Protecting, Maintaining and Improving the Health of All Minnesotans

Delivered Via Email

April 22, 2024

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

Re: Enclosed State Licensing Orders
Event ID: 6296N-H1

Dear Administrator:

A survey of the Home Care Provider named above was completed on Apri 4, 2024, for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these regulations that are issued in accordance with Minnesota Statutes, sections 144A.43 to 144A.482.

In accordance with Minnesota Statute section 144A.477, for home care providers that are licensed to provide home care services and are also certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, with survey and enforcement by the Minnesota Department of Health as an agent for the United States Department of Health and Human Services, the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) are considered equivalent to the federal requirements. Because your facility is a certified home health agency, violations of the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) may lead to enforcement actions under Minnesota Statute section 144A.474. If your facility fails to comply with all the federal deficiencies issued as a result of this Department's survey completed on April 4, 2024, the findings supporting the federal violations shall be considered violations of the applicable licensure requirements.

The notice of termination from the Medicare program by the Centers for Medicare and Medicaid Services (CMS) or the failure to attain compliance with the federal regulations within the time periods

approved by CMS may constitute grounds for the revocation, suspension or nonrenewal of the license.

State licensing orders are delineated on the attached Minnesota Department of Health order form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for home care providers.

The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN requirement is not met as evidenced by."

We urge you to review these orders carefully. If you have questions, please contact the supervisor listed below. When all orders are corrected, the order form should be signed and returned to this office at:

Annette Winters, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minnesota Statutes, section 144A.474, subd. 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine(s) assessed.

The written request for reconsideration and all supporting documents must be received by the Commissioner within 15 calendar days of the correction order receipt date.

The Commissioner shall respond in writing to the request within 60 days of the date the provider requests a reconsideration. Any documentation received after the 15 calendar days will not be considered. You are required to send your written request and all supporting documents to Health.Homecare@state.mn.us; or, if you prefer you can mail it to:

Home Care Correction Order Reconsideration Process
Health Regulation Division
625 Robert St. N
St. Paul, MN 55164-0975
Telephone 651-201-4200
Health.CM-Cert@state.mn.us

Failure to correct state licensing correction orders may result in enforcement actions in accordance with the provisions of Minnesota Statutes, sections 144A.43 to 144A.482.

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically Delivered via Email

April 30, 2024

Annette Winters, Regional Operations Supervisor,
Federal Rapid Response Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, MN 55164-0975

Re: Event ID: 6296B-H1 and 6296N-H1

Dear Ms. Winters,

Enclosed please find a copy of Allina Health Home Health's Plan of Correction in response to Certification Letter and Health Survey 2567 and state licensing orders, for the survey conducted on 4/4/2024. Please feel free to contact me at 952-807-4922 or karen.leutner@allina.com with any questions.

Thank you,

Karen Leutner, PT

Karen Leutner, PT
Director Home Health
Allina Health

Allina Health
HOME HEALTH

MR 10733
2925 Chicago Avenue
Minneapolis, MN 55407
651-635-9173
TOLL FREE 800-261-0879

MR 59000
1324 Fifth North Street
New Ulm, MN 56073
507-217-5555

Mother Newborn Home Health
MR 15508
800 E 28th Street, Suite 508
Minneapolis, MN 55407
612-863-4478

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/04/2024**

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

(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
00000	Initial Comments On 3/25/24 - 4/4/24 an abbreviated complaint survey was conducted. The following licensing orders are being issued as a result of the survey: ST810 *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.	00000		**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
00810	Individual Abuse Prevention Plan CFR(s): 144A.479, Subd. 6(b) (b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the agency failed	00810	**00810 Plan** Procedure for implementing the plan of correction **Measures put in place/systemic changes to ensure deficient practice does not recur** Policy Review and Revisions • Clinical Assessment policy reviewed, updates made to include process for assessing patient risk for abuse (Exhibit D). • Individual Abuse Prevention Plan form created to be completed at assessment timepoints which includes identifying the patient's susceptibility to abuse by another individual and states specific measures to be taken to minimize the risk of abuse (Exhibit C). **Corrective action for patients found to have been impacted by the deficient practice/how will we identify other patients having the potential to be affected by the same deficient practice and actions to be taken** Education • Coach nurses involved in care of P1 on assessment expectations and instruct in completion of Individual Abuse Prevention Plan for P1.	

Office of Primary Care and Health Systems Management

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

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00810	Continued from page 1 develop and implement an individual abuse prevention plan for 1 of 1 (P1) who was provided services by the agency. P1 lacked a plan that contained an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected). P1's recertification summary dated 2/1/24 – 3/31/24 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT, (sitting bone) three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder with a suprapubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. P1 was oriented to person, place, time, environment, and family. Upon observation on 3/28/24 at 2:15 p.m. RN-B was completing P1's 60-day recertification assessment. RN-B did not question P1 about any abuse or safety measures. Upon interview on 3/28/24 at 4:15 p.m. P1 stated he had never been asked by agency staff about abuse or safety. He was not aware of any abuse prevention plan the agency had assessed on him or any interventions placed. Upon interview on 4/1/24 at 9:55 a.m. registered nurse, (RN)-B stated she was trained to ask about abuse upon patient's admission assessment. She stated, "I am not sure what we do to prevent abuse." RN-B denied awareness of a specific assessment to identify and care plan abuse prevent for patients. Upon interview on 4/1/24 at 10:58 a.m. RN-D P1's case	00810	• Allina Home Health will train all RNs, PTs, OTs, SLPs and SWs in the completion of Individual Abuse Prevention Plan including ongoing monitoring and completing measures identified to minimize risk **Monitoring procedure to ensure the plan of correction is effective** • Nursing supervisor to complete co visit for P1 with RN-B to ensure accurate completion of patient's Individual Abuse Prevention Plan • Audit 20 admission visits following education to staff for completion and accuracy of the Individual Abuse Prevention Plan **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** May 10, 2024 Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.	**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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00810	Continued from page 2 manager stated she has never asked him if was being abused and had no documentation if he felt abused or at harm. She stated if she noticed any abuse, she would report the abuse. Upon interview and record review on 4/3/24 at 11:59 a.m. the director of home care stated she would provide documents on how the agency provided abuse prevention for P1. She denied there was an assessment for patient risk of harm document to provide. The list consisted of multiple visits she had compiled from P1's chart: -Visit note dated 3/28/24 indicated P1 was assessed for vulnerability and home safety risk: Falls, assessed risk for falls. Patient at risk for harm or abuse: No -Visit note dated 3/25/24 indicated P1 was non-ambulatory, phone at bedside. -Visit note dated 3/21/24 indicated P1 was assessed for vulnerability and home safety risk: Family provides 24-hour care. Assessed risk for falls. Instructed on home safety, fall prevention and Patient at risk for harm or abuse: No -Visit note dated 3/18/24 indicated P1 Assessed risk factors. Denies falls today. Pt. non-ambulatory, phone at bedside. Not at risk for abuse. Pt instructed on 24/7 nurse triage line, Located on Home Care folder, and to call with concerns. Instructed pt/CG to call 911 for emergencies. Pt/CG verbalized understanding. -Visit note dated 3/14/24 P1 Assessed vulnerability and home safety risks: pt parents provide 24-hour care. Assessed risk for falls. Instructed on home safety, fall prevention. Patient at risk for harm or abuse: No -Visit note dated 3/11/24 P1 Home Visit DC Planning: Spoke with patient about DC planning. Assessed for: ongoing homebound status. DC will occur when: patient/caregiver is able to demonstrate goals met. Anticipate DC: On time due to progressing toward goals. Patient and/or caregiver response to discharge planning education agrees. -Visit note dated 3/7/24 indicated P1 Assessed risk factors denies falls today. Pt non-ambulatory. Has phone at bedside. Not at risk for abuse. Pt instructed on 24/7 nurse triage line, Located on Home Care folder, and to call.	00810		**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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00810	Continued from page 3 with concerns. Instructed pt/CG to call 911 for emergencies. Pt/CG verbalized understanding. -Visit note dated 02/26/2024 indicated P1 Assessed risk factors. Denies falls today. Instructed on falls prevention (i.e., keep phone/personal items within reach, keep home free of clutter and secure rugs, wear appropriate footwear, instructed light on at night, instructed to always use, instructed slow position changes. Not at risk for abuse. Pt instructed on 24/7 nurse triage line, Located on Home Care folder, and to call. with concerns. Instructed pt/CG to call 911 for emergencies. Pt/CG verbalized understanding. -Visit note dated 02/22/2024 indicated P1 assessed patient vulnerability and home safety risks: parents provide 24-hour care. Assessed risk for falls. Instructed on home safety, fall prevention Patient at risk for harm or abuse: No -Visit note dated 02/20/2024 SN – indicated P1 assessed patient vulnerability and home safety risks: Assessed risk for falls. Instructed on falls prevention. Patient at risk for harm or abuse: No -Visit note dated 02/15/2024 SN – indicated P1 was assessed patient vulnerability and home safety risks: parents provide cares. Assessed risk for falls. Instructed on home safety, fall prevention. Patient at risk for harm or abuse: No -Visit note dated 02/12/2024 indicated assessed risk factors denies falls today. Pt non-ambulatory has phone at bedside. Not at risk for abuse. Pt instructed on 24/7 nurse triage line, Located on Home Care folder, and to call with concerns. Instructed pt/CG to call 911 for emergencies. Pt/CG verbalized understanding. -Visit note dated 02/08/2024 SN – indicated P1 was assessed patient vulnerability and home safety risks: no risk. Assessed risk for falls. Instructed on home safety, fall prevention. Patient at risk for harm or abuse No -Visit note dated 02/05/2024 indicated P1 was assessed patient vulnerability and home safety risks: no risk	00810		**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

Minnesota State Department of Health

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00810	Continued from page 4 assessed risk for falls. Instructed on home safety, fall prevention Patient at risk for harm or abuse: No Recertification note dated 01/31/2024 SN - OASIS RECERTIFICATION. Assessed patient vulnerability and home safety risks: no risk. Assessed risk for falls. Instructed on home safety, fall prevention. Patient at risk for harm or abuse: No Start of care visit for 08/10/2022 OASIS START OF CARE Assessed patient vulnerability and home safety risks: yes -bedbound, non-ambulatory. Assessed risk for falls. Instructed on safety for bedbound patients including railings, lowering the bed. Patient at risk for harm or abuse No An individual abuse prevention plan policy and/or procedure was requested, however not received.	00810		**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248091	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2024

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G0000	INITIAL COMMENTS On 3/25/24 – 4/4/24 an abbreviated complaint survey was conducted. This resulted substandard care and an extended survey at Allina Home Health. The agency was found to have not met the requirements at 42 CFR Part 484 for Home Health Agencies. The cumulative effects of these findings resulted in the Home Health Agency's inability to ensure provision of quality of care. H80912032C/MN105624 was substantiated deficiencies were issued as a result of the complaint investigation: G374, G406, G430, G442, G448, G478, G486, G488, G514, G528, G536, G574, G584, G602, G682, G808, G810. The survey resulted in an Immediate Jeopardy (IJ) at CFR 484.50 Condition of Participation: Patient Rights. The IJ began on 3/27/24 at 12:01 p.m., when the agency failed to protect multiple patients from potential abuse when the facility failed to report, thoroughly investigate, or protect other patients when the agency was notified of a romantic relationship between a registered nurse (RN)-A nurse and a patient (P1). RN-A sexually abused P1 over approximately ten months while assigned as P1's primary caregiver. The Interim Vice President of Operations, the Director of Home Health, The Risk Management Manager, and a Registered Nurse Supervisor were notified of the IJ on 3/27/24 at 12:01 p.m. The immediate jeopardy was removed on 4/4/24 at 10:42 a.m. after it could be verified the agency had implemented an acceptable removal plan.	G0000		**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0374	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 of assessment. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and record review the	G0374	**G0374 Plan** **Policy Review and Revisions** • Review of Oasis Report Policy completed, identified need to update to include "The encoded OASIS data must accurately reflect the patient's status at the time of assessment" **(See Exhibit E)**	

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

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

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G0374	Continued from page 1 facility failed to ensure the oasis assessment accurately reflected the health status of 2 of 2 patients assessed (P1 & P2). P1's Oasis assessment indicated he was on a regular diet, however he was on a feeding tube. P1 was assessed to not be vulnerable, on interviews with P1 and registered nurse (RN-B) both identified reasons he does have vulnerability risks. In addition, documentation on his recertification assessment indicated P1 had vulnerability risk. P2's oasis assessment indicated P2 was over age 65 and had no central line or tunneled device. P1 was assessed not to be vulnerable even with a current inability to self-manage important medications. Findings Include: P1's Oasis recertification dated 3/28/24 indicated Under the title Recertification summary: Primary diagnosis for Home Health: S [sic] other diagnoses and recent medical procedures impacting episode: left blank Clinical and functional limitations requiring skilled care: left blank Psychosocial concerns/observations: No barriers/concerns Vulnerability risk: 0 – None P1's recertification summary dated 4/1/24 – 5/30/24 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT, (sitting bone), three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder with a suprapubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. Safety and nutritional assessment indicated a regular diet. Functional assessment: Paralysis Readmission risks/rehab potential unintentional weight loss of a total of 10 lbs. or more	G0374	***G0374 Plan*** ***Continued from page 1*** **Education** • Coaching provided to clinician involved with patient identified regarding accurately reflecting the patient's status in their Oasis coding at the time of assessment • Develop and administer education to home health RNs, PTs, OTs and SLPs on updated Oasis Reporting Policy **Monitoring** • Following clinician education an audit of 20 Oasis assessment contacts will be completed to ensure Oasis assessment accurately reflects patient's health status **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0374	Continued from page 2 in the past twelve months. Decline in mental, emotional, or behavior status in the past three month. Currently taking five or more medications. Upon observation on 3/28/24 at 2:15 p.m. P1 told RN-B of the Botox procedure he had completed on 3/27/24. P1 had called it a surgical procedure as he was placed under general anesthesia and had Botox injection into his bladder. He mentioned had and was continuing to have bladder spasms and increased pain following the procedures. This information was not on the Oasis certification under new procedures. Upon interview on 3/28/24 at 4:15 p.m. P1 stated he considered himself vulnerable because he is a paralyzed. He stated he is "forced" to rely on nursing staff and his family for all cares including his safety. "I also take a lot of meds, and some make me loopy." Upon interview on 4/1/24 at 9:55 a.m. registered nurse, RN-B stated would identify P1 as vulnerable due to his condition of being "bed bound", having 5 wounds and on being a stage IV, having a catheter and a feeding tube and the "main reason" he is dependent on care givers for what he can't do. P2's recertification summary dated 3/22/24-5/20/24, indicated P2 received services from the HHA for end stage renal disease, atrial fibrillation (rapid heart rate), and chronic respiratory failure. P2 had morbid obesity and was dependent on renal dialysis. P2's start of care assessment dated 3/22/24, indicated the following: -in section MAHC-10 yes patient 65 years or older -in section O0110-had no central or tunneled catheter -P2 had 0-NONE checked. P2's hospital discharge summary paperwork dated 2/8/24, indicated P2 was not 65 years or older. P2 had an invasive central line required for dialysis treatment.	G0374		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0374	Continued from page 3 P2's start of care summary dated 3/22/24, indicated P2 had not been taking warfarin as ordered upon hospital discharge and P2 required education about the importance of medications and taking as prescribed. The summary further stated sister was P2's PCA and would now be reminding P2 about medications. An observation and interview on 3/28/24 at 3:26 p.m., P2 was seated in a recliner chair in the living room. P2 had a tee-shirt that was pulled down and a dialysis catheter was seen on the right upper chest area. P2 stated the dialysis catheter was placed when in the hospital and was used for dialysis treatments. P2 further stated he did not take warfarin for a few weeks as he thought he was out of the medication. P2 stated the agency staff found a bottle with the hospital discharge information during a visit last week. When interviewed on 3/28/24, registered nurse (RN)-C verified P2 had a dialysis catheter in the right chest and was not aware of a surgical wound or other current skin issues. When interviewed on 4/1/24 at 2:31 p.m., care manager (CM)-A stated not taking medications as directed due to inability to find them or know how to get more would make P2 vulnerable. CM-A further verified P2's start of care assessment lacked indication of a central dialysis catheter. CM-A expected staff to have a dialysis catheter documented when present on the start of care. An Oasis assessment policy was requested however none received.	G0374		**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0406	Condition of Participation: Patient rights. CFR(s): 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. This CONDITION is NOT MET as evidenced by: Based on the number and/or severity of the deficiencies cited the home health agency (HHA) failed to meet the	G0406	**G0406 Plan** **Procedure for implementing the plan of correction.** **Measures put in place/systemic changes to ensure deficient practice does not recur.** **Policy Review and Revisions** • AHCS Patient Bill of Rights policy reviewed, no updates needed. • Grievance and Complaint Resolution policy reviewed, no updates needed. Allina Home Health process for investigating complaints reviewed. Updates made to include a process to investigate complaints of abuse, including sexual abuse, by an Allina Employee **(See Exhibit A)**.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248091	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2024

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G0406	Continued from page 4 CFR 484.50 Condition of Participation: Patient Rights. The agency failed to protect a patient (P1) from abuse when registered nurse (RN)-A sexually abused P1 over approximately ten months while assigned as P1's primary caregiver. The agency failed to thoroughly investigate a sexual abuse allegation when a family friend reported to the agency on 7/31/23 allegations of a romantic relationship regarding P1 and his primary caregiver registered nurse RN-A. The agency failed to immediately report the allegations to the state agency (SA) and the agency failed to protect 171 other patients RN-A was providing cares for from 8/1/23 until her termination on 3/29/24. The survey resulted in an Immediate Jeopardy (IJ) at CFR 484.50 Condition of Participation: Patient Rights. The IJ began on 3/27/24 at 12:01 p.m., when the agency failed to protect multiple patients from potential abuse when the facility failed to report, thoroughly investigate, or protect other patients when the agency was notified of a romantic relationship between a registered nurse (RN)-A nurse and a patient (P1). RN-A sexually abused P1 over approximately ten months while assigned as P1's primary caregiver. The Interim Vice President of Operations, the Director of Home Health, The Risk Management Manager, and a Registered Nurse Supervisor were notified of the IJ on 3/27/24 at 12:01 p.m. The immediate jeopardy was removed on 4/4/24 at 10:42 a.m. after it could be verified the agency had implemented an acceptable removal plan. The immediate jeopardy that began on 3/27/24, was removed on 4/4/24 when verified the facility contacted all patients seen by RN-A determining psychosocial needs that may be affected by RN-A's actions, reviewed its policy and procedures response process to allegations of abuse and/or assault as well as their investigation process then educated staff on the agencies policy, procedures and systems for responding to and investigating allegations of abuse and/or assault, and staff completed Allina's Home Health Professional Boundaries training. Findings include: Refer to G430: The agency failed to protect patients from abuse when RN-A sexually abused P1 over approximately ten months while assigned as P1's primary caregiver. The facility received an allegation of a romantic relationship between registered nurse (RN)-A and (P1). When this was initially reported on 7/31/23,	G0406	***G0406 Plan*** ***Continued from page 4*** **Policy Review and Revisions *(cont.)*** • AHCS Professional Boundaries policy reviewed, no updates needed. • Review of Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota completed, update made to the definition of "immediately" to remove language stating, "but no more than 24 hours" **(See Exhibit B)** • Clinical Assessment policy reviewed, identified need to update process for assessing patient risk for abuse identified. Individual Abuse Prevention Plan form created to be completed at assessment timepoints **(See Exhibit C)** **Education** • Develop and administer education to all Allina Home Health RNs, PTs, OTs, SLPs and SWs regarding AHCS Patient Bill of Rights policy • Develop and administer education to all Allina Home Health staff regarding Grievance and Complaint Resolution policy • Develop and administer education to Allina Home Health leaders on the updated complaint investigation process and tools (education completed on 4/4/24). • Assign Professional Boundaries training to all staff for completion which includes review of Professional Boundaries policy (education completed on 4/4/24) • Train all staff on updated Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota policy with updated verbiage defining "immediately" (education completed on 4/4/24) **Corrective action for patients found to have been impacted by the deficient practice/how will we identify other patients having the potential to be affected by the same deficient practice and actions to be taken** • Allina Home Health will contact all patients seen by RN-A from 8/1/23 - 3/20/24, determining psychosocial needs of patients that may be affected by RN-A's actions (completed on 4/3/24) with no reports of abuse. • Allina Home Health will train all RNs, PTs, OTs, SLPs and SWs in the completion of Individual Abuse Prevention Plan	**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0406	Continued from page 5 the agency failed to investigate or take action to protect other patients from potential abuse. RN-A continued to provide care to numerous other patients before being removed from the schedule. This had the potential to affect 171 patients under RN-A's care. Refer to G478: The agency failed to investigation an allegation of sexual abuse for 1 of 1 patient (P1) reviewed for abuse. The agency did not have policies, procedures, or a system in place to identify a process to investigate allegations of sexual abuse. Refer to G486: The agency failed to take action to prevent further potential violations to patients following allegations of sexual abuse for 1 of 1 patient (P1). The agency received a complaint allegation of a romantic relationship between (P1) and registered nurse (RN)-A. The agency substantiated that a relationship occurred, however allowed RN-A to see 171 other patients in the time she was removed from caring for P1 and the time RN-A was terminated from the agency. Refer to G488: The agency failed to ensure allegations of sexual abuse were immediately reported the state agency for 1 of 1 patient (P1) reviewed when a family friend called the agency to report a romantic relationship between P1 and his nurse (RN)-A.	G0406	***G0406 Plan*** ***Continued from page 5*** **Monitoring procedure to ensure the plan of correction is effective** • Ongoing, a manager not directly involved in complaint will review process followed for the investigation of complaints received by the agency to ensure all steps have been followed **Monitoring procedure to ensure the plan of correction is effective *(cont.)*** • Complaints will be reviewed on a quarterly basis at the AHCS Quality Council (QAPI committee) to identify trends and opportunities for improvement • Following education to all staff audit 20 admission visits for completion and accuracy of the Individual Abuse Prevention Plan **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0430	Be free from abuse CFR(s): 484.50(c)(2) Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property; This ELEMENT is NOT MET as evidenced by: Based on interview and record review, the agency failed to protect patients from abuse when RN-A sexually abused P1 over approximately ten months while assigned as P1's primary caregiver. The facility received an allegation of a romantic relationship between registered nurse (RN)-A and (P1). When this was initially reported on 7/31/23, the agency failed to investigate or take action to protect other patients from potential abuse. RN-A continued to provide care to numerous other patients before being removed from the schedule. This had the potential to affect 171 patients under RN-A's care.	G0430	**G0430 Plan** **Procedure for implementing the plan of correction** **Measures put in place/systemic changes to ensure deficient practice does not recur** **<u>Policy Review and Revisions</u>** • AHCS Patient Bill of Rights policy reviewed. No updates needed. • Grievance and Complaint Resolution policy reviewed. No updates needed. • Allina Home Health process for investigating complaints reviewed. Updates made to include a process to investigate complaints of abuse, including sexual abuse, by an Allina Employee (See Exhibit A) • AHCS Professional Boundaries policy reviewed. No updates needed.	

