DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

November 4, 2020

Administrator
Home Health Care Inc
800 Boone Avenue North Suite 200
Golden Valley, MN 55427-4476

RE: Event ID: B51W12

Dear Administrator:

On October 26, 2020, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our visit, we have determined that your facility has achieved substantial compliance.

Feel free to contact me with any questions related to this letter.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically Delivered Via Email

October 1, 2020

Administrator
Home Health Care Inc
800 Boone Avenue North Suite 200
Golden Valley, MN 55427-4476

RE: Event ID: B51W11

Dear Administrator:

An extended survey was completed at your agency on September 11, 2020 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division noted one or more deficiencies and found that your agency was not in substantial compliance with the participation requirements. The findings from this survey are documented on the electronically delivered form CMS 2567.

At the time of this survey it was determined that the following Condition(s) of Participation were found not met:

G 700 - Skilled Professional Services

Since these deficiencies limit your capacity to provide adequate care to patients, you must respond within ten calendar (10) days with your plan of correction. The plan must be specific, realistic, include the date certain for correction of each deficiency and be signed and dated by the administrator or other authorized official of the agency. An acceptable plan of correction must contain the following elements:

The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;

- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- What correction action(s) will be accomplished for those patients found to have been affected by the deficient practice;
- How you will identify other patients having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the

- The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements, i.e., what quality assurance program will be put into place;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

If your agency has failed to achieve compliance by the date certain, sanctions including but not limited to fines of up to $10,000.00 per day, may be recommended for imposition to the Centers for Medicare and Medicaid Services (CMS) Regional Office. Informal dispute resolution (IDR) for the cited deficiencies will not delay imposition of any recommended enforcement actions. A change in the seriousness of the noncompliance at the time of the revisit may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

The plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Office: (320) 223-7343 Mobile: (320) 290-1155

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days of your receipt of this notice may result in imposition of sanctions, decertification and/or a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action. If, upon a revisit within forty five (45) days of the survey exit date, correction is not ascertained, we will have no recourse except to recommend to the Centers for Medicare and Medicaid Services Chicago Region V Office that sanctions be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of the visit with the President of your agency's Governing Body.

HOME HEALTH AIDE TRAINING AND/OR COMPETENCY EVALUATION PROHIBITION

Federal Law, as specified in 42 CFR 484.36 (a) (2), prohibits any home health agency from offering and/or conducting a home health aide training and/or competency evaluation program which, within the previous two years, has been found:

(A) Out of compliance with requirements of 42 CFR 484.36 (a) or (b);

(B) To permit an individual that does not meet the definition of "home health aide" as specified in §484.4 to furnish home health aide services (with the exception of licensed health professionals and volunteers);

(C) Has been subject to an extended (or partial extended) survey as a result of having been found to have furnished substandard care (or for other reasons at the discretion of CMS or the State);

(D) Has been assessed a civil monetary penalty of not less than $5,000 as an intermediate sanction;

(E) Has been found to have compliance deficiencies that endanger the health and safety of the HHA's patients and has had a temporary management appointed to oversee the management of the HHA;

(F) Has had all or part of its Medicare payments suspended; or

(G) Under any Federal or State law within the 2-year period beginning on October 1, 1988--

(1) Has had its participation in the Medicare program terminated;
(2) Has been assessed a penalty of not less than $5,000 for deficiencies in Federal or State standards for HHAs;
(3) Was subject to a suspension of Medicare payments to which it otherwise would have been entitled;
(4) Had operated under a temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients; or
(5) Was closed or had its residents transferred by the State.

Therefore, Home Health Care Inc is precluded from conducting a home health aide training and/or competency evaluation program for a period of two years beginning September 11, 2020.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.745, you have one opportunity to dispute condition-level survey findings warranting a sanction through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Home Health Agency Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies.

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of sanctions.

If you have any questions on this matter, please do not hesitate to call.

Sincerely,

Your signature block goes here

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	R-C 10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{G 000}	INITIAL COMMENTS On 10/26/20, a Post Certification Revisit (PCR) was conducted to determined compliance with Conditions of Participation (CoPs) cited during at the complaint survey exited on 9/11/20. Based on the PCR, we have found the facility corrected the COPs and corresponding deficiencies. This agency is back in compliance with requirements at 42 CFR. Part 484 for Home Health Agencies.	{G 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427

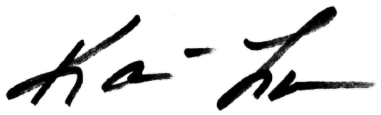
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS An abbreviated survey was completed at your agency on 9/9/20-9/11/20 to conduct complaint investigations. Home Health Care Inc., was found NOT to be in compliance with requirements at 42 CFR Part 484, requirements for Home Health Agencies. The following complaints were found to be UNSUBSTANTIATED: H8037020C The following complaint was found to be SUBSTANTIATED: H8037021C with deficiencies issued at G374, G608, G700, G710 In addition, the Condition of Participation: Skilled Professional Services §484.75 at G700, was found NOT met. As a result, an extended survey was conducted. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Federal Law as specified in 42 CFR 484.80 (f)(3), prohibits any home health agency to offer and/or conduct home health aide training and/or competency testing which, within the previous two years has been subjected to an extended or partially extended survey as a result of having been found to have furnished substandard care.			
G 374	Accuracy of encoded OASIS data CFR(s): 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time	G374	Submission of a plan of correction does not indicate agreement Person's Responsible Sharon Panasuk, RN Director of Clinical Services Sharlene Walczak, RN Clinical Manager Lauren Gatzke, RN Clinical Supervisor Robin Martinek, RN Clinical Supervisor Heather Chisholm, RN Clinical Supervisor Lack of knowledge and supervisory oversight lead to the deficient practice. Clinician documentation lacked appropriate documentation as it related to wound assessment 1) Policy and processes related to Comprehensive assessment and oasis data collection reviewed. 2) Clinicians educated on oasis documentation required including comprehensive assessment and Oasis data collection in regards to Wound assessment and documentation. 3) Survey charts concerns reviewed with clinicians 4) 100% chart Audit for proper documentation of wound assessments and measurements, oasis documentation until compliance is achieved then 10% Compliance date 10/26/2020	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharon A Panasuk, RN MSN	Director of Clinical Services	10/9/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 374	Continued From page 1 of assessment. This STANDARD is not met as evidenced by: Based on interview and document review, the agency failed to encode the Home Health Outcome and Assessment Information Set (OASIS) data accurately for 2 of 4 patients (P1, P5) who received wound care from the agency. Findings include: P1's plan of care (POC) for the certification period dated 7/11/20 through 9/8/20, indicated P1 was admitted on 7/11/20, with a primary diagnosis of a stage 3 (through the second layer of skin into the fat tissue) pressure ulcer to the right heel, and included physician orders for skilled nurse visits three times weekly for various assessments and wound care to the right ankle. P1's OASIS discharge assessment completed on 8/19/20, indicated P1 had a stage 2 pressure ulcer to the right heel, however, did not indicate the status of the wound bed, drainage, odor, surrounding tissue, or the size of the wound. P5's POC for the certification period dated 6/11/20 through 8/9/20, indicated P5 was admitted on 6/11/20, and included physician orders for skilled nurse visits twice weekly for one week (6/11/20-6/14/20), and then three visits weekly for 8 weeks (6/16/20- 8/9/20), with one PRN (as needed visit), for various assessments and wound care to stage 2 (open wound below the surface of the skin) pressure ulcer to left heel. P5's OASIS follow up assessment completed 8/7/20, indicated P5 had a stage 2, pressure ulcer to the left heel, however, did not indicate the status of the wound bed, drainage, odor,	G 374	 Approved 10/21/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 374	Continued From page 2 surrounding tissue, or the size of the wound. When interviewed on 9/21/20, at 4:43 p.m. DCS verified the lack of accurate OASIS data and stated, "There are no measurements that I can see." DCS indicated it was difficult to show improvement or worsening of a wound without encoding accurate data. Review of the agency's undated policy, Pressure Ulcer Dressing Change, and Management/Prevention of Pressure Ulcers, lacked direction regarding encoding accurate wound status when completing OASIS data.			
G 608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is not met as evidenced by: Based on interview and document review, the agency failed to ensure the patient's care delivery was coordinated with the caregivers, regarding the care and services identified in the plan of care for 1 of 5 patients (P1) reviewed. Findings include: P1's POC for the certification period dated 7/11/20 through 9/8/20, indicated P1 was admitted on 7/11/20, with a primary diagnosis of a stage 3 (through the second layer of skin into the fat tissue) pressure ulcer to the right heel, and included physician orders for skilled nurse visits (SNV) three times weekly for various assessments and wound care to the right ankle.	G608	Submission of a plan of correction does not indicate agreement Person's Responsible Sharon Panasuk, RN Director of Clinical Services Sharlene Walczak, RN Clinical Manager Lauren Gatzke, RN Clinical Supervisor Robin Martinek, RN Clinical Supervisor Heather Chisholm, RN Clinical Supervisor Lack of knowledge, process and oversight lead to the deficient practice. Clinician failed to coordinate and communicate adequate care delivery and coordination 1) Policy and processes reviewed related to care coordination and documentation and education created on care coordination, care delivery and documentation 2) Clinicians educated on care delivery, care coordination and documentation. 3) Employees coached in relations to charts sited in the survey process 4) 100% chart Audit until compliance is achieved then 10% Compliance date 10/26/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 3	G 608		

Review of P1's Care Coordination Note, dated 7/15/20, and signed by registered nurse (RN)-A on 7/16/20, included, "Please call [caregiver] for any questions or concerns. Please check in with Nurses after each visit."

