random audits will continue quarterly to ensure compliance is sustained.

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H 300	Continued From page 9 and home health aide services, two times a week for five weeks effective 07/30/2023 to assist with personal care, hygiene, and activities of daily living (ADLs). Continued review of Patient #7's clinical record showed that home health aide (HHA) services were not provided as ordered the weeks of 07/30/2023 and 08/13/2023. On 08/24/2023 at 09:54 am, the vice president of clinical operations 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 #5 and #7.	H 300	These reviews and meetings will be done for at least 3 quarters threshold set at 100% and if the threshold is not met, the clinical managers and HR Generalist team will be retrained and will be reminded each time the Director of QA and Education and Director of Human Resources determines that the process is not being followed 100%. The findings both positive and negative will be discussed at quarterly company executive meetings with the CEO and Senior Vice President.	
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 two of nine active patients included in the sample (Patients #7 and #8). Findings included: 1. On 08/22/2023 at 02:30 am, review of Patient #7's plan of care (POC) showed a duration period of 07/03/2023 through 08/31/2023. The patient's diagnoses included stage II sacral pressure ulcer, pressure induced deep tissue damage right heel,	H 364	**What corrective actions will be accomplished to address the identified deficient practice?** The Director of QA and Education will schedule a staff meeting by 10/11/2023. At that meeting, the 2 patients #7 & #8 will be discussed, and the clinicians assigned will amend the Plan of care to include the emergency protocols specific to the diagnoses. The amended plan of care will be sent to the PCP for signature and be made part of the original POC.The meeting will educate on the need to ensure that all emergency protocols under the emergency pathways in HCHB are individualized and specific as discussed with a provider about the patient's diagnoses. This includes but is not limited to weights for heart failure, blood pressure parameters for hypertension, pulse oximetry parameters for oxygen-dependent or respiratory-related diagnoses, glucose parameters for diabetics, and other diagnoses-related parameters necessary in the care of specific disease processes. The Director of QA and Education will educate the field staff that upon the start of care, recertification, resumption of care, and any change in condition, registered nurses, physical therapists, occupational therapists, and speech therapists case managing the client/beneficiary will reach out to the overseeing provider of the plan of care and discuss an individualized specific set of parameters related to the patient's disease processes and include these parameters in the plan of care on each patient. The clinical managers will continue the education on the importance of the specific disease parameters throughout November before each weekly case conference. The final date of completion for this teaching is October 31, 2023. The clinical manager or clinical quality team will assess for completion of patient-specific individualized emergency protocol parameters daily during the review of the OASIS documents received in the Homecare Homebase workflow.	10/31/23 10/31/23

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H 364	Continued From page 10 chronic respiratory failure with hypoxia, hypertension, muscle weakness, spinal stenosis, lymphedema, osteoarthritis, bipolar disorder, anxiety disorder, obstructive sleep apnea, hypothyroidism, dependence on supplemental oxygen, history of pulmonary embolism, history of falling, and long-term use of anticoagulants. The POC showed that the patient was receiving Xarelto 20mg orally daily. Continued review of the POC lacked evidence of emergency protocols related to the patient's risk of bleeding secondary to the long-term use of anticoagulants. 2. On 08/22/2023 at 01:09 pm, review of Patient #8's plan of care (POC) showed a duration period of 07/26/2023 through 09/23/2023. The patient's diagnoses included dysphagia, other sequelae of nontraumatic intracranial hemorrhage, epilepsy, muscle weakness, encephalopathy, anemia, hypertension, hyperlipidemia, acid reflux, adjustment disorder with anxiety, and history of falling. The POC showed that the patient was receiving Keppra 750 mg oral twice daily and Lacosamide 150mg oral twice daily for seizures. Continued review of the POC lacked evidence of emergency protocols related to the patient's diagnosis of seizures. On 08/24/2023 at 09:54 am, the vice president of clinical operations 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 included emergency protocols to properly manage the patients' diagnoses for Patients #7 and #8.	H 364	**What measures will be put into place or what systemic changes will you make to ensure deficient practice does not recur?** The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will complete and review with the Clinical Manager monthly chart audits assessing 10 charts a month for patient- specific emergency protocol parameter compliance. The review will confirm 100% completion of patient- specific emergency protocol parameters. The results will be discussed with the clinical managers. The clinical managers will discuss the results in the weekly case conference meetings. **How will the corrective actions be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will monitor compliance by auditing 10 charts a month for a goal of 100% compliance on patient-specific emergency protocol parameters present in each medical record. Compliance by the above-named disciplines with the completion of patient-specific individualized emergency protocol parameters will be monitored and checked upon review of the documentation at the designated OASIS data points by the clinical manager and clinical support team daily during the review of the OASIS. If the parameters are not present, the clinical manager will reach out to the clinician one-on-one to discuss obtaining the parameters. Compliance with this intervention will be 100% by 10/31/23. The findings both positive and negative will be discussed at weekly case conference meetings ensuring that the team has the opportunity to correct the action in real time.	10/31/23 and monthly 10/31/23