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G0430	Continued from page 6 The Immediate Jeopardy (IJ) began on 3/27/24 at 12:01 p.m., when the agency failed to protect multiple patients from potential abuse when the facility failed to report, thoroughly investigate, or protect other patients when the agency was notified of a romantic relationship between a registered nurse (RN)-A nurse and a patient (P1). RN-A sexually abused P1 over approximately ten months while assigned as P1's primary caregiver. The Interim Vice President of Operations, the Director of Home Health, The Risk Management Manager, and a Registered Nurse Supervisor were notified of the IJ on 3/27/24 at 12:01 p.m. The immediate jeopardy was removed on 4/4/24 at 10:42 a.m. after it could be verified the agency had implemented an acceptable removal plan. Findings Include: The agency investigative summary dated 7/31/23 indicated the agency received a call from a friend of P1's family on 7/31/23, reporting RN-A, P1's nurse, stopped dating P1 and he had issues with getting supplies. The friend reported RN-A was involved in a romantic relationship with P1. Interviews revealed that RN-A and P1 did not have a relationship prior to P1's start of care of 8/10/22. The agency spoke to P1 who said he did have a romantic relationship with RN-A and that he was getting his supplies. P1 told the agency RN-A never told him she could not be his nurse. The agency told P1 he had a new case manager assigned. RN-A was interviewed by the agency on 8/2/23 and denied a relationship with P1 but admitted that she saw P1 outside of working hours to assist him with needs while his personal caregivers were away. A written warning for violating professional boundaries was issued to RN-A and RN-A continued to work with other patients. A letter from the Office of Minnesota Attorney General dated 10/24/23 addressed to the agencies Human Resources Director enclosed a subpoena indicated per the Minnesota Statutes second 214.10 subdivision 3, to produce a copy of the complete employment records, personnel file, and/or supervisors anecdotal file, including, but not limited to application for employment, curriculum vitae, job description, employment contracts, performance evaluations, records of verbal and written complaints, incident reports, internal investigation documents, disciplinary actions/warnings, leave of absence documents, and termination documents in your possession of P1. The	G0430	***G0430 Plan*** ***Continued from page 6*** **Policy Review and Revisions *(cont.)*** • Review of Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota completed, update made to the definition of "immediately" to remove language stating "but no more than 24 hours" **(See Exhibit B)** • Clinical Assessment policy reviewed, identified need to update process for assessing patient risk for abuse identified. Individual Abuse Prevention Plan form created to be completed at assessment timepoints **(See Exhibit C)** **Education** • Develop and administer education to all Allina Home Health c RNs, PTs, OTs, SLPs and SWs regarding AHCS Patient Bill of Rights policy • Develop and administer education to all Allina Home Health staff regarding Grievance and Complaint Resolution policy • Develop and administer education to Allina Home Health leaders on the updated complaint investigation process and tools (education completed on 4/4/24). • Assign Professional Boundaries training to all staff for completion which includes review of Professional Boundaries policy (education completed on 4/4/24) • Train all staff on updated Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota policy with updated verbiage defining "immediately" (education completed on 4/4/24) **Corrective action for patients found to have been impacted by the deficient practice/how will we identify other patients having the potential to be affected by the same deficient practice and actions to be taken** • Allina Home Health will contact all patients seen by RN-A from 8/1/23 - 3/20/24, determining psychosocial needs of patients that may be affected by RN-A's actions (completed on 4/3/24) with no reports of abuse. • Allina Home Health will train all RNs, PTs, OTs, SLPs and SWs in the completion of Individual Abuse Prevention Plan **Monitoring procedure to ensure the plan of correction is effective** • Ongoing, a manager not directly involved in complaint will review process followed for the investigation of complaints received by the agency to ensure all steps have been followed	**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0430	Continued from page 7 records were to be sent to the Investigator of Health and Teacher Licensing Division no later than 11/6/23. The document was issued by the Minnesota Board of Nursing on 10/23/24. The requested employment records were emailed to the Minnesota Attorney General on 10/30/23. P1's recertification summary dated 2/1/24 - 3/31/24 indicated P1 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT, sitting bone, three pressure ulcers on his back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder with a suprapubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. P1 was oriented to person, place, date, time, environment, and family. A letter from the Minnesota Board of nursing (Board) dated 1/29/24 was emailed to RN-A. The letter indicated Minnesota Board of Nursing had received a complaint about her nursing practice involving and allegation which would violate the Minnesota Nurse Practice Act (“NPA”). "The Board received a complaint alleging about being engaged in an inappropriate relationship with a patient while working at the agency: -MN Stat.148.261, subd. 1 (5) Failure to or inability to perform professional or practical nursing as defined in MN Stat. 148.171, subd. 14 or 15, with reasonable skill and safety, including failure of a registered nurse to supervise or a licensed practical nurse to monitor adequately the performance of acts by any person working at the nurse's direction. -MN Stat.148.261, subd. 1 (6) Engaging in unprofessional conduct, including, but not limited to, a departure from or failure to conform to board rules of professional or practical nursing practice that interpret the statutory definition of professional or practical nursing as well as provide criteria for violations of the statutes, or, if no rule exists, to the minimal standards of acceptable and prevailing professional or practical nursing practice, or any nursing practice that may create unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not be established under this clause. MN Stat.148.261, subd. 1 (11) Engaging in any unethical	G0430	***G0430 Plan*** ***Continued from page 7*** • Complaints will be reviewed on a quarterly basis at the AHCS Quality Council (QAPI committee) to identify trends and opportunities for improvement • Following education to all staff audit 20 admission visits for completion and accuracy of the Individual Abuse Prevention Plan **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0430	Continued from page 8 conduct, including, but not limited to, conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient. Actual injury need not be established under this clause. -MN Stat.148.261, subd. 1 (12) Engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient or engaging in sexual exploitation of a patient or former patient. An investigation is being conducted to determine if the allegations are true or not. The Board specifically reviewing your nursing practice as a result of information the Board has received and has asked the Attorney General to conduct an investigation." A civil lawsuit summons dated 3/19/24 was received by the agencies Employee Relations (ER) business unit. The lawsuit indicated P1 was the Plaintiff and RN-A, and the agency were the Defendants. The letter indicated RN-A and the agency were being sued and must reply within 20 days to protect their rights. The facts in the summons indicated: -P1 now a paraplegic having sustained catastrophic injuries in a roll-over care accident at the age of 18. -P1 at that time was a teenager with a wide circle of friends and is now isolated and confined to his bed virtually 24-hours a day. -P1 lives with long-term, profound depression, had chronic pain, endures severe bed sores and host of other serious medical conditions. -P1 followed an elaborate regimen of medications to alleviate his pain and depression. RN-A in the summer of 2022 was assigned to P1 as his nurse, making three home visits a week to check vitals, dress wounds, breathing function, took urine samples reordered medical supplies. The visits generally lasted 90 minutes. -RN-A became P1’s case manager after two months. At that time, she sent P1 a text message expressing her romantic interest in him. The day after the first text, RN-A kissed P1 for the first time. The romantic interludes quickly went from kissing to	G0430		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0430	Continued from page 9 fondling, to dozens of instances of digital penetrations and oral sex. RN-A introduced sex toys into the relationship. Intercourse had been discussed, but not consummated because P1 had chronic and excruciating bladder pain and a urinary tract infection which prevented it. -RN-A took “selfie” photos in various stages of undress and gave to P1. P1 has retained the photographs. -RN-A and P1 exchanged hundreds of romantic text messages. P1 has retained the texts. -RN-A attitude to P1 soured, she began complaining about inconsequential personal matters between the two, questions his ability to ever father a child with her and to live outside of a hospital bed. -On 7/14/23 RN-A ended the relationship. -P1 already isolated, physically, and emotionally vulnerable, was utterly shattered by RN’s betrayal. An agency investigation report dated 3/19/24, indicated the agency's Employee Relations (ER) received notification of a civil lawsuit involving RN-A. RN-A was alleged to have engaged in inappropriate conduct while conducting care for P1. The compliant was substantiated. Between 3/19/24 and 3/21/24 records were reviewed, and interviews were conducted: 1. On 3/19/24 RN-A was placed on administrative leave pending outcome of the investigation 2. On 3/19/24 RN-A was interviewed by phone 3. On 3/21/24 the investigation record was closed. The summary of the investigation findings indicated RN-A was assigned to care for P1 from 10/12/22 to 8/1/23. During RN-A's interview she admitted that she had a "personal relationship" with P1, and they exchanged text messages that were "sometimes work related. When asked if any of the text messages were sexual in nature, RN-A stated she did not want to answer that question. When RN-A was asked if she ever kissed P1 RN-A began to cry and said she was already being investigated by the Board of Nursing and did not "want to do this again." RN-A terminated the interview. A Minnesota Adult Abuse Reporting Center (MAARC) report was filed by the agency on 3/20/24 by the agency.	G0430		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0430	Continued from page 10 Upon interview on 3/26/24 at 11:26 a.m. the Human Resources Directed stated the agency provided the information requested in the Minnesota Board of Nursing subpoena but took no further action to determine why the information was requested. Upon interview on 3/25/24 at 2:08 p.m. the Home Health Director stated the agency received a call 7/31/23 from a friend of P1 who shared P1 was in a romantic relationship with his nurse and the couple broke up and since the break-up she was concerned he was not getting his wound supplies. She stated RN-A denied a romantic relationship but admitted to seeing P1 outside of work. P1 did admit to romantic involvement with RN-A. The director denied interviewing any other HHA staff or any other HHA clients. The director turned the investigation over to ER on 8/1/24. RN-A was removed from P1's assignments on 7/31/23. On 2/1/24 RN-A shared that she was investigated by the Board of Nursing and was feeling "so stressed out" that she wanted to take a leave of absence starting 2/2/24. RN-A was granted the leave and she returned to work after 2/9/24. The director stated the agency did not do an investigation of why RN-A was being investigated by the Board of Nursing. She stated then on 3/19/24 the agency received notification of a civil case regarding the HHA, because of RN-A committing sexual abuse. She stated on 3/19/24 she immediately reached out to employee relations and worked with them to interview RN-A. She stated RN-A was terminated "based on some of her answers to the questions," but she elected to resign. The director stated the agency did not reach out to P1 after these allegations, nor any other staff members or other patients seen by RN-A from 8/1/24 until 3/19/24. Upon interview on 3/25/24 at 3:06 p.m. RN-A stated P1 never made any inappropriate requests during his nursing visits, his visits took a long time for him to get situated because P1 had a lot of wounds. RN-A stated she was not comfortable talking about her relationship with P1 without her attorney present. In addition, she stated she took a leave of absence from work following the e-mail she received from the Minnesota Board of Nursing about being investigated. Upon interview on 3/26/24 at 9:12 a.m. family member (FM)-A stated he did not want to be interviewed or have P1 interviewed without an attorney present because the situation was too emotionally scarring to P1 to be brought up again. FM-A requested all questions go	G0430		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0430	Continued from page 11 through his attorney and requested a list of questions via email. Upon interview on 3/26/24 at 11:26 a.m. the Human Resources Directed stated the agency provided the information requested in the Minnesota Board of Nursing subpoena but took no further action to determine why the information was requested. Upon interview on 3/27/24 at 9:42 a.m. P1 stated he had suffered mental and emotional stress at the hands of RN-A. He stated he felt coerced and manipulated "that is all I want to say without an attorney present." Agency policy titled Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota dated 4/2022 indicated reports of suspected or known incidents of maltreatment must be reported as soon as possible, but in no event longer than 24 hours. One definition of abuse was criminal sex conduct. A vulnerable adult was described as a person age 18 or older who regardless of resident or type of service received, possess a physical, mental, or emotional infirmity which impairs the person's ability to basic cares without assistant and as a result of the infirmity and the dependence, the adult has an impaired ability to protect themselves from maltreatment. The immediate jeopardy that began on 3/27/24, was removed on 4/4/24 when verified the facility contacted all patients seen by RN-A determining psychosocial needs that may be affected by RN-A's actions, reviewed its policy and procedures response process to allegations of abuse and/or assault as well as their investigation process then educated staff on the agencies policy, procedures and systems for responding to and investigating allegations of abuse and/or assault, and staff completed Allina's Home Health Professional Boundaries training.	G0430		**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0442	Written notice for non-covered care CFR(s): 484.50(c)(8) Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. The HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204.	G0442	**G0442 Plan** **<u>Policy Review and Revisions</u>** • Review of Home Health-Beneficiary Notices Policy completed, no updates needed. Policy was not followed for patients identified **<u>Education</u>** • Coaching provided to clinician involved with patient identified regarding requirement to provide proper written notice in advance of a specific service being	

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G0442	Continued from page 12 This ELEMENT is NOT MET as evidenced by: Based on interview and record review the agency failed to provide proper written notice in advance of specific services being furnished if the agency believes that the serve may non-covered; or in advance of the agency reducing or terminating ongoing care. This deficient practice did not allow Medicare beneficiaries to exercise or dispute their Medicare-covered services for 3 of 17 (P1, P5, P12) patients reviewed. P1's skilled nursing services were reduced from three times per week to two without providing advance notice. P5's physical therapy services were terminated due to P5 not reaching her goals without notice given to P5 to dispute. P12's physical therapy, skilled nursing and occupational services ended due to P12 reaching goals and was not given notice to dispute. Findings include: Medicare Claims Processing Manual Chapter 30 – Financial Liability Protections dated 12/20/23 indicated the Advance Beneficiary Notice of Non-coverage (ABN) is a type of financial liability notice. The ABN musted be provided far enough in advance of delivering potentially non-covered items or services to allow sufficient time for the beneficiary to consider all available options. Reductions involve any decrease in services or supplies, such as frequency, amount, or level of care, provided by the HHA and/or care that is part of the POC. If a reduction occurs for an item or service that will no longer be covered by Medicare, but the beneficiary wants to continue to receive the care and assume the financial charges, the HHA must issue the ABN prior to providing the non-covered items or services. Retrieved from https://www.cms.gov on 4/4/24. P1's start of care certification dated 8/10/22 and certifications through dated 8/4/23 indicated skilled nursing frequencies was: 3 visits every week. 8/10/22 to 10/8/22: 1 to 8 (PRN) as needed visits Comments: assess wound/cares, skin/pressure relief, pain, medications, gastrointestinal/gastrourinal GI/GU, safety. P1's certification dated 10/9/2022 to 12/3/2022 indicated skilled nursing visits frequency was:	G0442	***G0442 Plan*** ***Continued from page 12*** **Education *(cont.)*** furnished if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. • Educate all home health RNs, PTs, OTs and SLPs on Home Health-Beneficiary Notices Policy and requirement to provide proper written notice in advance of a specific service being furnished if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. **Monitoring** • Following employee education audits will be completed on 20 discharges/reduction in service to confirm compliance with issuing proper written notice to the patient. **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0442	Continued from page 13 10/9/22 – 12/7/22: 3 visits every week for 8 weeks. 10/9/22 to 12/7/22: 1-6 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 12/4/2022 to 2/4/23 indicated skilled nursing visit frequency was: 12/4/22 – 12/7/22: 2 visits every 4 days for 4 days. 12/11/22 - 2/4/22: 3 visits every week for 8 weeks. 12/4/22 – 2/4/22: 1-5 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 2/6/23 – 4/6/23 indicated skilled nursing visit frequency was: 2/6/2023 to 2/11/2023: 3 visits every 6 days for 6 days. 2/12/2023 to 3/18/2023: 3 visits every week for 5 weeks. 2/6/2023 to 3/18/2023: 1-4 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 4/7/23 – 6/5/23 indicated skilled nursing visit frequency was: 4/7/23 – 4/8/23: 1 visit every 2 days for 2 days. 4/9/23 to 6/5/23: 3 visits every week for 4 weeks. 4/7/23 to 6/5/23: 1-4 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 6/6/23 – 8/4/23 indicated skilled nursing visit frequency was: 6/6/23 – 6/11/23: 1 visits every 3 days for 4 days.	G0442		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0442	Continued from page 14 6/11/2023 to 7/8/2023: 3 visits every week for 7 weeks. 6/6/2023 to 8/4/2023 1-5 PRN visits Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 8/5/23 – 10/3/23 indicated skilled nursing visit frequency was: 8/6/23 – 9/30/23: 2 visits every week for 7 weeks. 8/5/23 – 10/3/23: 1-5 PRN visits. 10/1/23 – 10/3/23: 1 visit every 3 days for 3 days. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 10/4/23 – 12/2/23 indicated skilled nursing visit frequency was: 10/4/23 – 10/7/23: 1 visit every 4 days for 4 days. 10/8/23 – 12/2/23: 2 visits every week for 8 weeks. 10/4/23 – 12/2/23: 1-5 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 12/3/23 – 1/31/24 indicated skilled nursing visit frequency was: 12/3/23 – 1/31/24: 2 visits every week for 8 weeks. 12/3/23 – 1/31/24: 1-3 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 2/1/24 – 3/31/24 indicated skilled nursing visit frequency was: 2/1/24 – 2/10/24: 2 visits every 10 days for 10 days. 2/11/24 – 2/20/24: 2 visits every week for 2 weeks. 2/25/24 – 3/30/24: 1 visit every week for 5 weeks.	G0442		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0442	Continued from page 15 2/1/24 – 3/31/24: 1-3 PRN visits Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's orders from the wound care clinic dated 3/5/24 indicated P1's plan was to continue with 3 days weekly skilled nursing visits. P1's recertification summary dated 4/1/24 – 5/30/24 indicated P1 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT, (sitting bone) three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder with a suprapubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. P1 was oriented to person, place, time, family and environment. Upon interview on 3/28/24 at 2:00 p.m. P1's family member (FM)-A stated P1's skilled nursing decreased in 8/1/23. He stated P1 had been getting skilled nursing visits consistently three times a week since his start of care on 8/10/22 and the skilled nursing care was decreased to twice a week on 8/1/23. FM-A stated "no two nurses" give him "the same story" as to why visits decreased. FM-A denied signing any Medicare form or educated on how to dispute the decrease in services. Upon interview on 3/24/24 at 4:15 p.m. P1 stated he did not sign any Medicare form approving the decrease in visits. He denied receiving education on how to dispute the decrease in skilled nursing services through Medicare. Upon interview on 4/1/24 at 10:58 a.m. RN-D P1's case manager stated she has had discussion with FM-A and P1 about the decrease in skilled nursing services due Medicare may not pay because education needs to remain a component of the visits for Medicare to pay. RN-D denied providing an ABN form to the family. P5's certification dated 2/1/24 – 3/31/24 indicated P5 pertinent diagnoses were chronic obstructive pulmonary	G0442		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0442	Continued from page 16 disease with exacerbation and acute respiratory failure with hypoxia (difficulty breathing), congestive heart failure, rheumatoid arthritis, and osteoporosis. P5's services were physical therapy for strength, gait, activity tolerance and safety. Skilled nursing for oxygenation, safety, medication changes, and lab draws. 2/1/24 – 2/10/24: P5's physical therapy visits were 1 visit every 10 days for 10 days to evaluate and treat for gait, balance, and exercises. 2/6/24 – 2/17/24: 1 visit every 12 days for 12 days for lower extremity strength, activity tolerance, gait/transfer training, and safety instruction. 2/18/24- 3/24/24: 1 visit every week for 2 weeks. For lower extremity strength, activity tolerance, balance, gait/transfer training and safety. 3/24/24 – 3/30/24 1 visit for 1 week for strength, gait, balance, transfers manual therapy, modalities, and oxygen saturation checks. Upon observation on 3/29/24 at 3:10 p.m. physical therapist (PT)-A explained to P5 that the visit would be P5's last physical therapy visits because P5 has not functionally improved. She explained to P5 that after six off therapy P5 only increased her ambulation by 20 feet. PT-A told P5 to have her daughter assist with any exercises P5 had learned through therapy. P5 responded that she was just having a bad day and that she was tired because occupational therapy (OT) had just worked with her. P5 stated her daughter works full-time and has family that assisting with exercises would be a burden on her. P5 stated she wanted to continue with physical therapy. PT-A informed P5 that it was Medicare standards that if someone is not improving therapy cannot be renewed. An ABN form was not discussed. Upon interview on 4/1/24 at 11:00 a.m. PT-A stated she did not use the ABN form because it was not required because P5 had completed the visits as ordered on the service agreement. Upon interview on 4/1/24 at 11:12 a.m. P5 stated she wanted to continue with therapy. She denied signing any Medicare forms about physical therapy ending or to whom	G0442		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0442	Continued from page 17 to report a dispute. Upon interview on 4/4/14 at 4:15 p.m. The Director of Home stated that an ABN form is required for Medicare patient who wish to continue services under Medicare or have the option to choose another payor source. In addition, an ABN form was to be used for all Medicare reductions in services. P12's recertification summary dated 2/2/24-4/1/24, indicated P12 received services from the HHA for bladder cancer, artificial opening of urinary tract and heart failure. P12's summary further indicated P12 had the following services: -skilled nursing 1 visit every 9 days (2/2/24-2/10/24) and then 1 visit weekly for 3 weeks (2/11/24-3/2/24) for respiratory assessment, genitourinary assessment, skin/wound assess, pain and anxiety. -physical therapy 1 visit every 9 days (2/2/24-2/10/24) and then 1 visit every 3 days (2/8/24-2/10/24) then weekly visits for 5 weeks (2/11/24-3/16/24) for gait and transfer training, balance, exercises, and education. -occupational therapy 1 visit every 9 days (2/2/24-2/3/24). Then 2 visits for 3 weeks (2/4/24-2/24/24) for activities daily living, safety, and education. -skilled nursing intervention for discharge planning indicated P12 will receive proper notification 48 hours or more of discharge for Medicare patients. P12's skilled nursing visit note dated 2/29/24, indicated P12 was being discharged from skilled nursing services due to goals met. P12's physical therapy home care note dated 3/29/24, indicated P12 was discharged from physical therapy as all goals were met. P12's occupational therapy visit note dated 3/27/24, indicated P12 was discharged from occupational therapy services with all goals met. P12's ABN notice for discontinuation of Services was requested however was not received.	G0442		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0442	Continued from page 18 A facility policy titled Home Health-Beneficiary Notices effective 11/26/22 indicated an ABN notice is issued to Traditional Medicare beneficiaries when payment is expected to be denied. In addition, the ABN needs to be re-issued at least annually to assure patient rights are maintained.	G0442		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0448	Freedom from discrimination or reprisal CFR(s): 484.50(c)(11) Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the HHA or an outside entity. This ELEMENT is NOT MET as evidenced by: Based on interview and record review the agency failed to be free from any discrimination of reprisal for exercising his rights after the family requested a family friend to file a complaint against the home heath agency. P1 and P1's family stated immediately following the complaint filing his skilled nursing visits decreased. The family felt it retaliation for the complaint filed. Findings Include: P1's start of care certification dated 8/10/22 to 10/8/22 indicated skilled nursing frequencies was: 2 visits every 4 days for 4 days 8/10/22 – 8/13/22. 8/14/22 to 10/8/22: 3 visits every week for 8 weeks. 8/10/22 to 10/8/22: 1 to 8 (PRN) as needed visits Comments: assess wound/cares, skin/pressure relief, pain, medications, gastrointestinal/gastrourinal GI/GU, safety. P1's certification dated 10/9/2022 to 12/3/2022 indicated skilled nursing visits frequency was: 10/9/22 – 12/7/22: 3 visits every week for 8 weeks. 10/9/22 to 12/7/22: 1-6 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety.	G0448	**G0448 Plan** **Procedure for implementing the plan of correction** **Measures put in place/systemic changes to ensure deficient practice does not recur** **Policy Review and Revisions** • AHCS Patient Bill of Rights policy reviewed. No updates needed, meets regulatory requirements. • Grievance and Complaint Resolution policy reviewed. No updates needed, meets regulatory requirements **Education** • Develop and administer education to all Allina Home Health RNs, PTs, OTs, SLPs and SWs regarding AHCS Patient Bill of Rights policy • Develop and administer education to all Allina Home Health staff regarding Grievance and Complaint Resolution policy **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	