P1's Patient Profile with a print date of 9/9/20, indicated P1 resided in an assisted living facility.

When interviewed on 9/9/20, at 10:39 a.m. P1's caregiver (CG)-A stated P1 developed a pressure ulcer to the right heel, and because P1's caregivers were unable to provide the wound care needed, a referral was made to the home health agency. CG-A stated, although SNV were ordered three times weekly, "We made call after call to get them [the agency] to come out. We had it on our schedule every Monday, Wednesday, and Friday, to call the agency, to make sure they were coming." CG-A stated the agency's staff would say they were coming at a certain time, and then would not show up until late in the day or not at all, and would not give report to P1's caregivers in her home. CG-A stated the home health agency's staff did not measure the wound, and never had wound care supplies, so would ask the caregivers in P1's home, for supplies.

During an interview on 9/9/20, at 2:10 p.m. the agency's director of clinical services (DCS) stated staff should be coordinating patients' care with their caregivers, providers, and should reach out to their supervisor with care concerns. DCS stated she was not aware of any concerns regarding the home care services provided to P1.

Review of the documentation provided by P1's caregivers included the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 4 -7/11/20-SNV completed for home care, start of care assessment. -7/15/20-P1's CG-C called the agency requesting that a nurse come to see P1 to provide wound care, because P1 had not been seen by the agency since 7/11/20. RN-A arrived, provided wound care, and stated she would continue to visit P1, three times per week. 7/21/20-RN-A saw P1 and changed dressing to right heel. 7/28/20-CG-D called registered nurse supervisor (RNS)-B and RN-A to follow up on wound care schedule, due to lack of SNV since 7/21/20. CG-D asked multiple times what the schedule was, for the agency to provide services. RN-A did not answer request, however, stated she would make SNV today, and would follow up with caregivers. RN-A completed SNV later that day, and reported she had visited last week, couldn't recall what day, but P1 was in the beauty shop. RN-A stated she had not received any wound care supplies, so would follow up on that, and would be back the next day to provide wound care. RN-A stated, starting next week, wound care would be scheduled for Monday, Wednesday, Friday, each week. 7/29/20-RN-A provided wound care, conflict with supply delivery persists. 7/31/20-CG-B called RN-A regarding P1's wound care supplies. RN-A stated she had a call out to P1's provider. RN-A stated she had been using "therapeutic honey" to the wound. RN-A asked what CG-B could do on her end to help with getting the prescription from the provider. CG-B explained wound supplies and related questions would have to be taken care of by the home health agency. RN-A stated she would be there later that day, hopefully by 4:30 p.m., before caregivers left for the day, but did not show.	G 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 5 8/1/20-CG-D called RN-A regarding SNV on 8/3/20. RN-A stated she would make SNV at 8:00 a.m. 8/3/20-RN-A didn't make SNV until 4:15 p.m. 8/5/20-RN-A provided SNV, reported the wound had not improved, but was not getting worse. RN-A stated the wound would be measured on 8/7/20. 8/7/20-2:03 p.m.-CG-D called RN-A to see if she was coming for SNV. RN-A's voicemail was full and CG-D could not leave a message. 8/7/20-5:03 p.m.-CG-D called RN-A and notified her of P1's appointment on 8/10/20. RN-A stated she would complete wound care by 11:00 a.m. on 8/10/20. CG-D asked if she had completed wound care today, RN-A stated she had been there that afternoon. CG-D asked if wound was measured and for an update of the wound. RN-A stated she did not measure the wound, and the wound continued to be "static." RN-A reported she continued to not have the ordered supplies to perform the correct wound care. RN-A stated her supervisor was aware of the supply issue. 8/10/20-3:53 p.m. CG-D called RN-A to see if she planned on coming today per schedule. RN-A stated she knew P1 had an appointment so she had not come. RN-A stated she would be there shortly to complete wound care. 8/10/20-4:15 p.m. RN-A completed wound care. 8/12/20-4:50 p.m. CG-D called RN-A regarding scheduled SNV for wound care today. RN-A stated it was her day off and another nurse was supposed to be there. RN-A stated she would contact her supervisor and follow up. 8/12/20-10:24 p.m. CG-B documented no phone calls from the agency, and no SNV was made to provide wound care. 8/14/20-11:32 a.m. CG-D called RN-A. RN-A stated she would make SNV at 12:30 p.m. and	G 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 6 stated she would measure the wound on the right heel. CG-D again asked RN-A to stop in the caregivers' office to give an update on the status of the wound. RN-A never arrived. CG-C called the agency at 4:00 p.m., reporting concerns regarding P1's care. CG-C was transferred to RNS-B, whom did not answer, and left a message urging her to call back as soon as possible to discuss concerns regarding P1's home care management and requesting that a nurse come to P1's home to provide wound care today. CG-C called RN-A to ask if she was coming to see P1. RN-A stated she was on her way. RN-A arrived at P1's home at 5:00 p.m. At this time, there were no caregivers staffed, so no updates or notes regarding progress were provided by RN-A. 8/17/20-10:31 a.m.- RN-A arrived and provided wound care. CG-D saw RN-A as she was leaving and inquired about an update of the wound. RN-A stated she measured the wound on 8/10/20, however, on 8/10/20 RN-A reported she had not measured the wound and would measure it on 8/14/20. RN-A stated the wound was 2 cm larger in circumference and 0.5 cm deeper than it was on 8/10/20. RN-A reported she had been paying out of pocket for wound care supplies and that she was almost out of supplies. RN-A stated she had been applying therapeutic honey to the wound and covering it, due to not having orders or supplies. CG-C called RNS-B to discuss the concerns above, and reported there was no SNV on 8/12/20 to provide wound care, even though P1 was scheduled to have wound care on Monday, Wednesday, and Friday. CG-C told RNS-B that RN-A did not come to P1's home unless the caregivers call on P1's scheduled days and request for her to come. Due to these concerns, CG-C stated the family was actively	G 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 7	G 608		

seeking another agency. RNS-B stated she would speak directly with RN-A's direct supervisor and she would call CG-C back. No call was received.
8/17/20-1:21 p.m. CG-C called the agency, spoke to a care manager and reported P1 was being admitted to another agency, and that the agency's services were being terminated. The agency's care manager stated
she would notify the care team, who would perform P1's discharge.
8/19/20-9:56 a.m. CG-C received a call from P1's new home care agency, stating they contacted the agency and they stated they were unaware that P1 was being discharged from their services.
8/19/20-1:33 p.m. RN-A arrived at P1's home at 12:43 p.m. and entered the caregivers' office at 1:00 p.m., reporting that she performed wound care and discharged P1 from the agency's service.

During an interview on 9/9/20, at 2:33 p.m. registered nurse (RN)-A stated, "I tried to get in there as often as I could, it depends on location and my schedule that day," and indicated if she could not make the visit when scheduled, she would call to let P1's caregivers know. RN-A indicated she did not know why the visits were missed, because she did not document it, and stated she should have called her RN supervisor (RNS)-A when she could not make the visit, and should have completed a missed visit report so the provider was aware. RN-A stated, "A lot of times, it was timing," and stated she would go there late in the day. RN-A stated, when she arrived, "There was no one to open the door. They changed their buzzer system, and I couldn't get in," however, stated she did not follow through with attempting to complete the visits as ordered, and did not contact her supervisor or P1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 8	G 608		

physician. RN-A stated she never received orders for the wound care and never received wound care supplies, and stated she kept calling the doctor's office. RN-A stated she brought her own supplies and there were not any specific orders for the wound care. RN-A stated she repeatedly asked P1's caregivers for specific wound care orders, but they would direct RN-A to call the physician because they did not have orders either. RN-A stated, "At least once or twice a week, I called the clinic," but indicated she never heard back from the physician. RN-A stated, the plan was to discharge P1 because she could not get a hold of her physician, did not have any written orders, and did not ever receive the wound care supplies. When asked if she reached out to RNS-A, RN-A stated she did not. RN-A stated, "I did a few measurements, but I did not document my measurements." When asked about the wound care that was provided, RN-A stated, "Those were the supplies I had on hand. I had some wound care honey I purchased myself. There was no order for it." RN-A indicated that she had used the wound care honey for another client and always had it on hand. RN-A stated, "I should have contacted the physician...I did not reach out to my supervisor." RN-A indicated she knew P1's caregivers were frustrated, just as she was, and that is why she discharged P1.

