Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/24/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCENTCARE FAIRVIEW HOME HEALTH - EAST LLC	**3507 Highpoint Drive N, S140 , Oakdale, Minnesota, 55128**

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00000	Initial Comments On 10/21/24 through 10/24/24, a recertification and complaint visit was conducted. The following licensing orders are being issued as a result of the survey: 875 and 1245. S/S-D This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected). *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. PLEASE DISREGARD THE HEADING OF THE FOURTH COLU N WHI H STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPL S TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EAC PAGE. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	00000		
00875	Termination of Service Plan	00875		

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William Rosheen, RN	Administrator	11/21/24

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00875	Continued from page 1 CFR(s): 144A.4791, Subd. 10 (a) If a home care provider terminates a service plan with a client, and the client continues to need home care services, the home care provider shall provide the client and the client's representative, if any, with a written notice of termination which includes the following information: (1) the effective date of termination; (2) the reason for termination; (3) for clients age 18 or older, a statement that the client may contact the Office of Ombudsman for Long-Term Care to request an advocate to assist regarding the termination and contact information for the office, including the office's central telephone number; (4) a list of known licensed home care providers in the client's immediate geographic area; (5) a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17); (6) the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination; and (7) if applicable, a statement that the notice of termination of home care services does not constitute notice of termination of any housing contract. (b) When the home care provider voluntarily discontinues services to all clients, the home care provider must notify the commissioner, lead agencies, and ombudsman for long-term care about its clients and comply with the requirements in this subdivision. This LICENSURE REQUIREMENT is NOT MET as evidenced b Based on interview and document review, the agency failed to provide the client and client representative with a written notice of termination which included all required components and information for 2 of 5 clients (C1, C2) reviewed for discharge. C1's start of care (SOC) was 3/4/24. P1's plan of care (POC) for the certification period 7/2/24 to 8/30/24,	00875	**00875 Termination of Service Plan** On review, C #1 and 2 was not notified, in writing, of discharge from agency (NOMNC). The patient was not provided with options of other support services or physician's care prior to being discharge from agency. To ensure compliance this standard is met the Administrator or designee will: 1. Ensure patients are provided with information that conveys to them and/or their caregivers of the patient's rights including active and informed participation in their care with discharge planning and discharge from services. 2. Ensure that patients and staff are informed of patient rights, responsibilities, consent, and patient's rights are respected. 3. Provide education to the Clinical Manager, Patient Care Managers, Registered Nurses, LVNs, Therapists, Therapy Assistants, and Social Workers and will include the following topics • C 2.4 Availability of Services- Acceptance, Admission, Ongoing and Discharge • HH 2.0.1 "Patient Rights, Responsibilities and Consent" • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • HH 2.1.5 "Plan of Care" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge **Immediate Action:** All Clinicians involved in care of C #1 and 2 will receive remedial education about provision of the patient being informed and notified of pending discharge, allowed participation in the discharge planning process and assisting patient with obtaining post discharge care and/or services when continued care or services are identified as well as delivering written notice of agency's change or termination of services . Additional clinicians identified to be out of compliance with the above requirements will receive counseling and remedial education by the Clinical Manager/PCM to ensure understanding and compliance.	12/12/24 12/12/24

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00875	Continued from page 2 included diagnoses of chronic venous hypertension with ulcer of left lower extremity, non-pressure chronic ulcer other than left lower leg, manic episode, rheumatoid arthritis, and hemiplegia. The POC further indicated C1 received skilled nurse visits (SNV) two times weekly for two weeks, one time week for two weeks, one visits every other week for four weeks, then one time per week for one week for various assessments, wound care evaluation and treatment and education. Occupational therapy and social worker were ordered for one visit. Review of the C1's medical record identified C1 had a facility-initiated discharge on 7/31/24. The medical record lacked evidence C1 had been provided with a written notice of termination which included the effective date of termination, the reason for termination, a statement that the client may contact the Office of Ombudsman for Long-Term Care to request an advocate to assist regarding the termination and contact information for the office, including the office's central telephone number, a list of known licensed home care providers in the client's immediate geographic area, a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17), and the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination. During interview on 10/22/24, at 3:30 p.m. the clinical manager (CM)-A stated a written notice of termination with all the required components had not been provided to C1 as required. C2's SOC was 1/22/21. P2's POC for the certification period 11/18/21 to 1/16/21, included diagnoses of pneumonitis due to inhalation of food or vomit, malignant neoplasm (cancer) of tongue, dysphagia (swallowing difficulty), malignant neoplasm of head, face and neck, pain, diabetes, depression, encounter for attention to tracheostomy (artificial tube in neck to breathe), and encounter for attention to gastrostomy (artificial tube in stomach for nutrition). The POC further indicated C2 received SNV one time per week for one week, one time every three weeks for three weeks, then one visit every two weeks for two weeks for various assessments, medication management, infection control, management of diabetes and symptoms, and education. Review of the C2's medical record identified C2 had a	00875	**Corrective Action:** The Administrator or designee will 1. Provide education during mandatory clinical staff education training to include the following policies: • C 2.4 Availability of Services-Acceptance, Admission, Ongoing and Discharge • HH 2.0.1 "Patient Rights, Responsibilities and Consent" • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • HH 2.1.5 "Plan of Care" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge 2. The Administrator or designee will review required information in detail including patient rights, responsibilities, discharge planning with Notice of Medicare Non Coverage (NOMNC). Clinical Manager/Patient Care Manager (PCM) or designees using the Discharge Report to audit clinical and coordination notes, and timely NOMNC added to the patient record to confirm compliance with organization policies. The Administrator or designee will instruct the Clinical Manager/ PCM this is part of their supervision, oversight, and audit responsibilities, to ensure compliance. **Audit Activity** Each patient record will be audited for physician ordered plan which includes a frequency for ordered services that have been reviewed by clinician with patient /caregiver until 100% obtained and continue for 60 days. 1. A current census will be reviewed by Visit to Orders Comparison Report to ensure compliance with frequency of visits to Plan of Care. 2.. 100% of discharged patients will be audited for no less than 60 days to ensure that the patient/caregiver, at the time of discharge • Received discharge planning with documentation of any necessary assistance in obtaining post discharge care and/or services • Received NOMNC timely 3. This audit will be performed by the Clinical Manager or designee under the direction of the agency Administrator. Designated Registered Nurses and or Therapists may assist with audits as determined by the agency Administrator. 4. The benchmark or target goal for this audit is 100%. Individuals completing audits will notify the Clinical Manager and Administrator of clinicians who demonstrate ongoing non-compliance for a "corrective action plan" per the organization's policy.	12/12/24

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00875	Continued from page 3 facility-initiated discharge on 1/14/24. The medical record lacked evidence C2 had been provided with a written notice of termination which included the effective date of termination, the reason for termination, a statement that the client may contact the Office of Ombudsman for Long-Term Care to request an advocate to assist regarding the termination and contact information for the office, including the office's central telephone number, a list of known licensed home care providers in the client's immediate geographic area, a statement that the home care provider will participate in a coordinated transfer of care of the client to another home care provider, health care provider, or caregiver, as required by the home care bill of rights, section 144A.44, subdivision 1, clause (17), and the name and contact information of a person employed by the home care provider with whom the client may discuss the notice of termination. The agency's Transfer and Discharge policy with last revision date 6/13/24, directed agency staff to notify the patient, the patient's representative, attending physician, podiatrist, or allowed practitioner of the patient's condition and reason for discharge. In addition, the patient would be provided with verbal and/or written instructions regarding, community services available to the patient, medication use and/or a copy of the final medication profile, home exercise plan, any procedures and/or treatments to be performed; and/or follow-up visits for physician care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	00875	**Ongoing Monitoring:** Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program with an expected threshold of 100%. Audit results will be tracked, trended, shared with agency leadership, and reported to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations.	12/12/24 and Ongoing
01245	TB Infection Control CFR(s): 144A.4798, Subd. 1 (a) A home care provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The home care provider must maintain written evidence of compliance with this subdivision. This LICENSURE REQUIREMENT is NOT MET as evidenced b	01245	**01245 TB Infection Control** On review, 2 of 5 personnel records reviewed revealed that the agency did not ensure that TB screening was completed in accordance with organizational policy for at-risk personnel and current CDC guidelines. Education provided by the agency Administrator or designee to the clinical staff, Office Coordinator and Patient Care Managers will include the following topics: 1. Review the organizational policy entitled "Section 1: Injury and Illness Prevention: Health Employment Requirements: Pre-Employment TB Testing" which requires a 2-step TB test at hire for employees and contractors hired after January 1, 2019.	12/12/24

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01245	Continued from page 4 Based on record review and interview, the licensee failed to complete tuberculosis (TB) screening on 2 of 5 employees in compliance with the most current guidelines issued by the Center for Disease Control and Prevention (CDC). The licensee's TB risk assessment dated 8/2/24, indicated a low risk level. Licensed practical nurse, (LPN)-B's Mantoux tuberculin skin test had the first of two steps given on 8/15/23 with results read on 8/17/23. Results recorded as 0 mm. Step 2 was given on 9/7/23 and read on 9/10/23 with results listed as 0 mm. Document failed to include interpretation of results for both step 1 and step 2. Registered nurse, (RN)-C's Mantoux tuberculin skin test had the first of two steps given on 2/20/23 with results read on 2/22/23. Results recorded as 0.0 mm. Step 2 was given on 3/13/23 and read on 3/15/23 with results listed as 0.0 mm. Document failed to include interpretation of results for both step 1 and step 2 of the test. Licensee's policy revised 10/14/24, failed to include guidance on interpretation and documentation of results.	01245	2. Agency's policy IP-3 entitled "Pre-Employment and Annual TB Testing" states in part, • "All clinical employees who work in a setting that is classified as low risk shall receive baseline TB screening upon hire, using two-step tuberculin skin test (TST) or a single blood assay for M. Tuberculosis (BAMT) to test for infection with M. Tuberculosis." • Ensure that the TB documentation is complete to include test results (negative/positive). 3. Establish and review an agency process to ensure that an employee has fulfilled the TB requirement prior to providing direct patient care. Clearly delineate the roles of the Patient Care Managers and the Office Coordinator in ensuring compliance to this Standard. **Audit Activity:** 1. The Office Coordinator will perform an audit of 100% of employee personnel records within 45 days of the implementation date. The audit is to ensure that each clinician providing direct patient care has met the requirements below prior to serving patients: • For a 2-Step TB test with results documented (negative or positive) • For any employee found to be out of compliance with the above requirement, the agency will make immediate plans for correction. 2. This audit will be performed by the Clinical Manager/designee under the direction of the agency Administrator. 3. The benchmark or target goal for this audit is 100%. **Ongoing Monitoring** As part of ongoing monitoring the Administrator or designee will review 10% of personnel records each quarter for compliance with TB testing and documented results. This metric will be included with clinical record review results and will be tabulated quarterly, and compliance threshold reported to and monitored by the Administrator or designee, QAPI committee and the Professional Advisory Committee (PAC).	12/12/24 12/12/24 and Ongoing

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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E0000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 10/21/24 to 10/24/24, during a recertification survey. The facility was in full compliance and no deficiencies were issued.	E0000		
G0000	INITIAL COMMENTS On 10/21/24 through 10/24/24 a recertification survey was conducted. This resulted in an extended survey at Accentcare Fairview Home Health East. 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. The Condition of Participation: Patient rights 484.50 at G434, G442, G454, G458 and G468 were found not met. Unduplicated census previous 12 months: 920 Total home visits conducted: 7 Accentcare Fairview Home Health East 3507 Highpoint DR. N. Suite S140 Oakdale, MN. List Hours of Operation:8am-5PM List total number of records reviewed: 17 In addition to the recertification, the following complaints were reviewed. As a result: H71669132C/108726 H7078034C/97913	G0000	**G0406 Condition of Participation: Patient Rights** This CONDITION will be met by the Administrator and/or designee to: (1) Ensure patients are provided with information that conveys to them and/or their caregivers of the patient's rights including active and informed participation in their care with discharge planning and discharge from services. (2) Ensure that patients and staff are informed of patient rights, responsibilities, consent, and patient's rights are respected. (3) Provide education to the Clinical Manager, Patient Care Managers (PCM), Registered Nurses, LPNs, Therapists, Therapy Assistants, and Social Workers and will include the following topics • Policy HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • Policy HH 2.0.1 Patient Rights, Responsibilities and Consent • AC Best Practice "My Patient, My Responsibility" • HH Protocol-Safe Discharge • **Immediate Action:** All Clinicians involved in care of Patients #1 and 2 will receive remedial education about provision of the patient being informed and notified of pending discharge, allowed participation in the discharge planning process and assisting patient with obtaining post discharge care and/or services when continued care or services are identified as well as delivering written notice of agency terminating services The physician will also be notified of pending discharge with coordination of care and services.	12/12/24 12/3/24
G0406	Condition of Participation: Patient rights.	G0406		

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.

