	f OF HEALTH AND HU				FO	NTED: 04/27/2021 DRM APPROVED
STATEMEN	R MEDICARE & MEDIO IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLIE	SPITAL HOME HEALTH & HOSF	370 BI	ADDRESS, CITY, STATE, ZIP COD ELBY RD ENCEBURG, IN 47025	-	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
E 0000						
Bldg. 00	conducted by the I	eparedness Survey was ndiana State Department of nce with 42 CFR 484.102, for a sy.	E 0000			
	Survey dates: 2-1	0, 2-11, & 2-12-21				
	Facility: IN005272	2				
E 0024 Bldg. 00	441.184(b)(6), 48 483.73(b)(6), 484 485.68(b)(4), 485 491.12(b)(4), 494 Policies/Procedu [(b) Policies and must develop any preparedness point on the emergence (a) of this section paragraph (a)(1) communication p section. The poli be reviewed and years (annually for policies and proce following:] (6) [or (4), (5), or of volunteers in a emergency staffii process and role Federally designa professionals to a an emergency.	res-Volunteers and Staffing procedures. The [facilities] d implement emergency licies and procedures, based by plan set forth in paragraph n, risk assessment at of this section, and the blan at paragraph (c) of this icies and procedures must updated at least every 2 or LTC).] At a minimum, the redures must address the (7) as noted above] The use an emergency or other ng strategies, including the for integration of State and				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

procedures. (6) The use of volunteers in an

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 157055 B. WING 02/12/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 370 BIELBY RD DEARBORN COUNTY HOSPITAL HOME HEALTH & HOSPICE LAWRENCEBURG, IN 47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the agency E 0024 F024 03/12/2021 failed to ensure it had solicited volunteers for Immediate Action Implemented service during a disaster or emergency, to include to Correct Specific Deficiency their roles for integration with health care On March 8, 2021, Policy 33.33 professionals during the disaster/emergency for 1 **Emergency Management** of 1 home health agency disaster preparedness **Business Continuity Plan was** plan. updated to address the use of volunteers in an emergency, Findings included: including the process and role for integration of State and Federal Review of Agency's Emergency Preparedness designated health care plan, last reviewed on 12-30-2020, failed to professionals to address surge evidence the use of volunteers in their emergency needs during an emergency. preparedness plan. On March 8, 2021, the Emergency On 2-12-21 at 2:00 p.m., Alternate Administrator, Management Plan was updated to Employee B confirmed the lack of use of include the use of volunteers to volunteers in their Emergency Preparedness address surge needs during an program. emergency. At the time of survey exit on 2-12-21 at 2:51 p.m., Mandatory in-service for all staff when queried as to the lack of use of volunteers, regarding the use of volunteers in the Administrator provided nothing further. an emergency including the process and role for integration of State and Federal designated health care professionals to address surge needs during an emergency, was completed by the

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Event ID:

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 157055			COM	te survey ipleted 1 2/2021
	PROVIDER OR SUPPLIE	R SPITAL HOME HEALTH & HOS	:	STREET ADDRESS, CITY, STATE, 370 BIELBY RD LAWRENCEBURG, IN 470		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID PROVIDER'S PLAN (EACH CORRECTIVE AC CROSS-REFERENCED TC TAG DEFICIEN	TION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
G 0000 Bldg. 00	This visit was for a State Licensure su One (1) complaint with the recertifica	a Federal Recertification and a rvey of a home health agency. was investigated in conjunction ation survey. This survey was a extended on 2-10-21 at 4:25	G 000	Director of Clinica designee, on Marc Education provide following policy: Policy 33.33 Emer Management Bus Plan Staff unable to atte in-service was pro- educational packe education by Marc <u>New Process and Procedures to Em- Effectiveness of I Improvement and Compliance</u> Review/Revisions Emergency Mana- be completed ann necessary. This compliance p under the direct su Administrator with Governing Body.	ch 10, 2021. ed included the rgency iness Continuity end the ovided an et on the above ch 10, 2021. <u>A Monitoring</u> <u>Bsure</u> <u>Process</u> <u>A Continued</u> to the policy and gement Plan will ually and as	

	R MEDICARE & MEDIC			ONSTRUCTION		MB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	. (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COM	(X3) DATE SURVEY COMPLETED 02/12/2021	
		137 033				2/2021	
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP	COD		
		PITAL HOME HEALTH & HOSF		ELBY RD ENCEBURG, IN 47025			
DEANDC		I THAE HOME HEALTH & HOST				-	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY		DATE	
	findings	347254-Substantiated with					
	Survey dates: 2-10	, 2-11, & 2-12-21					
	Facility: IN005272						
	These deficiencies	reflect State Findings cited in					
		0 IAC 17. Refer to state form					
	for additional state	findings.					
	•	Iospital Home Health is					
	-	ducting a home health aide					
		ency evaluation program for a					
		beginning February 12, 2021					
		1, 2023 for being out of 84.100 Condition of					
		bliance with Federal, State, and					
		lations related to the health					
	-	its and §484.105 Condition of					
		nization and administration of					
	services.						
	Quality Review con	npleted on 3/5/2021 A4					
0848	484.100						
		Federal, State, Local Law					
Bldg. 00		cipation: Compliance with					
	Federal, State, ar						
	-	d to the health and safety of					
	patients.						
	The HHA and its	staff must operate and					
	furnish services ir	n compliance with all					
		, state, and local laws and					
		d to the health and safety of					
		r local law provides					
		, the HHA must be					
	licensed. Based on record rev	view and interview, the agency	C 0949	C949		06/01/2023	
	based on record rev	new and interview, the agency	G 0848	G848		06/01/2021	

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/12/2021	
NAME OF PROVIDER OR SUPPLIER DEARBORN COUNTY HOSPITAL HOME HEALTH & HOSP		370 B	T ADDRESS, CITY, STATE, ZIP COD IELBY RD RENCEBURG, IN 47025			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN BE PRIATE	(X5) COMPLETI DATE
	failed to disclose a and management (names and address of the new owning provide the names new owning corpo executive officer a Chairperson (see C Indiana license for G0860). The cumulative eff resulted in the age with the Condition Compliance with I	a change in Agency ownership (see G0850), failed to provide the ses of the managing employees (gentity (see G0856), failed to and business addresses of the oration including the chief and Governing Board G0858), and failed to obtain an the new owning entity (see fect of this systemic problem ncy being out of compliance a of Participation 42 CFR 484.100 Federal, State, and local laws and to the health and safety of		Immediate Action Implem to Correct Specific DeficieDearborn County Hospital Health & Hospice followed the change of ownership application previously subr and updated the applicatio additional information miss February 23, 2021 and Feb 25, 2021. This follow up ind the names and addresses managing employees of th owning entity as well as the names and business addre the new owning corporation including the chief executive officer, Governing Board Chairperson and overall m The agency continues to a work to deliver any further information required by ISE issue the change of owners approval.Dearborn County Hospital Health & Hospice submissi the license renewal occurred February 10, 2021. Licens renewal was received on N 17, 2021.The agency anticipates rec the change of ownership a by June 1, 2021, so that is completion date selected.New Process and Monitor Procedures to Ensure Effectiveness of Process	ency Home -up on nitted n with ing on oruary cluded of the e new e esses of n re anagers. ctively DH to ship Home ion of ed on ie March xeiving pproval the	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLIE	R R SPITAL HOME HEALTH & HOSI	370 BII	ADDRESS, CITY, STATE, ZIP COD ELBY RD ENCEBURG, IN 47025		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	E (X5) COMPLETION DATE	
				Improvement and Continued Compliance The agency will continue to wor with ISDH to deliver any further information required by ISDH to issue the change of ownership approval. The Administrator and the Governing Board will discuss o quarterly basis any anticipated changes of ownership or other changes requiring notice to ISE and report such changes. The Agency will submit any change ownership applications at least days in advance and include al necessary enclosures. The Administrator will monitor f receipt of the renewal request f ISDH starting in the month of October prior to expiration and confirm renewal is submitted timely for processing. This compliance process will be under the direct supervision of Administrator with oversight by Governing Body.	n a of 30 l or rom the	
G 0850 Bldg. 00	info. Standard: Disclo management info comply with the r subpart C, of this					
	Based on record re	view and interview, the sclose the change in	G 0850	G0850 Immediate Action Implemente to Correct Specific Deficiency		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER 157055	A. BUILDING B. WING	<u>00</u>	COMPLETED 02/12/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
		SPITAL HOME HEALTH & HOSP		ELBY RD ENCEBURG, IN 47025		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Findings included:			Dearborn County Hospital Hon	ne	
	-			Health & Hospice followed-up		
	1. Review of the	ASPEN database indicated the		the change of ownership		
	Indiana Departmen	nt of Health (IDOH) had		application previously submitte	ed	
	previously been in	formed Employee H was the		and updated the application wi		
		nate clinical supervisor and		additional information missing		
	Employee C was t	he alternate		February 23, 2021 and Februa		
		cal supervisor. The database		25, 2021. The agency continue	-	
	further indicated E	mployee H as a member/officer		actively work to deliver any fur		
	on the Governing	Body along with eight (8) other		information required by ISDH t		
	members with the	owner as Dearborn Home		issue the change of ownership		
	Health.			approval.		
		the IDOH received an		The agency anticipates receivi	ng	
		e in ownership (CHOW)		the change of ownership appro	oval	
		Other Entity A, effective		by June 1, 2021, so that is the		
		rn communication was sent to		completion date selected.		
	-	ted 11-9-2020, referring them to				
		gency website and specifically		New Process and Monitoring	-	
	-	follow the instructions		Procedures to Ensure		
	provided to compl	ete the CHOW.		Effectiveness of Process		
				Improvement and Continued		
		H had not received the Agency's		<u>Compliance</u>		
	-	plication which expired on		The agency will continue to wo		
	12-31-2020.			with ISDH to deliver any furthe		
	1.0.1.00.01			information required by ISDH t		
		OH attempted to contact licensed		issue the change of ownership		
	-	l number in Aspen Central		approval.		
		reached a switchboard in		The Administrator and the		
		ing self as Other Entity A, that		Governing Board will discuss of		
		th the number IDOH had listed.		quarterly basis any anticipated		
		was made to contact the		changes of ownership or other		
		ed in ACO with the phone being		changes requiring notice to ISI		
		Entity A (not reported to		and report such changes. The		
		ecific request to speak with the		Agency will submit any change		
		ed in ACO, Employee H.		ownership applications at least		
		ered the call and stated he was		days in advance and include a	11	
		ed with the home health agency		necessary enclosures.		
		vare the agency was actively		This compliance process will b		
	seeing patients wit	h a current patient census.	1	under the direct supervision of	ine	