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G0448	Continued from page 19 P1's recertification dated 12/4/2022 to 2/4/23 indicated skilled nursing visit frequency was: 12/4/22 – 12/7/22: 2 visits every 4 days for 4 days. 12/11/22 - 2/4/22: 3 visits every week for 8 weeks. 12/4/22 – 2/4/22: 1-5 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 2/6/23 – 4/6/23 indicated skilled nursing visit frequency was: 2/6/2023 to 2/11/2023: 3 visits every 6 days for 6 days. 2/12/2023 to 3/18/2023: 3 visits every week for 5 weeks. 2/6/2023 to 3/18/2023: 1-4 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 4/7/23 – 6/5/23 indicated skilled nursing visit frequency was: 4/7/23 – 4/8/23: 1 visit every 2 days for 2 days. 4/9/23 to 6/5/23: 3 visits every week for 4 weeks. 4/7/23 to 6/5/23: 1-4 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 6/6/23 – 8/4/23 indicated skilled nursing visit frequency was: 6/6/23 – 6/11/23: 1 visits every 3 days for 4 days. 6/11/2023 to 7/8/2023: 3 visits every week for 7 weeks. 6/6/2023 to 8/4/2023 1-5 PRN visits Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety.	G0448		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0448	Continued from page 20 The agency investigative summary dated 7/31/23 indicated they received a call from a friend of P1's family on 7/31/23 reporting RN-A, P1's nurse, stopped dating P1 and he had issues with getting supplies. The friend reported RN-A was in a relationship with P1. RN-A was removed from care with P1 on 8/1/23. P1's recertification dated 8/5/23 – 10/3/23 indicated skilled nursing visit frequency was: 8/6/23 – 9/30/23: 2 visits every week for 7 weeks. 8/5/23 – 10/3/23: 1-5 PRN visits. 10/1/23 – 10/3/23: 1 visit every 3 days for 3 days. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 10/4/23 – 12/2/23 indicated skilled nursing visit frequency was: 10/4/23 – 10/7/23: 1 visit every 4 days for 4 days. 10/8/23 – 12/2/23: 2 visits every week for 8 weeks. 10/4/23 – 12/2/23: 1-5 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 12/3/23 – 1/31/24 indicated skilled nursing visit frequency was: 12/3/23 – 1/31/24: 2 visits every week for 8 weeks. 12/3/23 – 1/31/24: 1-3 PRN visits. Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's recertification dated 2/1/24 – 3/31/24 indicated skilled nursing visit frequency was: 2/1/24 – 2/10/24: 2 visits every 10 days for 10 days. 2/11/24 – 2/20/24: 2 visits every week for 2 weeks. 2/25/24 – 3/30/24: 1 visit every week for 5 weeks.	G0448		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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(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
G0448	Continued from page 21 2/1/24 – 3/31/24: 1-3 PRN visits Comments: assess wound/cares, skin/pressure relief, pain, medications, GI/GU, safety. P1's orders from the wound care clinic dated 3/5/24 indicated P1's plan was to continue with 3 days weekly skilled nursing visits. Upon interview on 3/28/24 at 2:00 p.m. P1's family member (FM)-A was question why P1's skilled nursing decreased "immediately" after a family friend filed a complaint to the agency. He stated P1 had been getting skilled nursing visits consistently three times a week since his start of care on 8/10/22 and the skilled nursing care was decreased to twice a week on 8/1/23. FM-A stated "no two nurses" give him "the same story" as to why visits decreased. Upon observation on 3/28/24 at 3:45 p.m. RN-B was asked why the skilled nursing had been decreased. RN-B replied that she did not know why. FM-A showed RN-B the orders in which RN-D was using for the dressing changes she had just completed where the form indicated 3/5/24 "continue 3 days weekly skilled nursing visits." RN-B told FM-A that she would change the visits back to 3 times weekly and speak with her supervisor about the change. Upon interview on 3/28/24 at 4:15 p.m. P1 stated he was unaware why his skilled nursing visits had been decreased form 3 times a week to 2 times a week and then to 1 time a week. He stated he was "certain" it was from the complaint and the fear of losing his visits was adding to his anxiety. He stated staff had told him because he has not improved in over a year, other staff had told him it was because they were "running out of education material." Upon interview on 4/1/24 at 10:58 a.m. RN-D stated the reason the P1's visits were being decreased was because per Medicare guidelines the agency is required to be teaching P1 or his caregiving. She stated P1 and his family have been educated on everything and "recently" FM-A leaves the room when she is providing cares to P1. RN-D could not identify any specific education completed with the family. She stated the education is general wound care. She stated she had never provided	G0448		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0448	Continued from page 22 educational handout materials and did not document any specific education give to the family or P1. She stated she did not have any documentation of education and return demonstration from, P1, FM-A, or FM-B. An agency policy titled Vulnerable Adult Maltreatment: Assessment and Reporting in Minnesota effective date 4/2022 indicated the agency will not retaliate any against any employee, practitioner, contractor, volunteer, or other person who, in good faith reports suspected maltreatment of a vulnerable adult, nor against any person with respect to whom a vulnerable adult maltreatment report is made.	G0448		**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0478	Investigate complaints made by patient CFR(s): 484.50(e)(1)(i) The HHA must— (i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics: (A) Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; (B) Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA. This ELEMENT is NOT MET as evidenced by: Based on interview and record the agency failed to investigation allegations of sexual abuse. The agency did not have policies or procedures in place to identify a process to investigate allegations of sexual abuse. See G430 Based on interview and record the agency failed to investigation an allegation of sexual abuse for 1 of 1 patient (P1) reviewed for abuse. The agency did not	G0478	**G0478 Plan** **Procedure for implementing the plan of correction** **Measures put in place/systemic changes to ensure deficient practice does not recur** **<u>Policy Review and Revisions</u>** • AHCS Patient Bill of Rights policy reviewed. No updates needed. • Grievance and Complaint Resolution policy reviewed. No updates needed. • Allina Home Health process for investigating complaints reviewed. Updates made to include a process to investigate complaints of abuse, including sexual abuse, by an Allina Employee **(See Exhibit A)** • AHCS Professional Boundaries policy reviewed. No updates needed. • Review of Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota completed, update made to the definition of “immediately” to remove language stating “but no more than 24 hours” **(See Exhibit B)** • Clinical Assessment policy reviewed, identified need to update process for assessing patient risk for abuse identified. Individual Abuse Prevention Plan form created to be completed at assessment timepoints **(See Exhibit C)** **<u>Education</u>** • Develop and administer education to all Allina Home Health RNs, PTs, OTs, SLPs and SWs regarding AHCS Patient Bill of Rights policy • Develop and administer education to all Allina Home Health staff regarding Grievance and Complaint Resolution policy • Develop and administer education to Allina Home Health leaders on the updated complaint investigation process and tools (education completed on 4/4/24).	

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G0478	Continued from page 23 have policies, procedures, or a system in place to identify a process to investigate allegations of sexual abuse. Finding include: P1's recertification summary dated 2/1/24 – 3/31/24 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT (sitting bone), three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder with a suprapubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. P1 was oriented to person, place, time, environment, and family. The agency investigative summary dated 7/31/23 indicated they received a call from a friend of P1's family on 7/31/23 reporting RN-A, P1's nurse, stopped dating P1 and he had issues with getting supplies. The friend reported RN-A was in a relationship with P1. Interviews revealed that RN-A and P1 did not have a relationship prior to initiation of care. The agency spoke to P1 who said he did have a romantic relationship with RN-A and that he was getting supplies. P1 told the agency RN-A never told him she could not be his nurse. The agency told P1 he has a new case manager assigned. RN-A was interviewed by the agency on 8/2/23 and denied a relationship with P1 but admitted that she saw P1 outside of working hours to assist him with needs while his personal caregivers were away. A written warning for violating professional boundaries was issued to RN-A and RN-A continued to work. On 1/29/24 a letter from the Minnesota Board of Nursing was emailed to RN-A. The letter indicated the RN-A was involved in an allegation that she engaged in an inappropriate relationship with a patient while working at the HHA. On 2/1/24 RN-A contacted the agency requesting a leave of absence because she received a letter from the Minnesota Board of Nursing that they are looking into her and she needed time off.	G0478	***G0478 Plan*** ***Continued from page 23*** **Education (cont.)** • Assign Professional Boundaries training to all staff for completion which includes review of Professional Boundaries policy (education completed on 4/4/24) • Train all staff on updated Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota policy with updated verbiage defining "immediately" (education completed on 4/4/24) **Corrective action for patients found to have been impacted by the deficient practice/how will we identify other patients having the potential to be affected by the same deficient practice and actions to be taken** • Allina Home Health will contact all patients seen by RN-A from 8/1/23 - 3/20/24, determining psychosocial needs of patients that may be affected by RN-A's actions (completed on 4/3/24) with no reports of abuse. • Allina Home Health will train all RNs, PTs, OTs, SLPs and SWs in the completion of Individual Abuse Prevention Plan **Monitoring procedure to ensure the plan of correction is effective** • Ongoing, a manager not directly involved in complaint will review process followed for the investigation of complaints received by the agency to ensure all steps have been followed • Complaints will be reviewed on a quarterly basis at the AHCS Quality Council (QAPI committee) to identify trends and opportunities for improvement • Following education to all staff audit 20 admission visits for completion and accuracy of the Individual Abuse Prevention Plan **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0478	Continued from page 24 Employee Relations received notification of a civil lawsuit against RN-A and Allina Home Health on 3/19/24. RN-A was alleged to have sexually assaulted P1 during the time she was P1's primary nurse in the summer of 2022 until July 2023. An agency investigation report dated 3/19/24 indicated the agency's Employee Relations (ER) received notification of a civil lawsuit involving RN-A. RN-A was alleged to have engaged in inappropriate conduct while conducting care for P1. The compliant was substantiated. Between 3/19/14 and 3/21/24 records were reviewed, and interviews were conducted: 1. On 3/19/24 RN-A was placed on administrative leave pending outcome of the investigation 2. On 3-19-24 RN-A was interviewed by phone 3. On 3/21/24 the investigation record was closed. The summary of the investigation findings indicated RN-A was assigned to care for P1 from 10/12/22 to 8/1/23. During RN-A's interview she admitted that she had a "personal relationship" with P1, and they exchanged text messages that were "sometimes work related. When asked if any of the text messages were sexual in nature, RN-A stated she did not want to answer that question. When RN-A was asked if she ever kissed P1 stated began to cry and said she was already being investigated by the Board of Nursing and not "want to do this again." RN-A terminated the interview. Upon interview on 3/25/24 at 2:08 p.m. the Home Health Director stated the agency received a call 7/31/23 from a friend of P1 and shared P1 was in a romantic relationship with his nurse and the couple broke up and since the break-up she was concerned about he was not getting his wound supplies. The director stated RN-A denied a romantic relationship but admitted to seeing P1 outside of work. P1 did admit to romantic involvement with RN-A. The director denied interviewing any other agency staff or any other HHA clients. The director turned the investigation over to employee relations on 8/1/24. RN-A was removed from P1's assignments on 7/31/24. On 2/1/24 RN-A shared that she was investigated by the Board of Nursing and was feeling "so stressed out" that she wanted to take a leave of absence from starting 2/2/4. RN-A was granted	G0478		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0478	Continued from page 25 the leave and she returned to work after 2/9/24. The director did not identify any other investigation activity. Upon interview on 3/27/24 at 9:42 a.m. P1 stated he had suffered mental and emotional stress at the hands of P1. He stated he did feel coerced and manipulated “that is all I want to say without an attorney present.” Upon interview on 3/27/24 at 2:40 p.m. the Risk Management Manager stated the risk management team, did not assist in any investigation when the agency filed the MAARC report on 3/20/24 because the agency closed the case in August of 2022 because the agency had completed their investigation then. In addition, she stated If the agency would have filed a MAARC report on 7/31/24 risk management would have assisted in that investigation. Upon interview on 3/27/24 at 9:38 a.m. RN-E stated she supervised RN-A and when the initial allegations came in on 7/31/24 she was emailed the information from the staff member who took the call. She stated she called the complainant who told her she was concerned of a romantic relationship between RN-A and P1. She stated she reached out to the human resources department to meet and talk about the situation. RN-E called P1, and he admitted to having a romantic relationship with RN-A. No further questions were asked of P1. She stated she did not reach out to any other staff members of patients as part of an investigation. In addition, she did not let the complainant know the results of any investigation. RN-E stated when the agency became aware on 2/1/24 that RN-A was being investigated by the Minnesota Board of Nursing the agency gave RN-A some requested time off. The agency did not investigate the allegations again RN-A because they were unaware of who the patient was. On 3/19/24 when the agency receive notification that there was a civil lawsuit involving RN-A the agency brought her in for questioning and during the meeting the agency as going to terminate RN-A but RN-A resigned. No other investigation activity was identified. P1 was not interviewed. Upon interview on 3/27/24 at 12:09 p.m. the human resource consultant stated she became involved in the investigation on 3/19/24 when the agency received information of the civil suit. She stated the civil lawsuit were very detailed between P1 and RN-A. She stated they did not investigate because in August of	G0478		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0478	Continued from page 26 2023 the agency was unable to substantiate any findings, but on a violation of policy. She stated RN-A was interviewed to the sexual nature of the allegations and began to cry and ended the interview. RN-A then resigned. A facility policy titled Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota effective 4/2022 indicated the facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors. The policy did not indicate any investigative activities.	G0478		**Date of completion** May 10, 2024 *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0486	Protect patient during investigation CFR(s): 484.50(e)(1)(iii) (iii) Take action to prevent further potential violations, including retaliation, while the complaint is being investigated. This ELEMENT is NOT MET as evidenced by: Based on interview and record review the agency failed to take action to prevent further potential violations to patients following allegations of sexual abuse for 1 of 1 patient (P1). The agency received a complaint allegation of a romantic relationship between (P1) and registered nurse (RN)-A. The agency substantiated that a relationship occurred, however allowed RN-A to see 171 other patients in the time she was removed from caring for P1 and the time RN-A was terminated from the agency. Findings include: P1's recertification summary dated 2/1/24 – 3/31/24 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT (sitting bone), three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder with a prepubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. P1 was oriented to person, place, time, environment, and family.	G0486	**G0486 Plan** **Procedure for implementing the plan of correction** **Measures put in place/systemic changes to ensure deficient practice does not recur** **<u>Policy Review and Revisions</u>** • AHCS Patient Bill of Rights policy reviewed. No updates needed. • Grievance and Complaint Resolution policy reviewed. No updates needed. • Allina Home Health process for investigating complaints reviewed. Updates made to include a process to investigate complaints of abuse, including sexual abuse, by an Allina Employee **(See Exhibit A)** • AHCS Professional Boundaries policy reviewed. No updates needed. • Review of Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota completed, update made to the definition of "immediately" to remove language stating "but no more than 24 hours" **(See Exhibit B)** • Clinical Assessment policy reviewed, identified need to update process for assessing patient risk for abuse identified. Individual Abuse Prevention Plan form created to be completed at assessment timepoints **(See Exhibit C)** **<u>Education</u>** • Develop and administer education to all Allina Home Health RNs, PTs, OTs, SLPs and SWs regarding AHCS Patient Bill of Rights policy • Develop and administer education to all Allina Home Health staff regarding Grievance and Complaint Resolution policy • Develop and administer education to Allina Home Health leaders on the updated complaint investigation process and tools (education completed on 4/4/24).	

