DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

March 12, 2024

Administrator
ALLINA HEALTH HOME HEALTH
2925 Chicago Avenue
MINNEAPOLIS, MN 55407

Re: Event ID: 61F32-H1

Dear Administrator:

A standard survey was completed at your agency on February 14, 2024, for the purpose of assessing compliance with Federal certification.
At the time of survey, the survey team from the Minnesota Department of Health - Health Regulation Division, noted one or more deficiencies. Electronically attached is a copy of the Statement of Deficiencies (CMS-2567).

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

Ordinarily, a provider or supplier will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview. If possible, please type your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original to the following address within ten calendar days of your receipt of this notice:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and a loss of Federal reimbursement.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248091	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLINA HEALTH HOME HEALTH	2925 Chicago Avenue , MINNEAPOLIS, Minnesota, 55407

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E0000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 2/12/24-2/14/24, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E0000		
G0000	INITIAL COMMENTS On 2/12/24- 2/14/24, a recertification survey was conducted. This resulted in a standard survey at Allina Health Home Health. The agency was found to have not met the requirements at 42 CFR. Part 484 for Home Health Agencies. The cumulative effects of these findings resulted in the Home Health Agency's inability to ensure provision of quality of care. Unduplicated census previous 12 months: 15,101 Total home visits conducted: 7 Parent Location visited: Allina Corporate 29i5 Chicago Avenue Minneapolis, MN 55407 Branch Visited: New Ulm Home Care Agency 1324 5th Street North New Ulm, MN 56073 List Hours of Operation: 8-4:30 List total number of records reviewed: 17	G0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen S Leutner	Home Health Director	03/26/2024

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G0000	Continued from page 1 In addition to the recertification, the following complaints were reviewed. As a result: No deficiency was issued for complaint H80919689C/95773	G0000		
G0514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to ensure a resumption of care was completed within 48 hours after return from a hospital stay for 1 of 5 patients (P13) who had been discharged from the agency. Findings include: P13's Plan of Care (POC) for certification period 12/6/23-2/3/24, indicated P13 had diagnoses of paraplegia, bladder dysfunction, and diabetes. Furthermore, P13's POC indicated P13 required skilled nursing services from the agency. P13's hospital discharge summary dated 2/5/24, indicated P13 was admitted to the hospital on 2/2/24-2/5/24 for infection. Furthermore, P13's hospital discharge summary indicated P13 required skilled home nursing and occupational therapy. P3’s medical record lacked information the agency had resumed services as ordered. When interviewed on 12/14/24 at 1:15 p.m., registered nurse (RN)-A verified R13's hospital discharge orders were scanned into the medical record on 2/5/24. The hospital R13 was admitted to was outside the Allina family and stated at times the communication was not as good with outside hospitals. RN-A further stated there was a breakdown somewhere between intake and the charge nurse team. RN-A stated this was complicated as P13 had been discharged the same day as their certification	G0514	G0514/484.55(a)(1): Timely Resumption of Care Policy titled; Home Health Admission was reviewed. It was determined that the policy clearly defined time frame at which admission to home health must occur following facility discharge. The policy and procedures outlined in the policy were not followed. Coaching was provided to case manager and staffing team who did not follow standard work outlined in the policy for admitting patient within 48 hrs of facility discharge on 2/15/2024. Education to home health staffing team assistants, nurses, physical therapists,occupational therapists and speech therapists regarding standard work for tracking hospitalized patients and completing the initial assessment within 48 hrs of referral, patient's return home, or physician or allowed practitioner ordered start/resumption of care date began on March 20, 2024 and will be completed by March 31, 2024. Audit process: Will begin April 1, 2024 and will include 10% resumption of care visits performed between 4/1/24 and 4/13/24 and will continue over a three month period to ensure the initial assessment has been completed within 48 hrs of referral, patient's return home, or physician/allowed practitioner ordered resumption date. Audits will continue at a minimum of 5 resumption of care visits per month until 100% compliance is achieved. Title of person responsible for implementing acceptable plan of correction: Home Health Director	April 13, 2024