During an interview on 9/11/20, at 8:04 a.m. RNS-A stated, "I personally have not been reached out to by [RN-A]." RNS-A stated the expectation was that the home care visits would be completed as they were set up, and the basic training provided to the staff nurses was for the nurse to call the provider to get wound care orders and order for supplies, and if those measures weren't successful, they should call the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 9	G 608		

office to any one of the supervisors. RNS-A stated, "[RN-A] needed to reach out to us."

During an interview on 9/11/20, at 10:43 a.m. RNS-B indicated P1's caregivers called on 7/17/20, late in the day, inquiring about the frequency of visits because wound care was to be completed three days a week, and had only been completed once since the start of care visit on 7/11/20. RNS-B stated she called RN-A, and RN-A planned to visit P1 on 7/18/20, however, RN-A "apparently" did not visit P1 until 7/21/20. RNS-B stated P1's caregivers called again on 8/5/20, inquiring about wound care supplies because they were never received. RNS-B asked P1's caregiver to fax the most recent orders to the durable medical equipment (DME) company, and stated, "Apparently, they never sent them." RNS-B stated RN-A never called her and added, "I never had any indication that there was an issue at all." RNS-B stated on 8/18/20, P1's caregivers called, asking for RN-A's phone number. RNS-B stated, "I don't know if [RN-A] ever reached out to her supervisor, but she did not reach out to me." RNS-B denied receiving calls and/or voice messages on 8/14/20 and 8/17/20 from P1's caregivers, with concerns regarding P1's home care services and the lack of coordination.

When interviewed on 9/14/20, at 8:51 p.m. CG-C stated she called the agency several times, would leave voicemail for RNS-B, however, she never received calls back. CG-C stated, when RN-A visited, she would not seek out staff to give updates, she would "come and go." CG-C stated on 8/17/20, she called the agency and spoke to RNS-B. CG-C stated she went through the ongoing concerns, the documentation they had of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	800 BOONE AVENUE NORTH SUITE 200

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
G 608	Continued From page 10 missed visits, lack of appropriate wound care, lack of wound care supplies, and the lack of reporting of the status of the wound, to caregivers. CG-C stated she reported that RN-A made the comment that the wound was getting worse, and said she was going to have to discharge P1 from home care services anyway, because she never received any supplies. CG-C asked RNS-B how she could help so that P1's wound care would be provided appropriately, and RNS-B stated she would talk to RN-A's supervisor and have her call CG-C back. CG-C stated she asked for RN-A's supervisor's phone number, however, RNS-B would not provide it and stated she would have RN-A's supervisor call her back. CG-C stated she never received a call from RN-A's supervisor. Review of the agency's undated policy, Plan of Care, included, "The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary..."
G 700	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician and medical social work services as specified in §409.45 of this

G700	Submission of a plan of correction does not indicate agreement Person's Responsible Sharon Panasuk, RN Director of Clinical Services Sharlene Walczak, RN Clinical Manager Lauren Gatzke, RN Clinical Supervisor Robin Martinek, RN Clinical Supervisor Heather Chisholm, RN Clinical Supervisor Lack of Process, Supervisor and Follow up lead to the deficiency. Clinician failed to document adequate wound care and assessment, or provide interventions according to the plan of care. 1) Policy related to professional service provision and plan of care reviewed and education related to professional service provision and plan of care 2) Clinicians educated on providing skilled services and the regulations regarding this deficiency 3) Employees coached in relations to charts sited in the survey process 4) 100% chart Audits for documentation of frequency of visits and that skilled services match orders and plan of care, until compliance is achieved then 10% Compliance Date 10/26/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 700	Continued From page 11 chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. This CONDITION is not met as evidenced by: Based on interview and document review, the agency was found not to be in compliance with the Condition of Participation at 484.75, Skilled Professional Services. The agency failed to ensure skilled nursing services were provided effectively and safely in accordance with physicians' orders for 3 of 4 patients (P1, P3, P5) reviewed for wound care. Findings include: Refer to G710: Based on interview and document review, the agency failed to ensure skilled nursing visits (SNV) were provided per order frequency and failed to assess wounds as directed in the plan of care (POC), to show progress towards goals, for 3 of 4 patients (P1, P3, P5), reviewed. In addition, the agency failed to provide wound care treatment as specified in the POC, for 1 of 4 patient (P1), reviewed.			
G 710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on interview and document review, the agency failed to ensure skilled nursing visits (SNV) were provided per order frequency and failed to assess wounds as directed in the plan of care (POC), to show progress towards goals, for 3 of 4 patients (P1, P3, P5), reviewed. In addition, the agency failed to provide wound care	G710	Submission of a plan of correction does not indicate agreement Person's Responsible Sharon Panasuk, RN Director of Clinical Services Sharlene Walczak, RN Clinical Manager Lauren Gatzke, RN Clinical Supervisor Robin Martinek, RN Clinical Supervisor Heather Chisholm, RN Clinical Supervisor Lack of Process, Supervision and Follow up lead to the deficiency. Clinicians failed to provide care according to the plan of care 1) Policies reviewed regarding physician orders, plan of care and service delivery. Education created regarding physician orders, plan of care and service delivery 2) Clinicians educated on following plan of care, documenting interventions and regulations regarding this 3) 100% chart Audit for frequency of visits and interventions provided in comparison to physician orders and plan of care until compliance is achieved then 10% Compliance Date 10/26/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 12 treatment as specified in the POC, for 1 of 4 patients (P1), reviewed. Findings include: P1's POC for the certification period dated 7/11/20 through 9/8/20, indicated P1 was admitted on 7/11/20, with a primary diagnosis of a stage 3 (through the second layer of skin into the fat tissue) pressure ulcer to the right heel, and included physician orders for skilled nurse visits three times weekly for various assessments and wound care to the right ankle, with goals of the wound showing progress, as evidenced by decrease in signs of infection, decrease in drainage, decrease in size, and decrease or no necrotic tissue. In addition, P1's POC directed to assess for signs and symptoms of infection and appropriate measures to manage infection, and to provide wound care by cleaning wound with normal saline (NS) or wound cleanser, pack with Nugauze (cotton gauze packing strips for sterile drainage of open and/or infected wounds), cover with ABD (abdominal) pad (high absorbency), and secure with Kerlix (woven gauze bandage roll) and tape Review of P1's medical record indicated, following the start of care visit, P1 had skilled nursing visits only once during the week of 7/13/20, once during the week of 7/20/20, twice during the week of 7/27/20, three visits during the week of 8/3/20, twice during the week of 8/10/20, and once during the week of 8/17/20, with discharge on 8/19/20. There was no documentation to indicate the physician was notified or consulted regarding the decreases in skilled nurse visits. P1's Nursing Visit Record, dated 7/15/20, included, removed the old	G 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 13	G 710		

dressing, cleaned the wound with wound cleanser, and applied non adherent gauze and Coban wrap (self adherent wrap to secure dressing), instead of following the wound care orders listed on the POC. P1's Nursing Visit Record, dated 7/21/20, indicated the wound care provided included, cleaned hands, donned gloves, cleaned with NS or wound cleanser, applied therapeutic honey to site, applied bandage, wrapped with Kerlix and tape. Each Nursing Visit Note, until P1 was discharged, continued to document this same process, including applying therapeutic honey to the site, instead of following the wound care orders listed on the POC. Further, upon admission, P1's wound was assessed with measurements of 1.1 centimeters (cm) (length) x 2.3 cm (width) x 0.4 cm (depth) however, the medical record lacked documentation of any further assessment of the size of the wound throughout the remainder of the SNVs to determine if P1's wounds were healing.

P1's Patient Profile with a Print date of 9/9/20, indicated P1 resided in an assisted living facility.

When interviewed on 9/9/20, at 10:39 a.m. P1's caregiver (CG)-A stated, "We made call after call to get them [the agency] to come out. We had it on our schedule every Monday, Wednesday, and Friday, to call the agency, to make sure they were coming." CG-A indicated P1's caregivers were not able to provide the wound care, therefore, acquired the agency to provide home care. However, P1's wound was progressively getting worse. CG-A stated the agency's staff would say they were coming at a certain time, and then wouldn't show up until late in the day or not at all, and wouldn't give report to P1's caregivers in her home. CG-A stated the agency's staff didn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 14	G 710		

measure the wound, and never had wound care supplies, so would ask the caregivers in P1's home, for supplies.