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H 365	Continued From page 11	H 365	**What corrective actions will be accomplished to address the identified deficient practice?**	
H 365	3914.3(n) PATIENT PLAN OF CARE The plan of care shall include the following: (n) Types and frequency of laboratory tests ordered, if applicable. 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 the frequency of ordered laboratory tests in the plan of care (POC) for one of nine active patients included in the sample (Patient #4). Findings included: On 08/22/2023 at 11:43 am, review of Patient #4's plan of Care (POC) showed a duration period of 07/13/2023 through 09/10/2023. The patient's diagnoses included chronic obstructive pulmonary disease, heart failure, osteoarthritis, muscle weakness, benign prostatic hyperplasia, iron deficiency anemia, hypercholesterolemia, kidney cancer, difficulty walking, and history of falling. The records showed an order dated 07/12/2023 for a complete blood count (CBC), complete metabolic panel (CMP), ferritin, and transferrin blood levels. Continued review of the records showed that the blood work was drawn on 07/20/2023, 07/27/2023, 08/03/2023, 08/10/2023, ad 08/17/2023. However, the POC failed to include the frequency of labs ordered. On 08/24/2023 at 09:54 am, the vice president of clinical operations was made aware of the findings. At the time of survey, the home care agency	H 365	The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will conduct a nursing meeting with the nursing staff inclusive of registered nurses and licensed practical nurses. At the same care conference meeting, the clinicians assigned to patient #4 will be retrained on writing lab orders with specified frequency. The order will be amended by adding the frequency and will be sent to PCP for signature. The topic will be on following the plan of care as it relates to lab orders. Education will be completed on the proper way to write a laboratory order. The education session will be conducted on or by 10/11/2023. The clinical manager will assess prior to approving all orders written for labs for the following information. The following minimum requirements for lab orders are to be added: Labs ordered (i.e. CBC, CMP), route labs being obtained (via central line or peripheral draw); reason for the labs including diagnosis or diagnosis codes; the frequency with duration; Identifying information of provider spoken with: “Spoke with _____ in Dr or provider _____’s office. T.O.R.B.” **What measures will be put into place or what systemic changes you will make to ensure deficient practice does not reoccur?** The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will review 10 charts monthly for 100% compliance in the completion of the lab orders inclusive of the criteria described above and discuss results with the clinical managers. **How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will review 10 charts monthly for 100% compliance in the completion of the lab orders inclusive of the criteria described above and discuss results with the clinical managers. Compliance with this intervention will be 100% by 12/30/23. This review will be done for at least 3 quarters threshold set at 100% and if the threshold is not met, the Clinical Manager will be retrained and will be reminded each time the Director of QA and Education determines that the process is not being followed 100%. The findings both positive and negative will be discussed at weekly case conference meetings ensuring that the team has the opportunity to correct the action in real time.	10/11/23 10/31/23 and monthly 10/11/23 and on-going for at least 3 quarters Random audits will continue quarterly to ensure compliance is sustained.

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H 365	Continued From page 12 failed to ensure that the patient's plan of care included the frequency of laboratory tests ordered for Patient #4.	H 365	**What corrective actions will be accomplished to address the identified deficient practice?**	
H 430	3916.1 SKILLED SERVICES GENERALLY Each home care agency shall review and evaluate the skilled services provided to each patient at least every sixty-two (62) calendar days. A summary report of the evaluation shall be sent to the patient's physician. 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 an evaluation of skilled services was conducted every 62 calendar days, for four of nine active patients in the sample (Patients #3, 5, 7, and #8). Findings included: Review of the home care agency's (HCA's) records beginning 08/21/2023 through 08/24/2023 lacked documented evidence that the agency reviewed and evaluated the provision of skilled services, in accordance with the regulations. On 08/24/2023 at 09:54 am, the vice president of clinical operations was made aware of the findings. At the time of the survey, the home care agency failed to review and evaluate the provision of skilled services every 62 days for Patients #3, 5, 7, and #8.	H 430	The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will conduct an education meeting with all staff addressing the following disciplines: registered nurses, physical therapists, occupational therapists, and speech-language pathologists. The topic will be the completion of the 62-day summary note on the recertification of the patient. The education session will be conducted on or by 10/11/2023. The new 62 day summary Coordination notes has been created and will be discussed with the clinicians at. the 10/11/23 care conference The Senior Vice President of Analytics and Operational Support in coordination with the system administrator created a coordination note labeled 62-day summary. The coordination consists of the following information necessary for each patient: past medical history, skilled need for services at recertification, skilled intervention performed, and patient/ caregiver response to interventions. The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will complete the initial education on the 62-day summary coordination note. The Clinical Manager will instruct each clinician at the time of the recertification case conference to complete the note on the patient being recertified. The recertification case conference will continue to take place weekly. **What measures will be put into place or what systemic changes you will make to ensure deficient practice does not recur?** The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will complete and review with the Clinical Manager monthly chart audits assessing 10 charts a month for the presence of the 62-day summary note. The review will confirm 100% completion of the charts having the 62-day summary notes present on all recertified patients. The results will be discussed with the clinical managers. The clinical managers will discuss the results in the weekly case conference meetings. **How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The VP of Clinical Operations and Regulatory and Compliance and the Director of QA and Education will complete and review with the Clinical Manager monthly chart audits assessing 10 charts a month for the presence of the 62-day summary note. The review will confirm 100% completion of the charts having the 62-day summary notes present on all recertified patients.	10/11/23 and weekly thereafter Random audits will continue quarterly to ensure compliance is sustained.