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G0514	Continued from page 2 period was ending and they had not returned home yet. Communication between the intake team and nurses were important to ensure the patient was seen upon return from home. When interviewed on 12/14/24 at 2:15 p.m., the administrator stated there was a breakdown in the process. When intake received the orders, the nurses should have been notified. The Administrator further stated R13 had not discharged from the hospital by the end of their certification period and technically was discharged from the agency. The administrator further stated she was unsure if the resumption of care order would have been adequate, but if the right communication had occurred between intake and the nursing team, the correct orders would have likely been obtained and P13 would have been seen upon discharge. The administrator stated P13 was contacted and verified home care services had not started. The agency had obtained new orders so care could start. An agency policy titled Admission to Home Care dated 6/14/23, directed staff to schedule the admission visit within 48 hours of a referral or facility discharge.	G0514		
G0528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is NOT MET as evidenced by: Based on interview and document review the agency failed to ensure a comprehensive assessment accurately reflected the current health status upon return from hospitalization and transitional care stay for 1 of 7 (P9) patients observed on a home care visit. Findings include: P9's Plan of Care (POC) for certification period 12/26/23- 2/23/24, indicated P9 was disoriented and had diagnoses of dementia, diabetes and anxiety. Furthermore, P9's POC indicated P9 was incontinent and dependent on activities of daily living (ADL). P9's start of care comprehensive assessment dated 12/26/23, indicated P9 was incontinent of bowl and bladder. P9's hospital discharge summary was requested however was not provided.	G0528	G0528/484.55(c)(1): Comprehensive assessment reflects current health status at ROC Policy titled, Nursing Services was reviewed along with procedure for resumption of care visits. Both the policy and procedure clearly define expectations for staff when completing a resumption of care visit, to complete a comprehensive assessment and ensure patient's plan of care accurately reflects their current health status and care needs. It was determined the policy and procedures outlined were not followed for this patient. Education to home health nurses, physical therapists, occupational therapists, and speech therapists regarding resumption of care comprehensive assessment and ensuring plan of care accurately reflects patient's current health status and care needs began on March 20, 2024. and will be completed by March 31, 2024 Audit Process: Will begin April 1, 2024 and will include 10% of resumption of care visits performed between 4/1/24 and 4/13/24 and will continue over a three month period to ensure the patient's current health status and care needs are reflective of the comprehensive assessment. Audits will continue at a minimum of 5 resumption of care visits per month until 100% compliance is achieved. Title of person responsible for implementing acceptable plan of correction: Home Health Director	April 13, 2024

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G0528	Continued from page 3 P9's resumption of care (ROC)comprehensive assessment dated 1/20/24, indicated P9 was recently hospitalized. P9's ROC assessment further indicated P9 had no incontinence or catheter and had no UTI within the past 14 days, however indicated a recent diagnosis of UTI on 1/15/24. Furthermore, P9's ROC lacked interventions related to monitoring or minimizing risk of UTI. When interviewed on 2/13/24 at 11:10 a.m., at registered nurse (RN)-A verified P9's ROC assessment did not include P9's recent UTI infection and continence was different than what was indicated on the start of care assessment. Furthermore, RN-A stated it was important to include this information to ensure P9's POC would include appropriate interventions to minimize risk of further UTI infections. When interviewed on 2/14/24 at 2:03 p.m., the administrator expected staff to have an accurate ROC assessment that reflected any health changes or diagnoses from their hospitalization. Furthermore, this was important to ensure cares and goals included recent changes to the patient's health. A facility policy titled Nursing Services dated 4/25/23, directed nurses to complete the initial comprehensive assessment and re-evaluate and revise the POC to address changes in patient's clinical condition.	G0528		
G0572	Plan of care CFR(s): 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. This STANDARD is NOT MET as evidenced by: Based on interview and document review the agency failed to ensure provider notification was made for 2 of 4 patients (P10, P6) reviewed for missed visits. Furthermore, the agency failed to ensure home health aide (HHA) visits were reduced due to agency scheduling	G0572	G0572/484.60(a)(1):Plan of Care Policy titled, Missed Visits and the procedure for missed visits in home health were reviewed and found to clearly define staff expectations when ordered home health visits are missed. It was determined that the policy and procedures outlined were not followed by staff. Education to home health team assistants, nurses, physical therapists, occupational therapists, speech therapists and social workers on missed visit policy and procedure for missed visits began March 20, 2024 and will be completed by March 31, 2024 Will begin April 1, 2024 and will include 10% of charts where missed visits are identified between 4/1/24 and 4/13/24 and will continue over a three month period to ensure that missed visits are documented (including provider notification and reason) Audits will continue at a minimum of 5 charts with missed visits present per month until 100% compliance is achieved. Title of person responsible for implementing acceptable plan of correction: Home Health Director	April 13, 2024