During an interview on 9/9/20, at 2:10 p.m. the agency's director of clinical services (DCS) stated missed visits should be documented in the medical record, and verified the record lacked documentation of the missed visits. DCS indicated each agency visiting nurse had a stock supply bag of wound care dressings, enough to get the client through until supplies came in, and although it may take time to get the supplies, if the nurse was having difficulty obtaining the supplies from the DME (durable medical equipment), she should have called her supervisor. DCS stated the nurse documented that she used therapeutic honey, but that wasn't in the order. Further, DCS stated the expectation was for the case manager to assess and measure the wound once a week, however, she verified no measurements were completed for P1's wound after the start of care assessment, throughout the home care episode.

When interviewed on 9/9/20, at 2:33 p.m. registered nurse (RN)-A stated, "I tried to get in there as often as I could, it depends on location and my schedule that day," and indicated if she couldn't make the visit when scheduled, she would call to let P1's caregivers know. RN-A indicated she didn't know why the visits were missed because she didn't document it, and stated she should have called her RN supervisor (RNS)-A when she couldn't make the visit, and should have completed a missed visit report so the provider was aware. RN-A stated, "A lot of times, it was timing," and stated she would go there late in the day. RN-A stated, when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 15	G 710		

arrived, "There was no one to open the door. They changed their buzzer system, and I couldn't get in," however, stated she didn't follow through with attempting to complete the visits as ordered, and didn't contact her supervisor or P1's physician. RN-A stated she never received orders for the wound care and never received wound care supplies, and stated she kept calling the doctor's office. RN-A stated she brought her own supplies and there weren't any specific orders for the wound care. RN-A stated she repeatedly asked P1's caregivers for specific wound care orders, but they would direct RN-A to call the physician because they didn't have orders either. RN-A stated, "At least once or twice a week, I called the clinic," but indicated she never heard back from the physician. RN-A stated, the plan was to discharge P1 because she couldn't get a hold of her physician, didn't have any written orders, and didn't ever receive the wound care supplies. When asked if she reached out to RNS-A, RN-A stated she did not. RN-A stated, "I did a few measurements, but I did not document my measurements." When asked about the wound care that was provided, RN-A stated, "Those were the supplies I had on hand. I had some wound care honey I purchased myself. There was no order for it." RN-A indicated that she had used the wound care honey for another client and always had it on hand. RN-A stated, "I should have contacted the physician...I did not reach out to my supervisor."

When interviewed on 9/10/20, at 9:00 a.m. assistant director of nursing (ADON) stated, by the second visit, if supplies were not received, RN-A should have reached out to her supervisor for help.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 16	G 710		

During a telephone interview on 9/10/20, at 9:18 a.m. the DME company staff stated RN-A called them on 7/29/20, 11 days after P1 was admitted to home care, to inquire about supplies. DME staff stated they never received an order for wound care supplies for P1, and usually there would be multiple notes of home care staff checking on the status of the order, however, no one called until RN-A called on 7/29/20.

During a telephone interview on 9/10/20, at 9:56 a.m. P1's physician's RN, stated orders for home care visits were three times per week for wound care, and orders for supplies were faxed on 7/14/20 to the home health agency. P1's physician's RN stated no other phone calls or requests were received from the agency or RN-A, until a request was received on 7/28/20 from P1's caregivers, to switch home care providers.

When interviewed on 9/10/20, at 11:05 a.m. CG-B stated, on 7/29/20, RN-A was still waiting for supplies and was using what was available to her, and stated, "I remember [RN-A] asked me to contact [P1's] provider to ask to order supplies. As the home care provider, that is their duty. I didn't even know what provider [RN-A] was in contact with." CG-B indicated RN-A would promise to come, and wouldn't show up, and stated, "We literally had it set up in our computer system to make sure [RN-A] was coming, and we would watch for her. Our receptionist was alerted to notify us when [RN-A] got here. Most of the time, [RN-A] didn't show up. We called her frequently, chasing her around." CG-B indicated the wound "got worse," and stated, on 8/6/20, measurements documented by P1's caregivers were 1.5 cm x 1.0 cm x .75 cm, with "tunneling inward and purulent drainage and odor."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 17	G 710		

During an interview on 9/11/20, at 8:04 a.m. RNS-A stated, "I personally have not been reached out to by [RN-A]." RNS-A stated the expectation was that the home care visits would be completed as they were set up, and the basic training provided to the staff nurses was for the nurse to call the provider to get wound care orders and order for supplies, and if those measures weren't successful, they should call the office to any one of the supervisors. RNS-A stated, "[RN-A] needed to reach out to us."

During an interview on 9/11/20, at 10:43 a.m. RNS-B indicated P1's caregivers called her on 7/17/20, late in the day, inquiring about the frequency of visits because wound care was to be completed three days a week, and had only been completed once since the start of care visit on 7/11/20. RNS-B stated she called RN-A, and RN-A planned to visit P1 on 7/18/20, however, RN-A did not visit P1 until 7/21/20. RNS-B stated P1's caregivers called again on 8/5/20, inquiring about wound care supplies because they were never received. RNS-B asked P1's caregiver to fax the most recent orders to the DME company, and stated, "Apparently, they never sent them." RNS-B stated RN-A never called her and added, "I never had any indication that there was an issue at all." RNS-B stated on 8/18/20, P1's caregivers called, asking for RN-A's phone number. RNS-B stated, "I don't know if [RN-A] ever reached out to her supervisor, but she did not reach out to me."

When interviewed on 9/14/20, at 8:51 a.m. P1's CG-C stated P1 was seen at the wound care clinic on 7/6/20, and because P1's caregivers could not provide the wound care, a referral was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 18 sent to the agency. Wound care orders were sent with the referral, and were resent to the agency when RN-A reported she didn't receive them. CG-C stated RN-A kept saying she didn't have the orders, kept saying they ordered supplies and hadn't received them yet, and kept saying she couldn't get in touch with P1's physician. CG-C stated RN-A used therapeutic honey the entire time, which was not ordered, and didn't have anything to cover it, so P1's caregivers were providing supplies for a while, but didn't have anything left. CG-C indicated RN-A reported on 8/17/20, that the wound was 2 cm larger in circumference and 0.5 cm deeper than it was on 8/10/20, however, CG-C stated RN-A had reported to P1's caregivers on 8/10/20, that she had not measured the wound, which was also documented in P1's medical record in her home. CG-C stated RN-A continued to state she was having difficulty obtaining orders from P1's physician and wound care supplies. CG-C stated she reached out to RN-A's supervisor multiple times, would leave messages, and never received a call back. CG-C stated on 8/17/20, she called and spoke to RNS-B, discussed all of the concerns, including missed visits, no supplies, not following the orders, and let her know that P1's family was involved and would be seeking a different home care agency. RNS-B told CG-C that she would bring the concerns to RN-A's supervisor (RNS-A), and would have RNS-A call her back. When CG-C asked for RNS-A's phone number, RNS-B would not provide it. CG-C stated she never received a call back from RNS-A. On 8/18/20, CG-C stated she called the agency and informed a care manager that P1's family were terminating services with the agency. P3	G 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 19 P3's POC for the certification period dated 1/23/20 through 3/22/20, indicated P3 was admitted on 7/27/19, and included physician orders for skilled nurse visits weekly for various assessments and medication management. Review of P3's medical record included a Nursing Visit Record, dated 2/20/20, which identified an open area to P3's sacrum, and indicated P3's physician was notified and wound care orders were requested. P3's physician orders, dated 2/21/20, included wound care orders to change dressing three times per week, on Monday, Wednesday, and Friday, with silver alginate dressing and gauze. Review of SNVs revealed P3 did not have another SNV until 2/27/20, six days later, and no further visits again until a physician's order indicated home care services were on hold on 3/3/20. There was no documentation to indicate the physician was notified or consulted regarding the decreases in skilled nurse visits. In addition, there was no documentation in the medical record to indicate the size of the wound identified on 2/20/20, and no documentation during subsequent visits of the size of the wound on the sacrum, to show assessment of the status of the wound, as directed in the POC. During an interview on 9/10/20, at 3:57 p.m. registered nurse case manager (RNCM)-A stated, P3's order on 2/24/20 included SNV three times a week for dressing changes, and stated, "[P3] was seen on 2/20, and wasn't seen again until 2/27. We may not have had supplies yet." RNCM-A indicated case managers were expected to do weekly wound measurements, assessing drainage, tissue, odors, stage, and what treatment was being provided, in the wound assessment. RNCM-A stated he was not alerted	G 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 20	G 710		

to to wound identified on 2/20/20, and noted there was no wound documented on the 3/6/20 resumption of care assessment, however, there was wound documentation again on 3/11/20. RNCM-A stated, the notes looked identical and he was doubtful P3 had a wound on his sacrum on 3/11/20, and the note had possibly been copied and pasted from a previous note. RNCM-A stated, "We would expect that each note be current with that visit." RNCM-A indicated it would be difficult to assess the status of the wound, and whether or not it was improving, as directed in the POC, without accurate documentation.