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Miriam Boschen, RN	Administrator	11/21/24

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G0406	Continued from page 1 CFR(s): 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. This CONDITION is NOT MET as evidenced by: Based on interview and document review, the agency failed to protect and promote patient rights as outlined in the Combined Federal and State Home Care Bill of Rights. The agency failed to discharge 2 of 5 patients (P1, P2) for an appropriate cause, inform patients and their representatives of pending discharge, allow participation in the discharge planning process and assist patients with obtaining post discharge care and services when continuing care and service needs were identified. These combined failures resulted in Condition level noncompliance. See 434: the agency failed to ensure 1 of 17 patients (P1) was informed and consented to services or care being provided, including any ongoing changes in services. See G442: the agency failed to give written notice in advance of the agency terminating on-going services for 2 of 5 patients (P1, P2). See G454: the agency failed to notify the patient, her representative and other physicians involved with the patient's care the agency was considering a discharge for 1 of 5 patients (P1) who was discharged from the agency. See G458: the agency failed to ensure patient's physician agreed discharge was appropriate with goals met and patient no longer required home health care services for 1 of 5 patients (P2) See G468: the agency failed to provide 2 of 5 patients (P1, P2) with information required related to other available home care providers at the time of a facility-initiated discharge	G0406	**Corrective Action**: The Administrator or designee will 1. Provide education during mandatory clinical staff education training to include the following topics: Review of the organizations Home Health Policies: • Policy HH 2.1.7 " Transfer and Discharge of Patient -NOMNC, • Policy HH 2.0.1 "Patient Rights Responsibilities and Consent". • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge 2. The Administrator or designee will review required information in detail including patient rights, responsibilities, discharge planning with Notice of Medicare Non Coverage (NOMNC). 3. Clinical Manager/Patient Care Manager (PCM) or designees using the Discharge Report to audit clinical and coordination notes, and timely NOMNC added to the patient record to confirm compliance with organization policies. The 4. Administrator or designee will instruct the Clinical Manager/ PCM this is part of their supervision, oversight, and audit responsibilities, to ensure compliance. **Audit Activity** 1. A minimum of 100% of discharged patients will be audited for no less than 60 days to ensure that the patient/caregiver, at the time of discharge • Received discharge planning with documentation of any necessary assistance in obtaining post discharge care and/or services • Received NOMNC timely • Evidence of coordination of care with physician notification of patient discharge 2. This audit will be performed by the Clinical Manager or designee under the direction of the Agency Administrator. Designated RNs and or Therapists may assist with audits as determined by the Agency Administrator. 3. The benchmark or target goal for this audit is 100%. Individuals completing audits will notify the Clinical Manager and Administrator of clinicians who demonstrate ongoing non-compliance for a "corrective action plan" per the organization's policy. **Ongoing Monitoring:** Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program with an expected threshold of 100%. Audit results will be tracked, trended, shared with agency leadership, and reported to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations.	12/12/24 12/12/24 12/12/24 and Ongoing
G0434	Participate in care CFR(s): 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where	G0434		

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G0434	Continued from page 2 appropriate, with respect to– (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be fumished. This ELEMENT is NOT MET as evidenced by: Based on interview and document review the agency failed to ensure 1 of 17 patients (P1) was informed and consented to services or care being provided, including any ongoing changes in services. Findings Include: P1's start of care (SOC) was 3/4/24. P1's plan of care (POC) for the certification period 7/2/24 to 8/30/24, included diagnoses of chronic venous hypertension with ulcer of left lower extremity, non-pressure chronic ulcer other than left lower leg, manic episode, rheumatoid arthritis, and hemiplegia. The POC further indicated P1 received skilled nurse visits (SNV) two times weekly for two weeks, one time week for two weeks, one visits every other week for four weeks, then one time per week for one week for various assessments, wound care evaluation and treatment and education. Occupational therapy and social worker visits were ordered for one visit. Record review of P1's physician orders revealed the following: -On 7/16/24, an order was obtained by RN-B for skilled nurse visit (SNV) performed with observation and assessment of hypertension with ulcers to both lower extremities, depression, pain assessment and education, fall prevention, home safety training, performed medication reconciliation and education regarding	G0434	**G0434 Participate in care** On review, Patient #1 was not notified, in writing, of service changes (HHCCN/NOMNC) prior to receiving physician discharge order. The patient was not provided with options of other support services or physician's care prior to being discharge from agency. To ensure compliance this standard is met the Administrator or designee will: (1) Ensure patients are provided with information that conveys to them and/or their caregivers of the patient's rights including active and informed participation in their care with discharge planning and discharge from services. (2) Ensure that patients and staff are informed of patient rights, responsibilities, consent, and patient's rights are respected. (2) Ensure that patients and staff are informed of patient rights, responsibilities, consent, and patient's rights are respected. (3) Provide education to the Clinical Manager, Patient Care Managers, Registered Nurses, LVNs, Therapists, Therapy Assistants, and Social Workers and will include the following topics • C 2.4 Availability of Services- Acceptance, Admission, Ongoing and Discharge • HH 2.0.1 "Patient Rights, Responsibilities and Consent" • HH 2.1.7 entitled "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 entitled "Care Planning and Coordination" • HH 2.1.5 entitled "Plan of Care" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge **Immediate Action:** All Clinicians involved in care of Patient #1 will receive remedial education about provision of the patient being informed and notified of pending discharge, allowed participation in the discharge planning process and assisting patient with obtaining post discharge care and/or services when continued care or services are identified as well as delivering written notice of agency's change or termination of services . Additional clinicians identified to be out of compliance with the above requirements will receive counseling and remedial education by the Clinical Manager/PCM to ensure understanding and compliance.	12/12/24 12/3/24

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247166	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2024

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G0434	Continued from page 3 high-risk medications. No additional visits required at that time due to patient had wound care provided by medical nurses. May schedule up to two as needed (PRN) visit for re-evaluation if future needs were identified. -On 7/25/24, an order was obtained by LPN-A for wound care to new right lower extremity wound. Keep clean and dry and leave open to air. continue to monitor. On left lower extremity ulcer, clean with normal saline, pat dry, apply skin prep to peri wound, apply medical grade honey gel, cover with bordered foam and change dressing two times per week and PRN for soiled or dislodged dressing. Record review of P1's care coordination and visit notes 7/2/24 through 8/27/24 identified the following: -On 7/18/24, a nurse visit was conducted by licensed practical nurse (LPN)-A with wound care provided. Continuing education was needed on wound management and pain. Patient agreed to elevate lower extremities, seek medical care for increased pain, swelling, redness or warmth and try ice pack on legs and Tylenol as needed for pain. P1's care giver was not contacted. -On 7/23/24, a nurse visit was conducted by LPN-A with wound care performed. It was noted client had an appointment scheduled on 8/5/24, with a primary care physician. Continued education was given on wound care management, and pain. Pt agreed to have care giver manage wounds on non-nursing days and keep her scheduled appointments. P1's care giver was not contacted. -on 7/30/24, P1 contacted an agency nurse regarding concerns related to her nursing visits frequency, which had recently been significantly reduced from two times per week to one visit every two weeks. P1 requested to talk with her case manager registered nurse (RN)-B. It was noted RN-B would be notified to contact P1. -on 7/31/24, clinical manager (CM)-A obtained order from P1's primary physician to discharge P1 from home care services as she had not been seen in clinic for two months and the nurse practitioner would be unable to continue signing orders for her care. The agency did have a plan of care that remained active until 8/30/24 and P1 had an pending appointment to establish care with a primary physician on 8/5/24. -on 7/31/24, FM-C called the agency, angry P1 was not receiving wound care and services as ordered. FM-C stated P1 needed on-going wound care. CM-A notified	G0434	**Corrective Action:** The Administrator or designee will • provide education during mandatory clinical staff education training to include the following topics: Review of the organizations Home Health Policies: • C 2.4 Availability of Services-Acceptance, Admission, Ongoing and Discharge • HH 2.0.1 "Patient Rights, Responsibilities and Consent" • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • HH 2.1.5 "Plan of Care" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge • The Administrator or designee will review required information in detail including patient rights, responsibilities, discharge planning with Notice of Medicare Non Coverage (NOMNC). Clinical Manager/Patient Care Manager (PCM) or designees using the Discharge Report to audit clinical and coordination notes, and timely HHCCN/NOMNC added to the patient record to confirm compliance with organization policies. The Administrator or designee will instruct the Clinical Manager/ PCM this is part of their supervision, oversight, and audit responsibilities, to ensure compliance. **Audit Activity** Each patient record will be audited for physician ordered plan which includes a frequency for ordered services that have been reviewed by clinician with patient /caregiver until 100% obtained and continue for 60 days. 1. A current census will be reviewed by Visit to Orders Comparison Report to ensure compliance with frequency of visits to Plan of Care. 2. The PCM will monitor physician order changes for decreases in plan frequency to ensure patient is notified of the change in visit frequency and delivered an HHCCN or reducing/terminating on-going services. 3. 100% of discharged patients will be audited for no less than 60 days to ensure that the patient/caregiver, at the time of discharge • Received discharge planning with documentation of any necessary assistance in obtaining post discharge care and/or services • Received HHCCN/NOMNC timely	12/12/24 12/12/24