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G0486	Continued from page 27 The agency investigative summary dated 7/31/23 indicated they received a call from a friend of P1's family on 7/31/23 reporting RN-A, P1's nurse, stopped dating P1 and he had issues with getting supplies. The friend reported RN-A was in a relationship with P1. Interviews revealed that RN-A and P1 did not have a relationship prior to initiation of care. The agency spoke to P1 who said he did have a romantic relationship with RN-A and that he was getting supplies. The agency told P1 he had a new case manager assigned. RN-A was interviewed by the agency on 8/2/23 and denied a relationship with P1 but admitted that she saw P1 outside of working hours to assist him with needs while his personal caregivers were away. A written warning for violating professional boundaries was issued to RN-A and RN-A continued to work. Upon interview on 3/25/24 at 2:08 p.m. the Home Health Director stated the agency received a call 7/31/23 from a friend of P1 and shared P1 was in a romantic relationship with his nurse and the couple broke up and since the break-up she was concerned about he was not getting his wound supplies. PT-A stated RN-A denied a romantic relationship but admitted to seeing P1 outside of work. P1 did admit to romantic involvement with RN-A. The director denied interviewing any other residents at the time of the allegations and RN-A was allowed to work with any other agency patients. The director did not indicate how the residents who RN-A care for were kept safe during the investigation. She stated none of patients complained to the agency. The director provided a list of the patient's RN-A saw from the time of the allegations of 7/31/23 until her termination date of 3/20/24. On 3/25/24 at 3:06 p.m. RN-A stated she was removed from caring for P1 on 8/1/23 for a relationship. She stated her duties at the agency remained the same except for the inability to see P1. On 3/26/24 at 10:09 a.m. Excel spread sheet was provided listing all patients RN-A provided care for between 8/1/24 and 3/19/29. The list consisted of 686 nursing visits completed on a total of 171 patients. An agency policy titled Vulnerable Adult Maltreatment: Assessment and reporting in Minnesota dated 4/2022 did provide any documentation about preventing further potential abuse. No other abuse policies were provided.	G0486	***G0486 Plan*** ***Continued from page 27*** **Education *(cont.)*** • Assign Professional Boundaries training to all staff for completion which includes review of Professional Boundaries policy (education completed on 4/4/24) • Train all staff on updated Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota policy with updated verbiage defining "immediately" (education completed on 4/4/24) **Corrective action for patients found to have been impacted by the deficient practice/how will we identify other patients having the potential to be affected by the same deficient practice and actions to be taken** • Allina Home Health will contact all patients seen by RN-A from 8/1/23 - 3/20/24, determining psychosocial needs of patients that may be affected by RN-A's actions (completed on 4/3/24) with no reports of abuse. • Allina Home Health will train all RNs, PTs, OTs, SLPs and SWs in the completion of Individual Abuse Prevention Plan **Monitoring procedure to ensure the plan of correction is effective** • Ongoing, a manager not directly involved in complaint will review process followed for the investigation of complaints received by the agency to ensure all steps have been followed • Complaints will be reviewed on a quarterly basis at the AHCS Quality Council (QAPI committee) to identify trends and opportunities for improvement • Following education to all staff audit 20 admission visits for completion and accuracy of the Individual Abuse Prevention Plan **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0488	Immediate reporting of abuse by all staff CFR(s): 484.50(e)(2) Any HHA staff (whether employed directly or under arrangements) in the normal course of providing services to patients, who identifies, notices, or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the HHA and other appropriate authorities in accordance with state law. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential sexual abuse were immediately reported the state agency for 1 of 1 patient (P1) when a family friend called the agency to report a romantic relationship between P1 and his nurse (RN)-A. Findings include: P1's recertification summary dated 2/1/24 – 3/31/24 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT (sitting bone), three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder with a suprapubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. P1 was oriented to person, place, time, environment, and family. The agency investigative summary dated 7/31/23 indicated the agency received a call from a friend of P1's family reporting RN-A, P1's nurse, stopped dating P1 and he had issues with getting supplies. The friend reported RN-A was in a relationship with P1. The agency spoke to P1 who said he did have a romantic relationship with RN-A. On 1/29/24 a letter from the Minnesota Board of Nursing was emailed to RN-A. The letter indicated RN-A was involved in an allegation that she engaged in an inappropriate relationship with a patient while working at the HHA.	G0488	**G0488 Plan** **Procedure for implementing the plan of correction** **Measures put in place/systemic changes to ensure deficient practice does not recur** **Policy Review and Revisions** • Review of Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota completed, update made to the definition of "immediately" to remove language stating "but no more than 24 hours" **(Exhibit B)** **Education** • Train all Allina Home Health staff on updated Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota policy with updated verbiage defining "immediately" (education completed on 4/4/24) **Corrective action for patients found to have been impacted by the deficient practice/how will we identify other patients having the potential to be affected by the same deficient practice and actions to be taken** • Allina Home Health will train all RNs, PTs, OTs, SLPs and SWs in the completion of Individual Abuse Prevention Plan **Monitoring procedure to ensure the plan of correction is effective** • Ongoing, audits will be performed by Home Health Director on 5 Vulnerable Adult reports per month to ensure timeframe followed for filing meets expectation of "immediately" **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0488	Continued from page 29 On 2/1/24 RN-A contacted the agency requesting a leave of absence because she received a letter from the Minnesota Board of Nursing that they are looking into her and needed time off. The agency's Employee Relations department received notification of a civil lawsuit against RN-A and Allina Home Health on 3/19/24. RN-A was alleged to have sexually assaulted P1 during the time she was P1's primary nurse in the summer of 2022 until July 2023. A Minnesota Adult Abuse Reporting Center (MAARC) report was filed by the agency on 3/20/24 by the agency. Upon interview on 3/25/24 at 2:08 p.m. the Home Health Director stated the agency received a call 7/31/23 from a friend of P1 who shared P1 was in a romantic relationship with his nurse and the couple broke up and since the break-up she was concerned about P1 was not getting his wound supplies. P1 did admit to romantic involvement with RN-A. On 2/1/24 RN-A shared that she was investigated by the Board of Nursing for inappropriate relationship with a patient. The director stated on 3/19/24 the agency received notification of a civil lawsuit regarding the agency due to RN-A. The director denied reporting the allegations to the SA when the initial allegations came in 7/31/24 or on 2/1/24 when RN-A shared that she was being investigated for an inappropriately relationship with a patient. Agency policy titled Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota dated 4/2022 indicated reports of suspected or known incidents of maltreatment must be reported as soon as possible, but in no event longer than 24 hours. An updated policy titled Vulnerable Adult Maltreatment Assessment and Reporting in Minnesota dated 4/3/24 indicate reports of suspected or know incidents of maltreatment must be reported as soon as possible.	G0488	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs	G0514	**G0514 Plan** **Policy Review and Revisions** • Policy titled; Home Health Clinical Assessment was reviewed. No updates needed. • Determined policy not followed for identified patient.	

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G0514	Continued from page 30 of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. This ELEMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure the start of care assessment was completed within 48 hours of the patient's return home for 1 of 7 patients (P2) observed during home care visit. P2 discharged from the hospital on 2/10/24 however the agency closed the referral due to a request for a new home care order when P2's hospital discharge was delayed from 2/8/24 to 2/10/24. Findings include: P2's recertification summary dated 12/6/23-2/6/24, indicated P2 received services from the HHA for atrial fibrillation (rapid heart rate), chronic respiratory failure and obesity. P2's hospital discharge summary dated 2/8/24, indicated P2 was in the hospital from 12/26/23-2/10/24. P2's hospital provider order dated 2/8/24 and expiring 2/8/25, requested home care services of skilled nursing, physical therapy, occupational therapy, home health aide, and social work for P2 upon discharge from the hospital. P2's recertification summary dated 3/22/24-5/20/24, indicated P2 received services from the HHA for end stage renal disease, atrial fibrillation (rapid heart rate), and chronic respiratory failure. P2 had morbid obesity and was dependent on renal dialysis. P2's agency referral note dated 2/8/24, indicated Allina intake received the referral on 2/8/24 with a planned discharge of 2/8/24. P2's agency intake communication notes dated 2/8/24, indicated agency was at capacity, however "NW RN (northwest registered nurse) accepted in over cert".	G0514	***G0514 Plan*** ***Continued from page 30514 Plan Continued from*** **Education** • Develop and administer education to all home health RNs, PTs, OTs, SLPs and scheduling staff on completing the initial assessment within 48 hours of referral, patient's return home or physician or allowed practitioner ordered start /resumption of care date. **Monitoring** • Following employee education, audits will be completed on 10 Resumption of Care contacts and 10 Start of Care contacts to ensure compliance with expectation to complete initial assessment visit either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner -ordered start of care date **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0514	Continued from page 31 P2's hospital care coordination note dated 2/8/24, indicated P2 was placed with Allina Home care upon discharge. P2's hospital discharge summary dated 2/10/24, indicated P2 was discharging home after dialysis with home care services. P2's intake communication note dated 2/10/24, indicated a voicemail was left with the hospital requesting new orders as the 2/8/24 orders were expired as of 2/10/24 and P2 had not discharged. P2's referral was then closed. P2's provider order dated 3/19/24, indicated physician assistant (PA)-A ordered physical therapy for in home services. P2's agency referral dated 3/19/24, indicated in coordination with P2 and P2's sister, a start of care visit with physical therapy was scheduled for 3/22/24. P2's start of care assessment dated 3/22/24, indicated P2 was had discharged from the hospital on 2/10/24. P2 was discharged with home care services but had not been seen through Allina Home Health. A request for documentation indicating P2 was no longer accepted into services from the 2/8/24 hospital order was requested however was not received. When interviewed on 3/28/24 at 3:05 p.m., P2 stated he discharged from the hospital in February. P2 stated home care just started coming again last week. P2 was not sure why it was not started sooner. When interviewed on 4/1/24 at 2:31 p.m., care manager (CM)-A reviewed intake notes and stated a request for a new order was needed as P2 did not discharge on 2/8/24 like anticipated. CM-A stated since P2 was not at an Allina facility, communication was a little harder. CM-A verified there was no documentation or follow up after 2/10/24 until PA-A placed an order for physical therapy.	G0514		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0514	Continued from page 32 A follow up interview on 4/4/24 at 9:57 a.m., CM-A explained when a patient referral was accepted there was a 48-hour window to start care. If there was a delay in the ability to start care such as a delay in hospital discharge or patient's preference, the intake department requested a new order. CM-A verified the initial orders did not expire after 48 hours, but this helped the agency to start care within 48 hours of the order. When interviewed on 4/4/24 at 1:30 p.m., PA-A stated she was aware P2 was in the hospital for kidney failure but had not been aware home care was not following until P2's sister called the clinic to request therapy orders. PA-A then placed orders for in home physical therapy on 3/19/24. PA-A usually stated home care orders come from the hospital at the time of discharge. PA-A stated she had not seen Pt for a post hospital visit but believed one was now scheduled. When interviewed on 4/4/24 at 3:15 p.m., the Director of Home Care Services stated P2's initial hospital referral showed an opportunity for improved documentation on what the situation was and if there was any further follow up with P2 or the hospital. There was a lack of documentation to show why the referral was closed if there was any communication follow up with the hospital or with the supervisors on duty. Sometimes when a patient did not discharge from the hospital when planned, it was not known why and if we would be able to safely admit them. The decision is then placed back on the provider and a new order is requested. Furthermore, the director stated they would trust the supervisors to look into the situation but cannot provide any information as to why P2's referral was closed and if discussion with the supervisors or the hospital had taken place. A facility policy on start of care was requested however was not provided.	G0514		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is NOT MET as evidenced by:	G0528	**G0528 Plan** **<u>Policy and Procedure Review</u>** • Policy titled; Home Health Clinical Assessment was reviewed and identified a need to add detail to the Comprehensive Assessment portion of the policy on assessment of health, psychosocial, functional and cognition (Exhibit D)	

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G0528	Continued from page 33 Based on observation, interview, and record review the agency failed to ensure a comprehensive assessment accurately reflected the patient's status for 2 of 17 patients (P1 and P2) who received home health services. P1's comprehensive assessment failed address his psychosocial status including screening of P1's relationships, living environment, and impact on delivery of services. P2's comprehensive assessment failed to include an assessment of P2's dialysis treatment and dialysis catheter. Findings include: P1's recertification summary dated 2/1/24 – 3/31/24 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT, (sitting bone), three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder with a suprapubic catheter, neurogenic bowel ileostomy, and required a jejunectomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. P1 was oriented to person, please, time, environment, and family. Upon observation and interview on 3/28/24 at 2:15 p.m. P1 was confined to a hospital bed in his parents' home. P1 would shout out to his parents for any needs he required assistance with. P1 stated he had financial concerns, P1 had concerns about his insurance coverage and his ability to continue living at home and his parents aging and unable to care for him in the near future. P1 stated loneliness and how getting into the community, even the rehabilitation center would be beneficial for him. P1's nursing note dated 3/14/24 indicated P1's parent provide care 24 hours a day for P1. The note also indicated P1 was very anxious because FM-B did not pick-up any medications at the pharmacy. P1 was calling the pharmacy and was told the prescriptions were not ready. P1's nursing note dated 3/18/24 indicated P1 had anxiety during visit when it relates to medications or supply issues. P1 was non-ambulatory and had phone next to his bed.	G0528	***G0528 Plan*** ***Continued from page 33rom page 33*** **Education** • Coaching provided to clinician involved with patient identified regarding assessment of patient's current health, psychosocial, functional, and cognitive status • Educate home health RNs, PTs, OTs and SLPs on the Home Health Clinical Assessment including updates naming the requirement to assess the patient's current health, psychosocial, functional and cognitive status. **Monitoring** • Following employee education audits will be completed on 20 assessment visit contacts for the assessment of current health, psychosocial, functional and cognitive status. **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0528	Continued from page 34 P1's nursing note dated 3/25/24 indicated when P1 leaves home he experiences unsteady gait, weakness, poor endurance, and debilitating pain. P1's compressive assessment dated 3/28/24 indicated psychosocial concerns observations: No barriers/concerns. Decline in mental, emotional, or behavior status in the past three months. The assessment did not indicate any further details regarding the decline. Upon interview on 4/1/24 at 9:55 a.m. RN-B stated for the psychosocial assessment she looks at cognition, anxiety, and depression. She stated she asked patients mood and watches for signs of nonverbal ques for anxiety and depression including crying, anger, and being withdrawn. RN-B denied assessment for relationships, financial concerns, or community involvement. Upon interview on 4/4/24 at 4:15 p.m. the Director of Home Care stated she believed the staff were assessing for psychosocial needs. An email correspondence on 4/5/24 at 4:04 p.m. showed a snapshot of the criteria staff are to be basing their psychosocial assessments on: Relationship concerns, transportation concerns, housing concerns, food insecurity, lack of family/caregiver support and unable to afford medications. P2’s recertification summary dated 3/22/24-5/20/24, indicated P2 received services from the HHA for end stage renal disease, atrial fibrillation (rapid heart rate), and chronic respiratory failure. P2 had morbid obesity and was dependent on renal dialysis. P2’s start of care assessment dated 3/22/24, failed to include assessment of P2’s dialysis treatment including where services obtained, any needed coordination of care needed with dialysis facility, patient concerns with treatment, concerns with treatment, or any potential monitoring, education, or assessment of the central dialysis catheter. P2’s skilled nurse evaluation summary dated 3/22/24,	G0528		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0528	Continued from page 35 lacked indication any assessment, monitoring or education of P2's dialysis treatment or dialysis catheter occurred. An observation on 3/28/24 at 3:26 p.m., P2 was seated in a recliner chair in the living room. P2 had a tee-shirt that was pulled down and a dialysis catheter was seen on the right upper chest area. P2 stated the dialysis catheter was placed when in the hospital and was used for dialysis treatments. Upon interview on 3/28/24, registered nurse (RN)-C verified P2 had a dialysis catheter in the right chest and was not aware of any required monitoring, care, or restrictions. Furthermore, RN-C was not aware of where P2 received dialysis treatment. Upon interview on 4/1/24 at 2:31 p.m., care manager (CM)-A verified P2's start of care assessment lacked indication of a central dialysis catheter, or any interventions needed to support P2's dialysis treatment. A comprehensive policy and/or procedure was requested, however no provided.	G0528		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is NOT MET as evidenced by: Based on observation, interview, and record review the agency failed to ensure medication reconciliation was completed for 3 of 3 patients (P1, P2 and P7) observed in home visits. P1 had a recertification visit and the nurse failed to reconcile his medications. P2's medications were not reconciled and had medication questions that were not addressed by the nurse during the home visit. P7's medications also were not reconciled at the onsite visit. Findings include:	G0536	**G0536 Plan** **<u>Policy Review and Revisions</u>** • Policy titled; Medication Management Policy for Home Health was reviewed. No updates needed related to medication reconciliation. • Workflow titled; Home Health Medication Guide was reviewed. No updates needed. • Determined policies and workflow were not followed for patients identified **<u>Education</u>** • Coaching provided to clinician involved with patient identified on policies and workflows for when and how to perform medication reconciliation/review. • Develop and administer education to all home health RNs, PTs, OTs and SLPs regarding policies on and workflow on when and how to perform medication reconciliation and review.	

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G0536	Continued from page 36 P1's recertification summary dated 4/1/24 – 5/30/24 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT (sitting bone), three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder with a suprapubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. P1 was oriented to person, place, time, environment, and family. P1's care plan dated 3/28/24 indicated skilled nursing was to assess for new, high risk or changed or discontinued medications. The care plan did not identify when a medication reconciliation was to be completed. During an observation of a home visit on 3/28/24 at 2:15 p.m. registered nurse, (RN)-B was completing P1's sixty-day recertification assessment. P1 had a tray table over his bed with multiple bottles of liquid medications and a plastic container with three drawers filled with medications. RN-B asked P1 if he had any medications changes or any new allergies. RN-B failed to look at each of P1's medications bottes and care them to the medication list the agency had on file. Upon interview on 3/28/24 p.m. at 4:15 p.m. P1 stated he did not recall the nursing staff ever going through all his medication bottles and comparing them to a medication sheet. He also stated he did not have a sheet of what the "agency thinks I am taking." Upon interview on 4/1/24 at 9:55 a.m. RN-B stated during a recertification assessment the staff is to do a medication reconciliation. She stated that process was to find out if the patient had any new medications or any new allergies. When asked if she compares the bottles to the agency medication sheet she stated, "I guess I should be doing that." Upon interview on 4/4/24 at 4:15 p.m. the Director of Home Care stated medication review is done at each visit where the nurse inquiries about new medications	G0536	***G0536 Plan*** ***Continued from page 36*** **Monitoring** • Following clinician education ongoing covisits completed by leaders with RNs, PTs, OTs and SLPs will include observation and medication review and subsequent review of documentation to ensure compliance with regulation. **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0536	Continued from page 37 or new allergies. At the certification assessment the nurse is to complete a full reconciliation consisting of looking at all of the medications the patient has and comparing them to the agency medication list and notification the provider of any discrepancies. P2's recertification summary dated 3/22/24-5/20/24, indicated P2 received services from the HHA for end stage renal disease, atrial fibrillation (rapid heart rate), and chronic respiratory failure. P2 had morbid obesity and was dependent on renal dialysis. P2 had skilled nurse interventions of medication review at each visit and update medication list as needed, update provider of medication discrepancies or problems and instruct on medication purpose, dose, schedule, and side effects. P2's start of care assessment dated 3/22/24, indicated P2 was had discharged from the hospital on 2/10/24 and had not been taking warfarin (blood thinning medication) for the last month due to being out of the medication. A skilled nurse visit was requested asap to clarify medication questions and medication discrepancies forwarded to P2's provider for clarification. P2's skilled nurse visit note dated 3/22/24, indicated a focus on medication compliance. P2's medications were reconciled and was noted P2 had not taken warfarin in 2-3 weeks and required refills of triphrocaps capsules (supplement medication) and midodrine (medication to support blood pressure). P2's skilled nurse visit note dated 3/28/24, indicated P2 had change in medications since last visit however medications were not reconciled. P2's skilled nurse visit note dated 3/29/24, indicated P2 had no change in medications since last visit and medications were not reviewed. During an observation of a home visit on 3/28/24 at 3:26 p.m., registered nurse (RN)-C began the home visit. P2 stated had questions about medications that pharmacy had filled this week. RN-C stated was not able to look at the medications as RN-C could not get into the system but would "look into it later." RN-C continued the visit and completed the visit without coming back to address P2's medication concerns. RN-C further stated a nurse was coming on 3/29/24 and could	G0536		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0536	Continued from page 38 help with the medication questions at that time. When interviewed on 3/28/24 at 3:05 p.m., P2 stated the pharmacy filled medications that he had not taken since returning home from the hospital. P2 stated last week the nurse was supposed to clarify my medications with primary provider, but P2 had not heard back. P2 stated the medications filled from the pharmacy were listed as discontinued on the hospital discharge instructions. P2 stated “I am not sure what I am supposed to be taking” and wanted clarification in the visit today. When interviewed on 3/28/24 at 4:10 p.m. RN-C stated typically medications were reviewed and any questions answered, but just could not connect to internet to review his chart. RN-C was aware P2 had stopped taking warfarin, but P2 stated they were taking it now. RN-C was going to communicate to the next nurse about medication questions needing to be addressed. Upon interview on 4/1/24 at 2:31 p.m., care manager (CM)-A expected staff to complete a medication review if indicated in the plan of care. Furthermore, staff were expected to address medication questions or concerns the patient may have. P7’s Home Health Plan of care effective 3/2/24-4/30/24 dated 3/22/24-5/20/24, indicated P7 received services from the HHA for spondylosis with myelopathy (a neurologic condition that develops gradually over time as degenerative changes of the spine results in compression in compression of the spinal cord and nearby structures), spinal stenosis (the space inside the backbone is too small) of the thoracic region (the area between the abdomen/stomach and the base of the neck), encounter for orthopedic aftercare, and paroxysmal (resolving within seven days) atrial fibrillation (rapid heart rate). A review of the POC directed the staff to assess for new, high risk, changed or discontinued medications. Additionally, the plan of care directed the nurse review medications each visit and update the patient’s copy of the medication list. The POC directed the nurse to, if applicable, notify the prescribing physician of any medication discrepancies or problems and with the client is not achieving the desired effects of medications. P7’s start of care assessment dated 3/2/24, indicated	G0536		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248091	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/04/2024