DEFICIENCIES RRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	. ,		ONSTRUCTION	. ,	SURVEY
RRECTION	IDENTIFICATION NUMBER			00	(X3) DATE SURVEY COMPLETED	
	157055		VING	00		2/2021
	<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
DER OR SUPPLIE	R			ELBY RD		
COUNTY HOS	SPITAL HOME HEALTH & HOSP	ICE	LAWRE	ENCEBURG, IN 47025		
SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		COMPLET
	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	er stated he was unaware IDOH			Administrator with oversig	ht by the	
-	appropriate paperwork for the			Governing Body.		
supposed CHOW and expired license as of						
-	ting an email with this					
	the may forward to the new					
ners. IDOH not	iffied CMS.					
n 2-9-21, the A	ACO listed Administrator					
	ne IDOH and responded the					
	n Home Health were all					
olved as Other	Entity A purchased the					
	Entity A and another entity					
ed to purchase	the HHA (home health					
ncy). The liste	d Administrator confirmed					
reness of the A	gency still operating in					
ana.						
n entrance to A	Agency on 2-10-21 at 1:00 p.m.,					
	icense to operate a Home					
-	s not visible. When queried as					
	ocation, the Alternate					
-	ployee B, of the new Entity					
	ated: "Will look (as to					
tion)".						
2-10-21 at 1·17	p.m., when queried as to the					
	s license to operate in the					
	e Administrator, Employee A of					
	her Entity A) reported it was					
	as a change in ownership was					
•	fective 11-1-20 for said					
ency.						
2_10_21 at 3.18	p.m., the Administrator,					
m request unter						
				1		1
ed fol	the license a lowing copie request dated	yee A of the new Entity (Other Entity A) the license application was submitted with lowing copies provided: a) Other Entity A request dated 2-10-21 for \$250.00 to the 5 b) State form 48851, Renewal Application	the license application was submitted with lowing copies provided: a) Other Entity A	the license application was submitted with lowing copies provided: a) Other Entity A request dated 2-10-21 for \$250.00 to the	the license application was submitted with lowing copies provided: a) Other Entity A request dated 2-10-21 for \$250.00 to the	the license application was submitted with lowing copies provided: a) Other Entity A request dated 2-10-21 for \$250.00 to the

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	î î	UILDING	<u>00</u>		3) DATE SURVEY COMPLETED 02/12/2021	
	NAME OF PROVIDER OR SUPPLIER DEARBORN COUNTY HOSPITAL HOME HEALTH & HO			370 BIE	ADDRESS, CITY, STATE, ZIP (ELBY RD ENCEBURG, IN 47025	COD		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETI	
TAG		OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	12-31-2020 with t as the operating ag the new agency, O signed by the Adm Entity and dated 2 documents from th Investigation to O Employee B of Ott History Record Ch Entity A listing fo D, E & F; a one-pa listing seven (7) bo H, I, J, K, L, & M Administrator, Em two-page resume the Employee B of Ott organizational cha Other Entity A/La	e of license expiration of he agency name listed with IDOH gency in section I and name of other Entity A in section II, ninistrator, Employee A of Other -10-21; c) Two, one-page he Ohio Bureau of Criminal ther Entity B, with both for her Entity A, titled "Criminal neck"; a one-page document for ur (4) owners, Other Entity's C, age document for Entity A, oard members, Other Entity's G, ; a two-page resume for the aployee A of Other Entity A; a for the Alternate Administrator, her Entity A; a one-page rt, last revised 2-10-21, titled wrenceburg, IN/ Home Care with						
	On 2-11-21 at 11: Administrator of O (20) page docume Administrator of O agreement is in he provide services).' information contai page "Bill of Sale' the seller and Othe included signature 11-01-2020; a sev Transaction Agree 11-01-2020, listing the IDOH listed ag included signature document titled "I between IDOH list with an effective of	without individual names. 15 a.m., the Alternate Other Entity A, presented twenty nt and stated: "(Called by name) Other Entity A said the CMS re (agreement with CMS to ' This twenty-page packet of ined the following: a) a five (5) ' between IDOH listed agency as er Entity A as the buyer that is with effective date of en (7) page "Membership ement" with effective date of g acquisition of assets between gency and Other Entity A that is; and an eight (8) page interim Billing Agreement" ted agency and Other Entity A late of 11-01-2020 outlining and receipt of payment for said						

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUP AND PLAN OF CORRECTION IDENTIFICATION N 157055		(x2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLIE	R SPITAL HOME HEALTH & HOSP	370 BI	ADDRESS, CITY, STATE, ZIP COD ELBY RD ENCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION led signatures for both	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E (X5) COMPLETIO DATE	
G 0856 Bldg. 00	appropriately notifiad ministration/mar Ownership (CHOW renewal application At the time of surv when queried as to lack of a current ar home health agency information was pr 17-10-1(d) 484.100(a)(2) Officer, a director The name and act an officer, a director The name and act an officer, a director Agency failed to pr addresses of each i managing employee Agency license exp change in ownersh Findings included: 1. Review of the A Indiana Department previously been infiad administrator/altern Employee C was th administrator/clinie further indicated E	ey exit on 2-12-21 at 2:51 p.m., the above findings and the d active license to operate a y in Indiana, no further ovided. , agent, managing employee ldress of each person who is tor, an agent, or a managing HA as defined in §420.20I, 20.206 of this chapter. t review and interview, the rovide the names and ndividual serving as a e and/or officer prior to biration and at the time of a ip (CHOW) for 1 of 1 agency. ASPEN database indicated the t of Health (IDOH) had formed Employee H was the nate clinical supervisor and	G 0856	G0856 Immediate Action Implementer to Correct Specific Deficiency Dearborn County Hospital Horr Health & Hospice followed-up of the change of ownership application previously submitter and updated the application with additional information missing of February 23, 2021 and Februar 25, 2021. This follow up included the names and addresses of the managing employees of the ne owning entity as well as the names and business addresses the new owning corporation	/ ne on d th on ry ed ue w	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 157055 B. WING 02/12/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 370 BIELBY RD DEARBORN COUNTY HOSPITAL HOME HEALTH & HOSPICE LAWRENCEBURG, IN 47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE members with the owner as Dearborn Home including the chief executive Health. officer, Governing Board Chairperson and overall managers. 2. On 1-29-21, IDOH attempted to contact licensed The agency continues to actively entity via the listed number in Aspen Central work to deliver any further Office (ACO) and reached a switchboard in information required by ISDH to Kentucky identifying self as Other Entity A, that issue the change of ownership was unfamiliar with the number IDOH had listed. approval. A second attempt was made to contact the Administrator listed in ACO with the phone being The agency anticipates receiving answered as Other Entity A (not reported to the change of ownership approval IDOH) with the specific request to speak with the by June 1, 2021, so that is the Administrator listed in ACO, Employee H. completion date selected. Employee H answered the call and stated he was no longer associated with the home health New Process and Monitoring agency. Procedures to Ensure Effectiveness of Process 3. On 2-9-21, the ACO listed Administrator Improvement and Continued returned a call to the IDOH and responded the **Compliance** owners of Dearborn Home Health were all The agency will continue to work dissolved as Other Entity A purchased the with ISDH to deliver any further hospital and Other Entity A and another entity information required by ISDH to joined to purchase the HHA. The listed issue the change of ownership Administrator confirmed awareness of the approval. Agency still operating in Indiana. The Administrator and the Governing Board will discuss on a 4. During entrance conference on 2/10/21 at 1:17 quarterly basis any anticipated p.m., the Administrator, Employee A, indicated via changes of ownership or other phone she was indeed the current administrator, changes requiring notice to ISDH Employee B was the current Alternate and report such changes. The Administrator and Clinical Supervisor, and Agency will submit any change of Employee C was the current Alternate Clinical ownership applications at least 30 Supervisor. days in advance and include all necessary enclosures. 5. The agency failed to notify IDOH with changes This compliance process will be of the names and addresses of each individual under the direct supervision of the serving as managing employees. Administrator with oversight by the Governing Body. 17-10-1(d)(2)3SN111