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G0434	Continued from page 4 FM-C the provider would no longer sign orders for home care services due to P1 was non-compliant and did not keep her scheduled appointments with her provider. CM-A notified FM-C the agency had obtained an order for P1 to be discharged from home care services. P1's medical record lacked signed service agreements regarding the reduction in services, documentation a reduction in frequency of nurse visits was discussed with P1 or signed documentation P1 had been notified of the significantly reduced SNV to occur after the 7/23/24, nurse visit that had been provided two times per week. There was no evidence P1's primary care giver, FM-C, had been notified of the significantly reduced skilled nurse visits nor that she was notified and agreed to complete the two times per week dressing changes. During interview on 10/21/24, at 3:50 p.m. FM-C stated P1 had nurse visits two times per week to evaluate and change dressing to an ulcer on P1's leg that would not heal. The home care agency just stopped coming out to see P1. The agency had not called to notify anyone they were no longer going to come out, they just stopped nurse visits to P1 without any warning. FM-C had gotten involved about a week after the agency had stopped their visits and called the agency when P1 notified her the agency was only going to come every two weeks from now on and not the two times per week they were doing. The agency had shown FM-C how to change the dressing but had never mentioned to her that she would need to take them over. The first time she heard they were no longer going to see P1 was when FM-C had called the agency on 7/31/24 and she was P1's appointed health care agent. During telephone interview on 10/22/24, at 10:50 a.m. social worker for the Department of Human Services (SW)-D stated she had visited P1 and FM-C on 8/8/24, to investigate a self-neglect report from the agency. The agency was concerned if P1 or FM-C were caring for P1's wounds properly and about P1's dirty home environment. P1 had been seen by the wound care clinic that week and her home environment was clean during SW-D's visit. SW-D felt there was poor communication between the home care agency and the patient. P1 had reported to her, there had been no indication the agency was going to reduce her services or of the pending discharge. P1 relied heavily on assistance from FM-C to coordinate appointments and lots of other things. SW-D was concerned with P1's lack of services and was trying to help her coordinate other services. Before other services could be coordinated, she heard P1 was in the hospital. The vulnerable adult report had indicated P1	G0434	4. This audit will be performed by the Clinical Manager or designee under the direction of the agency Administrator. Designated Registered Nurses and or Therapists may assist with audits as determined by the agency Administrator. 5. The benchmark or target goal for this audit is 100%. Individuals completing audits will notify the Clinical Manager and Administrator of clinicians who demonstrate ongoing non-compliance for a "corrective action plan" per the organization's policy. **Ongoing Monitoring:** Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program with an expected threshold of 100%. Audit results will be tracked, trended, shared with agency leadership, and reported to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations.	12/12/24 and Ongoing

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G0434	Continued from page 5 had received skilled nurse visits and social work visits and due to missed appointments the physician had dropped services. SW-D stated that was not true, P1 had a doctor appointment prior to when SW-D had seen her on 8/8/24 and had another appointment schedule the following week. When interviewed on 10/22/24, at 12:45 p.m. P1's primary care provider, nurse practitioner (NP) states she had last seen P1 on 5/15/24, at the wound care clinic. She had missed four appointments since then and it was the clinic's policy to discharge after a certain number of missed appointments. She had not personally taken any calls from the home care agency. Her office had called while she was on vacation on 7/31/24, and asked if it was okay to discharge P1 from home care since she did not have a primary provider to sign orders and she had told them yes. She had signed P1's recertification for services 7/1/24 through 8/30/24 for home care, and at that time, had asked for a social worker visit to work with her and so they were still trying to find some options for her. During telephone interview on 10/22/24, at 3:00 p.m. LPN-A stated she had completed visits for P1 on 7/18/24, and 7/23/24. She could not remember if she had discussed discharge with P1, but it was the agency practice to discuss discharge ongoing. She had talked with P1 about decreasing her nurse visit frequency but could not remember if she had specifically talked with P1's care giver FM-C. The agency did not complete service agreements to show patient participation for changes in services. She did not have written documentation that reducing nurse visits had been discussed or agreed upon. LPN-A had noticed a change in P1's wounds and new wound on the other leg on her visit 7/23/24, so had called her doctor at the veteran's agency (VA) clinic for wound care orders. On P1's last visit from the agency on 7/23/24, LPN-A had not been aware that P1 was going to have decrease nurse visit frequency, or a pending discharge so had not discussed that with P1 or P1's primary care giver FM-C. When interviewed on 10/22/24, at 3:30 p.m. CM-A stated P1's wounds had been healing and so the team had discussed decreasing the frequency of nurse visits. She thought the plan had been to reduce P1's visits to 1xwk to monitor the wound and go from there. The MD decided he was not going to sign orders for P1 anymore. CM-A had called the physician and because P1 did not follow recommendations and skipped medical appointments it would be okay for the agency to discharge her from home care services. She was not aware LPN-A had obtained orders from P1's VA physician for wound care on	G0434		

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G0434	Continued from page 6 7/25/24. During telephone interview on 10/23/24, at 8:30 a.m. RN-B stated she was never P1's case manager. She kept getting listed as her case manager in the medical record, but she had never made any nurse visits to P1. She was not sure who was her case manager. It may have been a travel nurse that was no longer employed at the agency. The agency's policy, Patients' Rights, Responsibilities and Consent, with review date 2/15/22, indicated patient's rights included to participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to the completion of all assessments, the care to be furnished, based on the comprehensive assessment, establishment and revision of the plan of care, disciplines that would furnish the care, the frequency of visits, expected outcomes of care, including patient identified goals and anticipated risks and benefits, any factors that could impact treatment and any changes in the care to be furnished. Patients had the right to be notified verbally and in writing prior to the start of care and as changes occurred. Patients had the right to receive proper written notice consistent in advance of a specific serv ice being furnished if the agency believed that the service may be non-covered care or in advance of the agency reducing or terminating ongoing care.	G0434		
G0442	Written notice for non-covered care CFR(s): 484.50(c)(8) Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. The HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204. This ELEMENT is NOT MET as evidenced by: Based on interview and record review, the agency failed to give written notice in advance of the agency terminating on-going services for 2 of 5 patients (P1, P2) who were reviewed for discharges. P1's start of care (SOC) was 3/4/24. P1's plan of care (POC) for the certification period 7/2/24 to 8/30/24, included diagnoses of chronic venous hypertension with ulcer of left lower extremity, non-pressure chronic ulcer other than left lower leg, manic episode,	G0442	**G0442 Written notice for non-covered care** On review, Patient #1 was not notified, in writing, of service changes (HHCCN/NOMNC) prior to receiving physician discharge order. The patient was not provided with options of other support services or physician's care prior to being discharge from agency. To ensure compliance this standard is met the Administrator or designee will: (1) Ensure patients are provided with information that conveys to them and/or their caregivers of the patient's rights including active and informed participation in their care with discharge planning and discharge from services. (2) Ensure that patients and staff are informed of patient rights, responsibilities, consent, and patient's rights are respected. (3) Provide education to the Clinical Manager, Patient Care Managers, Registered Nurses, LVNs, Therapists, Therapy Assistants, and Social Workers and will include the following topics • C 2.4 Availability of Services- Acceptance, Admission, Ongoing and Discharge • HH 2.0.1 "Patient Rights, Responsibilities and Consent" • HH 2.1.7 entitled "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 entitled "Care Planning and Coordination" • HH 2.1.5 entitled "Plan of Care" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge • **Immediate Action:** All Clinicians involved in care of Patient #1 will receive remedial education about provision of the patient being informed and notified of pending discharge, allowed participation in the discharge planning process and assisting patient with obtaining post discharge care and/or services when continued care or services are identified as well as delivering written notice of agency's change or termination of services . Additional clinicians identified to be out of compliance with the above requirements will receive counseling and remedial education by the Clinical Manager/PCM to ensure understanding and compliance.	12/12/24 12/3/24

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G0442	Continued from page 7 rheumatoid arthritis, and hemiplegia. The POC further indicated P1 received skilled nurse visits (SNV) two times weekly for two weeks, one time week for two weeks, one visits every other week for four weeks, then one time per week for one week for various assessments, treatment and education. Occupational therapy and social worker were ordered for one visit. Record review of P1's care coordination and visit notes 7/2/24 through 8/27/24 identified the following: -On 7/23/24, a nurse visit was conducted by licensed practical nurse (LPN)-A with wound care performed. Reduction of services and/or pending discharge was not documented in the visit note or care coordination note. No further nurse visits were documented after 7/23/24. -on 7/31/24, clinical manager (CM)-A obtained order from nurse practitioner (NP)-B to discharge P1 from home care services as she had not been seen in clinic for two months and unable to continue signing orders for her care. -on 7/31/24, family member (FM)-C called the agency, angry P1 was not receiving wound care and services as ordered. FM-C stated P1 just needed on-going wound care. CM-A notified FM-C the provider would no longer sign orders for home care services due to P1 was non-compliant and did not keep her scheduled appointments with her provider. CM-A notified provider had given the orders for P1 to be discharged from home care services. P1's medical record lacked documentation P1 or FM-C had received written notice in advance of the agency discharging P1 on 7/31/24. During telephone interview on 10/21/24, at 3:50 p.m. FM-C stated the home care agency just stopped coming out to see P1. FM-C called the agency on 7/31/24, and was notified P1 was discharged. She was P1's appointed health care agent and neither she or P1 had received any advance notice of the discharge. During telephone interview on 10/22/24, at 3:00 p.m. LPN-A stated the agency did not complete service agreements to document patients were notified of pending decrease or termination of services. LPN-A was not aware the 7/23/24 visit would be P1's last visit. She had not been notified P1 was going to be discharged so she had not discussed a pending discharge with P1 or FM-C, nor had she given P1 a written notice of discharge.	G0442	**Corrective Action**: The Administrator or designee will 1. Provide education during mandatory clinical staff education training to include the following topics: Review of the organizations Home Health Policies: • C 2.4 Availability of Services-Acceptance, Admission, Ongoing and Discharge • HH 2.0.1 "Patient Rights, Responsibilities and Consent" • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • HH 2.1.5 "Plan of Care" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge 2. The Administrator or designee will review required information in detail including patient rights, responsibilities, discharge planning with Notice of Medicare Non Coverage (NOMNC). 3 Clinical Manager/Patient Care Manager (PCM) or designees using the Discharge Report to audit clinical and coordination notes, and timely HHCCN/NOMNC added to the patient record to confirm compliance with organization policies. **Audit Activity** Each patient record will be audited for service changes (HHCCN/NOMNC) and documentation of coordination of care which includes verbal or written instruction post discharge care/ instructions with patient /caregiver until 100% obtained and continue for 60 days. 1. 100% of discharged patients will be audited for no less than 60 days to ensure that the patient/caregiver, at the time of discharge • Received discharge planning with documentation of any necessary assistance in obtaining post discharge care and/or services • Received HHCCN/NOMNC timely 2. This audit will be performed by the Clinical Manager or designee under the direction of the agency Administrator. Designated Registered Nurses and or Therapists may assist with audits as determined by the agency Administrator. 3. The benchmark or target goal for this audit is 100%. Individuals completing audits will notify the Clinical Manager and Administrator of clinicians who demonstrate ongoing non-compliance for a "corrective action plan" per the organization's policy.	12/12/24 12/12/24

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G0442	Continued from page 8 When interviewed on 10/22/24, at 3:30 p.m. clinical manger (CM)-A stated she had called P1's physician and because P1 did not follow recommendations and skipped her medical appointments it would be okay for the agency to discharge her from home care services as the agency did not have a provider to sign orders. P1 was not given advance notice of the discharge as required. P2's SOC was 1/22/21. P2's POC for the certification period 11/18/21 to 1/16/21, included diagnoses of pneumonitis due to inhalation of food or vomit, malignant neoplasm (cancer) of tongue, dysphagia (swallowing difficulty), malignant neoplasm of head, face and neck, pain, diabetes, depression, encounter for attention to tracheostomy (artificial tube in neck to breathe), and encounter for attention to gastrostomy (artificial tube in stomach for nutrition). The POC further indicated P2 received SNV one time per week for one week, one time every three weeks for three weeks, then one visit every two weeks for two weeks for various assessments, medication management, infection control, management of diabetes and symptoms, and education. Review of P2's coordination and visit notes identified the following: -On 12/28/21, a skilled nurse visit (SNV) was completed. Medications were setup and assessments completed. No discharge plan was documented as patient was unable to manage medications. -On 1/7/24, registered nurse (RN)-D documented a case conference note for recertification due to the issue of not able to manage complex or high-risk medications regimen which required ongoing skilled nurse treatment. -On 1/14/22, RN-E completed a desk discharge for P2, without home visit. The discharge was documented as a RN discharge data collection only with no visit made. P2's physician order dated 1/27/24, indicated payor change with new start of care needed. P2's medical record lacked evidence P2 had been notified of pending discharge prior to being discharged from the agency on 1/14/24. During interview on 10/22/24, at 3:30 p.m. clinical manager (CM)-A stated P2 had a recertification visit in January 2022. P2 had a fee source change soon after, so the agency did a desk discharge and then P2 should have been admitted immediately again for services but was	G0442	**Ongoing Monitoring:** Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program with an expected threshold of 100%. Audit results will be tracked, trended, shared with agency leadership, and reported to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations.	12/12/24 and Ongoing

