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	11/03/2022

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 Fourth Post-Condition Revisit (PCR) survey for Federal Recertification and State Re-licensure of a Medicaid Home Health Agency. Survey Dates: 11-02-22, and 11-03-2022 Golden Heart Health Services continued to be out of compliance with Condition of Participation 42 CFR 484.60, Care Planning, Coordination of Services, and Quality of Care, and out of compliance with Condition of Participation 42 CFR 484.65, Quality Assessment and Performance Improvement (QAPI).	G0000	G0000 POC Accepted on 1-12-2023 Deborah Franco, RN GOLDEN HEART HEALTH SERVICES is submitting the following Plan of Correction in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction is not intended as an admission, does not constitute an admission by and should not be construed as an admission byGOLDEN HEART HEALTH SERVICES that the findings and allegations contained herein are accurate and truerepresentations of the quality of care and services provided to patients of the Agency. GOLDEN HEART HEALTH SERVICES desires this Plan of Correction to be considered our Allegation of Compliance."The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-01-13

	Condition-level deficiencies were identified during the November 19, 2021 survey, in which your agency was subject to a fully extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act. Condition-level deficiencies were also cited during your second PCR survey on 06-22-22, and your third PCR on 9-22-22, and therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency continues to be precluded from operating a home health aide training, skills competency, and/or competency evaluation program for a period of two years beginning November 19, 2021, and continuing through November 18, 2023. These deficiencies reflect State Findings cited in accordance with 410 IAC 17 et seq. QR by Area 3 pm 11-14-2022			
G0570	Care planning, coordination, quality of care	G0570	G0570	2022-12-27

	484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the agency failed to ensure the patients' plans of care had individualized goals for 5 of 6 active patient records reviewed (Patients #1, 2, 4, 5, and 6) (See G 572;) failed to ensure care visits were provided as ordered on the plan of care for 2 (Patients #2 and 6) of 6 patients (See G 572;) failed to provide evidence of rescheduled visits or physician notification/ documentation of missed visits for 2 (Patient # 6) of 6 patient records (See G 572;) and failed to provide documentation of physician signature of the plan of care		See G0572, G0574 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	required by agency policy for 2 (Patients # 4 and 5) of 6 active patient records reviewed (See G 574.) *			
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 individualized goals within the plans of care for 5 (Patients #1, 2, 4, 5, and 6) of 6 active patient records reviewed. 1. On 11-03-2022, the clinical record of Patient #1 for the certification period 09-17-2022 to 11-15-2022 was reviewed. The Plan of Care (POC) did not include a Plan of Care (POC) with individualized goals related to their diagnosis.	G0572	G0572 Administrator/Director of Nursing will attach a copy oftraining/in-service materials to the sign in sheet for all futurein-services. In-services done prior to01-01-2023 required all staff to sign directly on the training material.(On-going) --- --- --- --- --- Administrator/Director of Nursing/designee will audit allcurrent patient records to ensure MD orders are signed. Any unsigned orderswill be sent to MD for signature and tracked to ensure they are returnedsigned. Date completed 12-27-22 Administrator/Director of Nursing/designee will track	2022-12-27

	2. On 11-03-2022, the clinical record of Patient #2 for the certification period 09-11-2022 to 11-09-2022 was reviewed. The POC did not include a Plan of Care (POC) with individualized goals related to their diagnosis. 3. On 11-03-2022, the clinical record of Patient #4 for the certification period 09-18-2022 to 11-16-2022 was reviewed. The POC did not include a Plan of Care (POC) with individualized goals related to their diagnosis. 4. On 11-03-2022, the clinical record of Patient #5 for the certification period 08-28-2022 to 10-26-2022 was reviewed. The POC did not include a Plan of Care (POC) with individualized goals related to their diagnosis. 5. On 11-03-2022, the clinical record of Patient #6 for the certification period 09-05-2022 to 11-02-2022 was reviewed. The POC did not include a Plan of Care (POC) with individualized goals related to their diagnosis. 6. On 11-02-2022. Administrator		weeklyplans of care that have sent to MD to ensure they are returned signed by MDwithin 30 days. (On-going) --- --- --- --- --- Administrator/Director of Nursing will in-service nurses onthe requirement for plan of care to be individualized to include goalspertinent to their diagnoses for skilled patients. Date completed: 12-02-22. Director of Nursing will obtain verbal order from MD forpatient #1 to add individualized goals to plan of care. Expected date ofcompletion: 12-8-22. Director of Nursing/designee will audit all current patientplans of care to ensure they have individualized goals. Nurse will obtainorders to add individualized goals if plan of care missing individualizedgoals. Expected date of completion: 12-27-22. Director of Nursing/designee will audit all plans of carecompleted each week to	