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04/27/2021

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 157055 B. WING 02/12/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 370 BIELBY RD DEARBORN COUNTY HOSPITAL HOME HEALTH & HOSPICE LAWRENCEBURG. IN 47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE G 0858 484.100(a)(3) Responsible for the management of the HHA Bldg. 00 The name and business address of the corporation, association, or other company that is responsible for the management of the HHA, and the names and addresses of the chief executive officer and the chairperson of the board of directors of that corporation, association, or other company responsible for the management of the HHA. Based on document review and interview, the G 0858 G0858 06/01/2021 Agency failed to provide company management **Immediate Action Implemented** information that included the names and to Correct Specific Deficiency addresses of the chief executive officer, chairperson of the board of directors, and overall **Dearborn County Hospital Home** managers for 1 of 1 agency. Health & Hospice followed-up on the change of ownership Findings included: application previously submitted and updated the application with 1. Review of the ASPEN database indicated the additional information missing on Indiana Department of Health (IDOH) had February 23, 2021 and February previously been informed Employee H was the 25, 2021. This follow up included administrator/alternate clinical supervisor and the names and addresses of the Employee C was the alternate managing employees of the new administrator/clinical supervisor. The database owning entity as well as the further indicated Employee H as a member/officer names and business addresses of on the Governing Body along with eight (8) other the new owning corporation members with the owner as Dearborn Home including the chief executive Health. officer, Governing Board Chairperson and overall managers. 2. On 11-02-2020, the IDOH received an The agency continues to actively incomplete change in ownership (CHOW) work to deliver any further notification from Other Entity A, effective information required by ISDH to 11-01-2020. Return communication was sent to issue the change of ownership Other Entity A on 11-9-2020, referring them to the approval. home health agency website and specifically instructing them to follow the instructions The agency anticipates receiving provided to complete the CHOW. the change of ownership approval 3SN111 Event ID: Facility ID: IN005272 Page 12 of 39 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 157055	A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLI ORN COUNTY HO	^{ER} SPITAL HOME HEALTH & HOSPI	370 BI	address, city, state, zip cod ELBY RD ENCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
	 3. On 1-4-21, IDC license renewal ap 12-31-2020. 4. On 1-29-21, ID entity via the liste Office (ACO) and Kentucky identify was unfamiliar wi A second attempt Administrator list answered as Othe IDOH) with the sp Administrator list Employee H answ no longer associat and that he was av seeing patients wi Employee H furth was still awaiting supposed CHOW 12-31-2020 reque information so that owners. IDOH nd 5. On 2-9-21, the returned a call to owners of Dearbod dissolved as Othe hospital and Othe joined to purchase Administrator cor Agency's Indiana Health Agency wi to availability or I 	OH had not received the Agency's oplication which expired on OH attempted to contact licensed d number in Aspen Central I reached a switchboard in ring self as Other Entity A, that th the number IDOH had listed. was made to contact the ed in ACO with the phone being r Entity A (not reported to pecific request to speak with the ed in ACO, Employee H. vered the call and stated he was ted with the home health agency ware the agency was actively th a current patient census. er stated he was unaware IDOH appropriate paperwork for the and expired license as of sting an email with this at he may forward to the new otified CMS. ACO listed Administrator the IDOH and responded the rn Home Health were all r Entity A and another entity e the HHA. The listed afirmed awareness of the		by June 1, 2021, so that is the completion date selected. <u>New Process and Monitoring</u> <u>Procedures to Ensure</u> <u>Effectiveness of Process</u> <u>Improvement and Continued</u> <u>Compliance</u> The agency will continue to work with ISDH to deliver any further information required by ISDH to issue the change of ownership approval. The Administrator and the Governing Board will discuss on quarterly basis any anticipated changes of ownership or other changes requiring notice to ISDF and report such changes. The Agency will submit any change of ownership applications at least 3 days in advance and include all necessary enclosures. This compliance process will be under the direct supervision of th Administrator with oversight by th Governing Body.	a H Df 30	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 02/12/2021	
	NAME OF PROVIDER OR SUPPLIER DEARBORN COUNTY HOSPITAL HOME HEALTH & HOS			0 BIEL	DDRESS, CITY, STATE, ZIP CO .BY RD NCEBURG, IN 47025	DD		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA	IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLET DATE	
		ated: "Will look (as to						
	location of Agency state of Indiana, th the new Entity (Ot with the attorney's	⁷ p.m., when queried as to the ¹ 's license to operate in the e Administrator, Employee A of her Entity A) reported it was as a change in ownership was fective 11-1-20 for said						
	Employee A of the stated the license a the following copi check request date IDOH; b) State for for license to oper- identifying the dat 12-31-2020 with th as the operating ag the new agency, O signed by the Adm Entity and dated 2 documents from th Investigation to O Employee B of Ot History Record Ch Entity A listing for D, E & F; a one-pa listing seven (7) bo H, I, J, K, L, & M Administrator, Em- two-page resume f Employee B of Ot organizational cha Other Entity A/La	B p.m., the Administrator, e new Entity (Other Entity A) pplication was submitted with es provided: a) Other Entity A d 2-10-21 for \$250.00 to the m 48851, Renewal Application ate a Home Health Agency e of license expiration of the agency name listed with IDOH gency in section I and name of ther Entity A in section II, unistrator, Employee A of Other -10-21; c) Two, one-page te Ohio Bureau of Criminal ther Entity B, with both for ther Entity A, titled "Criminal ther Entity A, titled "Criminal teck"; a one-page document for ar (4) owners, Other Entity's C, age document for Entity A, board members, Other Entity's G, a two-page resume for the ployee A of Other Entity A; a for the Alternate Administrator, ther Entity A; a one-page rt, last revised 2-10-21, titled wrenceburg, IN/ Home Care with without individual names.						
	On 2-11-21 at 11:	5 a.m., the Alternate						

	R MEDICARE & MEDIC						OMB NO. 0938-03 (X3) DATE SURVEY	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CO		(X3) DA	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00		MPLETED	
		157055	B. W	B. WING		02/	12/2021	
NAME OF 1	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP	COD		
					LBY RD			
DEARBO	ORN COUNTY HOS	PITAL HOME HEALTH & HOS	PICE	LAWRE	NCEBURG, IN 47025			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETI	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Administrator of O	ther Entity A, presented twenty						
	(20) page documen	t and stated: "(Called by name)						
	Administrator of O	ther Entity A said the CMS						
	agreement is in her	e (agreement with CMS to						
	provide services)."	This twenty-page packet of						
		ed the following: a) a five (5)						
	page "Bill of Sale"							
	the seller and Other	Entity A as the buyer that						
	included signatures	with effective date of						
		n (7) page "Membership						
	-	nent" with effective date of						
		acquisition of assets between						
	-	ency and Other Entity A that						
	-	; and an eight (8) page						
		terim Billing Agreement"						
		ed agency and Other Entity A						
		te of 11-01-2020 outlining						
	-	nd receipt of payment for said						
		ed signatures for both						
	companies.							
	The Indiana Depart	ment of Health had not been						
	-	ed of these changes in						
		agement or of a Change of						
		<i>I</i>) in advance of the license						
	renewal application							
		· 0.10.01 (0.51						
		ey exit on 2-12-21 at 2:51 p.m., the above findings, the lack of						
		license to operate a home						
		diana, and the status of the						
		information was provided.						
		miormation was provided.						
	17-10-1(d)(4)							
0860	484.100(b)							
	Licensing							
Bldg. 00	(b) Standard: Lice	ensing.						
		ches, and all persons						
		s to patients must be						