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G0442	Continued from page 9 not. It had just gotten missed. She should have been set up for another start of care and that was not done so her services got unintentionally dropped. P2 was not notified of pending discharge and did not receive written notification of discharge. The Minnesota Department of Health Combined Federal and State Bill of Rights, last revised November 2019, identified patients would receive at least ten calendar days advance notice of the termination of a service by a home care provider. The agency's policy, Patients' Rights, Responsibilities and Consent, with review date 2/15/22, indicated the patient's rights included patients had the right to be notified verbally and in writing prior to the start of care and as changes occurred. Patients had the right to receive proper written notice consistent in advance of a specific serv ice being furnished if the agency believed that the service may be non-covered care or in advance of the agency reducing or terminating ongoing care. The agency's Transfer and Discharge policy with last revision date 6/13/24, directed agency staff to notify the patient, the patient's representative, attending physician, podiatrist, or allowed practitioner of the patient's condition and reason for discharge. In addition, the patient would be provided with verbal and/or written instructions regarding, as appropriate: i. Community services available to the patient; ii. Medication use and/or a copy of the final medication profile; iii. Home exercise plan; iv. Any procedures and/or treatments to be performed; and/or v. Follow-up visits for physician care	G0442		
G0454	HHA can no longer meet the patient's needs CFR(s): 484.50(d)(1) The transfer or discharge is necessary for the patient's welfare because the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity. The HHA must arrange a safe and appropriate	G0454	**G0454 HHA can no longer meet the patient's needs** On review, Patient #1 was not notified, in writing, of service changes (NOMNC) prior to receiving physician discharge order. The patient was not provided with options of other support services or physician's care prior to being discharge from agency. To ensure compliance this standard is met the Administrator or designee will: (1) Ensure patients are provided with information that conveys to them and/or their caregivers of the patient's rights including active and informed participation in their care with discharge planning and discharge from services.	12/12/24

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247166	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCENTCARE FAIRVIEW HOME HEALTH - EAST LLC	3507 Highpoint Drive N, S140 , Oakdale, Minnesota, 55128

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G0454	Continued from page 10 transfer to other care entities when the needs of the patient exceed the HHA's capabilities; This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to notify the patient, her representative and other physicians involved with the patient's care the agency was considering a discharge for 1 of 5 patients (P1) who was discharged from the agency. P1's start of care (SOC) was 3/4/24. P1's plan of care (POC) for the certification period 7/2/24 to 8/30/24, included diagnoses of chronic venous hypertension with ulcer of left lower extremity, non-pressure chronic ulcer other than left lower leg, manic episode, rheumatoid arthritis, and hemiplegia. The POC further indicated P1 received skilled nurse visits (SNV) two times weekly for two weeks, one time week for two weeks, one visits every other week for four weeks, then one time per week for one week for various assessments, wound care evaluation and treatment and education. Occupational therapy and social worker were ordered for one visit. Review of P1's medical record identified the following: Care Coordination note 7/30/24, P1 contacted an agency nurse regarding concerns related to the reduction in frequency of nursing visits from two times per week to one time every other week. P1 requested to talk with her case manager registered nurse (RN)-B. It was noted RN-B would be notified to contact P1, however no return call had been documented. Care Coordination note 7/31/24, clinical manager (CM)-A obtained order from nurse practitioner (NP)-B to discharge P1 from home care services as she had not been seen in clinic for two months and NP-B unable to continue signing orders for her care. Care Coordination note 7/31/24, FM-C called the agency, angry that P1 was not receiving wound care and services as ordered. FM-C stated P1 needed on-going wound care. CM-A notified FM-C the provider would no longer sign orders for home care services due to P1 was non-compliant and did not keep her scheduled appointments with her provider. CM-A notified FM-C the agency had obtained an order for P1 to be discharged from home care services. During interview on 10/21/24, at 3:50 p.m. FM-C stated P1 had nurse visits two times per week to evaluate and change dressing to an ulcer on P1's leg that would not	G0454	(2) Ensure that patients and staff are informed of patient rights, responsibilities, consent, and patient's rights are respected. (3) Provide education to the Clinical Manager, Patient Care Managers, Registered Nurses, LVNs, Therapists, Therapy Assistants, and Social Workers and will include the following topics • C 2.4 Availability of Services- Acceptance, Admission, Ongoing and Discharge • HH 2.0.1 "Patient Rights, Responsibilities and Consent" • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • HH 2.1.5 "Plan of Care" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge **Immediate Action:** All Clinicians involved in care of Patient #1 will receive remedial education about provision of the patient being informed and notified of pending discharge, allowed participation in the discharge planning process and assisting patient with obtaining post discharge care and/or services when continued care or services are identified as well as delivering written notice of agency's change or termination of services . Additional clinicians identified to be out of compliance with the above requirements will receive counseling and remedial education by the Clinical Manager/PCM to ensure understanding and compliance. 12/3/24 **Corrective Action:** The Administrator or designee will 1. Provide education during mandatory clinical staff education training to include the following topics: Review of the organizations Home Health Policies: 12/12/24 • C 2.4 Availability of Services- Acceptance, Admission, Ongoing and Discharge • HH 2.0.1 "Patient Rights, Responsibilities and Consent" • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • HH 2.1.5 "Plan of Care" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge	

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G0454	Continued from page 11 heal. The home care agency just stopped coming out to see P1. The agency had not called to notify anyone they were no longer going to come out, they just stopped nurse visits to P1 without any warning. FM-C had gotten involved about a week after the agency had stopped their visits and called the agency when P1 had told her they were only going to come every two weeks and not the two times per week they were doing. The first time she heard they were no longer going to see P1 was when FM-C had called the agency on 7/31/24 and she was P1's appointed health care agent. During telephone interview on 10/22/24, at 10:50 a.m. social worker for the Department of Human Services (SW)-D stated she had visited P1 and FM-C on 8/8/24, to investigate a self-neglect report from the agency. The agency was concerned P1 or FM-C were caring for P1's wounds properly and about P1's dirty home environment. P1 had been seen by the wound care clinic that week and her home environment was clean during SW-D's visit. SW-D felt there was poor communication between the home care agency and the patient. P1 relied heavily on assistance from FM-C to coordinate appointments and lots of other things. The vulnerable adult report had indicated P1 had received skilled nurse visits and social work visits and due to missed appointments the physician had dropped services. SW-D stated that was not true, P1 had a doctor appointment prior to when SW-D had seen her on 8/8/24 and had another appointment scheduled the following week. During telephone interview on 10/22/24, at 3:00 p.m. LPN-A stated she had completed visits for P1 on 7/18/24, and 7/23/24. On P1's last visit from the agency on 7/23/24, LPN-A had not been aware that P1 was going to have decrease nurse visit frequency, or a pending discharge so had not discussed that with P1 or P1's primary care giver FM-C. When interviewed on 10/22/24, at 3:30 p.m. CM-A stated she had called P1's physician and P1 had not followed recommendations to promote wound healing and had skipped scheduled medical appointments. The physician had given the agency permission to discharge as the primary physician would no longer follow the patient. She was not aware P1 had a veteran's agency (VA) physician involved who had given orders for wound care, and the agency had not notified that physician P1 was discharged for cause. The agency policy Physician Plan of Care with revision date 3/1/19, identified any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative, caregiver	G0454	2. The Administrator or designee will review required information in detail including patient rights, responsibilities, discharge planning with Notice of Medicare Non Coverage (NOMNC) 3. Review documentation necessary to provide evidence of patient, caregiver, physician coordination of care attempts to resolve issues. Clinical Manager/Patient Care Manager (PCM) or designees using the Discharge Report to audit clinical and coordination notes, and timely NOMNC added to the patient record to confirm compliance with organization policies. The Administrator or designee will instruct the Clinical Manager/ PCM this is part of their supervision, oversight, and audit responsibilities, to ensure compliance. **Audit Activity** Each patient record will be audited for evidence of NOMNC included in the record for termination of services until 100% obtained and continue for 60 days. 1. 100% of discharged patients will be audited for no less than 60 days to ensure that the patient/caregiver, at the time of discharge • Received discharge planning with documentation of any necessary assistance in obtaining post discharge care and/or services • Documentation to support coordination of care • Received NOMNC timely 2. This audit will be performed by the Clinical Manager or designee under the direction of the agency Administrator. Designated Registered Nurses and or Therapists may assist with audits as determined by the agency Administrator. 3. The benchmark or target goal for this audit is 100%. Individuals completing audits will notify the Clinical Manager and Administrator of clinicians who demonstrate ongoing non-compliance for a "corrective action plan" per the organization's policy. **Ongoing Monitoring:** Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program with an expected threshold of 100%. Audit results will be tracked, trended, shared with agency leadership, and reported to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations.	12/12/24 12/12/24

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G0454	Continued from page 12 and all physicians issuing orders for the home health agency plan of care. The agency policy Transfer and Discharge of Patients with revision date 6/13/24, identified a patient may be discharged for reasons including safety concerns, or the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the Agency to operate effectively is seriously impaired. The patient/patient representative and physician, podiatrist or allowed practitioner would be advised of the plan to discharge/transfer. The clinical manager or designee would make efforts to resolve problems prior to discharge/transfer. The agency would have documentation of their efforts made to resolve issues.	G0454	**G458 Outcomes/ goals have been achieved** On review, Patient #2 was discharged without documentation of completing treatment goals or outcomes having been met and failed to notify the physician on the discharge plan. To ensure compliance this standard is met the Administrator or designee will: 1. Ensure the outcomes and patient goals have or have not been achieved and documented prior discharge from service. 2. Ensure the physician is informed and agrees that the patient no longer requires home health agency services. 3. Ensure that patients and staff are informed of patient rights, responsibilities, consent, and patient's rights are respected. 4.. Provide education to the Clinical Manager, Patient Care Managers, Registered Nurses, LVNs, Therapists, Therapy Assistants, and Social Workers and will include the following topics • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge 5. Coordination of care is effective and appropriate to patient status with documented physician notification. **Corrective Action:** The Administrator or designee will: 1. Provide education during mandatory clinical staff education training to include the following policies: • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge	12/12/24 12/12/24
G0458	Outcomes/goals have been achieved CFR(s): 484.50(d)(3) The transfer or discharge is appropriate because the physician or allowed practitioner, who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved, and the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services; This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to ensure patient's physician agreed discharge was appropriate with goals met and patient no longer required home health care services for 1 of 5 patients (P2) reviewed for discharge from agency. P2's SOC was 1/22/21. P2's POC for the certification period 11/18/21 to 1/16/21, included diagnoses of pneumonitis due to inhalation of food or vomit, malignant neoplasm (cancer) of tongue, dysphagia (swallowing difficulty), malignant neoplasm of head, face and neck, pain, diabetes, depression, encounter for attention to tracheostomy (artificial tube in neck to breathe), and encounter for attention to gastrostomy (artificial tube in stomach for nutrition). The POC further indicated P2 received skilled nurse visits (SNV) one time per week for one week, one time every three weeks for three weeks, then one visit every two weeks for two weeks for various assessments, medication management, infection control, management of diabetes	G0458		