	during the QAPI interview. Administrator #2 indicated that the POC's would be part of the audits completed by the Director of Nursing. 410 IAC 17-13-1(a)(1)(D)(xiv)		ensure there are individualized goals for patient. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained. (On-going) Administrator will in-service schedulers/designee that whena visit is missed there must be documentation there was an attempt toreschedule that visit that week. If unable to reschedule that visit a missedvisit report must be completed and sent to the MD. Date completed: 12-2-22. Each week Director of Nursing/designee will audit all visitschedules and compare visit notes to schedule to ensure ordered visit frequencyis met. If visit frequency not met there must be documentation that agencyattempted to reschedule missed visit that week. If unable to reschedule theremust be a missed visit report competed and proof it was sent to MD. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) Administrator/Director of	

			clinicianswho are in-serviced sign documentation indicating they attended in-servicestarting 01-01-2023. All training andin-servicing prior to 01-01-2023 required staff sign the training materialdirectly. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
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;	G0574	G0574 Administrator/Director of Nursing will attach a copy oftraining/in-service materials to the sign in sheet for all futurein-services. In-services done prior to01-01-2023 required all staff to sign directly on the training material.(On-going) --- --- --- --- ---	2022-12-27

	(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. Based on record review and interview, the agency failed to provide documentation of physician signed plans of care for 2 (Patients #4 and 5) of 6 active patient records reviewed and documentation of missed visits for 2 (Patient #2 and 6) of 6 patient records. 1. On 11-03-2022 at 1:50 PM, Administrator #2 indicated the policy titled, "Plan of Care" (POC)had not changed. 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 ...". 2. On 11-03-2022, the clinical		Administrator/Director of Nursing/designee will audit allcurrent patient records to ensure MD orders are signed. Any unsigned orderswill be sent to MD for signature and tracked to ensure they are returned signed.Expected date of completion: 12-27-22. Administrator/Director of Nursing/designee will track weeklyplans of care that have sent to MD to ensure they are returned signed by MDwithin 30 days. (On-going) Administrator/Director of Nursing/designee will audit allvisit schedules weekly to ensure the scheduled frequency matches the orders onthe plan of care. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) Administrator/Director of Nursing will ensure all clinicianswho are in-serviced sign documentation indicating they attended in-servicestarting 01-01-2023. All training andin-servicing prior to 01-01-2023 required staff sign the training materialdirectly.	

	record of Patient #4 for the certification period 09-18-2022 to 11-16-2022 was reviewed. The plan of care indicated home health aide (HHA) services for Patient #4 would be 3 hours per day, 4 days per week. The services were provided 3 days per week. The plan of care orders were not signed by the physician. The supervisory note indicated the services were provided as ordered. 3. On 11-03-2022, the clinical record of Patient #5 for the certification period 08-28-2022 to 10-26-2022 was reviewed. The order was not signed by the physician. The supervisory note indicated the services were provided as ordered. 4. On 11-03-2022, the clinical record for Patient #2 for the certification period 09-11-2022 to 11-09-2022 was reviewed. The schedule indicated the patient had 5 missed visits. 5. On 11-3-2022, the clinical record of Patient #6 for the certification period 09-05-2022 to 11-02-2022 was reviewed. The schedule indicated the patient had 2 missed visits. 6. On 11-3-2022, Administrator		(On-going) Administrator will in-service schedulers/designee that whena visit is missed there must be documentation there was an attempt toreschedule that visit that week. If unable to reschedule that visit a missedvisit report must be completed and sent to the MD. Date completed: 12-02-22. Each week Director of Nursing/designee will audit all visitschedules and compare visit notes to schedule to ensure ordered visit frequencyis met. If visit frequency not met there must be documentation that agencyattempted to reschedule missed visit that week. If unable to reschedule theremust be a missed visit report competed and proof it was sent to MD. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	#2 indicated there were no documents located regarding missed visits or signed physician orders. 410 IAC 17-13-1(a)(1)(D)(iv)			
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) in accordance with agency policy as observed over 2 of 2 survey days.	G0640	G0640 All current clinical staff will be in-serviced on agency'sQAPI program and their role. In-services done prior 01-01-23 required all staffto sign directly on the trainingmaterial. (On-going) Going forward, asign in sheet will be kept to ensure all staff have been in-serviced. Administrator/Directorof Nursing will attach a copy of training/in-service materials to the sign insheet for all future in-services. (01-13-2023) After each in-service, the attendance sheetwill be reviewed to identify any staff who did not attend the in-services. Quarterly the Administrator/Director of Nursing will meetwith staff to review the previous quarter's QAPI findings. Staff will be	2023-01-13

	1. On 11-02-22 at 1:50 PM, Administrator #2 indicated the Quality Assessment and Performance Improvement (QAPI) B-260 policy previously shared on prior surveys had not been amended or revised in any way. 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 ... " 2. On 11-02-2022 at 09:00 AM during the entrance conference, Administrator #2 was queried about the data collection which was included in the agency's approved plan of correction. Administrator #2 indicated they had tracked the data and it would be provided. 3. On 11-02-2022 at 10:05 AM,		agency will be monitoring the next quarter as well asoperational changes that will be implemented to achieve new performance goals.A sign in sheet will kept to ensure all staff have been in-serviced. (On-going) Staff who are not able to attend anin-service will be identified from the sign-in sheet. These staff will beprovided with an alternative date and time for in-services. Due to staffing issues and schedulingconflicts, in-services may be offered via Zoom, Teams or other remote videoconferencing that allows for verification of attendance as well as two wayinteraction via audio and video. All new clinical staff will be in-serviced on agency QAPIprogram as part of their orientation. (On-going) QAPI audit tool will be revised by Administrator/Director ofNursing and/or QAPI Committee as needed to reflect current PerformanceImprovement Plans. (On-going) Administrator/Director of Nursing will attach a copy	