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 157055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLIE	^R SPITAL HOME HEALTH & HOSPI	STREET ADDRESS, CITY, STATE, ZIP COD 370 BIELBY RD PICE LAWRENCEBURG, IN 47025			•	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	(X5) COMPLETION DATE
	licensed, certified applicable, in acc licensing authorit requirements. Based on observat interview, the Age active license to op the state of Indiana Findings included: On entrance to Ag Agency's Indiana I Health Agency wa to availability or lo Alternate Adminis Entity (Other Entit location)". On 2-10-21 at 1:17 location of Agency state of Indiana, th the new Entity (Ot with the attorney's being processed ef Agency. On 2-10-21 at 3:18 Employee A of the stated the license a the following copie check request date IDOH; b) State for for license to opera- identifying the dat 12-31-2020 with th as the operating ag the new agency, O signed by the Adm	I, or registered, as cordance with the state y as meeting those tion, record review and ncy failed to produce a current, berate a home health agency in a for 1 of 1 agency.	G 0		G860 Immediate Action Implement to Correct Specific Deficient Dearborn County Hospital H Health & Hospice submissio the license renewal occurrect February 10, 2021. License renewal was received on Ma 17, 2021. New Process and Monitorint Procedures to Ensure Effectiveness of Process Improvement and Continue Compliance The Administrator will monitor receipt of the renewal request ISDH starting in the month of October prior to expiration at confirm renewal is submitted timely for processing. This compliance process will under the direct supervision Administrator with oversight Governing Body.	ncy ome n of d on urch urch <u>ng</u> or for st from f nd l be of the	03/17/2021

ENTERS FO							
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		NSTRUCTION		TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> B. WING		00	COMPLETED	
		157055	B. WI	NG		02/	12/2021
NAME OF	PROVIDER OR SUPPLIEI	ξ			DDRESS, CITY, STATE, ZIP	COD	
				370 BIE			
DEARBO	JRN COUNTY HOS	PITAL HOME HEALTH & HOSP	ICE	LAWRE	NCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE E APPROPRIATE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		e Ohio Bureau of Criminal					
	-	her Entity B, with both for					
		er Entity A, titled "Criminal					
		eck"; a one-page document for					
		r (4) owners, Other Entity's C, ge document for Entity A,					
	-	ard members, Other Entity's G,					
	•	a two-page resume for the					
		ployee A of Other Entity A; a					
		or the Alternate Administrator,					
		er Entity A; a one-page					
		t, last revised 2-10-21, titled					
	-	vrenceburg, IN/ Home Care with					
	position titles and v	vithout individual names.					
	At the time of surv	ey exit on 2-12-21 at 2:51 p.m.,					
	the Administrator f	ailed to produce a current and					
	active home health	agency license and when					
	-	ck of a current and active					
	_	home health agency in					
	Indiana, no further	information was provided.					
	17-10-1(a)						
0940	484.105						
	-	administration of services					
Bldg. 00		cipation: Organization and					
	administration of						
		ganize, manage, and					
		ources to attain and					
		est practicable functional					
		g providing optimal care to and outcomes identified in					
	•	of care, for each patient's					
		and rehabilitative needs.					
		sure that administrative and					
		ons are not delegated to					
		r organization, and all					
		shed directly are monitored					
		ne HHA must set forth, in					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055		ILDING NG	<u>00</u>	(X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLIEF		105	370 BI	ADDRESS, CITY, STATE, ZIP COD ELBY RD		
(X4) ID		SPITAL HOME HEALTH & HOSP		ID	ENCEBURG, IN 47025 PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMP	LETI ATE
	lines of authority, Based on record rev governing body fail management and ov agency did not open failed to appoint a d written bylaws, and quality assurance an (QAPI) and fiscal a G0942), and failed approved the appoi Administrator (See The cumulative effor resulted in the agen with the Condition	rational structure, including and services furnished. view and interview, the led to report changes in wnership; failed to ensure the rate without an active license, qualified administrator, adopt l oversee the management, and performance improvement ffairs of the Agency (See to ensure the Governing Board ntment of an Agency G0946). ect of this systemic problem cy being out of compliance of Participation 484.105 dministration of services.	G 0	940	G0940 Immediate Action Implemented to Correct Specific Deficiency Dearborn County Hospital Home Health & Hospice followed-up on the change of ownership application previously submitted and updated the application with additional information missing on February 23, 2021 and February 25, 2021. This follow up included the names and addresses of the managing employees of the new owning entity as well as the names and business addresses of the new owning corporation including the chief executive officer, Governing Board Chairperson and overall manager The agency continues to actively work to deliver any further information required by ISDH to issue the change of ownership approval. Dearborn County Hospital Home Health & Hospice submission of the license renewal occurred on February 10, 2021. License renewal was received on March 17, 2021. The Governing Board formally appointed the Administrator and Back-up Administrator during the board meeting on March 11, 2021. The Governing Board also	s.	1/20

	F OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	·	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER 157055	A. BUILDING B. WING	<u>00</u>	COMPLETED 02/12/2021	
NAME OF PF	ROVIDER OR SUPPLII	ER		ADDRESS, CITY, STATE, ZIP COD		
		SPITAL HOME HEALTH & HOSP		ELBY RD ENCEBURG, IN 47025		
(X4) ID		Y STATEMENT OF DEFICIENCIE			(X5)	
PREFIX		ENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETI	
TAG	REGULATORY (DR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
				formally adopted the QAPI		
				Program, budget as well as		
				policies and procedures during	the	
				March 11, 2021 meeting.		
				The agency anticipates receivin	-	
				the change of ownership approv	val	
				by June 1, 2021, so that is the		
				completion date selected.		
				New Process and Monitoring		
				Procedures to Ensure		
				Effectiveness of Process		
				Improvement and Continued		
				<u>Compliance</u>		
				The agency will continue to wor		
				with ISDH to deliver any further		
				information required by ISDH to		
				issue the change of ownership		
				approval. The Administrator and the		
				Governing Board will discuss or		
				quarterly basis any anticipated		
				changes of ownership or other		
				changes requiring notice to ISD	н	
				and report such changes. The		
				Agency will submit any change	of	
				ownership applications at least		
				days in advance and include all		
				necessary enclosures.		
				The Board of Managers shall		
				monitor on a quarterly basis tha	it	
				the current administrator and		
				back-up administrator have bee	n	
				disclosed to CMS and ISDH. The Administrator will monitor for	or I	
				receipt of the renewal request fr		
				ISDH starting in the month of	SIT .	
				October prior to expiration and		
				confirm renewal is submitted		
				1	1	

	R MEDICARE & MEDI		-		OMB NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION 00	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	COMPLETED		
		157055	B. WING		02/12/2021	
NAME OF I	PROVIDER OR SUPPLII	R		I ADDRESS, CITY, STATE, ZIP COD		
				IELBY RD		
DEARBO	ORN COUNTY HO	SPITAL HOME HEALTH & HOSP	ICE LAWF	RENCEBURG, IN 47025		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY (OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				timely for processing.		
				This compliance process will b		
				under the direct supervision of		
				Administrator with oversight by	the	
				Governing Body.		
G 0942	484.105(a)					
	Governing body					
Bldg. 00	Standard: Gove	rning body.				
		y (or designated persons so				
		t assume full legal authority				
	and responsibilit	y for the agency's overall				
	management an	d operation, the provision of				
	all home health	services, fiscal operations,				
	review of the age	ency's budget and its				
	operational plans	s, and its quality assessment				
	and performance	e improvement program.				
	Based on record r	eview and interview, the	G 0942	G0942	06/01/202	
	governing body fa	iled to report changes in		Immediate Action Implemente	ed be	
	management and	ownership; failed to ensure the		to Correct Specific Deficiency	/	
		erate without an active license,				
	**	qualified administrator, adopt		Dearborn County Hospital Hon		
	-	d oversee the management,		Health & Hospice followed-up	on	
		and performance improvement		the change of ownership		
		affairs of the Agency for 1 of 1		application previously submitte		
	Agency.			and updated the application wi		
				additional information missing		
	Findings included	:		February 23, 2021 and Februa	-	
	1 Regarding Char	nge of Management &		25, 2021. This follow up include the names and addresses of the		
	Ownership	ige of Management &		managing employees of the ne		
	2p			owning entity as well as the		
	Review of the AS	PEN database indicated the		names and business addresse	sof	
		nt of Health (IDOH) had		the new owning corporation		
	-	formed Employee H was the		including the chief executive		
		ernate Nursing Supervisor and		officer, Governing Board		
	Employee C as the			Chairperson and overall manage	gers.	
		rsing Supervisor with Other		The agency continues to active	-	