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G0458	Continued from page 13 and symptoms, and education. Review of P2's medical record identified the following: Coordination care note dated 12/28/21, identified a SNV was completed. Medications were setup and assessments completed. A discharge plan was not documented as P2 was unable to manage her medications. -On 1/7/22, registered nurse (RN)-D documented a case conference note for recertification due to the issue of not able to manage complex or high-risk medications regimen which required ongoing skilled nurse treatment. -On 1/14/22, RN-E completed a desk discharge for P2, without home visit. The discharge was documented as a RN discharge data collection only with no visit made. P2's physician order dated 1/27/22, indicated payor change with new start of care needed. P2's medical record lacked evidence of physician notification or order to discharge from home health care services. There was no evidence P2's primary physician had been consulted regarding a potential discharge of services. During interview on 10/23/24, clinical manager (CM)-A stated P2's services had gotten dropped prematurely and she had been discharged in error. P2's discharge was completed due to a change with P2's fee source and a new start of care was needed following the paper desk discharge. The physician was not notified of the discharge due to services were omitted in error. The agency's policy Transfer and Discharge of Patients, last revised 6/13/24 identified when the physician, podiatrist, or allowed practitioner responsible for the home health plan of care and the agency agree that the measurable outcomes and goals outlined in the plan of care have been achieved, and the patient no longer needs the services. The RN/qualified therapist would ensure that the treatment goals and patient outcomes have been met or are no longer applicable. The Agency staff would notify the patient, the patient's representative, attending physician, podiatrist, or allowed practitioner of the patient's condition and reason for discharge.	G0458	2. The Administrator or designee will review pending discharges for coordination of care and documentation to ensure physician has been notified of status of outcomes, goals and pending discharge. Clinical Manager/Patient Care Manager (PCM) or designees using the Recert Report to audit clinical and coordination notes to ensure appropriate care coordination with physician of patient's outcome and goal status pending discharge. The Administrator or designee will instruct the Clinical Manager/ PCM this is part of their supervision, oversight, and audit responsibilities, to ensure compliance. **Audit Activity** 1. Each discharged patient record will be audited for physician notification of outcomes and goals status prior to discharge until 100% obtained and continue for no less than 60 days. 2.. This audit will be performed by the Clinical Manager or designee under the direction of the agency Administrator. Designated Registered Nurses and or Therapists may assist with audits as determined by the agency Administrator. 3. The benchmark or target goal for this audit is 100%. Individuals completing audits will notify the Clinical Manager and Administrator of clinicians who demonstrate ongoing non-compliance for a "corrective action plan" per the organization's policy. **Ongoing Monitoring:** Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program with an expected threshold of 100%. Audit results will be tracked, trended, shared with agency leadership, and reported to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations.	12/12/24 12/12/24 and Ongoing
G0468	Provide contact info other services CFR(s): 484.50(d)(5)(iii)	G0468		

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G0468	Continued from page 14 (iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to provide 2 of 5 patients (P1, P2) reviewed for discharge, with information required related to other available home care providers at the time of a facility-initiated discharge. P1's start of care (SOC) was 3/4/24. P1's plan of care (POC) for the certification period 7/2/24 to 8/30/24, included diagnoses of chronic venous hypertension with ulcer of left lower extremity, non-pressure chronic ulcer other than left lower leg, manic episode, rheumatoid arthritis, and hemiplegia. The POC further indicated P1 received skilled nurse visits (SNV) two times weekly for two weeks, one time week for two weeks, one visits every other week for four weeks, then one time per week for one week for various assessments, wound care evaluation and treatment and education. Occupational therapy and social worker were ordered for one visit. P1's ordered home care services were stopped on 7/31/24, due to non-compliance and failing to keep scheduled medical appointments. P1's care coordination note dated 7/31/24, identified P1 was discharged by the agency as she no longer had a physician following her. Nurse practitioner (NP)-B was unwilling to sign orders related to P1 because she frequently missed her scheduled medical appointments. P1 did have an appointment to establish care at the veteran's clinic on 8/5/24. Per documentation, P1 had wounds that were not healing and new pressure ulcer on her elbow due to resting it on the bed. P1 had a recent nurse visit and was able to verbalize what was needed to help her wounds heal but P1 has chosen not to follow the plan of care. Family has been taught how to do wound care and had provided wound care between nurse visits in the past and were felt to be capable to provide care until P1 could find a provider to follow her for home health. An order was received to discharge P1 from home care services. P1's medical record lacked evidence P1 had received information related to other available home care providers in the area. During interview on 10/21/24, at 3:55 p.m. family member (FM)-C stated the agency just stopped coming to	G0468	**G0468 Provide contact info other services** On review, Patients #1 and 2 were not provided verbal or written instructions regarding appropriate community services, copy of final medication profile, home exercise plan, procedures and treatments to be performed and follow up physician visit. To ensure compliance this standard is met the Administrator or designee will: (1) Ensure patients are provided with information regarding discharge planning to include appropriate community services, copy of final medication profile, home exercise plan, procedures and treatments to be performed and follow up physician visit. (2) Provide education to the Clinical Manager, Patient Care Managers, Registered Nurses, LVNs, Therapists, Therapy Assistants, and Social Workers and will include the following topics • HH 2.1.7 entitled "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 entitled "Care Planning and Coordination" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge **Immediate Action:** All Clinicians involved in care of Patients #1 and 2 will receive remedial education about provision of the patient being informed and notified of pending discharge, appropriate community services, copy of final medication profile, home exercise plan, procedures and treatments to be performed and follow up physician visit. Patients are allowed participation in the discharge planning process and assisting patient with obtaining post discharge care and/or services when continued care or services are identified as well as delivering written notice of agency's change or termination of services. Additional clinicians identified to be out of compliance with the above requirements will receive counseling and remedial education by the Clinical Manager/PCM to ensure understanding and compliance. Corrective Action: The Administrator or designee will (1) Provide education during mandatory clinical staff education training to include the following topics: Review of the organizations Home Health Policies: • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge	12/12/24 12/3/24

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G0468	Continued from page 15 see P1 without any notice. The agency did not provide P1 with a list of alternative health care agencies in the area that may provide care and services. During telephone interview on 10/22/24 at 10:50 a.m. social worker for the Department of Human Services (SW)-A stated she had visited P1 and FM-C on 8/8/24. They asked her if there were other agencies in the area that could provide P1's care as they had not been provided with a list of alternative health care agencies, When interviewed on 10/22/24, at 3:00 p.m. licensed practical nurse (LPN)-A stated she had not provided P1 or FM-C with a list of other providers in the area when she completed her last visit on 7/23/24, because she had not been aware of the pending discharge. When interviewed on 10/22/24, at 3:30 p.m. clinical manager (CM)-A stated the agency had not provided P1 a list of other home care providers in the area at the time of the facility-initiated discharge. P2's SOC was 1/22/21. P2's POC for the certification period 11/18/21 to 1/16/21, included diagnoses of pneumonitis due to inhalation of food or vomit, malignant neoplasm (cancer) of tongue, dysphagia (swallowing difficulty), malignant neoplasm of head, face and neck, pain, diabetes, depression, encounter for attention to tracheostomy (artificial tube in neck to breathe), and encounter for attention to gastrostomy (artificial tube in stomach for nutrition). The POC further indicated P2 received skilled nurse visits (SNV) one time per week for one week, one time every three weeks for three weeks, then one visit every two weeks for two weeks for various assessments, medication management, infection control, management of diabetes and symptoms, and education. On 1/14/22, RN-E completed a desk discharge for P2, without home visit. The discharge was documented as a RN discharge data collection only with no visit made. Physician order dated 1/27/22, indicated P2 had a payor change with new start of care needed. P2's medical record lacked evidence P2 had received information related to other available home care providers in the area prior to being discharged from the agency on 1/14/22. During interview on 10/23/24, at 3:30 p.m. CM-A stated a desk discharge had been completed due to a change in her payor source. A new start of care should have been	G0468	Clinical Manager/Patient Care Manager (PCM) or designees using the Discharge Report to audit clinical and coordination notes associated with patient discharge planning to confirm compliance with organization policies. The Administrator or designee will instruct the Clinical Manager/ PCM this is part of their supervision, oversight, and audit responsibilities, to ensure compliance. **Audit Activity** Each discharged patient record will be audited for appropriate community services, copy of final medication profile, home exercise plan, procedures and treatments to be performed and follow up physician visit until 100% obtained and continue for 60 days. 1. 100% of discharged patients will be audited for no less than 60 days to ensure that the patient/caregiver, at the time of discharge • Received discharge planning with documentation appropriate community services, copy of final medication profile, home exercise plan, procedures and treatments to be performed and follow up physician visit. 2. This audit will be performed by the Clinical Manager or designee under the direction of the agency Administrator. Designated Registered Nurses and or Therapists may assist with audits as determined by the agency Administrator. 3. The benchmark or target goal for this audit is 100%. 4. Individuals completing audits will notify the Clinical Manager and Administrator of clinicians who demonstrate ongoing non-compliance for a "corrective action plan" per the organization's policy. **Ongoing Monitoring:** Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program with an expected threshold of 100%. Audit results will be tracked, trended, shared with agency leadership, and reported to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations.	12/12/24 12/12/24 and Ongoing

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NAME OF PROVIDER OR SUPPLIER **ACCENTCARE FAIRVIEW HOME HEALTH - EAST LLC**		STREET ADDRESS, CITY, STATE, ZIP CODE **3507 Highpoint Drive N, S140 , Oakdale, Minnesota, 55128**	

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G0468	Continued from page 16 initiated but it was missed. P2 had not been given information or listing regarding alternative home care providers in the area that could provide care prior to the facility-initiated discharge as required. The agency's Transfer and Discharge of Patients policy, revised 6/13/24, identified the patient would be provided with verbal and/or written instructions regarding, as appropriate for community services available to the patient, medication use and/or a copy of the final medication profile, home exercise plan, any procedures and treatments to be performed and follow up visits for physician care.	G0468	**G0536 A review of all current medications** To demonstrate the commitment to compliance and provide immediate correction, the Agency Administrator/designee will ensure Clinical Staff are compliant with documentation/review of medication profile to include complete medication reconciliation, drug interactions, duplicative therapy, and appropriate physician notification including potential adverse effects and drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, and noncompliance with drug therapy. **Immediate Actions:** The Administrator/designee will review 100% patient's records will have medication reconciliation completed by a qualifying clinician with notification of physician if there are inconsistencies and then prepare an updated medication list by 12/12/24.	12/12/24 12/3/24
G0536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is NOT MET as evidenced by: Based on observation, interview and document review, the agency failed to ensure all medications, including dose, route, frequency and time of administration, was comprehensively assessed and documented for 3 of 7 patients (P7, P9, P12) whose medications were reviewed during home visits. P7's plan of care (POC) for certification period 10/17/24 to 12/15/24, indicated P7's start of care (SOC) was 8/18/24, and diagnosis included acute cystitis (a bladder infection), hypertensive heart disease with heart failure (high blood pressure), anxiety, major depressive disorder (depression), and migraine. POC included a comprehensive medication list. During skilled nurse visit on 10/21/24 at 1:33 p.m., patient inquired about a medication not on her medication list, divalproex 1 tab daily for migraines. P7 asked registered nurse (RN)-A what the medication was used for. RN-A explained use of the medication and inquired how long P7 had been taking it. P7 stated she had been taking since she was discharged from the hospital. P7 indicated she took it PRN, not as prescribed as once daily. P7 stated she was unaware she was supposed to be taking it daily. Medication label indicated a fill date of 9/10/24. Divalproex was not listed on P7's medication list on POC.	G0536	**Corrective Action:** The Agency Administrator/designee will conduct education with clinical and supervisory staff regarding policies and require signed attestation of education by 12/3/24: • HH 2.1.4 Care Planning and Coordination • HH 2.2.6 Medication Profile Review and Reporting of Findings • VNAA 16.04 Assessment and Comprehensive Medication Review • VNAA 16.05 Medication Reconciliation • VNAA 16.06 Medication Orders and Documentation • AC Best Practice "My Patient, My Responsibility" Schedule visit to the patient's home will be completed to ensure that the agency's medication profile includes patient's current medications. Physician will be notified of all medication changes/discrepancies and non-compliance. The Clinical Supervisor/Clinical Manager will ensure that timely contact with the physician is documented in the clinical record by 12/12/24. **Systemic change**: The Clinical Manager/Patient Care Manager (PCM) will ensure the medication profile was compared to the Plan of Care/ 485; ensuring all medications are accurately and completely documented on the medication profile. All physician notifications of these medication issues will be validated during Plan of Care review and ongoing orders management process via PCM workflow and record. Medication changes and Plan of Care changes will be printed and delivered to the patients home daily and reviewed/education with patient/caregiver by visiting clinician to ensure compliance and accuracy.	12/12/24 12/12/24