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G0536	Continued from page 39 P7 was had discharged from the hospital on 2/29/24. P7 was admitted to home care services on 3/2/24 to coordinate visit with family member presence. During an observation of a home visit on 4/1/24, at 1:15 p.m. a review of the medications was completed with P7. During this visit, RN-E reviewed R7's medications as completed, and the following medications were listed on medication profile: -Acetaminophen (Tylenol Extra Strength) 500 mg, take every 6 hours for 1 week, then every 6 hours as needed for pain. P7 stated he is using three times daily with the gabapentin with good effect. Bisacodyl (DULCOLAX) 10 mg suppository, insert one suppository rectally once daily if needed for constipation. -Epinephrine (EPIPEN) 0.3 mg/0.3 ml, inject 0.3 mg intramuscularly (in the muscle) if needed for an allergic reaction. (P7 stated his current supply was expired.) -Gabapentin (NEURONTIN) 200 mg three times daily. P7 reports this had improved his pain management. P7 stated he used the gabapentin, Robaxin, and acetaminophen together for effective pain relief. -Guar Gum (NUTRISOURCE FIBER) packet, mix one packet in liquid then take by mouth two times daily. Mix one packet in four ounces of beverage or soft food. -Melatonin 3 mg tablet, take two tablets at bedtime. P7 stated he has been using 10 mg tablet as other supply was unavailable. -Methocarbamol (Robaxin) 500 mg, take two tables by mouth four time a day as needed. P7 stated he is currently using three times daily, with gabapentin and Tylenol. -Metoprolol succinate (Toprol XL) 25 mg Sustained Release Tablet, one half tablet (12.5 mg) by mouth once daily. -Oxycodone (Roxicodone) 5 mg immediate release tablet, take one to two tablets by mouth (five to ten milligrams) every four hours as needed for pain. The medication profile identified this was to be used as first choice for severe pain. P7 reported he has no supply present and has not used since right after he returned from the hospital.	G0536		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0536	Continued from page 40 -Sennosides (SENNA) 8.6 mg, one tablet by mouth at bedtime. P7 reported that he does not use this medication. -Warfarin (COUMADIN) 5 mg, two- and one-half tablets, to total 12.5 mg daily. P7 reported to nurse he also had Furosemide 20 mg which he uses as needed. Upon review of the label, it was noted that it was ordered on 3/14/24 with the directions to take daily. After all meds had been reviewed/reconciled between P7 and nurse, additional medications were noted in the client's medication bin to include the following: Amoxicillin (antibiotic), cyclobenzaprine (muscle relaxant), Tums, and Nystatin Powder. RN-E stated she was unaware of these medications in the home. P7 stated the cyclobenzaprine was a medication prescribed prior to his surgery. P7 stated the Amoxicillin was also a medication which had been prescribed prior to the hospitalization, and stated they were meds he had not completed. P7 stated he has not used the Nystatin Powder since he returned. P7 stated the medications were always kept in his basket. On 4/1/24, at 3:00 p.m. following home visit, RN-E stated medication reconciliation should be done upon admission, and with every visit thereafter RN-E stated she had not seen the medications in the basket prior to this visit and was unaware P7 had them. RN-E stated it was important to review medications with every visit to assure medications were taken as ordered. RN-E stated as P7 was already receiving a muscle relaxer (Robaxin), the use of a second muscle relaxer could have negative effects for P7. A facility policy titled Home Health Plan of Care revised 6/15/22, indicated a plan of care was based off the comprehensive assessment and included patient specific services, treatment, and teaching ordered and provided for a patient.	G0536		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses;	G0574	**G0574 Plan** **Procedure for implementing the plan of correction** **Measures put in place/systemic changes to ensure deficient practice does not recur**	

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G0574	Continued from page 41 (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based observation, interview, and record review the agency failed to provide all pertinent information required on the individual plan of care for 6 of 17 clients reviewed. (P1, P2, P4, P5, P9 and P10). P1's plan of care failed to provide his psychosocial status, identify all his supplies under durable medical equipment (DME) and provide patient specific interventions and education including measurable outcomes and goals identified by the HHA and P1. P2's plan of care failed to identify hemodialysis treatment and schedule, a right tunneled dialysis catheter, and	G0574	***G0574 Plan*** ***Continued from page 41*** **Policy Review and Revisions** • Policy titled; Home Health Plan of Care was reviewed. Updates made to include specialty DME as a plan of care requirement **(Exhibit F)** **Education** • Coaching provided to clinician involved with patient identified regarding plan of care requirements. • Educate home health RNs, PTs, OTs and SLPs on the Home Health Plan of Care including providing all pertinent information on the plan of care. **Monitoring** • Following employee education audits will be completed on 20 plans of care to ensure all pertinent information is present. **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0574	Continued from page 42 any cares or safety measures to prevent injury or infection of the dialysis catheter. P4's plan of care lacked indication of any secondary diagnoses even though P4 received skilled service related to intravenous therapy (IV) and wound care following hospitalization. P4's plan of care also lacked indication of DME supplies needed for provision of care which included IV therapy supplies, wound care supplies, and a cam (type of equipment) walker boot. P5's plan of care failed to identify all her DME supplies. P9's plan of care identified multiple diagnosis which included pressure ulcers (pressure injuries, also termed bedsores), encounters for fitting/adjusting/attention to urinary catheter (a tube which goes into the bladder to drain urine) and colostomy (a surgical process which creates a stomach opening to the colon). P9's POC medication listing also identified use of a nebulizer for respiratory (breathing) treatments and a Roho cushion (a specialized cushion to be placed in chair to decrease pressure). A review of the P9's POC lacked information for any DME related to pressure relief, dressing supplies, nebulizer machine, catheter, and ostomy supplies. P10's POC included diagnoses listing of osteomyelitis (a bone infection), and aftercare for surgical amputation. The POC medication listing indicated P10 received IV antibiotic therapy. Although the diagnoses listing and medication profile indicated the need for wound care, IV therapy, and potential for mobility aides, the POC lacked indication of supplies for these services under the DME listing. Findings Include: A website https://www.medicare.gov/coverage/durable-medical-equipment-dme-coverage viewed 3/27/24 indicated DME supplies included blood sugar meters, lancets and test strips, canes, commode chairs, continuous passive motion machines devices and accessories, continuous Positive Airway Pressure (CPAP) machines, crutches, home infusion supplies, hospital beds, infusion pumps and supplies, nebulizers and nebulizer medications, patient lifts, pressure-reducing support surfaces, suction pumps, traction equipment, walkers, wheelchairs and scooters. P1's recertification summary dated 4/1/24 – 5/30/24 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right IT, three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999.	G0574		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0574	Continued from page 43 P1 had a neurogenic bladder, suprapubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. Under safety and nutrition P1 was identified as having a regular diet. Under the title medications P1 had a nebulizer, with a disposable kit, reusable kit, a mask, and tubing, he was on albuterol (Proventil) 0.083 nebulizer solution given via nebulizer twice daily. P1 will be receiving a WellSense Map system (pressure sensing map). P1’s durable medical equipment included: -a colostomy bag -a hospital bed -electric wheelchair -manual wheelchair Under other mental, psychosocial, and cognitive the plan of care indicated to "see summary documentation". The summary indicated psychosocial concerns/observations: no barriers or concerns. There was no indication of his psychosocial status as indicated through interpersonal relationships, financial status, homemaker/household needs, vocational needs, family social problems or transportation needs. P1's pressure ulcer prevention goals: P1 will remain free from skin breakdown. Patient/caregiver will demonstrate teach-back of pressure education to reduce the risk of pressure ulcers by 10/3/23. There was no documentation of the teaching implemented or measurable outcomes on 10/3/23 through current plan of care. P1’s care planning goals indicated; all goals will be met by end of episode. Patient/caregiver will be independent with emergency response plan. Patient will remain safe in their home as determined by home safety assessment. Patient/caregiver will verbalize understanding of fall risk reduction techniques. Patient/caregiver will understand what next visit expectations are at end of each visit. Patient/caregiver will verbalize understanding of safe discharge plan. Oximetry levels will be maintained at a safe level at rest and during activity. Patient will understand prevention strategies for COVID-19. There is no documentation of the teaching implemented or how the goals were being measured for P1.	G0574		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0574	Continued from page 44 P1's medication goals: Patient/caregiver will teach back self-management of prescribed medication therapy by the following date of 10/3/23. The documentation did not indicate if patient did teach-back medication self-management since 10/3/23. P1's pain goals: To report understanding of pain management of regimen. Patient/caregiver will verbalize understanding of pain management regimen including pharmacological and non-pharmacological techniques through homecare episode. The documentation does not indicate a measurable outcome for pain management. P1's gastrointestinal ostomy goals: Patient/caregiver will teach back self-management of ostomy care. Pt is independent with ostomy. Patient is independent with his ostomy cares. P1's supra-pubic catheter goal: Patient/caregiver will teach back self-management of catheter care. P1 was independent with catheter cares. P1's psychosocial health goal: Patient/caregiver will teach back self-management of anxiety by the following date of 10/3/23. There was no documentation of the education given to P1 for the self-management of his anxiety of measurable goals of his status from 10/3/23 through current plan of care. P1's thoracic wound goal: Wound care will show 25% improvement by 10/3/23. There was no documentation of measurement, color, turgor, texture, moisture, or epithelization to measure improvement or decline from 10/3/23 and going forward. P1's gluteal wound goal: 15% improvement by 10/3/23. There was no documentation of measurement, color, turgor, texture, moisture, or epithelization to measure improvement or decline from 10/3/23 and going forward. P1's focus of care goals for the next 60 days: Wound care and healing. There was no patient identified goals. Upon observation on 3/28/24 2:00 p.m. P1 was observed to have a suprapubic catheter and supplies, a pressure relieving mattress, a nebulizer with medication and supplies, and a gastrostomy tube (G-tube) and supplies. These items were not listed under DME on P1's plan of care. Upon interview on 3/28/24 at 4:13 p.m. P1 stated he is	G0574		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0574	Continued from page 45 not aware of what his goals are through the agency. He stated the agency made-up all the goals. “I have never been asked about my goals. Would like to be able to get in the swimming pool again.” P1 stated he has not been asked about psychosocial concerns. P1 stated another goal for him would be going to appointments in a wheelchair again and not a stretcher. His appointments are difficult because currently he needs to go via ambulance because his height is 6 feet, 3 inches and due to his wounds and lack of mobility, he requires a stretcher, He stated he is concerned that his family will be unable to care for him soon because of their age. He stated that both his mother and Father struggle to complete the wound care “like the nurses do” and they “can’t reposition him like they used to.” P1 was state he has increased “different” pain during his assessment. On 3/28/24 P1 was placed under general anesthesia and had Botox injections in his kidneys. This surgical procedure was not documented on the plan of care. P5’s certification dated 2/1/24 – 3/31/24 indicated P5 pertinent diagnoses were chronic obstructive pulmonary disease with exacerbation and acute respiratory failure with hypoxia (difficulty breathing), congestive heart failure, rheumatoid arthritis, and osteoporosis. P5’s services were physical therapy for strength, gait, activity tolerance and safety. Skilled nursing for oxygenation, safety, medication changes, and lab draws. Durable medical equipment identified was a seated walker, oxygen concentrator, oxygen tubing connections. Upon observation on 3/29/24 at 3:00 p.m. during a home visit P5 was observed having a portable oxygen tank with supplies, a shower chair, and a standard walker over her toilet as a device assist her to stand from the toilet. Upon interview on 3/29/24 at 3:21 p.m. R5 stated her goal was to be able to walk up the stairs. This goal was not documented on the plan of care. P5 stated the therapist tells her what her goals should be “all the time.” Upon interview on 3/29/24 at 4:15 p.m. the home care director stated that nebulizers and supplies, shower chairs, portable oxygen concentrator and supplies, g-tube and supplies, catheters, and pressure relieving mattresses should be documented under DME on the plan of care. She stated goals should include the patient,	G0574		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0574	Continued from page 46 should be measurable and reassessed at the recertification time and with any changes. In addition, she stated that psychosocial should be assessed, but could not provide an assessment tool. She stated it would financial, living situation, food, and housing. Following the survey an email dated 4/5/24 at 3:53 indicated for psychosocial assessments the staff had the options of no barrier/concerns, relationship concerns, transportation concerns, housing concerns, food insecurity, lack of family/caregiver support and unable to afford medications. P2's recertification summary dated 3/22/24-5/20/24, indicated P2 received services from the HHA for end stage renal disease, atrial fibrillation (rapid heart rate), and chronic respiratory failure. P2 had morbid obesity and was dependent on renal dialysis. P2's plan of care lacked indication type and frequency of dialysis services were needed. P2's plan of care lacked had a tunneled dialysis catheter, when it was placed, or any interventions or safety measures required to maintain the catheter and prevent infection. An observation on 3/28/24 at 3:26 p.m., P2 was seated in a recliner chair in the living room. P2 had a tee-shirt that was pulled down and a dialysis catheter was seen on the right upper chest area. P2 stated the dialysis catheter was placed when in the hospital and was used for dialysis treatments 3 times a week. P2 stated he was not sure about any monitoring needed at home. Upon interview on 3/28/24, registered nurse (RN)-C stated she was unsure of where P2 received dialysis treatments or how often. RN-C verified P2 had a dialysis catheter in the right chest and P2's plan of care did not indicate a dialysis catheter was in place. RN-C was not sure of why it was not documented in the plan of care or if any monitoring or cares were needed. Upon interview on 4/1/24 at 2:31 p.m., care manager (CM)-A verified P2's plan of care contained no information about dialysis or a dialysis catheter in place. CM-A expected P2's plan of care to include P2's dialysis treatments and dialysis catheter. P4's Home Health Plan of Care (POC) effective	G0574		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0574	Continued from page 47 3/28/24-5/26/24, indicated P4 received services from the HHA for the primary diagnosis of essential (primary) hypertension (high blood pressure). The POC lacked identification of any secondary diagnoses. P4 was, however, identified as receiving skilled nurse visits for assessment and management of IV (intravenous-a process to give medications through the vein) management/cares, IV med delivery, IV dressing change, and dressing change to the right foot. In addition, P4 was to receive nursing assessment and education on disease process' which included diabetes (a disease which affects how the body uses blood sugar (glucose), hypoglycemia (low blood sugar), hyperglycemia (high blood sugar), hypertension, signs and symptoms of infection (in surgical site) and exacerbation (return/flare up) of infection. Although P4's POC indicated P4 was to use a cam walker boot (a boot placed to prevent pressure on healing surgical site), and had orders for IV dressing change, and dressing changes to the surgical site, the POC lacked DME listing for any of these supplies. P9's Home Health Plan of Care (POC) effective 2/10/24-4/9/24, indicated P9 received services from the HHA for the primary diagnosis of other specified diagnosis of the peritoneum. P9's secondary diagnosis included a pressure ulcer (pressure injuries, also termed bedsores) of the right buttocks, stage 4 (are deep wounds that may impact muscle, tendons, ligaments, and bone), pressure ulcer of right lower back unstageable (Ulcers covered with slough or eschar- a collection of dry, dead tissue within a wound). P9's POC also identified the diagnoses of depression and anxiety, encounter for fitting and adjustment of a urinary device, neuromuscular dysfunction of the bladder(a bladder malfunction caused by an injury or disorder of the brain, spinal cord, or nerves), encounter for attention to colostomy (a colostomy is surgery to create an opening for the colon (large intestine) through the belly (abdomen), and neurogenic bowel (disruption of signals between the brain and the bowel which may be caused by spinal cord injuries or nerve disease). P9's additional diagnoses included quadriplegia (paralysis of all four limbs and the torso), injury at C5 level of cervical spinal cord, dependence on wheelchair, and dependence on supplemental oxygen. Although many of the diagnosis listed required use of durable medical equipment (DME), the only items listed as DME were an electric wheelchair and Hoyer (trade name for a mechanical lift) lift. The DME listing lacked indwelling urinary catheters, insertion trays, drainage systems, ostomy supplies, oxygen equipment including oxygen	G0574		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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(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
G0574	Continued from page 48 concentrator, portable devices, and oxygen tubing, and supplies for treatment of the pressure ulcers as identified. Although P9's medication listing identified orders for routine nebulization of a medication the DME listing lacked identification of a nebulizer. P9 also has a Roho cushion (cushion is designed specifically for individual needs) listed under the medications, however, this was not listed under DME. P10's Home Health Plan of Care (POC) effective 3/3/24 to 5/1/23/24, indicated P10's principal diagnosis was Type 2 diabetes mellitus. Other pertinent diagnosis listed included subacute osteomyelitis (bone infection) of the left tibia and fibula (bones of the lower leg), with various identified infections. P10's diagnoses included encounter for orthopedic aftercare following surgical amputation. The POC identified P10 had acquired absence of both the left and right legs below the knees (amputation). The POC identified P10 had orders for IV antibiotics ordered. Although the POC identified a walker, wheelchair, crutches, bath chair and commode (portable toilet) were indicated for P10's care, it lacked identification of supplies for IV therapy, including tubing and dressing changes for IV site, wound vac (a machine to manage the wound site), or dressing supplies. P10 also had recommendations for use of rigid immobilizers bilaterally, however they were not identified within the POC. A facility policy titled Home Health Plan of Care dated 6/15/22 indicated the patient shall activity participate in the plan of care development, the policy indicated all medical supplies and required equipment are required on the plan of care but did not identify specially DME supplies. The plan indicated any recent surgical procedures are to be documented on the plan of care.	G0574		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0584	Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered	G0584	**G0584 Plan** **<u>Policy Review and Revision</u>** • Policy Home Health Physician Orders was reviewed, no updates needed. Policy was not followed for patient P7. • Policy Medication Management for Home Health was reviewed, no updates needed **<u>Education</u>** • Coaching provided to clinician involved with patient identified on the policy to obtain verbal orders.	

