STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	201081670A	A. BUILDING B. WING	06/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOBLE HOME HEALTH CARE LLC	2449 45TH STREET SUITE D, HIGHLAND, IN, 46322

(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
N0000	Initial Comments This visit was for a State Re-licensure survey. Facility ID: 012829 Survey Dates: 6/7/2022 - 6/14/2022	N0000		2022-07-14
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey. Facility ID: 012829 Survey Dates: 6/7/2022 - 6/14/2022 Noble Home Health Care LLC., is precluded	G0000		2022-07-14

	from providing its own home health aide training and competency evaluation for a period of two years from 6/14/2022 06/14/2024, due to being found out of compliance with Conditions of Participation 484.60 Care Planning, Coordination of Care and Quality of Care, 484.65 Quality Assessment and Performance Improvement, and 484.70 Infection Prevention and Control. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Quality Review Completed 06/29/2022			
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Facility ID: 012829 Survey dates: 6/7/2022, 6/8/2022, 6/9/2022, 6/10/2022, 6/13/2022, and 6/14/2022 At this Emergency Preparedness survey, Noble Home Health Care LLC., was found to not be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E0000		2022-07-14
E0001	Establishment of the Emergency Program (EP) 403.748,482.15,485.625 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360,	E0001	**E0001** 1. The comprehensive EmergencyPreparedness Plan will be updated to include an all-hazards risk assessmentbased on a	2022-07-14

	§491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on record review and interview, the home health agency failed: to develop and maintain an		facility-based and community-based risk assessment. 2. Strategies are being reviewedand updated for addressing all emergency events. 3. Agency is updating andimplementing individualized emergency preparedness plans for the patients. Theplan will provide appropriate instructions identified by the risk assessment. 4. Every month, the administrativestaff will review and update the patient's emergency contact information toaccurately reflect any changes. Quarterly the staff contact information will beupdated. This will be monitored quarterly by the administrator to ensurecompliance with condition 42 CFR484.102.	

	was updated and reviewed at least every 2 years (see tag E0004); develop and maintain a comprehensive emergency preparedness plan which included an all-hazards risk assessment based on a facility-based and community-based risk assessment; and failed to include strategies for addressing emergency events identified by the risk assessment (see tag E0006); to develop and implement individualized emergency preparedness plans for the patients which provided appropriate instructions, in the event of an emergency, to communicate with the agency (see tag E0017); to ensure the policies and procedures for emergency preparedness included procedures to inform state emergency preparedness officials of patients in need of evacuation based on the patient s medical/psychiatric condition and home environment (see tag E0019); to ensure a policy included a system for medical documentation that preserves patient information, protects patient confidentiality, and secures and maintains availability of records in the event of an emergency (see tag E0023); to ensure a policy included the use of volunteers or other emergency staffing in the event of an emergency (see tag E0024); to develop and maintain an emergency preparedness communication plan which included contact information for federal emergency preparedness staff (see tag E0031); to maintain documentation of all emergency preparedness training and failed to			

	demonstrate staff knowledge of emergency procedures (see tag E0037); and to conduct and document exercises to test the emergency plan annually (see tag E0039). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment and resulted in the agency being found out of compliance with the condition 42 CFR 484.102 Emergency preparedness.			
E0004	Develop EP Plan, Review and Update Annually 403.748(a),482.15(a),485.625(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal,	E0004	**E0004** 1. The emergency preparedness binder was reviewedand now includes a current All Hazard Risk Assessment and current information fromDistrict 1 Emergency preparedness meetings. 2. Binder will be updated monthly as needed,including any in-services and meeting minutes and employee contacts. 3. Included in QAPI program to be reviewed andupdated at least every two years. 4. Monthly, the Administrator, ordesignee, will attend the local emergency preparedness meeting and update thebinder with the most	2022-07-14

	State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . Based on record review and interview, the agency failed to develop and maintain an emergency preparedness plan which was updated and reviewed at least every 2 years. The findings include: Review of the agency s Emergency Preparedness Binder on 6/8/2022 evidenced the most recent all-hazards risk assessment was completed in 2018. Review failed to evidence any updates to the risk assessment since 2018. During an interview on 6/8/2022 at 2:06PM, when queried how the emergency preparedness plan was developed, administrator A stated, & the prior DON [director of nursing] was involved in all of that & when she left abruptly, she didn t pass that along &. At 2:07 PM, administrator A indicated the agency did not document any updates to the emergency preparedness plan. Administrator A indicated the risk assessment had not been updated since 2018.		current information discussed. The binder will be monitoredquarterly by the administrator.	