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G0536	Continued from page 17 During comprehensive medication review during the visit, multiple medication discrepancies were found. In addition to the divalproex, P7 stated she has stopped taking clonidine hcl 0.1 mg about a month ago. Clonidine was listed as an active medication on POC. P7 stated she thought she was still taking duloxetine 60 mg daily. Duloxetine was not found in P7's home. P7 stated she had been feeling increased anxiety lately and had an appointment scheduled with her primary care provider (PCP) in a few days to address anxiety. P7 had a bottle of calcium 600 mg with D3 with an expiration date on the bottle of November 2023. Calcium with D3 was not included on P7's POC and she stated she was not aware the medication was expired. P7 stated she had been taking pregabalin 150 mg once daily. Pregabalin was listed on POC as taking twice daily. P7 stated she had not been taking vitamin C or zinc gluconate daily as listed on the POC. P7 stated she did not have a current medication list in her home. During interview on 10/21/24 at 2:26 p.m., RN-A stated a medication reconciliation should be competed at start of care and changes updated with every visit. The PCP should be contacted with any discrepancies for clarification and orders. RN-A confirmed medication discrepancies and stated she would be updating the provider. RN-A stated it was concerning P7 did not have her duloxetine in her home and was experiencing increased anxiety. P9's POC for certification period 9/1/24 to 10/30/24, indicated P9's SOC was 9/1/24, and diagnosis included zoster without complications (shingles), malignant neoplasm of left breast (breast cancer), hypertensive heart disease (high blood pressure), type 2 diabetes, and chronic obstructive pulmonary disease (a lung disease caused by damage to the airway). POC included a comprehensive medication list. During a home visit on 10/22/24 at 1:31 p.m., P9 indicated her daughter assisted with managing her medications. Multiple discrepancies were found during a comprehensive review of medications. P9 was taking armodafinil 200 mg daily. POC listed armodafinil at 150 mg daily. P9 was taking gabapentin 100 mg three times a day. POC included gabapentin 100 mg for five days. POC did not include a start and stop date. P9 was taking omeprazole 20 mg twice a day; POC included omeprazole once per day. P9 was taking prednisone 5 mg daily as a long term medication. POC included prednisone as a taped medication. POC did not indicate start and stop dates for prednisone. P9 reported taking the following medications not listed on the POC: krill oil 500 mg	G0536	**Monitoring:** The Clinical Manager/designee will audit 100% medication reconciliation review of active census with required documentation of any discrepancies and communication to physician of identified medication issues are tracked daily by a member of the clinical operating team. Medication reconciliation process will be repeated continually until accuracy meets 100% threshold. 1. 100% of census will have a HH-Survey Recovery Coordination Note documented for medication reconciliation 2. The PCM/designee will review daily to ensure 100% compliance will be met by 12/12/24. **Ongoing Monitoring:** Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program with an expected threshold of 100%. Audit results will be tracked, trended, shared with agency leadership, and reported to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations	12/12/24 12/12/24 and Ongoing

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G0536	Continued from page 18 daily, niacin 500 mg daily, iron slow release 45 mg daily, and cranberry 15000 mg twice a day. P9 stated she did not have a current medication list in her home. P9 was also observed to be on oxygen, which was not on the medication list. During interview on 10/23/24 at 3:00 p.m., clinical manger (CM) stated the medication review could have been better and confirmed every patient should have an up to date medication list in their home. During interview on 10/23/24 at 3 p.m., clinical manager (CM) stated medications should be reviewed at start of care by comparing the bottles in the home with a current medication list. All discrepancies should be addressed with the provider and documented. CM stated all patients should have a current medication list in their home. CM stated medication changes should be reviewed at every home visit and education on proper disposal should happen if a medication was discontinued. CM stated medication reconciliation was important to ensure there are not interaction and so providers are aware of what was being taken. P12's plan of care (POC) 10/9/24 through 12/7/24, identified a start of care date 10/9/24. Diagnoses included presence of left artificial hip joint aftercare following joint replacement. heart disease with heart failure, atrial fibrillation (irregular heartbeat), diabetes and a history of falls. Skilled nurse visits (SNV) were ordered 1 visit every week for three weeks then every two weeks for six weeks for various assessments, evaluation, perform and teach wound care and education regarding medications and co-morbid conditions. Physical therapy (PT) was ordered one visit per week for one week then two visits per week for one week then one visit per week for five weeks evaluate rehab potential, home environment and safety and to increase functional independence. Medications included Tylenol 650 milligrams (mg) as needed (PRN), cetirizine 10 mg daily, Eliquis (a blood thinner) 5 mg two times per day (BID), fish oil 1000 mg daily, furosemide 20 mg PRN for edema (swelling), metformin (to treat diabetes) 500 mg daily, metoprolol (for blood pressure) 50 mg BID, mometasone nasal spray (to treat allergy symptoms) PRN, multivitamin 50 plus daily, rosuvastatin (for cholesterol) 10 mg daily, and vitamin D3 1000 units daily, During a home visit on 10/22/24, at 10:00 a.m. P12 stated she was not taking fish oil, a multivitamin, or vitamin D3 as she suspected they may be contributing to some nausea she was experiencing. P12 brought out her bottle of Eliquis, which was labeled 2.5 mg tablets and	G0536		

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G0536	Continued from page 19 reported she took one tablet from the bottle every morning and night. P12 stated she had been taking the same Eliquis dose since her heart disease diagnoses two years ago and did not remember having any changes with the medication. Review of P12's hospital discharge summary in her home identified order for Eliquis 5 mg BID, P12 was not aware her hospital discharge orders instructed her to take Eliquis 5 mg tablets BID. On review of medication bottles sent home with her from her hospital discharge identified a bottle of Eliquis 5 mg with instructions to take one tablet every day. P12 stated she had not noticed the changed dosage on the new bottle as she had been using up her old bottle first. Comparison of both bottles of Eliquis in the home identified Eliquis 5 mg BID was filled on 5/8/24, and Eliquis 2.5 mg BID was filled 10/3/24. When interviewed on 10/22/24, at 10:30 a.m. registered nurse (RN)-B stated she had physically looked at all the bottles P12 had on her counter, including the ones she had picked up after her hospitalization. The Eliquis bottle on the counter was the correct dose of 5mg BID. She had reviewed all P12's medications at start of care and recorded what P12 had reported to her that she was currently taking. RN-B was not aware P12 had another bottle of Eliquis in her possession. She did not know why the 2 bottles had different dosages and it would need to be clarified with P12's physician and the pharmacy as soon as possible. During interview on 10/22/24, at 3:30 p.m. the clinical manager (CM)-A stated a patient's medication list should reflect what the patient was actually taking. During interview on 10/23/24, at 8:30 a.m. RN-B stated she had clarified P12's Eliquis order with her physician. P12 was supposed to take Eliquis 5 mg BID. The physician was notified P12 had been taking an incorrect dose of the medication since her hospital return and would now correctly take the prescribed dose of 5 mg BID. The agency's policy Medications: Medication Reconciliation with revision date 5/1/23, identified a complete medication reconciliation should be performed at time of admission. Staff were to compare the medications the patient had in their home with the list of current medications from the discharging agency or provider. The staff were instructed to have the patient collect all medications, including prescribed and over-the-counter medications, and review and record name, dose, route indication and frequency. Staff were to note any differences between the labels, orders and patient use document and resolve the differences by	G0536		

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G0536	Continued from page 20 either patient education or clarify orders from the provider.	G0536	**G0562 Discharge Planning** On review, Patients #1 and 2 were not notified, in discharge planning and in writing, of service changes (NOMNC). The patient was not provided with options of other support services or physician's care prior to being discharged from the agency. To ensure compliance this standard is met the Administrator or designee will: (1) Ensure patients are provided with information that conveys to them and/or their caregivers of the patient's rights including active and informed participation in their care with discharge planning and receive information about support services and/or continued physician care. (2) Ensure that patients and staff are informed of patient rights, responsibilities, consent, and patient's rights are respected and a safe discharge is documented. (3) Provide education to the Clinical Manager, Patient Care Managers, Registered Nurses, LVNs, Therapists, Therapy Assistants, and Social Workers and will include the following topics • C 2.4 Availability of Services- Acceptance, Admission, Ongoing and Discharge • HH 2.0.1 "Patient Rights, Responsibilities and Consent" • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • HH 2.1.5 "Plan of Care" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge **Immediate Action:** All Clinicians involved in care of Patients #1 and 2 will receive remedial education about provision of the patient being informed and notified of pending discharge, allowed participation in the discharge planning process and assisting patient with obtaining post discharge care and/or services when continued care or services are identified as well as delivering written notice of agency's change or termination of services. Additional clinicians identified to be out of compliance with the above requirements will receive counseling and remedial education by the Clinical Manager/PCM to ensure understanding and compliance.	12/12/24 12/3/24
G0562	Discharge Planning CFR(s): 484.58(a) Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care provider by using and sharing data that includes, but is not limited to HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. This STANDARD is NOT MET as evidenced by: Based on interview and document review, the agency failed to discharge 2 of 5 patients for appropriate cause and failed to develop and implement an effective discharge planning process to effectively transition patients from home health services to post home health services care for 2 of 5 patients (P1, P2) reviewed for discharge. P1's start of care (SOC) was 3/4/24. P1's plan of care (POC) for the certification period 7/2/24 to 8/30/24, included diagnoses of chronic venous hypertension with ulcer of left lower extremity, non-pressure chronic ulcer other than left lower leg, manic episode, rheumatoid arthritis, and hemiplegia. The POC further indicated P1 received skilled nurse visits (SNV) two times weekly for two weeks, one time week for two weeks, one visits every other week for four weeks, then one time per week for one week for various assessments, wound care evaluation and treatment and education. Occupational therapy and social worker visits were ordered for one visit. Review of P1's medical record identified the following: -on 7/23/24, licensed practical nurse (LPN)-A conducted a visit for wound care and assessment. Interventions for wound and skin care was discussed as well as planned care coordination with P1's Veteran's Agency (VA) physician. No change of frequency or duration of services were identified.	G0562		