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G0584	Continued from page 49 services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. This ELEMENT is NOT MET as evidenced by: Based on interview and review of documents, the facility failed to complete the process of obtaining a verbal order, documentation of said order, and routing to the provider for review and signature, for one of one patient (P7), seen on a home visit for medication set up. P7 was receiving anticoagulant (blood thinners) therapy following discharge from the hospital, which required routine lab monitoring with medication adjustment based on results. Findings Include: P7's Home Health Plan of care effective 3/2/24-4/30/24 dated 3/22/24-5/20/24, indicated P7 received services from the agency for spondylosis with myelopathy (a neurologic condition which developed gradually over time with degenerative changes of the spine which result in compression in compression of the spinal cord and nearby structures), spinal stenosis (a disease in which the space inside the backbone is too small) of the thoracic region (the area between the abdomen/stomach and the base of the neck), follow up encounter for orthopedic aftercare, and paroxysmal (resolving within seven days) atrial fibrillation (rapid heart rate). A review of the plan of care (POC) directed the staff to assess for new, high risk, changed or discontinued medications. Additionally, the plan of care directed the nurse review medications each visit and update the patient's copy of the medication list. The POC directed the nurse to, if applicable, notify the prescribing physician of any medication discrepancies or problems and with the client is not achieving the desired effects of medications. A review of P7's discharge summary from the hospital, dated 2/29/24, indicated P7 was to be on warfarin 5 mg tablets, two tablets to total 10 mg, one daily. The discharge summary identified P7's INR (a test to see how the blood clotted when on an anticoagulant therapy) was to be checked on 3/2/24, with further dosing to be reviewed with primary care provider.	G0584	***G0584 Plan*** ***Continued from page 49*** **Education *(cont.)*** • Train all home health clinicians who obtain verbal orders from providers (RNs, PTs, OTs, SWs and SLPs) on the Home Health and Physician Order policy and the Medication Management for Home Health policy. **Monitoring** • Following education to staff, audits will be performed on 10 patients per month who are receiving coumadin with INR checks from our team. **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0584	Continued from page 50 P7's start of care assessment dated 3/2/24, indicated P7 had discharged from the hospital on 2/29/24. P7 was admitted to home care services on 3/2/24, which allowed P7 and agency to coordinate the initial visit with a family member present. A review of the initial visit notes on 3/2/24, indicated P7's INR was checked during the visit and was noted to be less than therapeutic. During the visit, the results of the INR was relayed to the INR clinic. At that time, new orders were received for an increase in warfarin to 17.5 mg on that date (3/2/24), then decrease to 12.5 mg daily until next INR check on 3/8/24. Although P7's warfarin was adjusted on the date of admission based on the results of the INR check completed, with the dosage of warfarin increased, the POC identified the order for warfarin under medications to be warfarin five mg, two tablets (to total 10 mg) daily, and lacked indication of the new orders of 3/2/24. A request was made for orders to reflect orders for INR review, and subsequent med adjustments based on 3/8/24. The order dated 3/8/24, indicated P7's INR was checked on 3/8/24, and was noted to be subtherapeutic. Orders were received on 3/8/24, for warfarin 17.5 mg on that date (3/8/24), then decrease to 12.5 mg daily. P7 was to have next INR checked on 3/15/24. A review of the narrative notes from 3/15/24, indicated P7's INR was at 2.7 and directions were received to continue on 12.5 mg of warfarin daily and to recheck INR on 3/22/24. A request was made for the documentation of orders received and processed for 3/15/24, although was not received. A review of the narrative notes of 3/22/24 was completed. P7's INR was checked at that time with results at 2.3. A call was placed to the INR clinic and orders were received to continue the dosing of warfarin at 12.5 mg daily. P7 was to have a recheck of his INR on 4/1/24. Although the narrative note reflected this information, the medical record lacked orders to reflect this was processed after receipt of verbal directions. Upon request from the agency for the order to reflect	G0584		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0584	Continued from page 51 the orders of 3/22/24 an order dated 3/22/24, at 12:27 p.m. was provided. Although dated 3/22/24, the content of this order was reflective of the order initially obtained on 3/8/24, with the directions for recheck on 3/15/24. The orders received on 3/22/24, for continuation of warfarin at 12.5 mg daily with a recheck of INR on 4/1/24, as indicated in the documentation of 3/22/24, were not found in the medical record. On 4/2/24, at 1:15 p.m., a review of the documentation and information was completed with registered nurse (RN) RN-F. RN-F identified, upon review of records, although there is documentation to reflect outreach on INR, there is no order on file to correspond with this. Upon interview on 4/4/14 at 4:15 p.m. The Director of Home stated that when there was outreach to a provider, it was the expectation that the process to complete the order was to create an order and route for signature and documentation of implementation. A policy titled Medication Management Policy for Home Health, approved on 12/14/23, identified if the physician changed the medication order, staff must document the reasons for changes, and record the new or changed medications as orders. The order was then to be sent to the prescriber physician for signature.	G0584		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0602	Communication with all physicians CFR(s): 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to assure there was communication with all physicians or allowed practitioners involved in the plan for 2 of 15 patients (P1 and P2) reviewed for provider communication. P2 was able to identify three provider types who the agency was not communicating with, Registered nurse (RN)-C and care manager (CM)-A were not aware of P2's dialysis facility or the nephrologist coordinating dialysis treatments. P1 had multiple providers such as a urologist, nutritionist, and psychiatrist. Findings include:	G0602	**G0602 Plan** **<u>Policy Review and Revisions</u>** • Policy titled Home Health Care Coordination Policy was reviewed. Update made to clarify “physician” as “physicians involved in the plan of care (those physicians who give orders that are directly related to home health skilled services)” (Exhibit G) **<u>Education</u>** • Coaching provided to clinicians involved with identified patients on the updated Home Health Care Coordination policy. • Develop and administer education to all home health RNs, PTs, OTs, SWs and SLPs on updated Home Health Care Coordination policy and the expectation to communicate plan of care updates to all physicians involved in the plan of care.	

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G0602	Continued from page 52 P2's recertification summary dated 3/22/24-5/20/24, indicated P2 received services from the HHA for end stage renal disease, atrial fibrillation (rapid heart rate), and chronic respiratory failure. P2 had morbid obesity and was dependent on renal dialysis. P2's recertification summary lacked indication of where P2 was receiving dialysis and the nephrologist providing care. Upon interview on 3/28/24 at 4:10 p.m., RN-C stated she was unsure of where P2 received dialysis care or who the nephrologist was. RN-C stated the provider may be listed in P2's hospital discharge in February but did not see a nephrologist listed in P2's EMR. Upon interview on 4/1/24 at 2:31 p.m.CM-A verified P2's medical record had not indicated a nephrologist or location of dialysis. CM-A stated it was harder to determine with outside providers. CM-A then was able to search outside networks within the electronic medical record system to determine P2's dialysis was at Fresenius Dialysis Center and was followed by Acumen Nephrology. P1's recertification summary dated 2/1/24 – 3/31/24 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT (sitting bone), three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder with a suprapubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. P1 was oriented to person, place, time, environment, and family. P1's patient care team received from agency on 4/1/24 at 10:37 a.m. indicated P1's Patient Care Team consisted of a Primary Care Physician (PCP), Physician Assistant (PA), two Physical Medicine and Rehabilitation, M.D and D.O, and a Pharmacist (PharmD). Upon interview on 3/8/24 at 4:15 p.m. P1 stated he had multiple providers. He stated he could not name them all. "It would be nice to have a list of all of them."	G0602	***G0602 Plan*** ***Continued from page 52*** **Monitoring** • Following clinician education 20 patient charts will be audited for the presence of documented communication will all physicians involved in the patient's plan of care. **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0602	Continued from page 53 He stated providers who were not on the agency list were a Urologist, who cares for all his catheter cares, a Nutritionist who cares for all his feeding tube supplies, a psychiatrist, “three or four” Physiatrists, and a Physical Therapist not through the agency. Upon interview on 4/1/24 at 10:58 a.m. RN-D stated she was aware that P1 had a psychiatrist because a “few months ago” she had taken “some lab orders” from a psychiatrist. She stated she recently took an antibiotic order from a urologist but could not recall the name. She denied adding the urologist to the P1’s provider list. RN-D said it made sense that due to the feeding tube P1 would have a nutritionist and she was aware that he did physical therapy through another provider. RN-D was certain if those professionals were on P1’s provider list or not. Upon interview on 4/4/24 at 4:15 p.m. the Director of Home Care stated that all providers should be on the patient’s provider list to assure all involved receive information on the patient. A provider notification policy was requested however none was provided.	G0602		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and record review the agency failed to use standard infection control precautions to prevent the transmission of infections for 1 of 1 patient (P1) observed during five wound care dressing changes. RN-B failed to prepare a clean barrier on a surface to place clean equipment before providing P1’s wound cares and failed to disinfect a spoon used to prepare a medication paste during the treatment process. Findings include:	G0682	**G0682 Plan** **<u>Policy Review and Revisions</u>** • Policy titled; AHCS Infection Prevention Policy was reviewed. No updates needed. • Procedure titled; Home Health Wound Assessment, Wound Care & Documentation was reviewed. No updates needed. • Determined policies and procedure were not followed for patient identified. **<u>Education</u>** • Coaching provided to clinician involved with patient identified. • Develop and administer education to all home health RNs, PTs, OTs and SLPs regarding policies on and procedure. **<u>Monitoring</u>** • Following clinician education ongoing covisits completed by leaders with RNs, PTs, OTs and SLPs will include observation of infection prevention and the use of standard precautions to prevent the transmission of infections and compliance with regulation.	

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G0682	Continued from page 54 P1's recertification summary dated 2/1/24 – 3/31/24 received services from the home health agency (HHA) for a Stage 4 pressure ulcer of his right ischial tuberosity IT,(sitting bone) three pressure ulcers on the back and two pressure ulcers on his thigh. P1 had a spinal cord injury T1-T16 in 1999. P1 had a neurogenic bladder and a suprapubic catheter, neurogenic bowel ileostomy, and required a jejunostomy tube for nutritional supplementation. P1 was bedbound. P1 was diagnosed with spastic hemiplegia affecting unspecified side, dysphagia, depression, and anxiety. P1 was oriented to person, place, time, environment, and family. Upon observation on 3/28/24 at 2:18 p.m. RN-B began the five dressing changes for P1. RN-B did not set-up a clean barrier space for the supplies. P1 had a hospital wash basin with multiple dressings and other supplies on a table near his bed. RN-B kept her gloves for changing in her pockets. RN-B used hand sanitizer and donned clean gloves as she removed dressing from P1's ischial wound. She cleansed the wound, packed the dressing with lidocaine saturated gauze and let the wound sit for thirty minutes as ordered. RN-B sanitized her hands and donned clean gloves then removed the three old dressings from P1's back. RN-B used the same gloves she removed the dressings to look through the basin to find the wash and dressings for cleansing P1's back wounds. RN-B laid the wash and the dressings on P1's bed sheet, cleansed her hands, donned clean gloves, and finished the back wounds without concerns. RN-B then went back to complete the ischial wound. She sanitized her hands and gloved. She reached into the bottom of the basin and found a rubber ended spoon laying on the bottom of the basis. She did not disinfect the spoon. She used the spoon to mix Flagyl (a crushed medication that P1's father had already crushed) and an ointment to make a paste, then used the spoon and her gloves to place the paste directly inside the wound bed. Upon interview on 4/1/24 a 9:55 a.m. RN-B stated she usually will set-up a barrier for wound care, but just "didn't" on 3/28/24 when her cares were observed. She stated the rubber ended spoon is stored in the basin after use to be there for the next use. She stated the spoon gets "wiped down" after the procedure, but she would not be certain that other contaminants do not come into contact with the spoon between dressing changes since it stored uncovered at the bottom of the basis.	G0682	**Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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G0682	Continued from page 55 Upon interview on 4/4/24 at 4:15 p.m. the Home Care Director stated her expectation of staff is to set-up a clean barrier field before providing any wound care and that an equipment must be sanitized prior to use. An agency pressure ulcer procedure sheet developed in cooperation with Leading Age dated 5/2023 indicated staff were to prepare an area in a clean, convenient location and assemble the necessary supplies. The procedure also indicated for topical agents that a sterile cotton-tipped applicator or sterile tongue blade is to be used.	G0682		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*
G0808	Onsite supervisory visit every 14 days CFR(s): 484.80(h)(1)(i) (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services— (A) A registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section. This ELEMENT is NOT MET as evidenced by: Based on interview and record review the agency failed to ensure home health aide (HHA) supervisory visits were completed every 14 days for 1 of 3 patients (P11) currently receiving HHA services from the agency. Findings include:	G0808	**G0808 Plan** **Policy Review and Revisions** • Policy titled; Home Health Aide Training, Competency Testing and Supervision was reviewed, no updates needed. • Determined policies were not followed for patient identified. **Education** • Coaching provided to clinician involved with patient identified. • Develop and administer education to all home health RNs, PTs, OTs and SLPs regarding the Home Health Aide Training, Competency Testing and Supervision policy. **Monitoring** • Following education to staff 20 charts of patients receiving home health aide services will be audited for the presence of documented home health aide supervision every 14 days. **Title of person responsible for implementing the plan of correction** Karen Leutner, Director, Allina Home Health **Date of completion** **May 10, 2024** ***Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.***	

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G0808	Continued from page 56 P11's recertification summary dated 1/20/24-3/19/24, indicated P11 had diagnoses of lumbar and cervical fractures (bone fracture of neck and spine) and subdural hemorrhage (brain bleed). P11 had orders for HHA to provide cares for 1 visit every 8 days from 1/20/24-1/27/24 and weekly visits from 1/28/24-2/17/24. Furthermore, P11's HHA interventions directed professional staff (skilled nursing/therapy) to perform supervision of HHA at least every 14 days. P11's change order dated 2/15/24, indicated P11 required HHA visits to continue for weekly visits from 2/18/24-3/9/24. P11's change order dated 3/3/24, indicated P11 required HHA visits to continue for weekly visits from 3/3/24-3/16/24. A review of P11's HHA visit notes for recertification period 1/20/24-3/19/24, indicated P11 was seen by HHA as ordered. P11's skilled nursing and skilled therapy notes for recertification period 1/20/24-3/19/24, indicated HHA supervisory visits occurred on 2/15/24 and 3/15/24, and did not occur at least every 14 days. When interviewed on 4/4/24 at 3:10 p.m., care manager (CM)-A stated skilled visits such as nursing or physical therapy should be completing supervisory visits at least every 14 days. Furthermore, CM-A verified P11 did not have supervisory visits every 14 days for the certification period of 1/20/24-3/19/24. When interviewed on 4/4/24 at 3:35 p.m. the director of home health expected staff skilled staff to perform supervisory visits at least every 14 days. Furthermore, the director of home health stated this was important to ensure patients received cares as ordered from HHA staff without concerns. A facility policy titled Home Health Aide Training, Competency Testing and Supervision reviewed 3/15/24, directed all HHA staff to be supervise care as outlined by federal and state regulations, standards of practice and as often as needed to assure safe care delivery. Furthermore, when skilled nursing or therapy services were being provided the RN/therapist must make a	G0808		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

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

(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
G0808	Continued from page 57 supervisory visit in the patient's home at least every 2 weeks to assess the relationship and determine whether goals are being met.	G0808		**Date of completion May 10, 2024** *Staff members who are unable to complete the training in the required timeframe due to PTO or a leave of absence will be required to complete upon return to work prior to performing patient care.*

Allina Health Home Health List of Exhibits

MDH Extended Abbreviated Survey, Event ID 6296B-H1

Exhibit Letter	Document Name
A	Response Process to Allegations of Abuse or Assault
B	Vulnerable Adult Policy
C	Individual Abuse Prevention Plan
D	Clinical Assessment Policy
E	Oasis Reporting Policy
F	Home Health Plan of Care Policy
G	Home Health Care Coordination Policy

Response Process to Allegations of Abuse and/or Assault
In an Allina Health Facility/Under Care of Allina Health in Minnesota*

Reference #: SYS-PC-RMC-002.A3

Responsible Person	Task	Date	Time	Completed By
Employee/Staff who observe conduct or receive complaint	Allina Health employee/staff receiving the complaint immediately notifies one of the following Leaders: • Unit Leader; • Administrative Nursing Supervisor (ANS) (aka: House Supervisor, Patient Flow Supervisor); or if the Unit Leader or ANS is not available, another Leader			
	Submit a Safety Event Report (PVSR)			
Leader or Patient Care Staff	Determine if patient needs immediate medical attention, and contact primary or attending provider for notification of allegations, and further assessment and/or treatment of the patient.			
Leader or leader's designee (Leader)	Separate patient from **subject of complaint (Subject),** if Subject is known.			
	Consider whether 1:1 is needed for patient and/or Subject.			
	Immediately after checking on patient needs, contact the following to assist in removal of Subject from contact with patients and initiate fact collection/evaluation: • Risk Manager (RM) to guide investigation, fact collection, and response; • If Subject is employee or volunteer, contact HR. • If Subject is medical staff/APP Staff member, contact Medical staff leader (VPMA/DOMA or Chief of Staff).			
	If Subject is not identified or cannot be located, and may present an ongoing risk to safety of others in the facility, contact Security for assistance.			

Response Process to Allegations of Abuse and/or Assault
In an Allina Health Facility/Under Care of Allina Health in Minnesota*

Reference #: SYS-PC-RMC-002.A3

Responsible Person	Task	Date	Time	Completed By
HR (If Subject is employee/volunteer) **Medical Staff leader. (If subject is a medical staff/APP staff member.)**	Take action to remove an identified Subject from all contact with patients, as soon as Subject is identified.			
Leader	Determine who is best person to lead the patient interview process, and if presence of others at interview would be beneficial to interview process or to patient. Interview patient to: • Obtain primary information about allegation, including who, what, when, where; • Assure appropriate steps are taken for patient safety; • Notify patient of next steps. If sexual assault alleged, call SANE (Sexual Assault Nurse Examiner) Answering Service at 763-236-7371 (generally within 90 minutes) to perform the interview. Inform patient about SANE referral.			
	Communicate findings of interview to unit leader and Risk Manager as soon as possible (generally within 90 min).			
Leader	If Subject is not identified, take steps based on description, video and other available facts to identify Subject.			
HR and Leader (if subject is employee or volunteer) **Medical Staff leader (using applicable Medical Staff processes, if Subject is medical staff/APP)**	Interview Subject (as soon as possible, but typically within 4 hours). Include Risk Manager in fact-collection interview, at discretion of Risk Manager. If Subject who is an employee refuses to meet without a union rep, and union rep cannot be found promptly, place employee on administrative leave and schedule interview as soon as union rep can be located.			

Response Process to Allegations of Abuse and/or Assault
In an Allina Health Facility/Under Care of Allina Health in Minnesota*

Reference #: SYS-PC-RMC-002.A3

Responsible Person	Task	Date	Time	Completed By
	Unless complaint is determined to be unsubstantiated by end of interview, place Subject, who is an employee, on administrative leave. If Subject is a medical staff member, Medical Staff Leader will consult Medical Staff Bylaws and procedures for assuring the Subject is not allowed to provide patient care while the complaint is under evaluation. The Subject should remain on leave/not allowed to provide patient care until there is sufficient information available to return the person to patient care responsibilities. (Generally, until the concern is determined to be unsubstantiated)			
	Determine, in consultation with Risk Manager, what further fact collection (if any) is appropriate. Examples may include review of video, interviews with other staff or potential witnesses, chart review and obtaining information about assessment of patient injuries.			
	Determine if corrective action or other follow up is indicated with Subject. Meet with the Subject (and employee's union representative if applicable) to discuss the findings and deliver appropriate corrective action or discuss other follow up.			
Leader, Risk Manager, and HR or Medical Staff Leader (as applicable)	Determine when there is sufficient information to decide whether Subject may return to patient care responsibilities.			
Leader and Risk Manager	If allegation is substantiated or questionable, **complete Mandatory Reporting within 24 hours** of when facility staff first became aware of the matter, as outlined in the policy. Risk Manager should be consulted for guidance about completing a report.			
Leader	Follow up with the patient.			

Response Process to Allegations of Abuse and/or Assault
In an Allina Health Facility/Under Care of Allina Health in Minnesota*

Reference #: SYS-PC-RMC-002.A3

Responsible Person	Task	Date	Time	Completed By
Risk Manager	Coordinate with quality team to determine if causal analysis is appropriate. Review matter to identify and assure completions of other reporting obligations (e.g. ombudsman, AHE).			
	Assure documentation of factual findings and determinations are completed and retained, whether allegation substantiated or not.			

Reference: Vulnerable Adult Maltreatment: Assessment and Reporting SYS-PC-RMC-002

Implemented: December 2019

Revised: April 2022

Developers: Allina Health Risk Management Council

* Please keep this form in the ANS office for unit director

System-wide Policy/Procedure: **Vulnerable Adult Maltreatment: Assessment and Reporting in Minnesota**

Reference #: SYS-PC-RMC-002

Origination Date: August 2014
Next Review Date: April 2025
Effective Date: April 2024

Approval Date: April 2022
Approved By: Clinical Leadership Team

System-Wide Policy Ownership Group: Allina Risk Management Council
System Policy Information Resource: Business Unit Risk Managers

Stakeholder Groups
Inpatient Care Management Leadership
Health Information Management
Nurse Executive Council
AHG Nurse Executive Council
Allina Health Home Care Services Quality Committee
Courage Kenny Rehabilitation Institute
Allina Health Forensic Program
Allina Health Emergency Medical Services
Mental Health Services
Regulatory and Accreditation Committee

SCOPE:

Sites, Facilities, Business Units	Departments, Divisions, Operational Areas	People applicable to
Abbott Northwestern Hospital, Buffalo Hospital, Cambridge Medical Center, Faribault Medical Center, Mercy Hospital, New Ulm Medical Center, Owatonna Hospital, St. Francis Regional Medical Center, United Hospital, Allina Health Group; Allina Health Emergency Medical Services, Allina Health Home Care Services	All Patient Care Areas	All

POLICY STATEMENT:

All mandated reporters at Allina Health must make a vulnerable adult report whenever they have reason to believe that a patient or client in Minnesota, who is considered a vulnerable adult, is being or has been maltreated; or they have knowledge that a

vulnerable adult has sustained emotional abuse and/or a physical injury that is not reasonably explained. Mandated reporters may fulfill their reporting obligation by reporting following internal reporting procedures.

In Home Care, required reports must be made be made immediately (see number five in procedure section). In all other sites, required reports must be made as soon as possible, but in no event longer than 24 hours after the mandated reporter becomes aware of the suspected or known incident of maltreatment or unexplained physical injury.

Patient consent is not required except as noted below for voluntary reports and for reports pertaining to patients of substance abuse treatment programs.

While not all employees are considered mandated reporters, if any Allina Health employee witnesses or receives a report of suspected maltreatment of a vulnerable adult, including maltreatment reported by the vulnerable adult, that employee must immediately relay their concerns to a supervisor for appropriate follow up action. The employee/staff must confirm that the supervisor has received the report and is acting on it. If the vulnerable adult is in imminent danger, staff should immediately contact security or if necessary, local law enforcement.

Staff members who are unsure whether a matter is required to be reported are encouraged to discuss the matter with an immediate supervisor/manager.

Exceptions to the Reporting Requirement: When a report otherwise would be required under the standard set forth above, a report *is not required* if one of the following exceptions apply (see Flow Chart A & B):

1. **Adverse Health Events (Reported/Reportable AHE's)**
   No report is required for Adverse Health Events (AHE) (except for potential criminal events or radiologic events) that occur in a facility if the event is identified as an AHE within 24 hours of discovery and timely reported as an AHE. Mandated reporters should complete a Safety Event Report (formerly known as a Patient Visitor Safety Report/PVSR) and provide immediate notification directly to the business unit Risk Manager if the potentially reportable event is a suspected AHE.