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H 430	Continued From page 13 This is a repeat deficiency from last survey 06/16/2022.	H 430	Compliance with the completion of the 62-day summary will be monitored monthly. If the 62-day summary notes are not present, the clinical manager will reach out to the clinician one-on-one to discuss the importance of completing the 62-day summary note. Compliance with this intervention will be 100% by 10/31/23. This review will be done for at least 3 quarters threshold set at 100% and if the threshold is not met	10/31/23 and on-going for 3 quarters Random audits will continue quarterly to ensure compliance is sustained.
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 one of nine active patients in the sample (Patient #1). Findings included: On 08/21/2023 at 12:03 pm, review of Patient #1's clinical record showed a plan of care (POC) with a duration period of 07/26/2023 through 09/23/2023, for skilled nursing (SN) services one time per week for one week, two times per week for two weeks, and one time per week for five additional weeks to evaluate for needs requiring physician's orders and skilled nursing interventions. Conduct a skilled assessment of body systems, evaluate co-morbid conditions, and intervene to minimize complications. The patient's diagnoses included heart failure, chronic kidney disease, anemia, osteoarthritis, acid reflux, hyperlipidemia, disorders of adrenal gland, chronic obstructive pulmonary disease, and history of falling. Continued record review showed that the nurse visited the patient on 08/02/2023 and 08/08/2023 and documented each time that the patient was treated in the hospital for	H 452	**What corrective actions will be accomplished to address the identified deficient practice?** The Clinical Manager and the Director of QA and Education will hold a staff meeting with the skilled nurses to retrain all of them on assessment, interventions, provision, and collaboration of care with the physician or provider. The skilled nurse as the case manager for the patient will lead communication and cooperative efforts in creating an inter-professional plan of care focused on outcomes engaging the physician or provider who oversees the plan of care. The skilled nurses assigned to each patient will notify the physician or provider of any changes in condition noting in the chart who they spoke with and what the outcome of the communication is. The clinical Quality Assurance Process Improvement team will review 100% of all sudden changes in condition documentation, orders, and incident reports ensuring that communication has taken place with the provider. **What measures will be put into place or what systemic changes you will make to ensure deficient practice does not recur?** The clinical manager will complete a monthly meeting with the clinical Quality Assurance Process Improvement team to discuss the results of the audits for care coordination. The process will be implemented by 10/31/2023 **How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The clinical Quality Assurance Process Improvement team will complete the 100% audit of all sudden changes in condition documentation, orders, and incident reports ensuring that communication has taken place with the provider. The clinical manager will meet with the clinical Quality Assurance Process Improvement team monthly to discuss results and findings. Compliance with the completion of the following interventions will be monitored monthly. If interventions are not completed and the coordination with the physician or provider is not noted in the clinical records, the clinical manager will reach out to the clinician one-on-one to discuss the importance of completing the coordination with the physician or provider with each patient's change in condition. Compliance with this intervention will be 100% by 10/31/23.	10/11/23. Random audits will continue quarterly to ensure compliance is sustained. 10/31/23

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H 452	Continued From page 14 abdominal pain and prescribed a new medication. Furthermore, the nurse visited the patient on 08/15/2023 and noted the following: "Looks very agitated. States she was evaluated and treated at [hospital] 2 days ago [8/13/23] but left against medical advice. Denies any symptoms at the moment." There was no documented evidence in the clinical record that the nurse coordinated care with the physician following the client's repeated hospitalization/ emergency room visits and overall condition. On 08/24/2023 at 09:54 am, the vice president of clinical operations 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.	H 452	This review will be done for at least 3 quarters threshold set at 100% and if the threshold is not met, the Clinical Manager will be retrained and will be reminded each time the Director of QA and Education determines that the process is not being followed 100%. The findings both positive and negative will be discussed at weekly case conference meetings ensuring that the team has the opportunity to correct the action in real time.	10/31/23 and on-going for at least 3 quarters Random audits will continue quarterly to ensure compliance is sustained
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 three of nine active patients in the sample (Patients #2, 3, and #5).	H 453	**What corrective actions will be accomplished to address the identified deficient practice?** The Clinical Manager and the Director of QA and Education will hold a staff meeting with all disciplines to retrain all of them on following the ordered frequency in the plan of care as well as all other components of the plan of care including assessment, interventions, provision, and collaboration of care with the other disciplines and physician or provider. Education will highlight the following: The goal for a patient is to return to the highest level of function realistically attainable and within the context of the disability with home health services. All clinician visits outlined in the frequency on the plan of care should be completed as ordered. Patients/ Caregivers should be contacted a minimum of 24 hours before the appointment and provided a date and time frame of arrival for the appointment. This date and time will be adhered to by the discipline ordered. If the appointment is missed due to changes in the patient's schedule or any other patient-related reasons, the discipline must submit a missed visit note, contact the physician or provider and the clinical manager alerting them of the missed visit reason, notification of the physician or provider, and what day the appointment will be rescheduled to.	10/31/23