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G0562	Continued from page 21 -on 7/31/24, clinical manager (CM)-A obtained order from P1's primary physician to discharge P1 from home care services as she had not been seen in clinic for two months and the nurse practitioner would be unable to continue signing orders for her care. The agency did have a plan of care that remained active until 8/30/24 and P1 had an pending appointment to establish care with a primary physician on 8/5/24. -on 7/31/24, FM-C called the agency, angry P1 was not receiving wound care and services as ordered. FM-C stated P1 needed on-going wound care. CM-A notified FM-C the provider would no longer sign orders for home care services due to P1 was non-compliant and did not keep her scheduled appointments with her provider. CM-A notified FM-C the agency had obtained an order for P1 to be discharged from home care services. During interview on 10/22/24, at 3:00 p.m. LPN-A stated she had not been aware of P1's pending discharge during her visit on 7/23/24, so had not discussed discharge and post discharge care with P1 or her caregiver FM-C. When interviewed on 10/22/24, at 3:30 p.m. clinical manager (CM)-A stated on 7/31/24, she had called the nurse practitioner (NP)-A, who followed P1 for wound care, regarding P1's noncompliance with following recommendations and missed medical appointments and received an order to discharge P1. P1's caregiver was notified of the discharge during a telephone conversation and no further agency visits were conducted. P1's medical record lacked documentation of discharge planning, assistance with post-discharge care and obtaining services and medical appointments for after care. P1 and her representative were not aware of pending discharge and were unable to participate in the discharge planning process despite a continued need for home health services and wound care assessment and evaluation. P1's chosen VA provider had not been notified of details and response to her home health services or her pending discharge. P2's SOC was 1/22/21. P2's POC for the certification period 11/18/21 to 1/16/21, included diagnoses of pneumonitis due to inhalation of food or vomit, malignant neoplasm (cancer) of tongue, dysphagia (swallowing difficulty), malignant neoplasm of head, face and neck, pain, diabetes, depression, encounter for attention to tracheostomy (artificial tube in neck to breathe), and encounter for attention to gastrostomy (artificial tube in stomach for nutrition). The POC	G0562	**Corrective Action:** The Administrator or designee will 1. Provide education during mandatory clinical staff education training to include the following topics: Review of the organizations Home Health Policies: • C 2.4 Availability of Services-Acceptance, Admission, Ongoing and Discharge • HH 2.0.1 "Patient Rights, Responsibilities and Consent" • HH 2.1.7 "Transfer and Discharge of Patient-NOMNC" • HH 2.1.4 "Care Planning and Coordination" • HH 2.1.5 "Plan of Care" • AC Best Practice "My Patient, My Responsibility" • HH Protocol- Safe Discharge 2. The Administrator or designee will review 100% of discharged patients to ensure required documentation including patient rights, responsibilities, safe discharge planning with Notice of Medicare Non Coverage (NOMNC) and post discharge support has been provided to patient/caregiver. Clinical Manager/Patient Care Manager (PCM) or designees using the Discharge Report to audit clinical and coordination notes, and timely NOMNC added to the patient record to confirm compliance with organization policies. The Administrator or designee will instruct the Clinical Manager/ PCM this is part of their supervision, oversight, and audit responsibilities, to ensure compliance. **Audit Activity** The Administrator/ Clinical Manager or designee will: 1. Audit 100% of discharged patients for no less than 60 days to ensure that the patient/caregiver, at the time of discharge • Received and participated in discharge planning with documentation of any necessary assistance in obtaining post discharge care and/or services • Received NOMNC timely 2. The benchmark or target goal for this audit is 100%. Individuals completing audits will notify the Clinical Manager and Administrator of clinicians who demonstrate ongoing non-compliance for a "corrective action plan" per the organization's policy.	12/12/24 12/12/24

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G0562	Continued from page 22 further indicated P2 received SNV one time per week for one week, one time every three weeks for three weeks, then one visit every two weeks for two weeks for various assessments, medication management, infection control, management of diabetes and symptoms, and education. Review of P2's coordination and visit notes identified the following: -On 12/28/21, a skilled nurse visit (SNV) was completed. Medications were setup and assessments completed. No discharge plan was documented as patient was unable to manage medications. -On 1/7/24, registered nurse (RN)-D documented a case conference note for recertification due to the issue of not able to manage complex or high-risk medications regimen which required ongoing skilled nurse treatment. -On 1/14/22, RN-E completed a desk discharge for P2, without home visit. The discharge was documented as a RN discharge data collection only with no visit made. A physician order dated 1/27/24, indicated a payor change had occurred with a new start of care needed. During interview on 10/22/24, at 3:30 p.m. CM-A stated the agency had completed a desk discharge for P2 due to a fee source change and P2 should have had a new start of care visit completed immediately for continued services. That was not done and so P2's services had gotten dropped prematurely. P2 had not been notified of pending discharge and did not receive discharge planning prior to the actual discharge. P2's medical record lacked documentation of discharge planning, assistance with post-discharge care and obtaining services and medical appointments for after care. P2 was not made aware of pending discharge and was unable to participate in the discharge planning process despite a continued need for home health services, need for assessment and evaluation and medication management. P2's chosen provider had not been notified of details and response to her home health services or her pending discharge.	G0562	**Ongoing Monitoring:** Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program with an expected threshold of 100%. Audit results will be tracked, trended, shared with agency leadership, and reported to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations.	12/12/24 and Ongoing
G0564	Discharge or Transfer Summary Content CFR(s): 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information	G0564		

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G0564	Continued from page 23 pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. This STANDARD is NOT MET as evidenced by: Based on interview and document review, the agency failed to complete and send all necessary medical information pertaining to the patient's health care to involved practitioners to ensure the safe and effective transition of care for 1 of 5 patients (P2) reviewed for discharge. P2's SOC was 1/22/21. P2's POC for the certification period 11/18/21 to 1/16/21, included diagnoses of pneumonitis due to inhalation of food or vomit, malignant neoplasm (cancer) of tongue, dysphagia (swallowing difficulty), malignant neoplasm of head, face and neck, pain, diabetes, depression, encounter for attention to tracheostomy (artificial tube in neck to breathe), and encounter for attention to gastrostomy (artificial tube in stomach for nutrition). The POC further indicated P2 received skilled nurse visits (SNV) one time per week for one week, one time every three weeks for three weeks, then one visit every two weeks for two weeks for various assessments, medication management, infection control, management of diabetes and symptoms, and education. Care Coordination note dated 1/14/22, indicated RN-E completed a desk discharge for P2, without home visit. The discharge was documented as a RN discharge data collection only with no visit made. P2's physician order dated 1/27/22, indicated payor change with new start of care needed. P2's medical record lacked further nurse visits after the desk discharge dated 1/14/22. P2's medical record lacked evidence a discharge summary had been completed and/or P2's physician had been notified P2 had been discharged from home care services on 1/14/22. During interview on 10/24/24, at 11:30 a.m. clinical manager stated a desk discharge had been completed with the intention to restart services under a different fee source immediately following discharge. Because the start of care had been missed, P2 had her services dropped prematurely and no discharge summary had been done.	G0564	**G0564 Discharge or Transfer Summary Content** **Commitment to Compliance** To demonstrate the commitment to compliance and provide immediate correction, the Agency Administrator will ensure Clinical Staff are compliant with completion of discharge summary, to include but not limited to, post discharge goals and patient's plan of care. Patient #2 was reviewed and the agency confirmed that a discharge summary was not completed and failed to include documentation of post-discharge goals of care, and treatment plan, and was not sent to the receiving facility or health care practitioner to ensure the safe and effective transition of care **Immediate Correction**: The Agency Administrator met with Clinical Manager and Clinical Staff regarding required discharge summary documentation which includes all pertinent information to safely transition the patient to a receiving facility and/or health care provider/physician. **Corrective Action:** 1. The Agency Administrator/designee will conduct education with all clinical and supervisory staff regarding policies and require signed attestation of education: • HH 2.1.7 Transfer and Discharge of Patient • AC Best Practice "My Patient, My Responsibility" • AC Best Practice "Safe Discharge" 2. The Agency Administrator/designee will review the Agent Summary Report and Discharge Report daily to ensure discharge summaries are completed 3. The Agency Administrator/designee will validate discipline specific Discharge Summaries are completed daily via the fax console report during stand up. **Audit Activity:** As part of ongoing monitoring to ensure Agency Transfer/Discharge policy and regulations related to required Discharge Summary documentation are followed, the Administrator or designee will review 100% of discharged patient for compliance with appropriate Discharge Summary documentation and submission to facility and/or physician timely for no less than 60 days with 100% compliance.	12/12/24 12/3/24 12/12/24 12/12/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247166	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2024
NAME OF PROVIDER OR SUPPLIER: ACCENTCARE FAIRVIEW HOME HEALTH - EAST LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 3507 Highpoint Drive N, S140 , Oakdale, Minnesota, 55128	

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G0564	Continued from page 24 The agency's Transfer and Discharge policy with last revision date 6/13/24, identified at the completion of all Agency services, the last RN, or qualified therapist providing skilled care, would complete the discharge assessment for planned discharges and prepare a discharge summary of care, including services by the home health aide, if applicable, and would coordinate care by notifying the patient's physician, podiatrist, or allowed practitioner and clinical manager. A completed discharge summary would be sent to the physician, podiatrist, allowed practitioner or other health care professional responsible for providing care and services to the patient	G0564	**Ongoing Monitoring:** Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program with an expected threshold of 100%. Audit results will be tracked, trended, shared with agency leadership, and reported to the Quality Assurance Performance Improvement (QAPI) committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations.	12/12/24 and Ongoing
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 provide services as ordered in the Plan of Care (POC) and failed to inform the physician of services that were not provided . In addition, the agency failed to document the clinical impact and educate the client of the clinical impact of the missed visit. for 4 of 17 patients (P3, P7, P14, P15) reviewed for receiving services as indicated per the POC. Findings include: P3's plan of care (POC) 6/30/24 to 8/28/24, identified a start of care date 5/1/24. Diagnoses included multi-system degeneration of the autonomic nervous system, diabetes, kidney disease, chronic obstructive pulmonary disease, and malignant neoplasm of right kidney. Skilled nurse visits (SNV) were ordered one time per week for eight weeks for various assessments, wound care, treatments, education and evaluation.	G0572	**G0572 Plan of care** To demonstrate the commitment to compliance and provide immediate correction, the Agency Administrator or designee will ensure Clinical Staff are compliant with Care Planning, Coordination and Quality of Care. Patients #3, 7, 14 and 15 were reviewed and the agency confirmed that the agency failed to provide ordered services, failed to provide visits as ordered and did not notify physician of services not provided. The Agency Administrator or designee will ensure that agency will ensure clinicians furnishing services will ensure their efforts are coordinated effectively and support the objectives outlined/ ordered in the Plan of Care. To accomplish this, the Administrator/Alt. Administrator/Designee will take the following actions: **Corrective Action** 1. The Administrator/designee will ensure that the plan of care will be followed and that missed visits will be reported to the physician. 2. The Administrator or designee will provide education to all staff and will include the following topics • Policy HH 2.1.5 "Physician Plan of Care" • Policy HH 2.1.4 "Care Planning and Coordination Process" • AC Best Practice "My Patient, My Responsibility" 3. The Administrator or designee will instruct expectation that the plan of care will be followed and all missed visits will be documented, reported to the supervising RN/PT and to the physician.	12/12/24 12/12/24