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G0572	Continued from page 4 for 1 of 4 patients (P12) reviewed for missed visits. The agency also failed to document reasoning for missed visit for 1 of 4 patients (P2) reviewed for missed visits. Findings include: P6's plan of care with certification period dated 1/14/24-3/13/24, indicated P6 had diagnoses of iron deficiency anemia, encounter for fitting and adjustment of urinary device (catheter) and malignant neoplasm of the bladder. It further indicated P6 received home health aide services twice a week for six weeks for personal cares and urinary catheter care. P6's missed visit note dated 1/17/24, indicated a home health aide (HHA) visit had been missed due to R6 being admitted to the hospital however lacked documentation P6's primary physician was notified. P6's missed visit note dated 1/25/24, indicated a HHA visit was missed due to P6 not wanting HHA visit today because of other appointments however lacked documentation P6's primary physician was notified. During interview on 2/14/24 at 2:08 p.m., the clinical manager (CM)-A verified the primary physician had not been notified of the missed HHA visits on 1/17/24 and 1/25/24 stating their policy was to notify the primary physician and that's what staff are expected to do. During interview on 2/14/24 at 2:55 p.m., the administrator stated they have a clear process in regard to missed visits and the provider should be notified. It was important to notify the provider because the care plan was in agreement with the physician's orders and if the agency was not meeting the contract for care, we need to let them know so they can say what needs to happen, "it's important to follow." P10's plan of care (POC) for certification period of 1/14/24-3/13/24, indicated had diagnoses of urinary tract infection and pressure ulcer of left heel. Furthermore, P10's POC indicated P10 received home care from the agency since 9/23/2023. P10's SN visit strings dated 12/17/23-1/13/24, indicated P10 required 3 SN visits every week. P10's electronic medical record lacked indication P10's provider was notified of a missed SN visit for the week of 12/18-12/23/23.	G0572		

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G0572	Continued from page 5 P12's POC for certification period 12/5/23-2/2/24, indicated P12 had diagnoses of chronic kidney disease and congestive heart failure. Furthermore P12's POC indicated P12 had orders for HHA to assist with bathing and dressing once a week for 3 weeks from 12/12/23-12/30/23. P12's HHA visit note dated 12/23/23, indicated a missed visit due to full schedule. P12's HHA visit note dated 12/28/23, indicated a missed visit due to scheduling. P12's medical record lacked indication P12 was offered alternative times. P2's POC for certification period 1/25/24- 3/24/24, indicated P2 had diagnoses of tibia fracture and required HHA visits once a week for bathing between 1/28/24-2/24/24. P2's HHA visit note dated 2/5/24, indicated P2 missed a HHA visit on 2/2/24. P2's note lacked indication why the visit was missed or that an alternative date was offered. When interviewed on 2/13/24 at 2:15 p.m., registered nurse (RN)-A verified the missed nurse visit for P10 and missed HHA visits for P12 and P2. RN-A verified any missed visits had to be documented as to why the visit was missed and to ensure the provider and nurse were aware. Furthermore, RN-A stated visits should not be missed due to schedules being full. When interviewed on 12/14/24 at 2:15 p.m., the administrator expected all missed visits to be documented and providers to be notified. Furthermore, visits should not be missed due to full schedules and expected staff to follow the process of letting the scheduler know so the visit can be routed to a team member who may have more openings in their schedules stating it was a team approach. An agency policy titled Missed Visit revised 4/5/23, directed staff to notify staffing of a need to amend the visit schedule to complete the visit at an alternate time within the same week to prevent a missed visit. Furthermore, the policy directed staff to ensure documentation of a missed visit note included the reason for the missed visit and provider/case manager notification.	G0572		