E0006	Plan Based on All Hazards Risk Assessment 403.748(a)(1)-(2),482.15(a)(1)-(2),485.625(a)(1)-(§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.	E0006	**E0006** 1. Agency updated the comprehensive emergencyplan which includes an all hazard risk assessment and strategies identified bythe risk assessment. 2. All clients' emergency contact informationhas been updated to include individualized emergency evacuation locations andspecific emergency procedures. 3. The agencyreviewed and updated the Emergency preparedness binder and now includes acurrent all Hazard Risk Assessment and current information from District 1Emergency preparedness meetings. 4. Quarterly theadministrator will review the emergency preparedness binder contents for anyupdates or amendments to the current strategies that are necessary dependent onthe risk assessments identified.	2022-07-14

	(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the agency failed to develop and maintain a comprehensive emergency preparedness plan which included an all-hazards risk assessment based on a facility-based and community-based risk assessment; and failed to include strategies for addressing emergency events identified by the risk assessment. The findings include: Record review on 6/8/2022 evidenced an			

	agency policy revised 6/7/2022, titled Disaster/Emergency Preparedness which stated, & This plan uses the term all hazard to address all types of incidents. An incident is an occurrence, caused either by humans or by a natural phenomenon, which requires or may require action by home care and emergency service personnel to prevent or minimize loss of life or damage to property and/or the environment & Specific measures will be made for anticipated emergencies typical or appropriate for the geographical area served &. Record review on 6/8/2022 evidenced a Hazard and Vulnerability Assessment Tool for Naturally Occurring Events dated 2018, which indicated a 50% risk of acts of intent, 57% risk of civil unrest, and 47% risk of external flood. Review failed to evidence a current all-hazards risk assessment. Review of the agency s Emergency Preparedness binder on 6/8/2022 failed to evidence strategies for addressing the risk for acts of intent, civil unrest, and external flood as identified by the risk assessment. The emergency preparedness binder failed to include any strategies for addressing specific risks. During an interview on 6/8/2022 at 2:07 PM, registered nurse B indicated the current risk assessment was not in the emergency preparedness binder, but they would put it there once they received the risk assessment. When queried what emergency strategies should be included in the emergency plan, registered nurse B stated, & it s based on what disasters have already occurred, and what is likely to occur & we go according to things that can happen here and how it s going to affect the patients in their home &. Administrator A indicated the strategies for addressing the risks should be included in the emergency preparedness plan.			

E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on observation, record review, and interview, the agency failed to ensure the individualized emergency preparedness plans for each patient included specific patient care information or evacuation locations for 7 of 7 clinical records reviewed. (#1, 2, 3, 4, 5, 6, 7) The findings include:	E0017	**E0017** 1. Pt. #1created specific emergency instructions and included evacuation location. Pt. #2 created specific emergency instructions and included evacuation location. Pt. #3 created specific emergencyinstructions and included evacuation location. Pt. #4 created specific emergencyinstructions and included evacuation location. Pt. #5 created specific emergencyinstructions and included evacuation location. Pt. #6 Discharged from agency prior to survey. Pt. #7 Discharged from agency prior to survey. 2. All currentclients' emergency contacts profiles have been updated with specific emergencyinstruction, Evacuation locations and risk/disaster/power codes. 3. In-serviceson emergency preparedness to all staff will ensure the deficient practice	2022-07-14

	1. Record review on 6/8/2022 evidenced an agency policy updated 6/7/2022, titled Disaster/Emergency Preparedness which stated, & On admission, the admitting nurse will assign each patient a priority code, dictating that patient s emergency rating. The admitting nurse will obtain a list of contact numbers, and discuss emergency planning options with the patient and family. All information will be kept in the patient s chart and shall be kept in paper as well as electronic format. At that time, each patient will be given a list of items to have prepared and available for use in the event of an emergency &. 2. Observation of a home visit for patient #1 was conducted on 6/8/2022 at 8:00 AM to observe a routine home health aide visit. During the visit, a home folder was reviewed which contained an emergency preparedness plan. This plan failed to indicate any specific emergency instructions/needs for patient #1 and failed to include an evacuation location. 3. Observation of a home visit for patient #2 was conducted on 6/9/2022 at 2:00 PM to observe a routine skilled nurse visit. During the visit, a home folder was reviewed which contained an emergency preparedness plan. This plan failed to indicate any specific emergency instructions/needs for patient #2 and failed to include an evacuation location. 4. Observation of a home visit for patient #3 was conducted on 6/10/2022 at 8:41 AM to observe a routine home health aide visit. During the visit, a home folder was reviewed which contained an emergency preparedness plan. This plan failed to indicate any specific emergency instructions/needs for patient #3 and failed to include an evacuation location.		patient'srecertification, the emergency preparedness plan will be updated and will becase managed by administrative staff. The emergency preparedness plan will beincluded in QAPI program to be reviewed and updated every two years. 4. Everymonth, the administrative staff will review and update the patient's emergencycontact information for specific emergency instructions/needs and to include anevacuation site. This will be monitored quarterly by the administrator.	