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G0572	Continued from page 25 Physical therapy was ordered one time per week for two weeks, then one visit every two weeks for five weeks to improve physical functioning, safety, ambulation and gait training and improving strength and endurance. Review of P3's medical record lacked documentation of any skilled nurse visits for the weeks 7/14/24 and 8/18/24 and physical therapy visits for the weeks of 7/7/24, 8/4/24, and 8/18/24. There was no indication P3's physician had been notified when the SNV and PT visits were not conducted according to P3's POC. Further, there was no documentation of the clinical impact of the missed visits or that education was completed with P3 regarding the clinical impact of the missed visit. During interview on 10/24/24, at 3:45 p.m. the clinical manager stated she was unable to find documentation of the missing visits for P3 and was unable to find the reason the visits were omitted. P7's plan of care (POC) for the certification period 8/18/24 to 10/16/24, indicated P7's start of care (SOC) was 8/18/24, and diagnosis included acute cystitis (a bladder infection), hypertensive heart disease with heart failure (high blood pressure), anxiety, major depressive disorder (depression), and migraine. POC further indicated P7 received skilled nurse visits (SNV) once per week for 7 weeks, then once every 2 weeks for 2 weeks. Review of P7's clinical record lacked evidence of a SNV completed the weeks of 9/15/24 to 9/21/24. There was no indication in P7's medical record the provider was notified when the SNV was not completed per POC. During interview on 10/23/24 at 3:00 p.m., clinical manager (CM) confirmed P7 had not received all of the visits per the POC, the physician had not been notified of the missed visits. CM stated her expectation is the physician would be notified of all missed visits and the medical record contained evidence of the notification. P14's plan of care (POC) for the certification period 7/5/24 to 9/2/24, indicated P14's start of care (SOC) was 5/6/24, and diagnoses included pressure ulcer of right upper back, Multiple Sclerosis, and Trigeminal Neuralgia (a chronic pain disorder that causes severe facial pain). P14 received skilled nurse visits (SNV) once a week for one week then twice per week for eight weeks for various assessments , which included vital signs (blood pressure, temperature, pulse) and wound care to upper right back.	G0572	4. The Administrator or designee will inform all Registered Nurses, Physical Therapists, Occupational Therapists and Speech Therapists about the responsibility for supervision of patient care to include management of interventions, goals and specifically missed visits. 5. The Administrator or designee will review Missed Visit Report daily with the PCMs: • To ensure missed visits are documented and sent to physician timely • Orders will be obtained, as needed, from the physician for changes to the POC to ensure measurable outcomes and goals will be achieved. **Audit:** The Administrator will ensure compliance with missed visits and physician notification by: • Review of Missed Visit report daily with follow-up by PCMs/Clinical Support Staff (CSS) • Review of Fax status report daily • The Administrator or designee will review physician timely notification of missed visits for no less than 60 days with 100% compliance. **Ongoing Monitoring** As part of ongoing monitoring to ensure clinical supervision is executed/performed according to Agency policies listed above and regulations related to required Plan of Care components, including being patient specific, have measurable goals and outcomes, and was reviewed by a physician. The Administrator or designee will review 5% or a minimal of 20 clinical records each quarter for compliance with missed visit and notification to physician documentation. Clinical record review results will be tabulated quarterly, and compliance threshold reported to and monitored by the Administrator or designee, QAPI committee and the Professional Advisory Committee (PAC).	12/12/24 12/12/24 and Ongoing

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G0572	Continued from page 26 Review of P14's clinical record indicated a SNV was completed on 7/1/24, for recertification and a comprehensive assessment was completed. An order was obtained on 7/1/24, for SNV for once per week for 1 week then twice a week for eight weeks. Review of P14's clinical record for recertification period 7/5/24 to 9/2/24 revealed P14 received a SNV on 7/5/24, 7/8/24, 7/11/24, 7/18/24, 7/25/24, 8/5/24, 8/8/24, 8/12/24, 8/15/24, 8/19/24, 8/22/24, and 8/26/24. The record indicated a missed visit for 7/29/24 related to P14 refusal. There was no indication in P14's medical record the provider was notified when the SNV were not conducted according to the POC. Further, there was no documentation of the clinical impact of the missed visit or that education was completed with P14 regarding the clinical impact of the missed visit. During an interview on 10/23/24 at 10:04 a.m., registered nurse (RN)-A verified P14 had not received all the visits per the POC and the physician had not been notified of the missed visit. RN-A stated the physician should have been notified of the missed visit however, RN-A was unaware that the clinical impact of the missed visit should have been documented or that education of the clinical impact of the missed visit should have been done with P14. During an interview on 10/23/24 at 10:42 a.m., clinical manager (CM) verified P14 had not received all the visits per the POC, the physician had not been notified of the missed visit, no documentation was completed on the clinical impact of the missed visit and no education was provided to P14 regarding the clinical impact of the missed visit. CM stated the expectation was that the physician was notified of any missed visits. CM stated the agency needed a better process to ensure the physician is notified of missing visit. CM further stated she was unaware that the clinical impact of the missed visit should have been documented or that education of the clinical impact of the missed visit should have been done with P14. P15's POC for certification period 8/31/24 to 10/29/24, indicated P15's SOC was 8/31/24, and included diagnosis of atrial fibrillation, urinary tract infection, syncope and collapse (passing out), and hypertension. POC further indicated P15 would receive SNV once per week for 1 week, then once every 2 weeks for 2 weeks, then once per week for 1 week, then once every 2 weeks for 6 weeks. Physical therapy and a social worker were also included in the POC. Review of P15's clinical record indicated a SNV was	G0572		

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G0572	Continued from page 27 completed on 9/5/24 and 9/13/24. Verbal order documented 9/20/24 provided orders to move SNV to the following week for the week of 9/15/24 to 9/21/24. Clinical record failed to show completion of SNV from 9/21/24 through 10/23/24, a time span of 4 weeks. Clinical record failed to show evidence of updates to the provider. During interview on 10/23/24 at 2:57 p.m., CM confirmed the provider had not been updated on the missed visit for the week of 9/22/24 to 9/28/24. CM stated there was a note on 9/28/24 resident wanted to hold off on services, however the provider had not been updated on the patient's request. CM stated the staff had not followed the process for updating the provider with missed visits. The agency Home Care Staffing Guidelines policy revised 9/18/24, identified when a patient is missed resulting in fewer visits than the physician/practitioner ordered, the clinician shall document the missed visit along with a description of any unmet needs and how the patient needs were met in the clinical record, and the agency will promptly notify the physician/ allowed practitioner of the missed visit.	G0572	**G0580 Only as ordered by a physician** To demonstrate the commitment to compliance, and provide immediate correction, the Agency Administrator will ensure that the comprehensive assessment accurately reflects the patient's current health status and includes individualized patient specific measurable outcomes, goals on the plan of care and conforms to the physician's orders. Patients #12 was reviewed, and the agency confirmed that the agency failed to provide ordered services at patient request and did not notify physician of services not provided. The Agency Administrator or designee will ensure that assessing clinicians will review the plan of care with patients and if patient/caregiver declines services assessing clinician will notify the physician and revise the plan of care. **Corrective Actions** To provide immediate correction, the Agency Administrator met with all clinical staff regarding following the physician ordered plan of care including scheduling of ordered services and if declined at patient/caregiver request must be documented and physician notified. Appropriate revisions of the plan of care will be made by the assessing clinician. Continued non-compliance with policies regarding following physician's orders and notification of change in plan will be reported to the Administrator. The Administrator or designee will provide education with a signed attestation on performance of physician orders, and accurate documentation of services agreed upon with patient/caregiver.	12/12/24 12/12/24
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to provide home health aide services as ordered on referral or notify physician when HHA was not needed for 1 of 17 patients (P12) reviewed for referrals. P12's plan of care (POC) 10/9/24 through 12/7/24, identified a start of care date 10/9/24. Diagnoses included presence of left artificial hip joint aftercare following joint replacement. heart disease with heart failure, atrial fibrillation (irregular heartbeat), diabetes and a history of falls. Skilled nurse visits (SNV) were ordered 1 visit every week for three weeks then every two weeks for six weeks for various assessments, evaluation, perform and teach wound care and education regarding medications and co-morbid conditions. Physical therapy (PT) was ordered one visit per week for one week then two visits per week for one week then one visit per week for five weeks evaluate rehab potential, home environment and	G0580		

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G0580	Continued from page 28 safety and to increase functional independence. P12'sDocumentation of Face to Face and Certification for Home Health Services dated 10/3/24, identified the referral was initiated by P12's physician to start SNV and PT services for complex medication teaching and monitoring, gait training, home safety assessment, range of motion and therapeutic exercises. Additional services needed listed a need for home health aide (HHA) services. P12's SOC visit note dated 10/9/24, identified the plan of treatment, frequency and disciplines was discussed with the patient/caregiver and a referral was made to PT. However, the visit note lacked evidence HHA services had been offered as ordered or discussed. During interview during a home visit on 10/22/24, at 10:00 a.m. P12 stated she had been offered HHA services but had refused as she did not feel she needed that type of assistance. P12's medical record lacked evidence P12's physician had been notified of her refusal of the ordered HHA services as required. When interviewed on 10/22/24, at 3:30 p.m. the clinical manager (CM)-A stated it was the agency's practice to call for start of care orders for services needed and notify the physician at that time if some services were not needed or refused. An order to discontinue the HHA due to services not needed should have been included in P12's SOC order to notify the physician the service was not needed or wanted. The agency's policy Admission of Patients last revised 9/17/24, identified after completing the initial assessment, the nurse would contact the provider for approval of the plan of care, report the patient's status and obtain additional information and/or orders.	G0580	1. The Agency Administrator/designee will conduct education with all clinical and supervisory staff regarding policies and require signed attestation of education: • HH 2.1.5 Physician Plan of Care • HH 2.1.3 Admission of Patients • AC Best Practice "My Patient, My Responsibility" 2. The Agency Administrator/designee will review the referral to the Plan of Care (POC) and if services are not provided or declined by patient/ caregiver: • Ensure evidence of notification to physician of change in POC due to services not provided is documented and sent to physician 3. The Agency Administrator/designee will validate during a driveway coordination call, review the POC with the referral and cursory review of the POC **Resolution and Monitoring** To ensure that all patients have current and accurate orders and are being followed the Administrator/designee (1) Will conduct 100% review of patient referral and physician's Plan of Care for assessment completed as ordered and to ensure accuracy with any discrepancies communicated to the physician for reconciliation. (2) Findings reported will be reported to the Administrator/designee for corrective action if needed. (3) Following the above stated audit, this indicator will become a regular part of the quarterly audit process for the Quality Assurance Performance Improvement (QAPI) Program. The audit results will be tracked, trended, shared with agency leadership, and reported to the QAPI committee on a quarterly basis. After the audit threshold is achieved compliance will be monitored through the quarterly QAPI Clinical Record review and reported to PAC for review and recommendations. 11/21/24 Received 11/22/24 reviewed/accepted 11/25/24 spoke with Morgan Roschen- earliest completion date will be 12/10/24 or 12/11/24. Nicole Harvey Digitally signed by Nicole Harvey Date: 2024.12.03 09:14:27 -06'00'	12/12/24 and Ongoing

accentCare.

Accentcare Fairview Home Health-East LLC
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Office: 651-232-2800
Fax: 651-232-5501

Date: *November 21, 2024*

To Whom It May Concern:

Please find enclosed the returned CMS-2567 form in response to the State survey conducted October 24,2024.

The enclosed Plan of Correction outlines the methods by which the agency has brought / will bring these deficiencies into compliance. This remittance includes the immediate resolutions and the monitoring plan for all deficiencies cited during this survey.

AccentCare has a significant history of significant compliance to all Conditions of Participation and rules. We strive to conform to all standards and rules and feel we have executed a plan of correction and collected credible evidence that will demonstrate our commitment to resolving all of the cited deficiencies now and preventing them from recurrence in the future. Much effort has been taken to address the areas of concern.

Please accept this Plan of Correction as an attestation that the issues cited herein have been (or will be resolved) as indicated on their respective completion dates.

Thank you for this educational opportunity. If you have any questions or concerns please feel free to contact me using the information given below.

Sincerely,

Morgan Roschen, RN

Morgan Roschen, MSN, RN, Administrator
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