During a follow up phone interview on 9/21/20, at 12:51 p.m. DCS stated the visit nurse identified the wound on P3's sacrum on 2/20/20, faxed the physician, and orders were received on 2/21/20 for wound care and dressing changes three days per week. DCS stated, "It doesn't appear that we adjusted the frequency of the visits or completed any measurements of the wound. There was no follow through from the case manager...Once weekly doesn't correlate with the order for three times a week." DCS stated documentation on 3/6/20 during the resumption of care assessment, indicated no wound at all, however, the wound was noted at the next SNV on 3/11/20.

P5
P5's POC for the certification period dated 6/11/20 through 8/9/20, indicated P5 was admitted on 6/11/20, and included physician orders for skilled nurse visits twice weekly for one week (6/11/20-6/14/20), and then three visits weekly for 8 weeks (6/16/20- 8/9/20), with one PRN (as needed visit), for various assessments and wound care to stage 2 (open wound below the surface of the skin) pressure ulcer to left heel,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 21	G 710		

with goals of the wound showing progress, as evidenced by decrease in signs of infection, decrease in drainage, decrease in size, and decrease or no necrotic tissue.

Review of P5's medical record indicated, P5 had skilled nursing visit only twice during the week starting 6/16/20, 7/6/20, 7/13/20, and 7/20/20. Also identified, during the week of 8/3/20, P5 received four SNV, instead of three as ordered. On 8/10/20, P5's physician order was changed to wound care daily for two weeks. During the week of 8/10/20 and 8/17/20, P5 received only six SNV, instead of seven visits as ordered. There was no documentation to indicate the physician was notified or consulted regarding the increase or decreases in skilled nurse visits. In addition, the medical record indicated P5's wound to the left heel measured 3.4 cm x 2.2 cm x 0.1 cm on 6/11/20, however, the medical record lacked any further measurements of the wound from 6/11/20 through 9/9/20.

During a follow up phone interview on 9/21/20, at 4:43 p.m. DCS verified the missed and extra SNVs and indicated staff should be documenting modifications to the POC and notifying the physician. DCS stated, "There are no measurements that I can see. The case manager saw [P5] on 8/7 for recertification, and on 9/9, and I see no measurements then either." DCS stated the case manager should measure the wound once a week on Mondays, and if the patient isn't seen on Monday, a measurement should be done at least once a week. DCS indicated it was difficult to show improvement or worsening of a wound without measurements.

Review of the agency's undated policy, Missed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 22 Visits and Tips to Prevent, included, a skilled nurse missed visit was required when unable to see the patient for scheduled visit due to patient refusal, patient having a physician appointment, or if they were unable to coordinate or contact the patient for a visit. Further, the expectation was to make up a missed visit within 24-48 hours, call emergency contacts and physician's office if unable to contact the patient, and to contact the supervisor for direction if two consecutive missed visits occurred. Review of the agency's undated Wound Care Procedure, included, "Case Managers are required to see wound care clients weekly for measurements, assessment and changing plan of care as needed." Also included, wound assessment parameters should be documented in the integumentary assessment area, including length, width, and depth of the wound. Review of the agency's undated policy, Plan of Care, indicated the plan of care would be consistently reviewed to ensure that client needs are met, and will be updated as necessary, but at least every sixty days. Also included, "Professional staff shall promptly alert the client's physician to any changes that suggest a need to alter the Plan of Care."	G 710		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

October 1, 2020

Administrator
Home Health Care Inc
800 Boone Avenue North Suite 200
Golden Valley, MN 55427-4476

Re: Event ID: B51W11

Dear Administrator:

A survey of the Home Care Provider named above was completed on September 11, 2020 for the purpose of assessing compliance with State licensing regulations and to investigate a complaint. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under Minnesota Statutes Sections 144A.43 to 144A.482.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H03337	A. BUILDING: _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On 9/9/20 through 9/11/20, a surveyor of this Department's staff visited the above provider. As a result of the survey, no correction orders were issued. In addition, the following complaints were found to be UNSUBSTANTIATED: H8037020C, The following complaint was found to be SUBSTANTIATED: H8037021C	0 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS An abbreviated survey was completed at your agency on 9/9/20-9/11/20 to conduct complaint investigations. Home Health Care Inc., was found NOT to be in compliance with requirements at 42 CFR Part 484, requirements for Home Health Agencies. The following complaints were found to be UNSUBSTANTIATED: H8037020C The following complaint was found to be SUBSTANTIATED: H8037021C with deficiencies issued at G374, G608, G700, G710 In addition, the Condition of Participation: Skilled Professional Services §484.75 at G700, was found NOT met. As a result, an extended survey was conducted. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Federal Law as specified in 42 CFR 484.80 (f)(3), prohibits any home health agency to offer and/or conduct home health aide training and/or competency testing which, within the previous two years has been subjected to an extended or partially extended survey as a result of having been found to have furnished substandard care.	G 000		
G 374	Accuracy of encoded OASIS data CFR(s): 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time	G 374		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 374	Continued From page 1	G 374		

of assessment.
This STANDARD is not met as evidenced by:
Based on interview and document review, the agency failed to encode the Home Health Outcome and Assessment Information Set (OASIS) data accurately for 2 of 4 patients (P1, P5) who received wound care from the agency.

Findings include:

P1's plan of care (POC) for the certification period dated 7/11/20 through 9/8/20, indicated P1 was admitted on 7/11/20, with a primary diagnosis of a stage 3 (through the second layer of skin into the fat tissue) pressure ulcer to the right heel, and included physician orders for skilled nurse visits three times weekly for various assessments and wound care to the right ankle.

P1's OASIS discharge assessment completed on 8/19/20, indicated P1 had a stage 2 pressure ulcer to the right heel, however, did not indicate the status of the wound bed, drainage, odor, surrounding tissue, or the size of the wound.

P5's POC for the certification period dated 6/11/20 through 8/9/20, indicated P5 was admitted on 6/11/20, and included physician orders for skilled nurse visits twice weekly for one week (6/11/20-6/14/20), and then three visits weekly for 8 weeks (6/16/20- 8/9/20), with one PRN (as needed visit), for various assessments and wound care to stage 2 (open wound below the surface of the skin) pressure ulcer to left heel.

P5's OASIS follow up assessment completed 8/7/20, indicated P5 had a stage 2, pressure ulcer to the left heel, however, did not indicate the status of the wound bed, drainage, odor,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 374	Continued From page 2 surrounding tissue, or the size of the wound. When interviewed on 9/21/20, at 4:43 p.m. DCS verified the lack of accurate OASIS data and stated, "There are no measurements that I can see." DCS indicated it was difficult to show improvement or worsening of a wound without encoding accurate data. Review of the agency's undated policy, Pressure Ulcer Dressing Change, and Management/Prevention of Pressure Ulcers, lacked direction regarding encoding accurate wound status when completing OASIS data.	G 374		
G 608	Coordinate care delivery CFR(s): 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. This ELEMENT is not met as evidenced by: Based on interview and document review, the agency failed to ensure the patient's care delivery was coordinated with the caregivers, regarding the care and services identified in the plan of care for 1 of 5 patients (P1) reviewed. Findings include: P1's POC for the certification period dated 7/11/20 through 9/8/20, indicated P1 was admitted on 7/11/20, with a primary diagnosis of a stage 3 (through the second layer of skin into the fat tissue) pressure ulcer to the right heel, and included physician orders for skilled nurse visits (SNV) three times weekly for various assessments and wound care to the right ankle.	G 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 3	G 608		

Review of P1's Care Coordination Note, dated 7/15/20, and signed by registered nurse (RN)-A on 7/16/20, included, "Please call [caregiver] for any questions or concerns. Please check in with Nurses after each visit."

P1's Patient Profile with a print date of 9/9/20, indicated P1 resided in an assisted living facility.

When interviewed on 9/9/20, at 10:39 a.m. P1's caregiver (CG)-A stated P1 developed a pressure ulcer to the right heel, and because P1's caregivers were unable to provide the wound care needed, a referral was made to the home health agency. CG-A stated, although SNV were ordered three times weekly, "We made call after call to get them [the agency] to come out. We had it on our schedule every Monday, Wednesday, and Friday, to call the agency, to make sure they were coming." CG-A stated the agency's staff would say they were coming at a certain time, and then would not show up until late in the day or not at all, and would not give report to P1's caregivers in her home. CG-A stated the home health agency's staff did not measure the wound, and never had wound care supplies, so would ask the caregivers in P1's home, for supplies.

During an interview on 9/9/20, at 2:10 p.m. the agency's director of clinical services (DCS) stated staff should be coordinating patients' care with their caregivers, providers, and should reach out to their supervisor with care concerns. DCS stated she was not aware of any concerns regarding the home care services provided to P1.