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H 453	Continued From page 15 Findings included: 1. On 08/21/2023 at 02: 35pm, review of Patient #2's clinical record showed a plan of care (POC) with a duration period of 06/25/2023 through 08/23/2023 that indicated skilled nursing (SN) services twice a week for eight weeks, and once a week for one week to conduct assessments, instructions and disease management. The patient's diagnoses included congestive heart failure, type II diabetes mellitus, stage 4 chronic kidney disease, anemia, atrial fibrillation, chronic obstructive pulmonary disease, insomnia, presence of cardiac pacemaker, muscle weakness, and history of falling. Continued review of the clinical record lacked evidence that the SN visited Patient #2 two times a week as ordered the week of 07/09/2023. Furthermore, the POC showed an order for the SN to report to the physician blood sugar levels that fell outside the following parameters: "fasting blood sugar less than 60 or greater than 180." The nurse visited the patient the following dates: 07/27/2023, 08/01/2023, 08/10/23, 08/15/2023, and 08/17/2023 with no evidence of an assessment of the patient's blood sugar to determine if interventions were warranted. A home visit was conducted with the patient and her aide on 08/23/2023 at 03:05pm. She indicated that she was checking her blood sugar herself but could not find where she put her needles. The aide indicated that the nurse called the doctor's office to inform them but could not get anyone. 2. On 08/21/2023 at 04: 00 pm, review of Patient #3's clinical record showed a plan of care (POC) with a duration period of 06/30/2023 through 08/28/2023 that indicated occupational therapy	H 453	The Patient Service Coordinators will run the client's last scheduled report and the agent summary report in Homecare Homebase daily to ensure that all visits assigned per frequency are completed. If the visits are not completed as ordered, the Patient Services Coordinator will alert the Clinical Manager. The Clinical Manager will reach out to the clinician and discuss the rationale behind the missed visit, instructing the clinician to complete a missed visit coordination note, notify the physician, and reschedule the appointment with the patient. **What measures will be put into place or what systemic changes you will make to ensure deficient practice does not recur?** The Clinical Manager or Clinical Quality Assurance Process Improvement team will run the agent summary and client's last scheduled report weekly to assess that all visits scheduled are being completed as ordered in the plan of care. The Clinical Quality Assurance Process Improvement team will do a random selection of 10 charts and audit monthly for missed visit notes looking for the rationale for missed visits, notification of missed visits to the physician or provider, and that the visit was rescheduled with the patients. The Clinical QAPI team will also assess for the following of the plan of care with all interventions outlined on the 485. The clinical manager will complete a monthly meeting with the clinical Quality Assurance Process Improvement team to discuss the results of the audits. The process will be implemented by 10/31/2023. **How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The clinical manager will complete a monthly meeting with the clinical Quality Assurance Process Improvement team to discuss the results of the audits. The process will be implemented by 10/31/2023. Compliance with the completion of the following interventions will be monitored monthly by the VP of Clinical Operations and Director of QA and Clinical Education. If interventions are not completed or not noted in the clinical records, the clinical manager will reach out to the clinician one-on-one to discuss the importance of completing the frequency as ordered in the plan of care. Compliance with this intervention will be 100% by 10/31/23. This review will be done for at least 3 quarters threshold set at 100% and if the threshold is not met, the Clinical Manager will be retrained and will be reminded each time the Director of QA and Education determines that the process is not being followed 100%.	10/31/23 and monthly 10/31/23 10/31/23 10/31/23 and on-going for at least 3 quarters Random audits will continue quarterly to ensure compliance is sustained.