2. **Self-Abuse or Aggression Between Patients in a Facility**
   No report is required for verbal or physical aggression occurring between patients in the facility or self-abusive behavior by patients so long as the behavior does not cause serious harm. Such incidents must be internally reported and recorded, however, to facilitate review by the Department of Health and county and local welfare agencies. See: Internal Reporting

3. **Accidents**
   No report is required for events that are accidents involving vulnerable adults.

4. **Medical Errors Not Causing Harm**

No report is required if the event is an error that occurred during the provision of therapeutic conduct and did not result in injury or harm reasonably requiring medical or mental health care.

5. **Maltreatment or Unexplained Injury Prior to Admission (Partial Exception)**
   If a patient is a vulnerable adult solely because of admission to the facility, no report is required for maltreatment or unexplained physical injury that occurred prior to admission to the Allina Health facility unless one of the following applies:

   A. The patient was admitted from another facility and the mandated reporter has reason to believe the patient was maltreated at the previous facility; or

   B. The mandated reporter knows or has reason to believe that the patient is a vulnerable adult because they possess a physical, mental, or emotional infirmity which impairs the person's ability to provide for their basic care without assistance and as a result of the infirmity and the dependency, the adult has an impaired ability to protect themselves from maltreatment.

6. **Substance Abuse Treatment Program Patients (Unless Consent is Obtained)** – See Vulnerable Adult Maltreatment: Assessment and Reporting in Minnesota for Addiction Services System wide Policy/Procedure (SYS-PC-RMC-009)
   Federal laws protecting the confidentiality of substance abuse treatment program records do not provide an exception for reporting maltreatment of vulnerable adults. If maltreatment of a vulnerable adult in a substance abuse treatment program is known or suspected, the mandated reporter must immediately seek appropriate consent from the vulnerable adult or legal representative to make the vulnerable adult report. If consent is obtained, a report is required upon receipt of the consent. If consent is not obtained, do not make a report.

7. **Duplicative Reports**
   A report is not required if the mandated reporter knows that a report already has been made to the Minnesota Adult Abuse Reporting Center (MAARC) (formerly known as the Common Entry Point (CEP)).

Assessment of Risk and Suspected Maltreatment

Mandated reporters who suspect maltreatment or unexplained physical injury of a vulnerable adult should complete an assessment of the individual with a focus on objective findings. The assessment should include assessment for physical, emotional, or behavioral indicators. Make note of any injuries or evidence of old injuries. If current injuries are present or reported by the individual, arrange for a physical examination by an appropriate practitioner.

Inpatients in Facilities* Assessment Only
***See Facilities Definition**

A non-verbal assessment for indicators of physical, sexual or emotional abuse and neglect will be performed on all patients, including children (see policy: Maltreatment of Minors) who have an admission intake assessment.

All adult patients will be asked the following two abuse screening questions *when abuse is suspected and it is safe for the patient to answer honestly* and their condition permits:

1. "Have you been hit, kicked, pushed or otherwise mistreated by someone important to you?"

2. "Is someone important to you yelling at you, threatening you or otherwise trying to control your life?"

For hospital patients, develop and implement a specific plan for protecting the patient while hospitalized if such a plan is necessary.

Voluntary Reporting

This section applies to situations when the requirements for a mandatory report are not met, but staff members have reason to believe that vulnerable adult is being or has been maltreated, including "at-risk" patients. Consult your supervisor and Risk Manager before making a voluntary report. If a voluntary report is made, the PHI necessary to make the report may be disclosed in order to make the report.

A voluntary report may be made if:

1. The patient gives consent; or

2. The primary practitioner, in the exercise of professional judgment, believes the report is necessary to prevent serious harm to the vulnerable adult. A report may be made for this reason even if the patient objects, but the business unit Risk Manager must be consulted if this provision is used when a patient has decision-making capacity and the sole reason a person is a vulnerable adult is due to admission to the facility.

If a voluntary report is made, the vulnerable adult must be notified as described in the notification section of this policy, and both the report and the basis for making the voluntary report (i.e., the patient's consent or description of the reason the report was needed to prevent serious harm to the vulnerable adult) must be documented as described in the documentation section of this policy.

Method of Reporting

Internal Reporting of Potentially Reportable Events

Mandated reporters who work in a facility and have identified an event that involves a vulnerable adult and is potentially reportable to the MAARC should submit the report internally to the business unit Risk Manager and/or Social Services via the facility's

internal reporting mechanism. The responsible individual at the facility must evaluate the potentially reportable event and take the following actions:

1. If the event meets the reporting criteria, report to the MAARC

2. If the event does not meet the reporting criteria, document the internal report and decision

3. Within two working days, notify all mandated reports who submitted an internal report (in a manner that protects the confidentiality of the reporters) of the following:

    A. The event has been reported*; or

    B. The event has not been reported because it does not meet the reporting criteria, that if the reporter is dissatisfied with the decision the reporter may submit a report to the MAARC and the facility will not retaliate if a good faith report is made.

*Only one report is required to be made. Mandated reporters who follow facility internal procedures to report are not required to make a separate report to the MAARC.

Employees and volunteers who are not mandated reporters who have reason to believe a vulnerable adult has been maltreated should report the suspected maltreatment to their supervisor, who will then take steps to ensure a report is made in accordance with facility procedures and this policy.

Students and interns should report suspected maltreatment to their supervisor, who will then take steps to ensure a report is made in accordance with facility procedures and this policy.

Safety Event Report (PVSR) for Internal Events: In addition to the internal and/or MAARC report of the event, a Safety Event Report (PVSR) should be completed for any event of known or suspected maltreatment that occurred within an Allina facility or by an Allina employee, a practitioner, contractor, volunteer or other person providing care or services within an Allina facility

Reports to the MAARC

All mandated reports will be submitted via on-line format to Minnesota Adult Abuse Reporting Center (MAARC) at: http:mn.gov/dhs/reportadultabuse/. Following completion of the on-line report, print the form, and send via interoffice mail to Care Management. Care Management will record in the ROI Navigator. Care Management can also be contacted with questions. A Copy of the report **IS NOT** to be scanned into the electronic medical record.

In addition to this policy, staff should follow any specific reporting procedures or

requirements for their facility or program. Protected health information may be disclosed as necessary to make this report (except as noted for substance abuse treatment programs). Supplementary Information for Reports of Medical Errors causing harm that requires the care of a physician. If an individual makes an error in the provision of therapeutic conduct to a vulnerable adult that requires the care of a physician, a report is required unless another exception applies. For this purpose, the care of a physician includes any treatment or intervention but does not include a physician assessment solely to determine if treatment of intervention is needed. These errors should be reported according to the facility's internal procedure. If the facility believes the following conditions are met, it should provide the following supporting information with the report to the MAARC:

1. The necessary care was provided in a timely fashion as dictated by the condition of the vulnerable adult;

2. After receiving care, the health status of the vulnerable adult can reasonably be expected, as determined by the attending physician, to be restored to the vulnerable adult's preexisting condition;

3. The error is not part of a pattern of errors by the individual involved in the event;

4. The facility reports the error immediately, and records it internally in the facility;

5. The facility identifies and takes corrective action and implements measures designed to reduce the risk of further occurrence of this error and similar errors; and

6. The actions required under items (4) and (5) are documented for review and evaluation by the facility and any applicable licensing, certification, and ombudsman agency.

Notifying the Vulnerable Adult of a Report

When it has been determined that a vulnerable adult maltreatment report will be made, the person who will make the report or another staff person must promptly notify the vulnerable adult or the vulnerable adult's legal representative that a report has been or will be made, except in the following circumstances:

1. It is not required that the vulnerable adult be notified of the report if the primary practitioner, in the exercise of professional judgment, believes notifying the vulnerable adult would place the individual at risk of serious harm.

2. It is not required that an incapacitated vulnerable adult's legal representative be informed of the report if:

    A. The healthcare team reasonably believes the legal representative is responsible for the abuse, neglect, or other injury to the vulnerable adult;

and

B. The healthcare team determines, in the exercise of professional judgment, that informing the legal representative would not be in the best interests of the vulnerable adult.

Documentation of Maltreatment Reports

Allina HIM maintains a secure electronic document file* of written vulnerable adult reports. After a written report is submitted to MAARC, forward a copy to Allina HIM for scanning into the electronic document file*. A copy of the report **IS NOT** to be scanned into the electronic medical record. If the fact that a report was made is documented in the patient's medical record, it should be documented in a manner that does not include the name of the reporter.

Staff making a verbal or written report or providing additional patient health information to the investigating agency are to document the disclosure in the Release of Information Navigator in Excellian*. For guidance on using the Release of Information Navigator, see the Addendums section at the end of this policy, which contains links to tip sheets on Excellian.net.

The fact that notification of report was provided to the vulnerable adult or the vulnerable adult's legal representative, or the reasons why notification was not provided, should be documented using the process outlined above.

Medical record documentation should include the objective observations and physical findings including the observed behaviors, observed indicators of abuse or neglect, and quoted statements of the patient or significant others.

*For sites without ROI Navigator/Excellian/OnBase refer to site-specific procedures below regarding documentation of Vulnerable Adult reporting.

Consequences for Reporting/Failing to Report

A mandated reporter who negligently or intentionally fails to report is liable for damages caused by the failure. Anyone who reports vulnerable adult maltreatment in good faith is immune from liability under the law. Further, anyone who knows or has reason to know a vulnerable adult report has been made and who participates in good faith in an investigation of alleged maltreatment is immune from liability under the law.

Allina Health will defend and indemnify an employee who is a mandatory reporter who is found liable for damages for failing to report if the employee acted in good faith within the scope of employment and in the reasonable belief that their conduct was in the best interests of Allina Health.

Allina Health will not retaliate against any employee, practitioner, contractor, volunteer, or other person who, in good faith, reports suspected maltreatment of a vulnerable adult, nor against any person with respect to whom a vulnerable adult maltreatment

report is made.

Authorization of Investigating Agency to Access Health Information
After receiving a report of maltreatment from any source, the investigating agency is permitted by law to enter the facility and access records to the extent necessary to conduct its investigation. (Exception: Substance abuse treatment records cannot be provided without a signed authorization or court order for disclosure to the investigating agency).

In most cases, before the investigating agency will be given access to medical records, it should provide a document on agency letterhead indicating there is an ongoing investigation of maltreatment. The agency must provide the name of the vulnerable adult and the specific information which is sought (e.g., treatment or event dates).

1. The facility should forward the request to HIM for processing.

2. Health Information Management (HIM) staff will respond to the request and follow HIM procedures for release of information.

3. The release of health information to the investigating agency must be documented as provided in this policy.

DEFINITIONS:

Abuse:
1. Intentional and nontherapeutic infliction of physical pain or injury
2. Unreasonable confinement or forced separation
3. Conduct intended to produce mental or emotional distress
4. Criminal sexual conduct, including prostitution
5. Forcing the vulnerable adult to perform services against their will for another person's profit or advantage

Accident: A sudden, unforeseen, and unexpected occurrence or event which is not likely to reoccur and which could not have been prevented by the exercise of due care, and if the event occurs while the vulnerable adult is receiving services in a facility, it is an accident only if the facility and the staff providing services in the facility are in compliance with laws and rules relevant to the occurrence or event.

Caregiver: an individual or facility who has responsibility for the care of a vulnerable adult as a result of a family relationship, or who has assumed responsibility for all or a portion of the care of a vulnerable adult voluntarily, by contract, or by agreement.

Facilities: a hospital or outpatient surgery center, a nursing home, a residential or nonresidential facility or service licensed under chapter 245A, an assisted living facility, a home care provider; a hospice provider; or a person or service that offers, provides, or arranges personal care assistant services.

Financial Exploitation: The misuse of a vulnerable adult's funds, assets or property or the failure to use the vulnerable adult's financial resources to care for the vulnerable adult, which results in or is likely to result in detriment to the vulnerable adult.

Harassment*:* Repeated or malicious verbal, written or gestured language or treatment that would be considered by a reasonable person to be disparaging, derogatory, humiliating, harassing or threatening.

Healthcare team: licensed healthcare professionals or delegates (see list of titles in the mandated reporter definition below) engaged in or consulting on the care of the vulnerable adult, including the business unit Risk Manager.

Maltreatment: Includes abuse, neglect, harassment, and financial exploitation.

Mandated Reporter: A licensed professional or professionals' delegate engaged in any occupation that is licensed by a health-related board. Examples include but are not limited to: RN, LPN, SW, MD, Dentist, Chiropractor, Podiatrist, LADC, Psychologist, RT, OT/PT/ST, Dietician, Other Licensed Therapists.

Minnesota Adult Abuse Reporting Center (MAARC): formerly known as the Common Entry Point, it is the unit designated to receive reports of suspected maltreatment, it is available 24 hours per day/365 days a year at 844-880-1574.

Neglect: Neglect is the failure or omission by a caregiver to provide with care or services including but not limited to food, clothing, shelter, medical care and/or adequate supervision which is:

1. Reasonable and necessary to obtain and maintain the vulnerable adult's physical or mental health or safety; and
2. Not the result of an accident or therapeutic conduct Neglect also includes self- neglect by a vulnerable adult.

Self-Neglect: Absence of necessary food, clothing, shelter, health care or supervision.

Vulnerable Adult: A person age 18 or older who:

1. Is currently a resident or inpatient of a facility; OR
2. Receives hospice or home care services; OR
3. Receives services licensed by DHS under Chapter 245A (except that a person receiving only outpatient services for treatment of substance use disorder and mental illness is not a vulnerable adult unless they are unable to care for or protect themselves as described below); OR
4. Regardless of residence or type of service received, possesses a physical, mental, or emotional infirmity which impairs the person's ability to provide for his or her basic care without assistance and as a result of the infirmity and the dependency, the adult has an impaired ability to protect himself or herself from maltreatment.

PROCEDURES:

1. Maltreatment of Patients Prior to Receiving Allina Health Services

Responsibility:	Action:
Mandated Reporter	If the patient reports maltreatment or assessment indicates maltreatment may have occurred: • Document assessment in the electronic medical record (e.g. for admitted patients on Adult Admission flowsheet) • Gather information about the nature of the problem • Notify the charge nurse and the attending physician, and • Initiate a consult to Social Services • Consider consult with forensic nursing team (763-236-7371) to complete elder abuse forensic exam (Elder Maltreatment Examination Procedure SYS-PC-SANE-PROGRAM-16)
Social Worker	Gather information by interviewing • The person making the report and • The patient to obtain further details and nature of problem and immediate safety issues.
Social Worker and Manager or designee	Develop and implement a specific plan for protecting the patient while hospitalized, if such a plan is necessary.
Social Worker	Report the alleged maltreatment within 24 hours after concluding there is a reason to believe that a reportable event occurred to the Minnesota Adult Abuse Reporting Center (MAARC) in the county where the incident occurred, asking to be notified of the initial and final disposition.
	Document assessment and action plan in patient's chart. Document report to MAARC in ROI Navigator.

2. Maltreatment of Patients Occurring/Occurred in Allina Health Facility or Care

Responsibility:	Action:
Care staff, Leaders, HR, Social Worker, Risk Manager	Refer to the Response Process to Allegation of Abuse and/or Assault In an Allina Health Facility/Under Care of Allina Health process tool

3. Prevention Plan for Patient with Identified History of Abuse, Violence, or Harassment While Hospitalized

Responsibility:	Action:
Hospital Personnel	Recognize possible/potential sources of abuse, harassment, or violence • Patients with a history of physical or sexual violence toward self or others (history of criminal misconduct or physical aggression may come from law enforcement, medical records, or another healthcare provider) • Visitors (from the assessment of the vulnerable adult)

Social Services, RN	If one or more sources are present, create an individualized prevention plan that states specific measures to be taken to minimize the risk of abuse. For example, a patient with a history of violence toward others who does not have a correctional officer present at any or all times should have a room in a highly visible area.

4. Maltreatment of Patients Reported to Ambulatory Staff/Providers

Responsibility:	**Action:**
Any Clinic Staff or Provider	If the patient reports maltreatment or assessment indicates maltreatment may have occurred: • Notify the provider and/or supervisor • Gather information about the nature of the problem • Notify AHG Risk Management to discuss details and next steps
Mandated Reporter	Gather information by interviewing • The person making the report and • The patient to obtain further details and nature of problem, and immediate safety issues.
Mandated Reporter	Report the alleged maltreatment within 24 hours after concluding there is a reason to believe that a reportable event occurred to the Minnesota Adult Abuse Reporting Center (MAARC) in the county where the incident occurred.
Clinic Designee	Document Report to MAARC in ROI Navigator.

5. Maltreatment of Patients Reported to Home Care/Hospice Staff/Providers

Responsibility:	**Action:**
Staff/Clinician and/or Mandated Reporter	If the patient reports maltreatment or assessment indicates maltreatment may have occurred: • Gather information about the nature of the problem by interviewing the patient and relevant caregivers and staff to obtain further details and nature of problem, and immediate safety issues. Report the alleged maltreatment immediately after concluding there is a reason to believe that a reportable event occurred to the Minnesota Adult Abuse Reporting Center (MAARC) in the county where the incident occurred and the leader in charge
Staff or Clinician	• In addition to making the report online or by telephone, complete the Vulnerable Elderly/Adult/Child Report Tracker form. Route to: ○ **Hospice**- Director of Hospice AND Hospice Manager of Quality and Compliance

	○ **Home Care**- Director of Home Care AND Home Care Manager of Quality and Compliance • Notify the Program Director and Manager of Quality and Compliance, or their designee, immediately via email that a report has been made, attaching the Hospice Vulnerable Elderly/Adult/Child Report Tracker. • Allegations involving staff or anyone furnishing services are reported immediately to the Program Director.
Director of Program or designee	• Add report specifics to the business unit Report Log or designate someone within the program to do so. • Document Report to MAARC in ROI Navigator. • Determine a process to ensure that vulnerable adult/child reports are immediately investigated by designated team members. The intent of the investigation is to gather additional information regarding the situation that led to the report, validate or invalidate the concern leading to the report and identify potential solutions to improve patient safety. • Notify AHG Risk Management as appropriate to discuss details and next steps **<u>Allegations Involving Staff/Volunteers- per Hospice CoPs:</u>** • Immediately investigate all alleged violations involving anyone furnishing services on behalf of home care or hospice, and immediately take action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures. • Take appropriate corrective action in accordance with state law if the alleged violation is verified. Ensure that verified violations are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within 5 working days of becoming aware of the violation. Refer also to Response Process to Allegation of Abuse and/or Assault In an Allina Health Facility/Under Care of Allina Health process tool
Interdisciplinary Team Members	• Assess vulnerability by interviewing patient/caregivers, and others about the circumstances leading to the concern. • Notify interdisciplinary care team members. • Home Care: Obtain an order for social service consult if needed.

	• Consult with the following individuals, as necessary, to initiate a plan that will decrease and/or eliminate vulnerable risk: involved physician(s), AHCS leaders, patient, family/caregiver, or others in patient support system. Document the plan in the patient's medical record. • Consider notification to the state authorities if warranted. Involve manager/director in this decision. • Instruct patient/caregiver regarding resources immediately available if needed for crisis intervention • Assess ongoing vulnerability status and document to the interventions, including the progress made. • Upon discharge from the agency, the clinician will document the vulnerability status and transition plan to meet the patient's ongoing safety and welfare needs.

6. **Maltreatment of Patients Reported to Addiction/Substance Abuse Treatment Services Staff/Providers** (Vulnerable Adult Maltreatment: Assessment and Reporting in Minnesota for Addiction Services Policy/Procedure (SYS-PC-RMC-009)

7. **Maltreatment of Patients Reported to all CKRI Departments** (excluding the TRP) (Maltreatment of Vulnerable Adults: Prevention, Intervention, and Reporting Procedures CKRI-PC-028)

8. **Maltreatment of Patients Reported to CKRI Transitional Rehab Program Staff/Providers**
(Maltreatment of Vulnerable Adults" Prevention, Intervention, and Reporting Procedure for Transitional Rehabilitation Program CKRI-TRP-005)

9. **Maltreatment of Patients Reported to Emergency Medical Services (EMS) Staff**
Paramedics and EMTs are not considered mandated reporters by Allina Health; however, if any Paramedic or EMT witnesses or receives a report of suspected maltreatment of a vulnerable adult, including maltreatment reported by the vulnerable adult, that employee must immediately relay their concerns to a supervisor for appropriate follow up action. In the event the EMS Director of Risk cannot be contacted and a report needs to be made, the employee and/or supervisor may make a voluntary report as described in the policy. If a voluntary report is made, the EMS Director of Risk should be notified as soon as possible.

Responsibility:	**Action**:
Paramedic/EMT	If the patient reports maltreatment or assessment indicates maltreatment may have occurred: • Gather information about the nature of the problem • Notify 610/510 (on-duty supervisor) • Notify EMS Director of Risk (preferably by phone) to discuss details and next steps

EMS Director of Risk	Review the information and if needed contact the Paramedic or EMT for additional/clarifying information to determine whether a report should be submitted.
EMS Director of Risk	Report the alleged maltreatment within 24 hours after concluding there is a reason to believe that a reportable event occurred to the Minnesota Adult Abuse Reporting Center (MAARC) in the county where the incident occurred.
EMS Director of Risk	Document Report to MAARC in shared file management system.

