STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K140	A. BUILDING B. WING	09/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Heart Health Services Llc	7770 N MICHIGAN ROAD SUITE D, INDIANAPOLIS, IN, 46268

(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
G0000	INITIAL COMMENTS This visit was for a Third (3rd) Post Condition Revisit (PCR) survey for Federal recertification and State Re-licensure of a Medicaid Home Health Agency. Survey Dates: 09-21 and 09-22-2022. At this survey, Golden Heart Health Services was found to be out of compliance with Condition of Participation 42 CFR 484.65, Quality Assessment and Performance Improvement (QAPI). QR Completed 10/3/2022 A4	G0000	G0000 GOLDEN HEART HEALTH SERVICES is submitting the followingPlan of Correction in response to the 2567 issued by ISDH and/or CMS as it isrequired to do by applicable state and federal regulations. The submission ofthis Plan of Correction is not intended as an admission, does not constitute anadmission by and should not be construed as an admission by GOLDEN HEART HEALTHSERVICES that the findings and allegations contained herein are accurate andtrue representations of the quality of care and services provided to patientsof the Agency. GOLDEN HEART HEALTH SERVICES desires this Plan of Correction tobe considered our Allegation of Compliance.”	2022-10-21

			The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview the agency failed to provide documentation of physician signed plans of care for 4 (Patients #14, 17, 18, and 20) of 7 patient records reviewed and documentation of missed visits for 1 (Patient 16) of 7 patient records. A review of the plan of care for Patient # 20, with a start of care date of 10/29/2020, contained a plan of care for the certification	G0572	G0572 Administrator/designee will audit all active patient chartsfor signed MD orders/plans of care. To be completed by10-21-2022. Administrator/designee will send all unsigned MDorders/plans of care to MD for signature. To be completed by 10-21-2022. Administrator/designee will track all MD orders/plans ofcare done each week to ensure they are returned signed within thirty (30) days.(On-going) Administrator will in-service schedulers/Director ofNursing/nurses that if a visit is not made as ordered the Director of Nursingis to be notified. Completion date will be 10-12-2022. Director of Nursing will audit all visit notes submittedweekly to ensure the frequency ordered by MD has been met. If it is not	2022-10-21

	10/18/2022, with orders for home health aide services. When reviewed on 09/21 and 9/22/2022, the plan of care had not been signed by the attending physician. The administrator reviewed the clinical record and indicated the physician had not yet signed the orders contained in the plan of care. On 09-21-2022, the administrator indicated the agency policy and expectation is for all orders (to include the plan of care) to be signed within 30 days. On 09-22-2022 at 1:51 PM, Administrator _ provided a policy titled, "Plan of Care" (POC). The policy indicated but was not limited to, "...the Plan of Care/485 will be signed...physician orders will be obtained as quickly as possible but within thirty (30) days...". On 09-21-2022, the clinical record of Patient # 14 was reviewed. The POC for certification period 07-24-2022 to 09-21-2022 was not signed by the physician.		metthere must be a missed visit report and documentation missed visit report wassent to MD. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

On 09-21-2022, the clinical record of Patient #16 was reviewed. The patient had 5 missed visits between 09-04 to 09-20-2022. The physician was not notified and there were no orders to alter the POC.

On 09-21-2022, the clinical record of Patient # 18was reviewed. The POC for certification periods 06-17-2022 to 08-15-2022 and 08-16-2022 to 10-14-2022 were not signed by the physician.

On 09-21-2022, the clinical record of Patient # 17 was reviewed. the POC for certification periods 06-24-2022 to 08-22-2022 and 8-24-2022 to 10-22-2022 were not signed by the physician.

On 09-22-2022 at 1:50 PM, Administrator # 1 indicated the signed orders were not present for the records noted.

G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (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.	G0574	G0574 Administrator will in-service clinicians on requirements forthe plan of care by 10-19-2022. The individualized plan of care must include the following: (i) All pertinent diagnoses; (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	2022-10-21

	(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. Based on record review and interview, the agency failed to ensure the Plan of Care for 3 of 7 clinical records reviewed were followed as ordered by the physician (Patient # 14, 18 and 19); and failed to include an order for oxygen by nasal cannula for 1 (Patient 20) of 7 patients clinical records reviewed. A review of the clinical record for Patient # 20 with a start of care of 10/29/2020, contained a plan of care for the certification period of 08/20 through 10/18/2022. The plan of care failed to evidence an order for the use of oxygen by nasal cannula. The plan of care section for the 60-day summary evidenced Patient #20 wore oxygen at 2 liters per minute, by nasal cannula as needed during the night. On 09/22/2022 at 12:40 PM, RN # 3 when interviewed indicated		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 departmentvisits and hospital re-admission, and all necessary interventions to addressthe underlying risk factors. (xiii) Patient and caregiver education and training to facilitatetimely discharge; (xiv) Patient-specific interventions and education; measurableoutcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and	