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H 453	Continued From page 16 (OT) services once a week for two weeks for evaluation and treatment. The patient's diagnoses included dysphagia, hypopharynx carcinoma, neck and head cancer, type II diabetes mellitus, hypertension, spinal stenosis, emphysema, benign prostatic hyperplasia, hypothyroidism, acid reflux, muscle weakness, spondylosis, sacroiliitis, hyperlipidemia, history of falling, and encounter for attention to gastrostomy. Also, the POC showed an order for the nurse to perform finger stick blood sugar each visit and to report to the physician blood sugar levels that fell outside the following parameters: "fasting blood sugar less than 60 or greater than 180." The nurse visited the patients the following dates: 07/27/2023, 08/01/2023, 08/10/23, 08/15/2023, and 08/17/2023 with no evidence of an assessment of the patient's blood sugar to determine if interventions were warranted. 3. On 08/23/2023 at 10: 23 am, review of Patient #5's clinical record showed a plan of care (POC) with a duration period of 07/16/2023 through 09/13/2023 that indicated skilled nursing (nurse) services three times a week for three weeks, two times a week for one week, two times a week for one week, and one time every two weeks for two weeks to perform wound care and education effective 08/06/2023. The patient's diagnoses included type II diabetes mellitus, congestive heart failure, muscle weakness, abnormalities of gait and mobility, glaucoma, dementia, long term use of insulin, history of falling, wheelchair dependent, and stage II pressure ulcer. Continued review of the clinical record lacked evidence that the nurse visited Patient #5 three times a week as ordered during the week of 08/06/2023. On 08/24/2023 at 01:30 pm, the vice president of	H 453	The findings both positive and negative will be discussed at weekly case conference meetings ensuring that the team has the opportunity to correct the action in real time	

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H 453	Continued From page 17 clinical operations and administrator were made aware of the findings. At the time of the survey, the home care agency failed to ensure that skilled nursing services were provided in accordance with Patients #2, 3, and 5's plans of care.	H 453		
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 two of nine active patients in the sample (Patients #2 and #3). Findings included: 1. On 08/21/2023 at 02: 35pm, review of Patient #2's clinical record showed a plan of care (POC) with a duration period of 06/25/2023 through 08/23/2023 that indicated occupational therapy (OT) services once a week for one week, twice a week for one week, once a week for four weeks, and once a week for one week to establish / upgrade home exercise program and provide therapeutic exercises and education to increase independence and safety. The patient's diagnoses included congestive heart failure, type II diabetes mellitus, stage 4 chronic kidney disease, anemia, atrial fibrillation, chronic obstructive pulmonary disease, insomnia,	H 550	**What corrective actions will be accomplished to address the identified deficient practice?** The Clinical Manager and the Director of QA and Education will hold a staff meeting with all disciplines to retrain all of them on following the ordered frequency in the plan of care as well as all other components of the plan of care including assessment, interventions, provision, and collaboration of care with the other disciplines and physician or provider. Education will highlight the following: The goal for a patient is to return to the highest level of function realistically attainable and within the context of the disability with home health services. All clinician visits outlined in the frequency on the plan of care should be completed as ordered. Patients/ Caregivers should be contacted a minimum of 24 hours before the appointment and provided a date and time frame of arrival for the appointment. This date and time will be adhered to by the discipline ordered. If the appointment is missed due to changes in the patient's schedule or any other patient-related reasons, the discipline must submit a missed visit note, contact the physician or provider and the clinical manager alerting them of the missed visit reason, notification of the physician or provider, and what day the appointment will be rescheduled to. The Patient Services Coordinator will run the client's last scheduled report and the agent summary report in Homecare Homebase daily to ensure that all visits assigned per frequency are completed. If the visits are not completed as ordered, the Patient Services Coordinator will alert the Clinical Manager. The Clinical Manager will reach out to the clinician and discuss the rationale behind the missed visit, instructing the clinician to complete a missed visit coordination note, notify the physician, and reschedule the appointment with the patient. **What measures will be put into place or what systemic changes you will make to ensure deficient practice does not recur?** The Clinical Manager or Clinical Quality Assurance Process Improvement team will run the agent summary and client's last scheduled report weekly to assess that all visits scheduled	10/31/23 on-going 10/31/23 and weekly