ALGORITHM:

Flow Chart A: Vulnerable Adult Reporting Decision Chart: Events occurring during current admission to an Allina Health facility

Flow Chart B: Vulnerable Adult Reporting Decision Chart: Events occurring outside an Allina Health facility

Response Process to Allegations of Abuse and/or Assault in an Allina Health Facility/Under Care of Allina Health

ADDENDA:

1. Release of Information Navigator for Clinical Staff
2. Release of Information Navigator: How to Enter a Record of a Mandated Disclosure
3. MN Adverse Health Event List

PROTOCOL: N/A

FORMS: N/A

FAQ's: N/A

REFERENCES:

Related Regulation and Laws:

- Minnesota Statutes, section 626.557
- Minnesota Statutes, section 626.5572
- CMS 482.13(C)(3)

Alternate Search Terms: adult protection, abuse, elderly abuse, vulnerable

RELATED POLICIES:

Name of Policy	Content ID	Business Unit where Originated
Abuse Prevention Plan/Suspected Abuse	ABUSEPREVENTIONPLAN	AHCS

Maltreatment of Minors	SYS-PC-RMC-003	System-wide
Domestic Abuse	SYS-PC-RMC-004	System-wide
Adult at Risk or Elder Adult at Risk Maltreatment Assessment and Reporting Wisconsin	SYS-PC-RMC-010	System wide
Caregiver Misconduct Reporting Wisconsin	SYS-PC-RMC-011	System wide
Child Abuse or Neglect Reporting Wisconsin	SYS-PC-RMC-012	System wide
Elder Maltreatment Examination Procedure	SYS-PC-SANE-PROGRAM-16	System wide
Vulnerable Adult Maltreatment: Assessment and Reporting in Minnesota for Addiction Services	SYS-PC-RMC-009	System wide
Maltreatment of Vulnerable Adults: Prevention, Intervention, and Reporting Procedure	CKRI-PC-028	Courage Kenny Rehabilitation Institute

POLICIES REPLACING:

Name of Policy	**Content ID**	**Business Unit where Originated**
Procedure: Reporting and Managing Vulnerable Persons in Hospice and Palliative Care	HOS-098	Allina Health Home Health and Hospice
Procedure: Reporting and Managing Vulnerable Persons in Home Health	HH-054	Allina Health Home Health and Hospice
Abuse - Vulnerable Adult Maltreatment: Assessment and Reporting	RF-SW-003	River Falls
Procedure - Abuse: Vulnerable Adult Maltreatment: Assessment and Reporting	Reference # H-14	Faribault Medical Center
Procedure - Abuse: Vulnerable Adult Maltreatment: Assessment and Reporting	300.502	Owatonna Hospital
Procedure - Abuse: Vulnerable Adult	918164	Regina Hospital

Maltreatment: Assessment and Reporting		
Vulnerable Adult Procedure	CMC-PC-335	Cambridge Medical Center
Procedure - Abuse: Vulnerable Adult Maltreatment: Assessment and Reporting	PC0308	St. Francis Medical Center
Procedure - Abuse: Vulnerable Adult Maltreatment: Assessment and Reporting	MCY_PC_342	Mercy Hospital
Vulnerable Adult Abuse, Neglect, or Harassment Prevention, Intervention, and Reporting	A0024	Abbott Northwestern Hospital
Prevention of Abuse, Neglect, and Harassment Policy	MCY_AD_002	Mercy Hospital
Vulnerable Adult Procedure	213620	Buffalo Hospital

Individual Abuse Prevention Plan - Assessment

Consider the patient's susceptibility to abuse by another individual or the patient's risk of abusing other vulnerable adults or minors.

Physical Abuse

Inability to identify potentially dangerous situations | Lack of community orientation skills | Inappropriate interactions with others | Inability to deal with verbally/physically aggressive persons | Verbally/physically abusive or aggresive to others | **"Victim" history exists** | Other | None

Is patient susceptible to abuse or at risk of abusing other vulnerable adults or minors in this area? **Yes** | No

Action plan to be documented in Home Visit Required care plan.

Neglect Self-Care/Self Abuse

Dresses inappropriately | Does not eat regular meals | Inability to care for self-help needs | Lack/Failure of caregiver to provide needs resulting in harm | Lack of self-preservation skills (ignores personal safety) | **Current or history of self-injurious behaviors** | Current or history of suicidal ideation or behavior | Neglect of or refusal to take medications as prescribed | Neglect of medical needs | Problematic alcohol or drug use | Limited self-advocacy skills | Other | None

Is patient susceptible to abuse or at risk of abusing other vulnerable adults or minors in this area? **Yes** | No

Action plan to be documented in Home Visit Required care plan.

Sexual Abuse

Lack of understanding of sexuality | **Likely to seek or cooperate in an abusive situation** | Inability to be assertive | Other | None

Is patient susceptible to abuse or at risk of abusing other vulnerable adults or minors in this area? **Yes** | No

Action plan to be documented in Home Visit Required care plan.

Financial Exploitation

Difficulty handling financial matters | **Limited understanding of money/counting money** | History of impulsive choices regarding money | Easily influenced by others | History of financial exploitation | History of being overly generous while neglecting own needs | Has rep - payee, financial conservator, or guardian | Other | None

Is patient susceptible to abuse or at risk of abusing other vulnerable adults or minors in this area? **Yes** | No

Action plan to be documented in Home Visit Required care plan.

Allina Health | HOME CARE SERVICES

Policy: **Home Health Clinical Assessment**

Reference #: HH-015

Origination Date: 4/25/2011
Next Review Date: 4/25/2027
Effective Date: 4/25/2024

Approval Date: 4/25/2024

Approved By: Home Health Quality/ Compliance Manager

(Please utilize these definitions)

Policy Ownership Group: AHCS Quality/ Compliance Committee
Allina Policy Information Resource: Home Health Quality/ Compliance Mgr.

Stakeholder Groups
Home Health

SCOPE:

Sites, Facilities, Business Units	Departments, Divisions, Operational Areas	People applicable to (MD, NP, Administration, Contractors etc.)
Allina Health Home Care Services	Home Health	Administration, RN/LPN, PT/PTA, OTR/COTA, SLP,

POLICY STATEMENT:

Home health staff will conduct a clinical assessment:

- To obtain data to establish the patient specific plan of care
- To identify new and changed patient problems, needs, strengths, goals and preferences
- To establish a baseline physiologic status from which subsequent assessments are compared
- To support the regulations associated with Home Health Licensure and Home Health Medicare Certification

Data from the health history and the physical assessment are both objective and subjective and are usually obtained from the patient. However, information may be supplemented from a secondary source, such as a caregiver, multidisciplinary team, or records from the physician or referring institution.

PROCEDURE:

Comprehensive Assessments

1. The comprehensive assessment of the patient's current health status includes relevant past medical history as well as all active health and medical problems.

2. A comprehensive patient assessment is completed by a Registered Nurse, except when therapy is the only service ordered by the physician.

3. Staff will assess and record whether the caregiver and home environment is suitable and therapeutic for receiving home care services

4. The comprehensive patient assessment will include a review and reconciliation of all prescribed and Over the Counter (OTC) medications and preparations the patient is taking, and include identification/assessment of:
    a. missing medications
    b. potential adverse effects and drug reactions,
    c. expired preparations
    d. ineffective therapy,
    e. actual and potential significant side effects,
    f. actual and potential significant drug interactions,
    g. potential drug diversion,
    h. duplicate drug therapy and
    i. non-compliance with therapy.

5. The assessment, specific to age, need and disease history will include, but is not limited to:
    - General Presentation and Goals of Care,
    - Head/Neck/Nose/Eyes
    - Orientation/Mental Status/Cognition
    - Respiratory
    - Cardiac
    - Cardiovascular status/Edema
    - Gastrointestinal
    - Genitourinary system
    - Nutrition/Hydration
    - Integumentary/Skin
    - Musculoskeletal
    - Individual abuse prevention plan identifying risk for abuse, neglect, and exploitation
    - Environmental and personal safety deficits
    - Financial and community resource needs

6. Functional, Psychosocial, and Cognitive status are assessed and documented using the OASIS data elements with Home Care specific assessment criteria.
    When the patient is not required to have OASIS data collected, the functional status of the patient will be assessed using a related tool.

7. OASIS data collection is not required for patients less than 18 years of age, prenatal/postpartum patients, or patients who receive only personal care or homemaker services.

8. Risks and benefits of receiving services in the home setting versus an alternate site is identified and explored with the patient/patient representative.

9. Scheduled assessments are prioritized based on patient need.

10. Staff will complete a comprehensive admission patient assessment on all patients within 5 days of the initial visit.

11. Admission assessments will be completed by registered nurses, physical therapists, speech therapists, or occupational therapists.

12. Patient populations with specialized needs, i.e., mental health, newborn, pediatric, antepartum/postpartum, and palliative care will be assessed by professionals with appropriate skills and in accordance with specific policies developed for those services.
    a. Mother and Newborn: the comprehensive assessments are specific to population/need: antepartum maternal/fetal, postpartum maternal and newborn patients.

13. Discharge planning is initiated, patient-specific goals are expressed, and immediate/continuing care needs are recognized.

14. Clinical outcomes are projected based on what can realistically be achieved in the home setting and the degree of patient/patient representative participation and motivation.

15. Comprehensive assessments are conducted at the following timeframes:
    a. at admission to the agency,
    b. upon resumption of care following an in-patient stay,
    c. every sixty (60) days, as a recertification of care,
    d. when patient exhibits a significant change in condition,
    e. at discharge from the agency to measure clinical progress and determine transition needs for the patient/patient representative.

16. Assessments are completed within the required regulatory time frames:
    a. Admission assessment is started within 48 hours of referral date or on physician ordered SOC date, and is completed within five (5) days
    b. Resumption of Care assessment is started and completed within forty-eight (48) hours of facility discharge or on physician ordered date.
    c. All remaining assessments are completed in a timely fashion and prior to billing.

Initial Assessments

1. Professional disciplines, other than the discipline who performed the Admission Comprehensive assessment, will complete an Initial

Assessment which includes a broad overview specific to the discipline or specialty they represent.

2. The Initial assessments along with physician orders forms the foundation of the care planned for the patient by that discipline or specialty.

Therapy Re-assessments

1. Patients will be re-assessed every thirty (30) days of active therapy when receiving Physical Therapy, Occupational Therapy and Speech Language Pathology services.

2. The re-assessment will include:
    a. Progress made from initial assessment
    b. Progress towards goals
    c. Specific measures or test results, when applicable

Qualification Assessments (Payer Criteria):

1. The Start of Care (SOC) assessing clinician will complete an assessment at the first visit to determine if payer criteria for home care are met.

2. The assessing clinician will consult with agency supervising personnel, care navigation and the patient's physician to determine appropriate disposition for the patient, if payer criteria are not met.

Documentation

1. Staff will use the standard patient assessment form in electronic record to develop the patient care plan.

2. Identified problems, patient goals and physician orders are recorded in the patient care plan and function as the focus of care.

Related Regulation and Laws:

§484.55 Condition of Participation: Comprehensive Assessment of Patients

Related Policies:

Name of Policy	Content ID	Business Unit where Originated
Home Health Plan of Care	HH-044	Home Health
Admission to Home Health	HH-001	Home Health

Policies Replacing:

Name of Policy	Content ID	Business Unit where Originated

Allina Health | HOME CARE SERVICES

Policy: **OASIS Reporting**

Reference #: HH-037

Origination Date: 12/13/2012
Next Review Date: 4/29/2027
Effective Date: 4/29/2024

Approval Date: 4/29/2024

Approved By: Home Health Policy Review Committee

(Please utilize these definitions)

Policy Ownership Group: Home Health Policy Review Committee

Policy Information Resource: Home Health Quality/ Compliance Manager

Stakeholder Groups
Home Health

SCOPE:

Sites, Facilities, Business Units	Departments, Divisions, Operational Areas	People applicable to (MD, NP, Administration, Contractors etc.)
Allina Health Home Care Services	Home Health	RN, PT, OT, SLP, Administration

POLICY STATEMENT:

1. Home Health will comply with all regulatory requirements associated with electronic management of OASIS assessments.
2. OASIS assessments will be collected on all patients receiving skilled services but AHCS will only transmit those assessments of government payers (Medicare, Medicare HMO, Medicaid and Medicaid HMO)
3. The encoded OASIS accuracy must accurately reflect the patient's status at time of the assessment.
4. Assessment data quality and accuracy is validated by compliance team analysis.
5. Data from OASIS assessments are submitted electronically within thirty (30) days of the assessment.
6. Submission data reports are analyzed for errors by category and corrections are made, when appropriate and re-submitted within the required time frame.
7. OASIS assessments are inactivated when corrections are needed and when an assessment was submitted in error.

8. OASIS assessments are deleted from the transmission and a formal deletion request is generated when analysis indicates eligibility was not met or when the submission was originally made in error.

PROCEDURES:

PROTOCOL:

FORMS:

ALGORITHM:

ADDENDUMS:

FAQ's:

REFERENCES:
§484.45 Condition of participation: Reporting OASIS information

Related Policies:

Name of Policy	Content ID	Business Unit where Originated

Policies Replacing:

Name of Policy	Content ID	Business Unit where Originated

Allina Health | HOME CARE SERVICES

Policy: **Home Health Plan of Care**

Reference #: HH-044

Origination Date: 12/4/2013
Next Review Date: 4/29/2027
Effective Date: 4/29/2024

Approval Date: 4/29/2024

Approved By: Home Health Policy Review Committee

(Please utilize these definitions)

Policy Ownership Group: Home Health Policy Review Committee
Policy Information Resource: Home Health Quality/ Compliance Manager

Stakeholder Groups
Home Health

SCOPE:

Sites, Facilities, Business Units	Departments, Divisions, Operational Areas	People applicable to (MD, NP, Administration, Contractors etc.)
Allina Health Home Care Services	Home Health	RN/LPN, PT/PTA, SLP OT/COTA, MSW, HHA

POLICY STATEMENT:

Home Health services are furnished under the supervision and direction of the patient's physician or allowed practitioner in accordance with applicable regulatory requirements.

The Plan of Care (POC) is based on comprehensive assessment, patient goals and preferences, physician or allowed practitioner orders and information provided by patient/family and health care team members involved with the care of the patient.

Care planning is a dynamic ongoing process of treatment and service provision and analysis to ensure the patient needs are met and revised as needed and at least every sixty (60) days.

DEFINITIONS:

Plan of Care: All patient-specific services, procedures, disciplines, treatments and teaching ordered and provided for a patient within a sixty (60) day period or home health episode.

PROCEDURES:

1. An individualized POC signed by the physician or allowed practitioner shall be required for each patient receiving skilled and/or unskilled home health services.
2. The POC will include, but is not limited to:
    - All pertinent primary and secondary diagnoses, including dates of onset or exacerbation
    - Recent surgical procedures
    - Mental / Psychosocial / Cognitive Status
    - Type, frequency and duration of ordered disciplines/services
    - Therapy procedures and modalities, when ordered
    - Diagnostic tests
    - Medical prognosis and rehabilitation potential
    - Functional limitations and precautions
    - Activities permitted and/or restrictions
    - Specific dietary or nutritional requirements or restrictions
    - Medications, allergies and treatments
    - Medical supplies and required equipment
    - Specialty DME
    - Safety measures
    - Patient preferences and goals of care
    - Risks and benefits of accepting / declining care and treatment
    - Instructions to patient/caregiver
    - Treatment goals
    - Code status and Presence of advanced directives
    - Risk of Vulnerability, when indicated
    - Risk of Emergency Room Use and Hospitalization
    - Discharge plan
    - Name and address of physician or allowed practitioner directing home health
3. The POC is crafted by the assessing clinician following an applicable comprehensive assessment in consultation with the patient requests/goals and physician or allowed practitioner within five (5) days.
4. The physician or allowed practitioner providing Home Health oversight is consulted after the initial assessment of each additional professional ordered to approve additions or modifications to the POC.
5. Modifications to the POC are completed as physician or allowed practitioner orders, entered into electronic record and sent to the physician or allowed practitioner for signature.
6. Treatment orders shall include specific procedures, modalities to be used and the amount, frequency and duration.
7. The patient shall actively participate in the POC development and informed of any changes prior to the change.

8. Patient will signify agreement of the services by signature on the patient specific Service Plans and applicable Beneficiary Notices.
9. The POC will be reviewed by the ordering physician or allowed practitioner as often as the severity of patient condition warrants or at minimum every 60 days.
10. Professional staff shall alert the physician or allowed practitioner to any change that suggests a need to alter the POC.

PROTOCOL:

FORMS:

ALGORITHM:

ADDENDUMS:

FAQ's:

REFERENCES:

Related Regulation and Laws:

Medicare Conditions of Participation for Home Health:

§484.60(a) Standard: Plan of Care
§484.60(b) Standard: Conformance with physician orders
§484.60(c) Standard: Review and Revision of Plan of Care

Related Policies:

Name of Policy	Content ID	Business Unit where Originated

Policies Replacing:

Name of Policy	Content ID	Business Unit where Originated

Allina Health | HOME CARE SERVICES

Policy: **Home Health Care Coordination Policy**

Reference #: HH-005

Origination Date: 8/9/2006
Next Review Date: 4/29/2027
Effective Date: 4/29/2024

Approval Date: 4/29/2024

Approved By: Home Health Policy Review Committee

(Please utilize these definitions)

Policy Ownership Group: Home Health Policy Review Committee
Policy Information Resource: Home Health Quality/ Compliance Manager

Stakeholder Groups
Home Health

SCOPE:

Sites, Facilities, Business Units	Departments, Divisions, Operational Areas	People applicable to (MD, NP, Administration, Contractors etc.)
Allina Health Home Care Services	Home Health, Mother Newborn, AHHITS	SN/LPN, PT/PTA, OT/COTA, SLP, MSW, HHA

POLICY STATEMENT:

All personnel furnishing services shall maintain timely communication to assure that patient care is coordinated effectively and support the objectives outlined in the Plan of Care.

DEFINITIONS:

PROCEDURES:

1. Documentation of contact, interventions, communication and/or patient response is completed within 48 hours.
2. Patient will identify the specific goals they hope to achieve through home health services. These goals are communicated to all team members and directly relates to the planned home care interventions.
3. Staff will communicate patient changes in condition, problem-solving efforts, service requests/changes, missed visits, clinical goal progress and clinical measures outside the expected parameters to the appropriate team members and physician or allowed practitioners involved in the plan of care (those physicians or allowed practitioners who give orders that are directly related to home health skilled services), when applicable.
4. Physician or allowed practitioner ordered changes to the patient-specific care plan are communicated to the patient, caregiver, and applicable care team members at the time of the change.

5. The Interdisciplinary Teams (IDT) will meet regularly to review patient progress to goals. Professional staff are expected to attend and actively participate in these meetings, unless otherwise excused.
6. Discharge planning begins at the initial home care visit and continues throughout the course of care and involves the patient, family/caregiver, the physician or allowed practitioner, the agency staff providing care, and any community organizations as directed by the patient.
7. The designated Case Manager/Mother Newborn charge nurse or antepartum nurse will lead communication to other involved team and community members to ensure a coordinated discharge plan. They may consult with manager/supervisor and physician or allowed practitioner for guidance as necessary.
8. Transition Notes are documented at the time of patient transfer to a facility and include patient status at time of transfer, barriers/challenges to success and home care goals that remain unresolved.
9. Evidence of care coordination is documented in the following ways, which include, but are not limited to:
    a. Care Conference Notes,
    b. Care Transition Notes,
    c. Case Communication Notes,
    d. Telephone Encounter Notes,
    e. Missed Visit Notes, and
    f. Visit and Assessment Reports.

PROTOCOL:

FORMS:

ALGORITHM:

ADDENDUMS:

FAQ's

REFERENCES:

Related Regulation and Laws:
Medicare Conditions of Participation: §484.60(d) Standard: Coordination of Care

Alternate Search Terms:

Related Policies:

Name of Policy	Content ID	Business Unit where Originated

Policies Replacing:

Name of Policy	Content ID	Business Unit where Originated

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

April 22, 2024

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

RE: Event ID: 6296B-H1

Dear Administrator:

An abbreviated extended survey was completed at your agency on April 4, 2024, 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:

G406 CFR 484.50 Condition of Participation: Patient Rights.

REMOVAL OF IMMEDIATE JEOPARDY

On April 4, 2024,the conditions resulting in our notification of the immediate jeopardy having been removed.

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 deficient practice does not recur;
- 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) location. 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:

Annette Winters, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

Please make a copy of your plan of correction for your records.

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and a loss of Federal reimbursement. 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 (CMS) Location that your certification be terminated, effective July 3, 2024.

HOME HEALTH AIDE TRAINING AND/OR COMPETENCY EVALUATION PROHIBITION

Federal Law, as specified in 42 CFR **484.80(f)(3)**, 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 **484.80(f)(3);**

(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, your facility is precluded from conducting a home health aide training and/or competency evaluation program for a period of two years beginning April 4, 2024,

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,

Joanne Simon, Compliance Analyst
Minnesota Department of Health
Health Regulation Division
Telephone: 651-201-4161
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File