	Administrator #2 provided the four (4) documents: 4. A "Faxed Orders Tracking Log." 18 patients were identified on the tracking log as missing orders. The log was initiated on 10-19-22. No baseline data was identified to measure compliance with the stated Plan of Correction (POC) goal of "100% compliance to be achieved." 5. A Word document titled, "G0574" signed by Registered Nurse (RN) #1. The document outlined the POC. No other nurse signatures were provided by Administrator #2. 6**.** An undated/untitled word document for 23 patients of the Terre Haute branch and 13 patients for the Indianapolis location. The document indicates missing items from the patient's chart. The census for indicated 100% of the charts will be audited. 7. Three (3) medication profiles for patients indicating missing diagnoses or the need to add to the Plan of Care the reason for administration. medication. 8. On 11-02-2022 at 11:09 AM,		oftraining/in-service materials to the sign in sheet to provide documentation ofwhat was addressed at each QAPI training/in-service. (On-going) During quarterly QAPI Committee meetings, QAPI Committee wilreview Agency's QAPI Reports that show Agency's performance in terms ofobjectively measurable indicators, such as OASIS data. QAPI Committee will benchmark Agency's performanceagainst regional and national indicators in order to identify areas forimprovement. From this, QAPI Committee will select – one or more measures to beimproved and relevant data to collect to assess Agency's performance relativeto the chosen measures. QAPI Committee willthen develop a performance improvement plan to address the identifiedgoal. The Performance Improvement Planwill state the goal the agency intends to achieve and identify the specificperformance improvements that will be implemented to achieve this goal. QAPI Committee will present all of thisinformation to the Governing Body for	

	Administrator #2 provided a September 29, 2022 Board Meeting document that indicated but was not limited to, "The administrator reviewed recent QAPI information with the board. As part of the Plan of Correction, the RN consultant will share data with the administrator that will be tracked in the QAPI program. She will have this information for us in the next month." When queried about the data from the RN consultant, Administrator #2 could not provide data tracked or trended from the consultant. The October Board Meeting could not be held due to the funeral time for members of the board. When queried if there was an audit tool for QAPI data indicating how the POC would be tracked and trended, Administrator #2 did not provide a tool or baseline measurement data.		Governing Body approval, including alldata collection efforts. As performancegoals are achieved, new indicators will be assessed and new performanceimporvement plans will be implemented. QAPI Committee will devlop Performance Improvement Plans to addressperformance issues identified in the survey related to MD Orders, Plans of Carewithi Individualized Goals, Missed Visits, Frequency of Visits, SupervisoryVisits and Staff Signatures on documentation. Each Performance Improvement Plan will utilize objectively measurabledata, for example, percentage of MD oders signed within identified time frame,to measure effectiveness of Performance Improvement Program. The QAPI Committee members are the Administrator, Directorof Nursing, CEO, Consultant and individual representatives of each of theservices offered by the Agency (PT, OT, Speech, social work, home health aide,etc.). The DON will serve as therepresentative of the skilled nursing component of care.	

			Other staff may askedto participate as appropriate. Committee will meet at least quarterly in personor via video means (i.e. ZOOM). The Governing Body will receive quarterly updates on theQAPI program to include areas monitored, recommendations for discontinuingPerformance Improvement Plans that have achieved their purposes,recommendations for new Performance Improvement Plans, and the outcomes ofcurrent Performance Improvement Plans and recommendations regarding thesecurrent Performance Improvement Plans. Governing Body will review recommendationsof QAPI Committee and related data quarterly and determine if any new issuesneed to be addressed, if a current area can be removed and if they want to beinformed more often than quarterly. This will all be documented in theGoverning Body meeting minutes. --- --- ---	

			---------- Administrator/Consultant will create an QAPI audit tool thatwill identify, measure, analyze and track quality indicators that have beenapproved by the Governing Body. It will be capable of showing measurableimprovement in indicators that will improve health outcomes, client safety andquality of care. Expected date of completion 12-27-22. Administrator/Director of Nursing/Consultant will create anaudit tool that tracks issues cited in survey. There will be baselinemeasurement data. QAPI Committee will establish an objectively measurableperformance improvement goal. The Audittool will be utilized to gather objective data to allow performance to bemeasured against the stated goal. Expecteddate of completion 12-9-22. Administrator will review QAPI each month to ensure theaudit tool is completed. (On-going) The Administrator will be responsible for monitoring	

			thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

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
Michael Lucas	Administrator	1/7/2023 9:05:55 PM