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H 550	Continued From page 18 presence of cardiac pacemaker, muscle weakness, and history of falling. Continued review of the clinical record lacked evidence that the OT provided therapy as ordered the week of 08/06/2023. Furthermore, the POC included an order for the therapist to monitor the patient's weight every visit and notify the physician of weight gain of two pounds within one day or five pounds within seven days for congestive heart failure. The records showed that the OT visited Patient #2 on the following dates 06/29/2023, 07/02/2023, 07/05/2023, 07/13/2023, 07/20/2023, 07/27/2023, 08/03/2023, and 08/15/2023 with no evidence of assessing the patient's weight to determine if intervention was warranted. 2. On 08/21/2023 at 04: 00 pm, review of Patient #3's clinical record showed a plan of care (POC) with a duration period of 06/30/2023 through 08/28/2023 that indicated occupational therapy (OT) services once a week for two weeks for evaluation and treatment. The patient's diagnoses included dysphagia, hypopharynx carcinoma, neck and head cancer, type II diabetes mellitus, hypertension, spinal stenosis, emphysema, benign prostatic hyperplasia, hypothyroidism, acid reflux, muscle weakness, spondylosis, sacroiliitis, hyperlipidemia, history of falling, and encounter for attention to gastrostomy. Continued review of the clinical record showed a communication note from OT dated 03/02/2023 labelled "missed visit, no answer at the door." On 03/06/2023, OT noted the following: "OT evaluation rescheduled due to patient cancellation/ schedule conflict. Physician notified." Further review of the clinical records lacked evidence that OT followed up or evaluated the patient by the time of survey. On 08/24/2023 at 11:54 am, the vice president of clinical operation acknowledged that there was no	H 550	The Clinical Quality Assurance Process Improvement team will do a random selection of 10 charts and audit monthly for missed visit notes looking for the rationale for missed visits, notification of missed visits to the physician or provider, and that the visit was rescheduled with the patients. The Clinical Quality Assurance Process Improvement team will also assess for the following of the plan of care with all interventions outlined on the 485. The clinical manager will complete a monthly meeting with the clinical Quality Assurance Process Improvement team to discuss the results of the audits. The process will be implemented by 10/31/2023. **How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The clinical manager will complete a monthly meeting with the clinical Quality Assurance Process Improvement team to discuss the results of the audits. The process will be implemented by 10/31/2023. Compliance with the completion of the following interventions will be monitored monthly by the VP of Clinical Operations and Director of QA and Clinical Education. If interventions are not completed or not noted in the clinical records, the clinical manager will reach out to the clinician one-on-one to discuss the importance of completing the frequency as ordered in the plan of care. Compliance with this intervention will be 100% by 10/31/23. This review will be done for at least 3 quarters threshold set at 100% and if the threshold is not met, the Clinical Manager will be retrained and will be reminded each time the Director of QA and Education determines that the process is not being followed 100%. The findings both positive and negative will be discussed at weekly case conference meetings ensuring that the team has the opportunity to correct the action in real time.	10/31/23 10/31/23 and monthly 10/31/23 and on-going for at least 3 quadrants Random audits will continue quarterly to ensure compliance is sustained.

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H 550	Continued From page 19 evaluation from OT. She stated that she would reach out to the physical therapist to assess Patient #3 for the needs for occupational therapy services and get an order to start if indicated. At the time of the survey, the home care agency failed to ensure that occupational therapy services were provided in accordance with the plans of care for Patients #2 and #3.	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 Therapy (PT) services were provided in accordance with the patient's plan of care (POC) for six of nine active patients in the sample (Patient #1, 2, 4, 5, 7, and #8). Findings included: 1. On 08/21/2023 at 12:03 pm, review of Patient #1's clinical record showed a plan of care (POC) with a duration period of 07/26/2023 through 09/23/2023 that indicated physical therapy (PT) services one time per week for one week, two times a week for four weeks, and one time a week for four weeks to establish / upgrade home exercise program, to provide therapeutic exercises and soft tissue /joint mobilization designed to restore functional strength and range of motion. The patient had diagnoses that included heart failure, chronic kidney disease,	H 560	**What corrective actions will be accomplished to address the identified deficient practice?** The Clinical Manager and the Director of QA and Education will hold a staff meeting with all disciplines to retrain all of them on following the ordered frequency in the plan of care as well as all other components of the plan of care including assessment, interventions, provision, and collaboration of care with the other disciplines and physician or provider. Education will highlight the following: The goal for a patient is to return to the highest level of function realistically attainable and within the context of the disability with home health services. All clinician visits outlined in the frequency on the plan of care should be completed as ordered. Patients/ Caregivers should be contacted a minimum of 24 hours before the appointment and provided a date and time frame of arrival for the appointment. This date and time will be adhered to by the discipline ordered. If the appointment is missed due to changes in the patient's schedule or any other patient-related reasons, the discipline must submit a missed visit note, contact the physician or provider and the clinical manager alerting them of the missed visit reason, notification of the physician or provider, and what day the appointment will be rescheduled to. The Patient Services Coordinator will run the client's last scheduled report and the agent summary report in Homecare Homebase daily to ensure that all visits assigned per frequency are completed. If the visits are not completed as ordered, the Patient Services Coordinator will alert the Clinical Manager. The Clinical Manager will reach out to the clinician and discuss the rationale behind the missed visit, instructing the clinician to complete a missed visit coordination note, notify the physician, and reschedule the appointment with the patient.	10/31/23 10/31/23 and weekly on-going