Review of the documentation provided by P1's caregivers included the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 4 -7/11/20-SNV completed for home care, start of care assessment. -7/15/20-P1's CG-C called the agency requesting that a nurse come to see P1 to provide wound care, because P1 had not been seen by the agency since 7/11/20. RN-A arrived, provided wound care, and stated she would continue to visit P1, three times per week. 7/21/20-RN-A saw P1 and changed dressing to right heel. 7/28/20-CG-D called registered nurse supervisor (RNS)-B and RN-A to follow up on wound care schedule, due to lack of SNV since 7/21/20. CG-D asked multiple times what the schedule was, for the agency to provide services. RN-A did not answer request, however, stated she would make SNV today, and would follow up with caregivers. RN-A completed SNV later that day, and reported she had visited last week, couldn't recall what day, but P1 was in the beauty shop. RN-A stated she had not received any wound care supplies, so would follow up on that, and would be back the next day to provide wound care. RN-A stated, starting next week, wound care would be scheduled for Monday, Wednesday, Friday, each week. 7/29/20-RN-A provided wound care, conflict with supply delivery persists. 7/31/20-CG-B called RN-A regarding P1's wound care supplies. RN-A stated she had a call out to P1's provider. RN-A stated she had been using "therapeutic honey" to the wound. RN-A asked what CG-B could do on her end to help with getting the prescription from the provider. CG-B explained wound supplies and related questions would have to be taken care of by the home health agency. RN-A stated she would be there later that day, hopefully by 4:30 p.m., before caregivers left for the day, but did not show.	G 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 5 8/1/20-CG-D called RN-A regarding SNV on 8/3/20. RN-A stated she would make SNV at 8:00 a.m. 8/3/20-RN-A didn't make SNV until 4:15 p.m. 8/5/20-RN-A provided SNV, reported the wound had not improved, but was not getting worse. RN-A stated the wound would be measured on 8/7/20. 8/7/20-2:03 p.m.-CG-D called RN-A to see if she was coming for SNV. RN-A's voicemail was full and CG-D could not leave a message. 8/7/20-5:03 p.m.-CG-D called RN-A and notified her of P1's appointment on 8/10/20. RN-A stated she would complete wound care by 11:00 a.m. on 8/10/20. CG-D asked if she had completed wound care today, RN-A stated she had been there that afternoon. CG-D asked if wound was measured and for an update of the wound. RN-A stated she did not measure the wound, and the wound continued to be "static." RN-A reported she continued to not have the ordered supplies to perform the correct wound care. RN-A stated her supervisor was aware of the supply issue. 8/10/20-3:53 p.m. CG-D called RN-A to see if she planned on coming today per schedule. RN-A stated she knew P1 had an appointment so she had not come. RN-A stated she would be there shortly to complete wound care. 8/10/20-4:15 p.m. RN-A completed wound care. 8/12/20-4:50 p.m. CG-D called RN-A regarding scheduled SNV for wound care today. RN-A stated it was her day off and another nurse was supposed to be there. RN-A stated she would contact her supervisor and follow up. 8/12/20-10:24 p.m. CG-B documented no phone calls from the agency, and no SNV was made to provide wound care. 8/14/20-11:32 a.m. CG-D called RN-A. RN-A stated she would make SNV at 12:30 p.m. and	G 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 6 stated she would measure the wound on the right heel. CG-D again asked RN-A to stop in the caregivers' office to give an update on the status of the wound. RN-A never arrived. CG-C called the agency at 4:00 p.m., reporting concerns regarding P1's care. CG-C was transferred to RNS-B, whom did not answer, and left a message urging her to call back as soon as possible to discuss concerns regarding P1's home care management and requesting that a nurse come to P1's home to provide wound care today. CG-C called RN-A to ask if she was coming to see P1. RN-A stated she was on her way. RN-A arrived at P1's home at 5:00 p.m. At this time, there were no caregivers staffed, so no updates or notes regarding progress were provided by RN-A. 8/17/20-10:31 a.m.- RN-A arrived and provided wound care. CG-D saw RN-A as she was leaving and inquired about an update of the wound. RN-A stated she measured the wound on 8/10/20, however, on 8/10/20 RN-A reported she had not measured the wound and would measure it on 8/14/20. RN-A stated the wound was 2 cm larger in circumference and 0.5 cm deeper than it was on 8/10/20. RN-A reported she had been paying out of pocket for wound care supplies and that she was almost out of supplies. RN-A stated she had been applying therapeutic honey to the wound and covering it, due to not having orders or supplies. CG-C called RNS-B to discuss the concerns above, and reported there was no SNV on 8/12/20 to provide wound care, even though P1 was scheduled to have wound care on Monday, Wednesday, and Friday. CG-C told RNS-B that RN-A did not come to P1's home unless the caregivers call on P1's scheduled days and request for her to come. Due to these concerns, CG-C stated the family was actively	G 608		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 7	G 608		

seeking another agency. RNS-B stated she would speak directly with RN-A's direct supervisor and she would call CG-C back. No call was received.
8/17/20-1:21 p.m. CG-C called the agency, spoke to a care manager and reported P1 was being admitted to another agency, and that the agency's services were being terminated. The agency's care manager stated
she would notify the care team, who would perform P1's discharge.
8/19/20-9:56 a.m. CG-C received a call from P1's new home care agency, stating they contacted the agency and they stated they were unaware that P1 was being discharged from their services.
8/19/20-1:33 p.m. RN-A arrived at P1's home at 12:43 p.m. and entered the caregivers' office at 1:00 p.m., reporting that she performed wound care and discharged P1 from the agency's service.

During an interview on 9/9/20, at 2:33 p.m. registered nurse (RN)-A stated, "I tried to get in there as often as I could, it depends on location and my schedule that day," and indicated if she could not make the visit when scheduled, she would call to let P1's caregivers know. RN-A indicated she did not know why the visits were missed, because she did not document it, and stated she should have called her RN supervisor (RNS)-A when she could not make the visit, and should have completed a missed visit report so the provider was aware. RN-A stated, "A lot of times, it was timing," and stated she would go there late in the day. RN-A stated, when she arrived, "There was no one to open the door. They changed their buzzer system, and I couldn't get in," however, stated she did not follow through with attempting to complete the visits as ordered, and did not contact her supervisor or P1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 8	G 608		

physician. RN-A stated she never received orders for the wound care and never received wound care supplies, and stated she kept calling the doctor's office. RN-A stated she brought her own supplies and there were not any specific orders for the wound care. RN-A stated she repeatedly asked P1's caregivers for specific wound care orders, but they would direct RN-A to call the physician because they did not have orders either. RN-A stated, "At least once or twice a week, I called the clinic," but indicated she never heard back from the physician. RN-A stated, the plan was to discharge P1 because she could not get a hold of her physician, did not have any written orders, and did not ever receive the wound care supplies. When asked if she reached out to RNS-A, RN-A stated she did not. RN-A stated, "I did a few measurements, but I did not document my measurements." When asked about the wound care that was provided, RN-A stated, "Those were the supplies I had on hand. I had some wound care honey I purchased myself. There was no order for it." RN-A indicated that she had used the wound care honey for another client and always had it on hand. RN-A stated, "I should have contacted the physician...I did not reach out to my supervisor." RN-A indicated she knew P1's caregivers were frustrated, just as she was, and that is why she discharged P1.

During an interview on 9/11/20, at 8:04 a.m. RNS-A stated, "I personally have not been reached out to by [RN-A]." RNS-A stated the expectation was that the home care visits would be completed as they were set up, and the basic training provided to the staff nurses was for the nurse to call the provider to get wound care orders and order for supplies, and if those measures weren't successful, they should call the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 9	G 608		

office to any one of the supervisors. RNS-A stated, "[RN-A] needed to reach out to us."

During an interview on 9/11/20, at 10:43 a.m. RNS-B indicated P1's caregivers called on 7/17/20, late in the day, inquiring about the frequency of visits because wound care was to be completed three days a week, and had only been completed once since the start of care visit on 7/11/20. RNS-B stated she called RN-A, and RN-A planned to visit P1 on 7/18/20, however, RN-A "apparently" did not visit P1 until 7/21/20. RNS-B stated P1's caregivers called again on 8/5/20, inquiring about wound care supplies because they were never received. RNS-B asked P1's caregiver to fax the most recent orders to the durable medical equipment (DME) company, and stated, "Apparently, they never sent them." RNS-B stated RN-A never called her and added, "I never had any indication that there was an issue at all." RNS-B stated on 8/18/20, P1's caregivers called, asking for RN-A's phone number. RNS-B stated, "I don't know if [RN-A] ever reached out to her supervisor, but she did not reach out to me." RNS-B denied receiving calls and/or voice messages on 8/14/20 and 8/17/20 from P1's caregivers, with concerns regarding P1's home care services and the lack of coordination.