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2021 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	onstruction (X3) DATE SURVEY COMPLETED
LID I LAN	OF CONNECTION	157055	B. WING	<u></u>	02/12/2021
	PROVIDER OR SUPPLIEF	PITAL HOME HEALTH & HOSP	370 BI	ADDRESS, CITY, STATE, ZIP COD ELBY RD ENCEBURG, IN 47025	
X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Entity's, N, O, P, Q	, R, S, T, U, V and Employee H		work to deliver any further	
	listed as the Goverr	ing Board members.		information required by ISDH to issue the change of ownership)
	On 11-02-2020, the	IDOH received an incomplete		approval.	
	change in ownershi	p (CHOW) notification from			
	Other Entity A, effective 11-01-2020. Return			Dearborn County Hospital Hom	e
	communication was	s sent to Other Entity A		Health & Hospice submission o	
	referring them to th	e home health agency website		the license renewal occurred or	
	and specifically ins	tructing them to follow the		February 10, 2021. License	
	instructions provide	ed to complete the CHOW.		renewal was received on March 17, 2021.	1
	On 1-4-21, IDOH h	ad not received the Agency's			
	license renewal app	lication which expired on		The Governing Board formally	
	12-31-2020 and had	l not received a completed		appointed the Administrator and	d
	CHOW application	- -		Back-up Administrator during th	
				board meeting on March 11,	
	On 1-29-21, IDOH	attempted to contact licensed		2021. The Governing Board al	so
	entity via the listed	number in Aspen Central		formally adopted the QAPI	
	Office (ACO) and r	eached a switchboard in		Program, budget as well as	
	Kentucky identifyin	ng self as Other Entity A, that		policies and procedures during	the
	was unfamiliar with	the number IDOH had listed.		March 11, 2021 meeting.	
	A second attempt w	vas made to contact the		The agency anticipates receivir	ng
	Administrator listed	l in ACO with the phone being		the change of ownership appro	val
		Entity A (not reported to		by June 1, 2021, so that is the	
	· ·	cific request to speak with the l in ACO, Employee H.		completion date selected.	
	Employee H answe	red the call and stated he was		New Process and Monitoring	
	no longer associate	d with the home health agency		Procedures to Ensure	
	and that he was awa	are the agency was actively		Effectiveness of Process	
	seeing patients with	a current patient census.		Improvement and Continued	
	Employee H further	r stated he was unaware IDOH		<u>Compliance</u>	
		ppropriate paperwork for the		The agency will continue to wo	'k
		nd expired license as of		with ISDH to deliver any further	
		ing an email with this		information required by ISDH to	
		he may forward to the new		issue the change of ownership	
	owners. IDOH not	ified CMS.		approval.	
				The Administrator and the	
		D listed Administrator returned		Governing Board will discuss of	na
		and responded the owners of		quarterly basis any anticipated	
	Dearborn Home He	alth were all dissolved as Other		changes of ownership or other	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

3SN111 Facility ID: **IN005272**

If continuation sheet Page 21 of 39

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/12/2021		
	PROVIDER OR SUPPLIE	R SPITAL HOME HEALTH & HOSPI	STREET ADDRESS, CITY, STATE, ZIP COD 370 BIELBY RD ICE LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY C Entity A purchase A and another entit The listed Admini the Agency still op On entrance to Ag Agency's Indiana Health Agency wa to availability or lo Administrator, Enr (Other Entity A) s location)".	-	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) changes requiring notice to ISE and report such changes. The Agency will submit any change ownership applications at least days in advance and include al necessary enclosures. The Board of Managers shall monitor on a quarterly basis that the current administrator and back-up administrator have be disclosed to CMS and ISDH. The Administrator will monitor receipt of the renewal request ISDH starting in the month of October prior to expiration and	DH of 30 I at en for from		
	stated the license a the following copi check request date IDOH; b) State for for license to oper identifying the dat 12-31-2020 with t as the operating ag the new agency, C signed by the Adm Entity and dated 2 documents from th Investigation to O Employee B of Ot History Record Ch Entity A listing fo D, E & F; a one-pa listing seven (7) b H, I, J, K, L, & M Administrator, Em two-page resume for Employee B of Ot organizational cha Other Entity A/La	On 2-10-21 at 3:18 p.m., the Administrator, Employee A of the new Entity (Other Entity A) stated the license application was submitted with the following copies provided: a) Other Entity A check request dated 2-10-21 for \$250.00 to the IDOH; b) State form 48851, Renewal Application for license to operate a Home Health Agency identifying the date of license expiration of 12-31-2020 with the agency name listed with IDOH as the operating agency in section I and name of the new agency, Other Entity A in section II, signed by the Administrator, Employee A of Other Entity and dated 2-10-21; c) Two, one-page documents from the Ohio Bureau of Criminal Investigation to Other Entity B, with both for Employee B of Other Entity A, titled "Criminal History Record Check"; a one-page document for Entity A listing four (4) owners, Other Entity's C, D, E & F; a one-page document for Entity A, listing seven (7) board members, Other Entity's G, H, I, J, K, L, & M; a two-page resume for the Administrator, Employee A of Other Entity A; a two-page resume for the Alternate Administrator, Employee B of Other Entity A; a one-page organizational chart, last revised 2-10-21, titled Other Entity A/Lawrenceburg, IN/ Home Care with position titles and without individual names.		confirm renewal is submitted timely for processing. This compliance process will b under the direct supervision of Administrator with oversight by Governing Body.	e the		

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	(X2) MULTIPLE A. BUILDING B. WING				
	PROVIDER OR SUPPLIE	BR SPITAL HOME HEALTH & HOSF	STREET ADDRESS, CITY, STATE, ZIP COD 370 BIELBY RD PICE LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETI DATE	
	Administrator of C (20) page docume Administrator of C agreement is in he provide services). ¹ information contai page "Bill of Sale" the seller and Othe included signature 11-01-2020; a sev Transaction Agree 11-01-2020, listin IDOH listed agend included signature document titled "I between IDOH lis with an effective of billing of services services that inclu companies. The Indiana Depar appropriately noti- administration/ma Change of Owners license renewal ap 2. Regarding Time Operating Withou On 1-4-21, IDOH license renewal ap 12-31-2020 and ha CHOW applicatio Refer to the docur	eliness of License Renewal and t an Active License had not received the Agency's plication which expired on ad not received a completed					

	R MEDICARE & MEDIC	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION						
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) D.	ATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	CC	OMPLETED	
		157055	B. WING			02	2/12/2021	
NAME OF	PROVIDER OR SUPPLIEI	2	S	REET AD	DRESS, CITY, STATE, ZIP CO	DD		
VAIVIL OF	I KO VIDEK OK SUTTEIE	~	3	70 BIEL	BY RD			
DEARB	ORN COUNTY HOS	PITAL HOME HEALTH & HOSF	PICE L	AWREN	ICEBURG, IN 47025			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	П)	PROVIDER'S PLAN OF CORF	RECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	OULD BE	COMPLET	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE	
	overseeing the man	agement and fiscal affairs of						
	the Agency.							
	On 2 10 21 at 1.17	p.m., copies of the Agency's						
		t, bylaws and governing board						
	U U	ested from the Agency						
	•	C !						
	Administrator, Emj	ployee A (Other Entity A).						
	On 2-10-21 at 4:28	p.m., the Alternate						
	Administrator, Emp	ployee B (Other Entity A)						
	presented a policy	from Other Entity F, titled						
	"Bylaws", last revis	sed 4-28-15 and a policy from						
	Other Entity E, title	ed "Administrative Control",						
	last revised 11-5-20). Request was made a second						
	time for a copy of t	he Agency's actual bylaws and						
		inutes from Employee B (Other						
	Entity A).							
	On 2-11-21 at 11.1	5 p.m., the Alternate						
		ployee B (Other Entity A)						
		document stating "(Called by						
		or [Other Entity A]) says this is						
		, will this work?" which						
	-	Other Entity A's Board of						
		nost current Board meeting date						
		ocation of WebEx meeting and d to evidence the content or						
		A request for minutes of the						
	Agency Governing	Board was made a third time.						
	On 2-12-21 at 10:2	5 a.m., the Alternate						
	Administrator, Em	ployee B (Other Entity A)						
		ge document with a						
		ating: "Board meeting minutes.						
		For Dearborn is March (2021)".						
		lated 9-15-2020 and failed to						
		ion of this agency, purchase of						
		e application, adoption of						
		PI, budget approval and/or						
		ninistrator/alternate						
	approvar of the duit							