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H 560	Continued From page 20 anemia, osteoarthritis, acid reflux, hyperlipidemia, disorders of adrenal gland, chronic obstructive pulmonary disease, and history of falling. Continued review of the clinical record lacked evidence that PT services were provided as ordered the week of 08/06/2023. 2. On 08/21/2023 at 02: 35pm, review of Patient #2's clinical record showed a plan of care (POC) with a duration period of 06/25/2023 through 08/23/2023 that indicated physical therapy (PT) services three times a week for one week, twice a week for seven weeks to establish / upgrade home exercise program and provide therapeutic exercises and soft tissue /joint mobilization designed to restore functional strength and range of motion. The patient's diagnoses included congestive heart failure, type II diabetes mellitus, stage IV chronic kidney disease, anemia, atrial fibrillation, chronic obstructive pulmonary disease, insomnia, presence of cardiac pacemaker, muscle weakness, and history of falling. Continued review of the clinical record lacked evidence that PT services were provided as ordered the week of 07/02/2023. Furthermore, the POC included an order for the therapist to monitor the patient's weight every visit and notify the physician of weight gain of two pounds within one day or five pounds within seven days for congestive heart failure. The records showed that the PT visited Patient #2 every week from 06/25/2023 to 08/14/2023 with no evidence of assessing the patient's weight to determine if intervention was warranted. A home visit was conducted to the patient's home on 08/23/2023 at 03:05 pm. It was observed that the patient had bilateral lower extremity edema. Patient indicated that she was not weighing herself because she needed assistance as she could not stand too long on her feet. The vice	H 560	**What measures will be put into place or what systemic changes you will make to ensure deficient practice does not recur?** The Clinical Manager or Clinical Quality Assurance Process Improvement team will run the agent summary and client's last scheduled report weekly to assess that all visits scheduled are being completed as ordered in the plan of care. The Clinical Quality Assurance Process Improvement team will do a random selection of 10 charts and audit monthly for missed visit notes looking for the rationale for missed visits, notification of missed visits to the physician or provider, and that the visit was rescheduled with the patients. The Clinical Quality Assurance Process Improvement team will also assess for the following of the plan of care with all interventions outlined on the 485. The clinical manager will complete a monthly meeting with the clinical Quality Assurance Process Improvement team to discuss the results of the audits. The process will be implemented by 10/31/2023. **How the corrective actions will be monitored to ensure the deficiencies will not recur, i.e. what quality assurance program will be implemented?** The clinical manager will complete a monthly meeting with the clinical Quality Assurance Process Improvement team to discuss the results of the audits. The process will be implemented by 10/31/2023. Compliance with the completion of the following interventions will be monitored monthly by the VP of Clinical Operations and Director of QA and Clinical Education. If interventions are not completed or not noted in the clinical records, the clinical manager will reach out to the clinician one-on-one to discuss the importance of completing the frequency as ordered in the plan of care. Compliance with this intervention will be 100% by 10/31/23. This review will be done for at least 3 quarters threshold set at 100% and if the threshold is not met, the Clinical Manager will be retrained and will be reminded each time the Director of QA and Education determines that the process is not being followed 100%. The findings both positive and negative will be discussed at weekly case conference meetings ensuring that the team has the opportunity to correct the action in real time.	10/31/23 and weekly on-going 10/31/23 and monthly on-going Random audits will continue quarterly to ensure compliance is sustained. 10/31/23 10/31/23 10/31/23 and on-going for at least 3 quarters Random audits will continue quarterly to ensure compliance is sustained.

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H 560	Continued From page 21 president of clinical operations was made aware of the findings on 03/28/2023 at 01:30 pm. 3. On 08/22/2023 at 11:43 pm, review of Patient #4's clinical record showed a plan of care (POC) with a duration period of 07/13/2023 through 09/10/2023 that indicated physical therapy (PT) services two times a week for six weeks to establish / upgrade home exercise program, provide therapeutic exercises and soft tissue /joint mobilization designed to restore functional strength and range of motion. The patient's diagnoses included chronic obstructive pulmonary disease, heart failure, osteoarthritis, muscle weakness, benign prostatic hyperplasia, iron deficiency anemia, kidney cancer, hypercholesterolemia, difficulty walking, and history of falling. Continued review of the clinical record lacked evidence that PT services were provided as ordered during the weeks of 07/23/2023 and 08/13/2023. 4. On 08/23/2023 at 10: 23 am, review of Patient #5's clinical record showed a plan of care (POC) with a duration period of 07/16/2023 through 09/13/2023 that indicated physical therapy (PT) services one time a week for one week and two times a week for six weeks to establish / upgrade home exercise program, provide therapeutic exercises and soft tissue /joint mobilization designed to restore functional strength and range of motion. The patient's diagnoses included type II diabetes mellitus, congestive heart failure, muscle weakness, abnormalities of gait and mobility, glaucoma, dementia, long term use of insulin, history of falling, wheelchair dependent, and stage II pressure ulcer. Continued review of the clinical record lacked evidence that PT services were provided as ordered during the week of 07/13/2023.	H 560		