When interviewed on 9/14/20, at 8:51 p.m. CG-C stated she called the agency several times, would leave voicemail for RNS-B, however, she never received calls back. CG-C stated, when RN-A visited, she would not seek out staff to give updates, she would "come and go." CG-C stated on 8/17/20, she called the agency and spoke to RNS-B. CG-C stated she went through the ongoing concerns, the documentation they had of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 608	Continued From page 10 missed visits, lack of appropriate wound care, lack of wound care supplies, and the lack of reporting of the status of the wound, to caregivers. CG-C stated she reported that RN-A made the comment that the wound was getting worse, and said she was going to have to discharge P1 from home care services anyway, because she never received any supplies. CG-C asked RNS-B how she could help so that P1's wound care would be provided appropriately, and RNS-B stated she would talk to RN-A's supervisor and have her call CG-C back. CG-C stated she asked for RN-A's supervisor's phone number, however, RNS-B would not provide it and stated she would have RN-A's supervisor call her back. CG-C stated she never received a call from RN-A's supervisor. Review of the agency's undated policy, Plan of Care, included, "The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members. Planning for care is a dynamic process that addresses the care, treatment and services to be provided. The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary..."	G 608		
G 700	Skilled professional services CFR(s): 484.75 Condition of participation: Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician and medical social work services as specified in §409.45 of this	G 700		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 700	Continued From page 11 chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care. This CONDITION is not met as evidenced by: Based on interview and document review, the agency was found not to be in compliance with the Condition of Participation at 484.75, Skilled Professional Services. The agency failed to ensure skilled nursing services were provided effectively and safely in accordance with physicians' orders for 3 of 4 patients (P1, P3, P5) reviewed for wound care. Findings include: Refer to G710: Based on interview and document review, the agency failed to ensure skilled nursing visits (SNV) were provided per order frequency and failed to assess wounds as directed in the plan of care (POC), to show progress towards goals, for 3 of 4 patients (P1, P3, P5), reviewed. In addition, the agency failed to provide wound care treatment as specified in the POC, for 1 of 4 patient (P1), reviewed.	G 700		
G 710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care; This ELEMENT is not met as evidenced by: Based on interview and document review, the agency failed to ensure skilled nursing visits (SNV) were provided per order frequency and failed to assess wounds as directed in the plan of care (POC), to show progress towards goals, for 3 of 4 patients (P1, P3, P5), reviewed. In addition, the agency failed to provide wound care	G 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 12 treatment as specified in the POC, for 1 of 4 patients (P1), reviewed. Findings include: P1's POC for the certification period dated 7/11/20 through 9/8/20, indicated P1 was admitted on 7/11/20, with a primary diagnosis of a stage 3 (through the second layer of skin into the fat tissue) pressure ulcer to the right heel, and included physician orders for skilled nurse visits three times weekly for various assessments and wound care to the right ankle, with goals of the wound showing progress, as evidenced by decrease in signs of infection, decrease in drainage, decrease in size, and decrease or no necrotic tissue. In addition, P1's POC directed to assess for signs and symptoms of infection and appropriate measures to manage infection, and to provide wound care by cleaning wound with normal saline (NS) or wound cleanser, pack with Nugauze (cotton gauze packing strips for sterile drainage of open and/or infected wounds), cover with ABD (abdominal) pad (high absorbency), and secure with Kerlix (woven gauze bandage roll) and tape Review of P1's medical record indicated, following the start of care visit, P1 had skilled nursing visits only once during the week of 7/13/20, once during the week of 7/20/20, twice during the week of 7/27/20, three visits during the week of 8/3/20, twice during the week of 8/10/20, and once during the week of 8/17/20, with discharge on 8/19/20. There was no documentation to indicate the physician was notified or consulted regarding the decreases in skilled nurse visits. P1's Nursing Visit Record, dated 7/15/20, included, removed the old	G 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 13	G 710		

dressing, cleaned the wound with wound cleanser, and applied non adherent gauze and Coban wrap (self adherent wrap to secure dressing), instead of following the wound care orders listed on the POC. P1's Nursing Visit Record, dated 7/21/20, indicated the wound care provided included, cleaned hands, donned gloves, cleaned with NS or wound cleanser, applied therapeutic honey to site, applied bandage, wrapped with Kerlix and tape. Each Nursing Visit Note, until P1 was discharged, continued to document this same process, including applying therapeutic honey to the site, instead of following the wound care orders listed on the POC. Further, upon admission, P1's wound was assessed with measurements of 1.1 centimeters (cm) (length) x 2.3 cm (width) x 0.4 cm (depth) however, the medical record lacked documentation of any further assessment of the size of the wound throughout the remainder of the SNVs to determine if P1's wounds were healing.

P1's Patient Profile with a Print date of 9/9/20, indicated P1 resided in an assisted living facility.

When interviewed on 9/9/20, at 10:39 a.m. P1's caregiver (CG)-A stated, "We made call after call to get them [the agency] to come out. We had it on our schedule every Monday, Wednesday, and Friday, to call the agency, to make sure they were coming." CG-A indicated P1's caregivers were not able to provide the wound care, therefore, acquired the agency to provide home care. However, P1's wound was progressively getting worse. CG-A stated the agency's staff would say they were coming at a certain time, and then wouldn't show up until late in the day or not at all, and wouldn't give report to P1's caregivers in her home. CG-A stated the agency's staff didn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 14	G 710		

measure the wound, and never had wound care supplies, so would ask the caregivers in P1's home, for supplies.

During an interview on 9/9/20, at 2:10 p.m. the agency's director of clinical services (DCS) stated missed visits should be documented in the medical record, and verified the record lacked documentation of the missed visits. DCS indicated each agency visiting nurse had a stock supply bag of wound care dressings, enough to get the client through until supplies came in, and although it may take time to get the supplies, if the nurse was having difficulty obtaining the supplies from the DME (durable medical equipment), she should have called her supervisor. DCS stated the nurse documented that she used therapeutic honey, but that wasn't in the order. Further, DCS stated the expectation was for the case manager to assess and measure the wound once a week, however, she verified no measurements were completed for P1's wound after the start of care assessment, throughout the home care episode.

When interviewed on 9/9/20, at 2:33 p.m. registered nurse (RN)-A stated, "I tried to get in there as often as I could, it depends on location and my schedule that day," and indicated if she couldn't make the visit when scheduled, she would call to let P1's caregivers know. RN-A indicated she didn't know why the visits were missed because she didn't document it, and stated she should have called her RN supervisor (RNS)-A when she couldn't make the visit, and should have completed a missed visit report so the provider was aware. RN-A stated, "A lot of times, it was timing," and stated she would go there late in the day. RN-A stated, when she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 15	G 710		

arrived, "There was no one to open the door. They changed their buzzer system, and I couldn't get in," however, stated she didn't follow through with attempting to complete the visits as ordered, and didn't contact her supervisor or P1's physician. RN-A stated she never received orders for the wound care and never received wound care supplies, and stated she kept calling the doctor's office. RN-A stated she brought her own supplies and there weren't any specific orders for the wound care. RN-A stated she repeatedly asked P1's caregivers for specific wound care orders, but they would direct RN-A to call the physician because they didn't have orders either. RN-A stated, "At least once or twice a week, I called the clinic," but indicated she never heard back from the physician. RN-A stated, the plan was to discharge P1 because she couldn't get a hold of her physician, didn't have any written orders, and didn't ever receive the wound care supplies. When asked if she reached out to RNS-A, RN-A stated she did not. RN-A stated, "I did a few measurements, but I did not document my measurements." When asked about the wound care that was provided, RN-A stated, "Those were the supplies I had on hand. I had some wound care honey I purchased myself. There was no order for it." RN-A indicated that she had used the wound care honey for another client and always had it on hand. RN-A stated, "I should have contacted the physician...I did not reach out to my supervisor."

When interviewed on 9/10/20, at 9:00 a.m. assistant director of nursing (ADON) stated, by the second visit, if supplies were not received, RN-A should have reached out to her supervisor for help.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 16	G 710		

During a telephone interview on 9/10/20, at 9:18 a.m. the DME company staff stated RN-A called them on 7/29/20, 11 days after P1 was admitted to home care, to inquire about supplies. DME staff stated they never received an order for wound care supplies for P1, and usually there would be multiple notes of home care staff checking on the status of the order, however, no one called until RN-A called on 7/29/20.

During a telephone interview on 9/10/20, at 9:56 a.m. P1's physician's RN, stated orders for home care visits were three times per week for wound care, and orders for supplies were faxed on 7/14/20 to the home health agency. P1's physician's RN stated no other phone calls or requests were received from the agency or RN-A, until a request was received on 7/28/20 from P1's caregivers, to switch home care providers.