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/12/2021		
	PROVIDER OR SUPPLIE	R SPITAL HOME HEALTH & HOSP	STREET ADDRESS, CITY, STATE, ZIP COD 370 BIELBY RD PICE LAWRENCEBURG, IN 47025				
(X4) ID PREFIX TAG	(EACH DEFICIE! REGULATORY O administrator for th		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETIO DATE		
G 0946 Bldg. 00	Administrator, Em presented an elever Agency's bylaws ti Other Entity F kno contained eleven A At the time of surv when queried as to lack of a current ar home health agenc management and fi QAPI and appointr Administrator/Mar information was pr 17-12-1(b) 484.105(b)(1)(i) Administrator app (i) Be appointed b governing body; Based on record re Agency failed to en approved the appoi Administrator for 1 Findings included: Review of the ASF Indiana Departmer previously been im Administrator/Nur Employee C as the Administrator/Nur Entity's, N, O, P, Q	agement, no further ovided. pointed by governing body by and report to the view and interview, the nsure the Governing Board intment of an Agency I of 1 Agency. PEN database indicated the tt of Health (IDOH) had formed Employee H was the rnate Nursing Supervisor and	G 0946	G0946 Immediate Action Implement to Correct Specific Deficienc The Governing Board formally appointed the Administrator ar Back-up Administrator during to board meeting on March 11, 2021. The Governing Board at formally adopted the QAPI Program, budget as well as policies and procedures during March 11, 2021 meeting. New Process and Monitoring Procedures to Ensure Effectiveness of Process.	y nd the also		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLIE	R PITAL HOME HEALTH & HOSP	370 BIE	ADDRESS, CITY, STATE, ZIP COD ELBY RD ENCEBURG, IN 47025		
	1				(1/5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
		ne Agency on 2-10-21 at 1:00		Improvement and Continued		
	-	now Other Entity A and with		Compliance		
		inagement and leadership as		The Board of Managers shall		
	reported by Other I			monitor on a quarterly basis that	t	
	Administrator, Em	ployee B.		the current administrator and		
				back-up administrator have been	n	
	On 2-11-21 at 11:1	5 p.m., the Alternate		disclosed to CMS and ISDH.		
		ployee B (Other Entity A)		This compliance process will be		
		document stating "(Called by		under the direct supervision of the		
		or [Other Entity A]) says this is		Administrator with oversight by t	he	
	-	, will this work?" which		Governing Body.		
		Other Entity A's Board of				
		nost current Board meeting date				
		ocation of WebEx meeting and				
	meeting minutes.	d to evidence the content or				
	On 2-12-21 at 10:2	5 a.m., the Alternate				
	Administrator, Emp	ployee B (Other Entity A)				
	presented a two-page	ge document with a				
	handwritten note st	ating: "Board meeting minutes.				
	-	For Dearborn is March (2021)".				
		lated 9-15-2020 and failed to				
		ion of this agency, purchase of				
		application, adoption of				
		API, budget approval and/or				
		ninistrator/alternate				
	administrator for th	us Agency.				
		ey exit on 2-12-21 at 2:51 p.m.,				
	-	the above findings and the				
		ng Board approval of an				
		rnate Administrator, no further				
	information was pr	ovided.				
	17-12-1(b)(1)					
0000						
Bldg. 00						

	R MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA	(Y) M		ONSTRUCTION	(X3) DATE	BNO. 0938-039
	OF CORRECTION	IDENTIFICATION NUMBER	· /	JILDING	<u>00</u>	COMPLETED 02/12/2021	
		157055	B. WI		<u></u>		
NAME OF	PROVIDER OR SUPPLIEF			STREET	ADDRESS, CITY, STATE, ZIP COD		
		` PITAL HOME HEALTH & HOSF	PICE		ELBY RD ENCEBURG, IN 47025		
	1						(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETIC
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	N 0	TAG	DETELLICET		DATE
	This visit was for a	State Licensure survey of a	IN U	000			
		7. One (1) complaint was					
		unction with the licensure					
	survey.	anotion with the needsure					
	2						
	Complaint #: IN00	347254-Substantiated with					
	findings						
	Survey dates: 2-10	, 2-11, & 2-12-21					
	Facility: IN005272						
0422	410 IAC 17-10-1(ר)					
Bldg. 00	Licensure	Except as provided in 410					
Diag. 00	IAC 17-11-5, each						
		of one (1) year; and					
		year from the date of					
	issuance.						
	The licensee shal	l notify the department in					
		days in advance of closing					
	or selling the hom						
		and record review, the	N 04	422	N0422		06/01/20
	Agency failed to no	tify the Indiana Department of			Immediate Action Implement	ed	
	Health (IDOH) in v	vriting, 30 days in advance of			to Correct Specific Deficienc		
		ne health agency for 1 of 1				-	
	agency.				Dearborn County Hospital Hor Health & Hospice followed-up		
	Findings included:				the change of ownership application previously submitte		
	On 11-02-2020. the	IDOH received an incomplete			and updated the application w		
		p (CHOW) notification from			additional information missing		
	-	ective 11-01-2020. Return			February 23, 2021 and Februa		
		s sent to Other Entity A on			25, 2021. This follow up includ	•	
		them to the home health			the names and addresses of the		
		specifically instructing them			managing employees of the ne		
		ctions provided to complete			owning entity as well as the		
	the CHOW.	• •			names and business addresse	es of	
					the new owning corporation		
			1		I VI		

ENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î î	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 157055	A. BU B. W	JILDING ING	00	COMPLETED 02/12/2021		
		107000	D. W.			02/12/	2021	
NAME OF I	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD ELBY RD			
DEARBO	ORN COUNTY HO	SPITAL HOME HEALTH & HOSF	PICE		ENCEBURG, IN 47025			
(X4) ID		Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		DR LSC IDENTIFYING INFORMATION 15 a.m., the Alternate		TAG	including the chief executive		DATE	
		Other Entity A, presented twenty			officer, Governing Board			
		nt and stated: "(Called by name)			Chairperson and overall mana	agers.		
		Other Entity A said the CMS			The agency continues to activ	-		
		pre (agreement with CMS to			work to deliver any further	oly		
	-	" This twenty-page packet of			information required by ISDH	to		
	information contained the following: a) a five (5) page "Bill of Sale" between IDOH listed agency as the seller and Other Entity A as the buyer that included signatures with effective date of 11-01-2020; a seven (7) page "Membership				issue the change of ownershi			
					approval.			
					``			
					The agency anticipates receiv	ring		
					the change of ownership appr	-		
	Transaction Agree	ement" with effective date of			by June 1, 2021, so that is the			
	11-01-2020, listin	g acquisition of assets between			completion date selected.			
	IDOH listed agend	cy and Other Entity A that						
	included signature	es; and an eight (8) page			New Process and Monitoring	1		
	document titled "I	nterim Billing Agreement"			Procedures to Ensure			
	between IDOH lis	ted agency and Other Entity A			Effectiveness of Process			
	with an effective of	late of 11-01-2020 outlining			Improvement and Continued	<u> </u>		
	billing of services	and receipt of payment for said			<u>Compliance</u>			
		ded signatures for both			The agency will continue to w	ork		
	companies.				with ISDH to deliver any furthe			
					information required by ISDH			
	-	rtment of Health had not been			issue the change of ownershi	C		
		fied of these changes in			approval.			
		nagement or of a Change of			The Administrator and the			
		W) in advance of the license			Governing Board will discuss			
	renewal application	on.			quarterly basis any anticipate			
					changes of ownership or othe			
		vey exit on 2-12-21 at 2:51 p.m.,			changes requiring notice to IS			
		the above findings and the			and report such changes. The			
		nd active license to operate a			Agency will submit any chang			
	•	cy in Indiana, no further			ownership applications at leas			
	information was p	provided.			days in advance and include a	all		
					necessary enclosures.			
					This compliance process will I			
					under the direct supervision o Administrator with oversight b			
					Governing Body.	yune		

State Form

Event ID: 3SN111 Facility ID: IN005272 If continuation sheet Page 28 of 39

	R MEDICARE & MEDI						at 10 t 10 t -	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER		JILDING	00	COMPL		
		157055	B. WI	NG		02/12/	2021	
NAME OF I	PROVIDER OR SUPPLIE	R		STREET	ADDRESS, CITY, STATE, ZIP COD			
					ELBY RD			
DEARBO	ORN COUNTY HOS	SPITAL HOME HEALTH & HOSF	PICE	LAWR	ENCEBURG, IN 47025			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
N 0424	410 IAC 17-10-1	(o)						
	Licensure							
Bldg. 00) Each license shall:						
		ly for the home health						
		the application; and						
		erred or assigned.						
		nment, lease, or other						
		y or involuntary, including						
		nat qualify as changes of						
	ownership, a new							
	shall obtain a lice							
	bafore maintainin							
	home health age	N 0424		N0424				
	Based on interview	N 04	424	N0424	-	06/01/202		
	Agency, Other Ent			Immediate Action Implement				
	from the Indiana E			to Correct Specific Deficienc	зy			
	before maintaining business as a home							
	Agency.			Dearborn County Hospital Hor Health & Hospice followed-up				
	Agency.				the change of ownership	UII		
	Findings included:				application previously submitte	be		
	T mangs mended.			and updated the application w				
	On 11-02-2020, th			additional information missing				
	change in ownersh			February 23, 2021 and Februa				
	Other Entity A, eff			25, 2021. This follow up includ	-			
		as sent to Other Entity A on			the names and addresses of t			
		ig them to the home health			managing employees of the ne			
		d specifically instructing them			owning entity as well as the			
	e .	actions provided to complete			names and business addresse	es of		
	the CHOW.	. 1			the new owning corporation	-		
					including the chief executive			
	On 1-4-21, IDOH	had not received the licensed			officer, Governing Board			
		enewal application which			Chairperson and overall mana	igers.		
	expired on 12-31-2				The agency continues to activ	-		
	-			work to deliver any further	-			
	On entrance to Ag	ency on 2-10-21 at 1:00 p.m.,			information required by ISDH	to		
	-	icense to operate a Home			issue the change of ownership			
		s not visible. When queried as			approval.			
		ocation, the Alternate						
	Administrator Em	ployee B, of the new Entity			Dearborn County Hospital Hor	m 0		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/27/2021 FORM APPROVED