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H 560	Continued From page 22 5. On 08/22/2023 at 02:30 am, review of Patient #7's plan of care (POC) showed a duration period of 07/03/2023 through 08/31/2023 that indicated physical therapy (PT) services two times a week for four weeks and one time a week for one week effective 07/03/2023 to establish / upgrade home exercise program, provide therapeutic exercises and soft tissue /joint mobilization designed to restore functional strength and range of motion. The patient's diagnoses included stage II sacral pressure ulcer, pressure induced deep tissue damage right heel, chronic respiratory failure with hypoxia, hypertension, muscle weakness, spinal stenosis, lymphedema, osteoarthritis, bipolar disorder, anxiety disorder, obstructive sleep apnea, hypothyroidism, dependence on supplemental oxygen, history of pulmonary embolism, history of falling, and long-term use of anticoagulants. Continued review of the clinical record lacked evidence that PT services were provided as ordered during the week of 07/02/2023. 6. On 08/22/2023 at 01:09 pm, review of Patient #8's plan of care (POC) showed a duration period of 07/26/2023 through 09/23/2023 that indicated physical therapy (PT) evaluation and treatment effective 08/13/2023. The patient's diagnoses included dysphagia, other sequelae of nontraumatic intracranial hemorrhage, epilepsy, muscle weakness, encephalopathy, anemia, hypertension, hyperlipidemia, acid reflux, adjustment disorder with anxiety, and history of falling. Continued review of the clinical record lacked evidence that PT evaluated the patient as ordered by the time of survey. There was no documentation that could indicate the reason for the delay. Home visit conducted on 08/23/2023 at 04:09 pm with Patient #8 and his family revealed	H 560		

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H 560	Continued From page 23 their dissatisfaction with PT. They indicated that PT scheduled a visit the same day as surveyors (08/23/2023) with the family between 2 pm and 4 pm. By the time of home visit completion around 04: 25 pm, PT was a no show. A follow up with the agency on 08/24/2023 confirmed that PT did not go as scheduled. Instead, the PT evaluation was rescheduled for 08/28/2023. On 08/24/2023 at 01:30 pm, the vice president of clinical operations and administrator 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 #1, 2, 4, 5, 7, and #8.	H 560		
H 580	3925.1 SPEECH LANGUAGE PATHOLOGY SERVICES If speech language pathology services are provided, they shall be delivered 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 speech therapy (ST) services were provided in accordance with the patient's plan of care (POC) for one of nine active patients in the sample (Patient #5). Findings included: On 08/23/2023 at 10:32 am, review of Patient #5's clinical record showed a plan of care (POC) with a duration period of 07/16/2023 through	H 580	**What corrective action(s) will be accomplished to address the identified deficient practice:** The Clinical Manager and the Director of QA and Education will hold a staff meeting with the clinicians to retrain all of them in assessing and providing the patient speech therapy services and ensuring the implementation of the order as part of the plan of care . The Patient Services Coordinator will ensure that when orders are written for speech therapy that the patient will be assigned a Speech therapist and that all required visits are scheduled according to the plan of care. Speech therapist assigned to the patient will provide the therapy needed as part of the plan of care **What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur:** The Clinical Manager will review 100% all Admission orders to ensure and approve that all disciplines including Speech therapy ordered as part of the plan of care are identified and assigned to execute the orders.	10/31/23 and on-going Random audits will continue quarterly to ensure compliance is sustained. 10/30/23 and on-going Random audits will continue quarterly to ensure compliance is sustained.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL HEALTHCARE RESOURCES	501 SCHOOL STREET, SW SUITE 200 WASHINGTON, DC 20024

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 580	Continued From page 24 09/13/2023 for speech therapy (ST) services one time a week for one week and one time every three weeks for three weeks to evaluate and treat swallowing impairment. The patient had diagnoses that included type II diabetes mellitus, congestive heart failure, muscle weakness, abnormalities of gait and mobility, glaucoma, dementia, long term use of insulin, history of falling, and stage II pressure ulcer. Continued review of the clinical record lacked evidence that speech therapy (ST) services were provided as ordered during the week of 08/06/2023. On 08/24/2023 at 01:30 pm, the vice president of clinical operations and administrator were made aware of the findings. At the time of the survey, the home care agency failed to ensure that speech therapy services were provided in accordance with the plan of care for Patient #5.	H 580	**How is the corrective action(s) will be monitored to ensure that the deficient practice will not recur, i.e. what quality assurance program will be implemented.** The Clinical Manager will review 100% all 485 generated for the patients to ensure that all appropriate orders for disciplines such as Speech Therapy when required, are included in the order with the appropriate frequencies before approving. The QA reviewers will do the next level review 100% of all orders to ensure that PCP orders for speech therapy are followed, assigned to Speech therapist and scheduled appropriately. If the Clinical Manager review does not meet 100% threshold, the CM and the Director of Education and QA will retrain all the clinicians involved to ensure that the staff are in compliance with the regulations.	10/31/23 and on-going for 3 quarters. Random audits will continue quarterly to ensure compliance is sustained.