When interviewed on 9/10/20, at 11:05 a.m. CG-B stated, on 7/29/20, RN-A was still waiting for supplies and was using what was available to her, and stated, "I remember [RN-A] asked me to contact [P1's] provider to ask to order supplies. As the home care provider, that is their duty. I didn't even know what provider [RN-A] was in contact with." CG-B indicated RN-A would promise to come, and wouldn't show up, and stated, "We literally had it set up in our computer system to make sure [RN-A] was coming, and we would watch for her. Our receptionist was alerted to notify us when [RN-A] got here. Most of the time, [RN-A] didn't show up. We called her frequently, chasing her around." CG-B indicated the wound "got worse," and stated, on 8/6/20, measurements documented by P1's caregivers were 1.5 cm x 1.0 cm x .75 cm, with "tunneling inward and purulent drainage and odor."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 17	G 710		

During an interview on 9/11/20, at 8:04 a.m. RNS-A stated, "I personally have not been reached out to by [RN-A]." RNS-A stated the expectation was that the home care visits would be completed as they were set up, and the basic training provided to the staff nurses was for the nurse to call the provider to get wound care orders and order for supplies, and if those measures weren't successful, they should call the office to any one of the supervisors. RNS-A stated, "[RN-A] needed to reach out to us."

During an interview on 9/11/20, at 10:43 a.m. RNS-B indicated P1's caregivers called her on 7/17/20, late in the day, inquiring about the frequency of visits because wound care was to be completed three days a week, and had only been completed once since the start of care visit on 7/11/20. RNS-B stated she called RN-A, and RN-A planned to visit P1 on 7/18/20, however, RN-A did not visit P1 until 7/21/20. RNS-B stated P1's caregivers called again on 8/5/20, inquiring about wound care supplies because they were never received. RNS-B asked P1's caregiver to fax the most recent orders to the DME company, and stated, "Apparently, they never sent them." RNS-B stated RN-A never called her and added, "I never had any indication that there was an issue at all." RNS-B stated on 8/18/20, P1's caregivers called, asking for RN-A's phone number. RNS-B stated, "I don't know if [RN-A] ever reached out to her supervisor, but she did not reach out to me."

When interviewed on 9/14/20, at 8:51 a.m. P1's CG-C stated P1 was seen at the wound care clinic on 7/6/20, and because P1's caregivers could not provide the wound care, a referral was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 18 sent to the agency. Wound care orders were sent with the referral, and were resent to the agency when RN-A reported she didn't receive them. CG-C stated RN-A kept saying she didn't have the orders, kept saying they ordered supplies and hadn't received them yet, and kept saying she couldn't get in touch with P1's physician. CG-C stated RN-A used therapeutic honey the entire time, which was not ordered, and didn't have anything to cover it, so P1's caregivers were providing supplies for a while, but didn't have anything left. CG-C indicated RN-A reported on 8/17/20, that the wound was 2 cm larger in circumference and 0.5 cm deeper than it was on 8/10/20, however, CG-C stated RN-A had reported to P1's caregivers on 8/10/20, that she had not measured the wound, which was also documented in P1's medical record in her home. CG-C stated RN-A continued to state she was having difficulty obtaining orders from P1's physician and wound care supplies. CG-C stated she reached out to RN-A's supervisor multiple times, would leave messages, and never received a call back. CG-C stated on 8/17/20, she called and spoke to RNS-B, discussed all of the concerns, including missed visits, no supplies, not following the orders, and let her know that P1's family was involved and would be seeking a different home care agency. RNS-B told CG-C that she would bring the concerns to RN-A's supervisor (RNS-A), and would have RNS-A call her back. When CG-C asked for RNS-A's phone number, RNS-B would not provide it. CG-C stated she never received a call back from RNS-A. On 8/18/20, CG-C stated she called the agency and informed a care manager that P1's family were terminating services with the agency. P3	G 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 19 P3's POC for the certification period dated 1/23/20 through 3/22/20, indicated P3 was admitted on 7/27/19, and included physician orders for skilled nurse visits weekly for various assessments and medication management. Review of P3's medical record included a Nursing Visit Record, dated 2/20/20, which identified an open area to P3's sacrum, and indicated P3's physician was notified and wound care orders were requested. P3's physician orders, dated 2/21/20, included wound care orders to change dressing three times per week, on Monday, Wednesday, and Friday, with silver alginate dressing and gauze. Review of SNVs revealed P3 did not have another SNV until 2/27/20, six days later, and no further visits again until a physician's order indicated home care services were on hold on 3/3/20. There was no documentation to indicate the physician was notified or consulted regarding the decreases in skilled nurse visits. In addition, there was no documentation in the medical record to indicate the size of the wound identified on 2/20/20, and no documentation during subsequent visits of the size of the wound on the sacrum, to show assessment of the status of the wound, as directed in the POC. During an interview on 9/10/20, at 3:57 p.m. registered nurse case manager (RNCM)-A stated, P3's order on 2/24/20 included SNV three times a week for dressing changes, and stated, "[P3] was seen on 2/20, and wasn't seen again until 2/27. We may not have had supplies yet." RNCM-A indicated case managers were expected to do weekly wound measurements, assessing drainage, tissue, odors, stage, and what treatment was being provided, in the wound assessment. RNCM-A stated he was not alerted	G 710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 20	G 710		

to to wound identified on 2/20/20, and noted there was no wound documented on the 3/6/20 resumption of care assessment, however, there was wound documentation again on 3/11/20. RNCM-A stated, the notes looked identical and he was doubtful P3 had a wound on his sacrum on 3/11/20, and the note had possibly been copied and pasted from a previous note. RNCM-A stated, "We would expect that each note be current with that visit." RNCM-A indicated it would be difficult to assess the status of the wound, and whether or not it was improving, as directed in the POC, without accurate documentation.

During a follow up phone interview on 9/21/20, at 12:51 p.m. DCS stated the visit nurse identified the wound on P3's sacrum on 2/20/20, faxed the physician, and orders were received on 2/21/20 for wound care and dressing changes three days per week. DCS stated, "It doesn't appear that we adjusted the frequency of the visits or completed any measurements of the wound. There was no follow through from the case manager...Once weekly doesn't correlate with the order for three times a week." DCS stated documentation on 3/6/20 during the resumption of care assessment, indicated no wound at all, however, the wound was noted at the next SNV on 3/11/20.

P5
P5's POC for the certification period dated 6/11/20 through 8/9/20, indicated P5 was admitted on 6/11/20, and included physician orders for skilled nurse visits twice weekly for one week (6/11/20-6/14/20), and then three visits weekly for 8 weeks (6/16/20- 8/9/20), with one PRN (as needed visit), for various assessments and wound care to stage 2 (open wound below the surface of the skin) pressure ulcer to left heel,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 21	G 710		

with goals of the wound showing progress, as evidenced by decrease in signs of infection, decrease in drainage, decrease in size, and decrease or no necrotic tissue.

Review of P5's medical record indicated, P5 had skilled nursing visit only twice during the week starting 6/16/20, 7/6/20, 7/13/20, and 7/20/20. Also identified, during the week of 8/3/20, P5 received four SNV, instead of three as ordered. On 8/10/20, P5's physician order was changed to wound care daily for two weeks. During the week of 8/10/20 and 8/17/20, P5 received only six SNV, instead of seven visits as ordered. There was no documentation to indicate the physician was notified or consulted regarding the increase or decreases in skilled nurse visits. In addition, the medical record indicated P5's wound to the left heel measured 3.4 cm x 2.2 cm x 0.1 cm on 6/11/20, however, the medical record lacked any further measurements of the wound from 6/11/20 through 9/9/20.

During a follow up phone interview on 9/21/20, at 4:43 p.m. DCS verified the missed and extra SNVs and indicated staff should be documenting modifications to the POC and notifying the physician. DCS stated, "There are no measurements that I can see. The case manager saw [P5] on 8/7 for recertification, and on 9/9, and I see no measurements then either." DCS stated the case manager should measure the wound once a week on Mondays, and if the patient isn't seen on Monday, a measurement should be done at least once a week. DCS indicated it was difficult to show improvement or worsening of a wound without measurements.

Review of the agency's undated policy, Missed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	248037	A. BUILDING _____ B. WING _____	C 09/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH CARE INC	**800 BOONE AVENUE NORTH SUITE 200 GOLDEN VALLEY, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 710	Continued From page 22 Visits and Tips to Prevent, included, a skilled nurse missed visit was required when unable to see the patient for scheduled visit due to patient refusal, patient having a physician appointment, or if they were unable to coordinate or contact the patient for a visit. Further, the expectation was to make up a missed visit within 24-48 hours, call emergency contacts and physician's office if unable to contact the patient, and to contact the supervisor for direction if two consecutive missed visits occurred. Review of the agency's undated Wound Care Procedure, included, "Case Managers are required to see wound care clients weekly for measurements, assessment and changing plan of care as needed." Also included, wound assessment parameters should be documented in the integumentary assessment area, including length, width, and depth of the wound. Review of the agency's undated policy, Plan of Care, indicated the plan of care would be consistently reviewed to ensure that client needs are met, and will be updated as necessary, but at least every sixty days. Also included, "Professional staff shall promptly alert the client's physician to any changes that suggest a need to alter the Plan of Care."	G 710		