	having forgotten to enter an order on the plan of care or elsewhere in the clinical record for oxygen as needed at night 2 liters per minute via nasal cannula for Patient # 20. 1. On 09-22-2022 at 1:51 PM, Administrator #1 provided a policy titled, "Plan of Care, C580". The policy indicated but was not limited to, "...the Plan of care shall be completed in full to include:..type, frequency and duration of all services...". 2. On 09-22-2022 the clinical records of Patients 14, 18 and 19 were reviewed. The schedule of home health aide (HHA) visits were not followed as ordered: 3. Patient #14 was ordered HHA visits three, (3) days per week for nine, (9) weeks. Patient #14's schedule indicated they received HHA visits four (4) days per week with no change in order by the physician for the certification period 07-24-2022 to 09-21-2022.		(xvi) Any additional items the HHA or physician or allowedpractitioner may choose to include. Director of Nursing/designee willaudit all current plans of care to ensure the frequencies provided match MDorders. An MD order will obtained for patient whose frequency being provideddoesn't match current orders. This will be completed by 10-21-2022. Director of Nursing/designee willaudit all visit notes submitted weekly to ensure the frequency provided followsMD orders. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) Director of Nursing/designee will audit all plans of caresubmitted weekly by comparing to the comprehensive assessment to ensure plan ofcare is complete and accurate. Once 100% is	

	4. Patient #18 was ordered HHA visits seven, (7) days per week for seven (7) weeks. Patient #18's schedule indicated they received HHA visits for five (5) days per week with no change in order by the physician for the certification period 08-16-2022 to 10-14-2022. 5. Patient #19 was ordered HHA visits five (5) days per week for nine (9) weeks. Patient #19's schedule indicated they received HHA visits for seven (7) days per week with no change in order by the physician for the certification period 08-03-2022 to 10-01-2022. 6. On 09-22-2022 at 10:40 AM, Administrator #1 was queried about the patient's schedule. Administrator #1 indicated they are not following the correct order of visits. The Administrator queried the Administrative Assistant who did not give a response for the inconsistent visit schedule.		auditedquarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview the agency failed to provide a Quality Assessment and Performance Improvement Program (QAPI) as observed over 2 of 2 survey days.	G0640	G0640 Administrator/Director of Nursing will work with RNconsultant to establish data to be tracked for QAPI. That will include showingmeasurable improvement in indicators by measuring, analyzing, and trackingthose quality indicators. (On-going) administrator will discuss with Governing Body the data tobe tracked for QAPI to obtain their approval. This was done in their September29the Board meeting and will be discussed in the monthly board meetings. Consultant will review QAPI program quarterly to ensurethere is evidence of measuring, analyzing, and tracking of quality indicatorsappropriate to agency and approved by Governing Body. (On-going) Administrator will ensure that other agencies data used as abenchmark will be comparable to Golden Heart. (On-going)	2022-09-29

	5. On 9-22-2022, at 3:12 PM, the administrator indicated the QAPI data presented was all the documentation on QAPI and that the 3 outside agencies reported data used as a benchmark was different than the data this agency had collected and was like trying to compare apples to oranges. 1. On 09-22-2022 at 4:16 PM, the Administrator, Employee #1 , provided a policy titled Quality Assessement and Performance Improvement (QAPI) B-260. The policy indicated but was not limited to, "...Agency will develop, implement, evaluate and maintain an effective, ongoing agency wide, data driven QAPI program...The agency will maintain documentary evidence of its QAPI program and be able to demonstrate its operation...the program will be capable of showing measurable improvement in indicators that will improve health outcomes, client safety and quality of care...the agency will identify, measure, analyze and track quality indicators...".		Administrator will ensure data for QAPI are reported to theGoverning Body quarterly. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

2. On 09-21-2022 at 09:30 AM during the entrance conference, Administrator #1 was queried about the data related to the plans of correction prompting the post condition revisit (PCR). Administrator #1 indicated they had the data on their computer and could share it.

3. On 09-22-2022 at 3:12 PM, Administrator #1 provided governing body minutes from 07-22-2022 and 08-31-2022 that indicated QAPI data was reviewed. On 08-31-2022 the data indicated was reported as "comparable data". The comparable data was not inclusive of the agency. The Administrator indicated the trending and tracking of data was done by Consultant #1.

4. On 09-22-2022 at 3:45 PM, Administrator #1 called Consultant #1. Consultant #1 was queried on the data tracked and trended. Consultant #1 indicated they track recertifications sent to them for completion and corrections. There is no other data tracked or trended. When asked to

	clarify data reported, the Consultant further indicated emails are sent with corrections to be made by the clinicians. No data is reported to the board. When they receive a recertification or an initial assessment, they audit it for corrections only.			

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