STATEMEN AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER 157055		A. BUILDING B. WING	CONSTRUCTION X3	(X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLIE	^R SPITAL HOME HEALTH & HOSP	370 B	i address, city, state, zip cod IELBY RD RENCEBURG, IN 47025		
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		ated: "Will look (as to		Health & Hospice submission of		
	location)".			the license renewal occurred on		
				February 10, 2021. License		
		p.m., when queried as to the		renewal was received on March		
		y's license to operate in the		17, 2021.		
		e Administrator, Employee A of her Entity A) reported it was		The agency entirinates reasiving		
	• 、	as a change in ownership was		The agency anticipates receiving the change of ownership approva		
	-	fective 11-1-21 for said		by June 1, 2021, so that is the		
	Agency.			completion date selected.		
	0,0					
	On 2-10-21 at 3:18	p.m., the Administrator,		New Process and Monitoring		
		e new Entity (Other Entity A)		Procedures to Ensure		
		pplication was submitted with		Effectiveness of Process		
		es provided: a) Other Entity A		Improvement and Continued		
	-	d 2-10-21 for \$250.00 to the		<u>Compliance</u>		
		m 48851, Renewal Application		The agency will continue to work		
	-	ate a Home Health Agency e of license expiration of		with ISDH to deliver any further		
		ne agency name listed with IDOH		information required by ISDH to issue the change of ownership		
		ency in section I and name of		approval.		
		ther Entity A in section II,		The Administrator and the		
		inistrator, Employee A of Other		Governing Board will discuss on	a	
		-10-21; c) Two, one-page		quarterly basis any anticipated		
	documents from th	e Ohio Bureau of Criminal		changes of ownership or other		
	-	her Entity B, with both for		changes requiring notice to ISDH		
		her Entity A, titled "Criminal		and report such changes. The	_	
		eck"; a one-page document for		Agency will submit any change of		
		ur (4) owners, Other Entity's C,		ownership applications at least 30)	
	-	age document for Entity A, pard members, Other Entity's G,		days in advance and include all		
		a two-page resume for the		necessary enclosures. The Administrator will monitor for		
		ployee A of Other Entity A; a		receipt of the renewal request fro		
		or the Alternate Administrator,		ISDH starting in the month of		
		her Entity A; a one-page		October prior to expiration and		
		rt, last revised 2-10-21, titled		confirm renewal is submitted		
	Ũ	wrenceburg, IN/ Home Care with		timely for processing.		
		without individual names.				
				This compliance process will be		
	On 2-10-21 at 4:28	3 p.m., the Alternate		under the direct supervision of the	e	

	Γ OF HEALTH AND HU R MEDICARE & MEDIC						RM APPROVED IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A.B	UILDING	00	COMPLETED	
		157055	В. W	ING		02/12	/2021
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	< compared with the second sec		370 BIE	ELBY RD		
DEARBO	ORN COUNTY HOS	PITAL HOME HEALTH & HOSPI	CE	LAWRE	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Other Entity A, provided a			Administrator with oversight b	y the	
	-	acility Census form indicating			Governing Body.		
	-	dmissions since 11-1-2020 and					
	with a current censu	us of 90 patients.					
	$O_{2} 2 11 21 \text{ at } 11.1$	5 a.m. the Alternate					
		5 a.m., the Alternate ther Entity A, presented twenty					
		t and stated: "(Called by name)					
		ther Entity A said the CMS					
		e (agreement with CMS to					
	provide services)." This twenty-page packet of						
	information contained the following: a) a five (5)						
	page "Bill of Sale" between IDOH listed agency as						
	the seller and Other Entity A as the buyer that						
	included signatures	with effective date of					
	11-01-2020; a seve	n (7) page "Membership					
	Transaction Agreer	nent" with effective date of					
	11-01-2020, listing	acquisition of assets between					
		y and Other Entity A that					
	-	; and an eight (8) page					
		terim Billing Agreement"					
		ed agency and Other Entity A					
		ate of 11-01-2020 outlining					
		and receipt of payment for said					
		ed signatures for both					
	companies.						
	The Indiana Depart	ment of Health had not been					
		ed of these changes in					
		agement/operation of or of a					
		nip (CHOW) in advance of the					
	license renewal app						
		ey exit on 2-12-21 at 2:51 p.m.,					
	-	the above findings and the					
		d active license to operate a					
		y in Indiana, no further					
	information was pro	ovided.					
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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/12/2021 157055 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 370 BIELBY RD DEARBORN COUNTY HOSPITAL HOME HEALTH & HOSPICE LAWRENCEBURG, IN 47025 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE TAG N 0434 410 IAC 17-11-3 Renewal of home health licensure Bldg. 00 Rule 11 Sec. 3 An application for renewal of license shall be filed with the department at least sixty (60) days prior, but not sooner than ninety (90) days before, the expiration date of the current license. Based on document review and interview, the N 0434 N0434 03/17/2021 home health agency failed to ensure the renewal Immediate Action Implemented application for licensure was filed at least 60 days to Correct Specific Deficiency prior to the expiration of the Indiana home health license for 1 of 1 agency. Dearborn County Hospital Home Health & Hospice submission of Findings included: the license renewal occurred on February 10, 2021. License The Indiana State Department of Health did not renewal was received on March receive the renewal application by 12-31-2020 17.2021. when the agency's license expired. New Process and Monitoring On 1-29-21, IDOH attempted to contact licensed Procedures to Ensure entity via the listed number in Aspen Central Effectiveness of Process Office (ACO) and reached a switchboard in Improvement and Continued Kentucky identifying self as Other Entity A, that Compliance was unfamiliar with the number IDOH had listed. A second attempt was made to contact the The Administrator will monitor for Administrator listed in ACO with the phone being receipt of the renewal request from answered as Other Entity A (not reported to ISDH starting in the month of IDOH) with the specific request to speak with the October prior to expiration and Administrator listed in ACO, Employee H. confirm renewal is submitted Employee H answered the call and stated he was timely for processing. no longer associated with the home health agency and that he was aware the agency was actively This compliance process will be seeing patients with a current patient census. under the direct supervision of the Employee H further stated he was unaware IDOH Administrator with oversight by the was still awaiting appropriate paperwork for the Governing Body. supposed CHOW and expired license as of 12-31-2020. On 2-9-21, the ACO listed Administrator returned a call to the IDOH and responded the owners of Facility ID: IN005272 Event ID: 3SN111 Page 32 of 39 If continuation sheet State Form

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AND PLAN OF CORRECTION IDENTIFI		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLIE	^R SPITAL HOME HEALTH & HOSP	370 BIE	ADDRESS, CITY, STATE, ZIP C ELBY RD ENCEBURG, IN 47025	OD	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR		
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	Entity A purchased A and another entit The listed Adminis- the Agency still op On 2-10-21 at 3:18 Employee A of the stated the license at the following copic check request date IDOH; b) State for for license to opera- identifying the dat 12-31-2020 with th as the operating ag the new agency, O signed by the Adm Entity and dated 2 documents from th Investigation to Ot Employee B of Ot History Record Ch Entity A listing for D, E & F; a one-pa listing seven (7) bo H, I, J, K, L, & M; Administrator, Em- two-page resume f Employee B of Ot organizational cha Other Entity A/Lar position titles and The Indiana Depar appropriately notific changes in administration	B p.m., the Administrator, e new Entity (Other Entity A) application was submitted with es provided: a) Other Entity A d 2-10-21 for \$250.00 to the rm 48851, Renewal Application ate a Home Health Agency e of license expiration of the agency name listed with IDOH gency in section I and name of ther Entity A in section II, aninistrator, Employee A of Other -10-21; c) Two, one-page the Ohio Bureau of Criminal ther Entity A, titled "Criminal ther Entity A, a one-page tr, last revised 2-10-21, titled wrenceburg, IN/ Home Care with without individual names. therent of Health had not been fied 60 days in advance of these stration/management or of a ship (CHOW) and in advance of				

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157055		(X2) MULTIPLE (A. BUILDING B. WING	construction 00	X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLIE	^R SPITAL HOME HEALTH & HOSPI	370 B	f address, city, state, zip cod IELBY RD RENCEBURG, IN 47025		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLET DATE	
N 0458 Bldg. 00	when queried as to lack of a current at home health agence information was pre- 410 IAC 17-12-10 Home health agence administration/ma Rule 12 Sec. 1(f) employees shall policies. All emp Indiana shall be a certification, or re- perform the response records of emplo health services s shall include doc the job, including (1) Receipt of joc (2) Qualification (3) A copy of lim pursuant to IC 16 (4) A copy of cu- or registration. (5) Annual perfor Based on record re- failed to ensure pro- current and comple documentation that description for 7 (1)	(f) anagement Personnel practices for be supported by written loyees caring for patients in subject to Indiana licensure, egistration required to ective service. Personnel yees who deliver home hall be kept current and umentation of orientation to the following: b description. s. nited criminal history	N 0458	N0458 Immediate Action Implement to Correct Specific Deficience One-on-one education was provided to the Human Resou designee on keeping personn	rce	
	their employee reco of 7 employee reco evidence a perform recent annual appr	orientation to their position in ord for 3 (Employee A, C, & D) ords reviewed; failed to nance evaluation for the most aisal period for 6 (Employee A, 7 employee records reviewed for		records current and to include documentation of orientation including job description, qualifications, copy of limited criminal history and performar evaluation on March 12, 2021 the Administrator. Education included the followi	nce by	

STATEME	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE C	ONSTRUCTION	-	MB NO. 0938-039 E SURVEY
	NOF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		COMPLETED	
157055		B. WI	NG		02/1	2/2021	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					ELBY RD		
DEARB	ORN COUNTY HO	SPITAL HOME HEALTH & HOSP	ICE	LAWR	ENCEBURG, IN 47025		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
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TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Findings Included				policies:		
	1 Review of the	Administrator's, Employee A,			Policy 32.83 Employment Fi and Medical Record	les	
		ecord, failed to evidence the					
		ed and dated Administrator job			Policy 32.05 Job Description	15	
	description.	ed and dated Administrator job			Policy 32.88 Hiring Process	round	
	description.				Policy 32.61 Criminal Backg investigation Sanction-Scree		
	Review of the Alte			Process	sinny		
	Employee B, (Oth			Process Policy 32.02 Performance			
	evidence the prese			Management			
	Alternate Adminis			Policy 32.84 Licensure and			
	7 Hornate 7 fulling	autor job description.			Certification		
	Review of Registe	red Nurse's & Alternate Clinical			Policy 32.30 Orientation Per	iod	
	-	Supervisor, Employee C, (Other Entity A) record			Policy 33.129 Orientation for		
	failed to evidence the presence of a signed and				Direct Caregivers		
	dated registered nu						
	supervisor descrip	-			All Personnel records were		
					reviewed for the above		
	Review of Registe			documentation by the HR			
	Entity A) record fa	iled to evidence the presence of			designee on March 12, 202	1.	
	a signed and dated	registered nurse job					
	description.				Job descriptions for Employ	ees A,	
					B, C, D, E, F and G were sig	gned	
	-	red Nurse, Employee E, (Other			and dated by March 12, 202	1.	
		ailed to evidence the presence of					
	-	registered nurse job			The Administrator and the		
	description.				Back-up Administrator were		
					provided orientation by a		
	-	ll Therapist, Employee F, (Other			Governing Body Member an		
		ailed to evidence the presence of			Compliance Officer on Marc	h 11,	
	-	physical therapist job			2021.		
	description.				Education provided included	the	
	Davisour of C at C				following policies:		
		d Occupational Therapist , Employee G, (Other Entity A)			Policy 31.01A Administrative Control	;	
		idence the presence of a signed			• • • • • • • •	mont	
	and dated COTA j				Policy 31.05 Quality Improve		
		oo acsemption.			Performance Improvement P		
	2 Review of the	dministrator's, Employee A,			Policy 31.19 Compliance Ris	ъĸ	
		ecord failed to evidence			Assessment and Policy Development		
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CENTERS FOR MEDICARE & MEDICAID SERVICES

(X4) ID

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04/27/2021 PRINTED: FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/12/2021 157055 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 370 BIELBY RD DEARBORN COUNTY HOSPITAL HOME HEALTH & HOSPICE LAWRENCEBURG, IN 47025 SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE orientation to her Administrator's position. 484.105 Organization and Administration of Services Review of Registered Nurse and Alternate Clinical 410 IAC17-12-1 Home Health Agency Administration and Supervisor, Employee C's, (Other Entity A) record failed to evidence orientation to her registered Management nurse position and/or Alternate Clinical Administrator and the Back-up Supervisor position. Administrator reviewed and signed job description. Review of Registered Nurse's, Employee D, (Other Entity A) record failed to evidence orientation to Employee C was provided her registered nurse position. orientation to the Registered Nurse position and Alternate 4. Review of the following employee records from Clinical Supervisor position by the Other Entity A, failed to evidence the most current Director of Clinical Services on period performance evaluations signed, dated & March 12, 2021. timed by both the author and the following Education provided included the employees: Administrator, Employee A with hire following policies: date of 1-31-97; Alternate Administrator, Policy 33.08 Nursing Services Employee B, with date of hire of 1-3-12; Registered Policy 33.00 Admission for Care Nurse, Employee D with date of hire of 10-18-04; and Services Registered Nurse, Employee E, with date of hire Policy 33.16 Supervision of 9-29-08; Physical Therapist, Employee F, with date Paraprofessionals of hire of 8-21-19; & Certified Occupational Policy 33.33 Emergency Therapy Assistant, Employee F, with date of hire Management Business Continuity of 1-30-2020. Plan Policy 33.24 Plan of Care and 5. On 2/12/21 at 2:51 p.m., when queried for Physician Orders additional information regarding the above, the Review and signing of job Administrator was without comment & provided description. nothing further. Employee D was provided orientation to the Registered Nurse position by the Director of

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following policy:

description.

2021.

Clinical Services on March 12,

Education provided included the

Policy 33.08 Nursing Services Review and signing of job

	R MEDICARE & MEDI				OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157055		(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 02/12/2021	
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				Performance Evaluations for Employee A, B, D, E, F, and C were reviewed, signed, dated timed by the employees by M 12, 2021. Monitoring Procedures to Ensure Effectiveness of Pro- Improvement and Continued Compliance To ensure compliance with the above policies the Human Resource designee will audit new employee files for required documents, and monitor 5 employee files annually to val completed performance review This compliance process will funder the direct supervision of Administrator with oversight b Governing Body.	& arch <u>cess</u> <u>1</u> ne all ed idate ws. be f the
N 0529 Bldg. 00	report for each part (A) physician; (B) dentist; (C) chiropractor; (D) optometrist of (E) podiatrist; at least every two Based on record refailed to send a wr every 60 days to th (#1 & #6) clinical Findings included:	(2) A written summary atient shall be sent to the: or o (2) months. view and interview, the agency itten summary for each patient ie physician for 2 of 7 Patients records reviewed.	N 0529	N529 Immediate Action Implement to Correct Specific Deficience Mandatory in-service for all cl staff regarding the inclusion o 60 day summary and sending 60 day summary to the orderi physician, was completed by	c y inical f a I the ng

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 157055		(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 02/12/2021	
	PROVIDER OR SUPPLII ORN COUNTY HO	^{ER} SPITAL HOME HEALTH & HOSPI	370 BIE	.ddress, city, state, zip cod LBY RD NCEBURG, IN 47025	
DEARB((X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY OF Physician orders), At recertification patient's care and ordering physician Review of Patient start of care of 11- 1-5-21 through 3- pressure ulcer of t The clinical record of a 60-day summ of the plan of care Review of Patient start of care of 11- 11-5-2020 through neuromyelitis opti blood cells and an optic nerves and t attack the brain) a access device. Th evidence the inclu time of recertifica	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION , last revised 2-29-19, stated: " , a 60-day summary of the services are provided to the h" #1's clinical record evidenced a -6-2020, a certification period of 5-21, and a diagnosis of a he sacral (lower back) region. d failed to evidence the inclusion mary at the time of recertification e on 1-5-21. #6's clinical record evidenced a -5-2020, a certification period of h 1-3-21, and diagnosis of ica (disorder in which white tibodies primarily attack the he spinal cord but may also nd management of a vascular the clinical record failed to usion of a 60-day summary at the tion of the plan of care on 1-3-21. vey exit on 2-12-21 at 2:51 p.m., to the above findings and the ummary, the Administrator	ICE LAWRE ID PREFIX TAG	NCEBURG, IN 47025 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE/CED TO THE APPROPRIATE DEFICIENCY) Director of Clinical Services and designee, on March 3, 2021 and March 8, 2021. Education provided included the following policy: Policy 33.24 Plan of Care and Physician Orders Staff unable to attend the in-service was provided an educational packet on the above education on March 8, 2021. Patient #1 - 60 day summary for recertification dated January 5, 2021 to March 5, 2021 was send to the ordering physician on March 11, 2021. Patient #6 - 60 day summary for recertification dated January 7, 2021 to March 7, 2021 was send to the ordering physician on March 11, 2021. Patient #6 - 60 day summary for recertification dated January 7, 2021 to March 7, 2021 was send to the ordering physician on March 11, 2021. Monitoring Procedures to Ensure Effectiveness of Procest Improvement and Continued Compliance To ensure compliance with the above policy the Director of Clinical Services or designee w complete 5 patient chart review for 3 months, starting in March, ensure the physician was provide a 60 day summary. On-going monitoring will be completed as part of the quarterly quality improvement process to included clinical record reviews by Director of Clinical Services or designee	e e r t t r t r t r t r t r t r t r t r

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	EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 157055	È Í	JILDING	DNSTRUCTION 00	(X3) DATE COMPI 02/12	LETED
	PROVIDER OR SUPPLIEF	PITAL HOME HEALTH & HOSPIC	E	370 BIE	ADDRESS, CITY, STATE, ZIP COD ELBY RD ENCEBURG, IN 47025		
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					This compliance process w under the direct supervisior Administrator with oversigh Governing Body.	n of the	

Event ID: 3SN111 Facility ID: IN005272 If continuation sheet Page 39 of 39