	5. Record review for patient #4 was completed on 6/13/2022. Review evidenced an emergency preparedness plan which failed to indicate any specific emergency instructions/needs for patient #4 and failed to include an evacuation location. 6. Record review for patient #5 was completed on 6/13/2022. Review evidenced an emergency preparedness plan which failed to indicate any specific emergency instructions/needs for patient #5 and failed to include an evacuation location. 7. Record review for patient #6 was completed on 6/13/2022. Review evidenced an emergency preparedness plan which failed to indicate any specific emergency instructions/needs for patient #6 and failed to include an evacuation location. 8. Record review for patient #7 was completed on 6/13/2022. Review evidenced an emergency preparedness plan which failed to indicate any specific emergency instructions/needs for patient #7 and failed to include an evacuation location. 9. During an interview on 6/8/2022 at 11:45 AM, administrator A identified the individualized emergency preparedness plans as the emergency preparedness/risk/triage paper located in patient s home folders. During an interview on 6/13/2022 at 11:46 AM, registered nurse B stated, when queried how the agency individualized each patient s emergency preparedness plan, & that s up to EMS [emergency medical services] and the hospitals where the patient goes & we use the triage codes assigned & we don t have specific evacuation locations for patient &.			

E0019	Homebound HHA/Hospice Inform EP Officials 484.102(b)(2) §418.113(b)(2), §460.84(b)(4), §484.102(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] *[For homebound Hospice at §418.113(b)(2), PACE at §460.84(b)(4), and HHAs at §484.102(b)(2):] The procedures to inform State and local emergency preparedness officials about [homebound Hospice, PACE or HHA] patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment. Based on record review and interview, the agency failed to ensure the policies and procedures for emergency preparedness included procedures to inform state emergency preparedness officials of patients in need of evacuation based on the patient s medical/psychiatric condition and home environment. The findings include: Record review on 6/8/2022 evidenced an agency policy updated 6/7/2022, titled & Disaster/Emergency Preparedness which stated, & Keep track of where the patient is going and all necessary telephone numbers, or contact the Emergency Supervisor for arrangements to be made through the county emergency planners for transportation to an	E0019	**E0019** 1. Emergency Preparedness Plan has been updatedto include procedures in accordance to state guidelines. 2. Review, update and distribute phone list toagency administrative staff that include contact numbers emergency preparednessofficials and patients in need of evacuation based on the patient'smedical/psychiatric condition. 3. Emergency Preparedness Plan has been updatedto include procedures to inform state emergency preparedness officials ofpatients in need of evacuation based on the patient's medical/psychiatriccondition. 4. Quarterly theadministrator will review the emergency preparedness binder contents for anyupdates or amendments to the current state officials contact information forevacuation.	2022-07-14

	alternate care facility if other arrangements cannot be made &. Record review failed to evidence the emergency preparedness policies/procedures included procedures to inform state officials of patient s need of evacuation. During an interview on 6/8/2022 at 2:25 PM, registered nurse B stated, when queried how the agency plans to notify officials if a patient needs evacuation, & If a patient needs to be evacuated, we need to call local services and have them evacuated from the home &. Registered nurse B and administrator A indicated they did not know if the agency was required to contact state officials for evacuation.			
E0023	Policies/Procedures for Medical Documentation 403.748(b)(5),482.15(b)(5),485.625(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:]	E0023	**E0023** 1. Emergency preparedness policy will be updatedfor medical documentation to include preservation of patient information. 2. Emergency preparedness policy will be updatedto include a system that will preserve patient information, protectconfidentiality, and secure and maintain the availability of medical records. 3. Emergency preparedness policies andprocedures will be updated every two years. If any state or local changesoccur, policies will be updated accordingly. Staff will be in-serviced accordingto	2022-07-14

	[(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. Based on record review and interview, the agency failed to ensure the emergency preparedness policies and procedures included a system of medical documentation that preserved patient information, protected confidentiality, and secured and maintained the availability of records. The findings include: Record review on 6/8/2022 evidenced an agency policy revised 6/7/2022 titled Disaster/Emergency Preparedness which failed to evidence a system for medical documentation which maintained confidentiality, preserved patient information, and maintained the availability of records. During an interview on 6/8/2022 at 2:32 PM, registered nurse B stated, when queried how the agency would document in an emergency situation, & we would document on paper and store it in a locked box & it s probably not		changes. 4. Quarterly theadministrator will monitor, review and update policies that evidence the system formedical documentation which maintains confidentiality, preserves patientinformation and maintains the availability of records.	

	in the policy, but we will get it added &.			
E0024	Policies/Procedures-Volunteers and Staffing 403.748(b)(6),482.15(b)(6),485.625(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or 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. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an 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	E0024	**E0024** 1. Emergency preparedness policy will beupdated to address emergency staffing for surge needs. 2. Emergency preparedness policy will beupdated to address emergency staffing for surge needs. 3. Staff will be in-serviced on plan toaddress surge needs. 4. Quarterly theadministrator will review and update policies to evidence the use of volunteersor other emergency staffing procedures and place in the emergency binder.	2022-07-14

	health care professionals to address surge needs during an emergency. Based on record review and interview, the agency failed to ensure the emergency preparedness plan policies included emergency staffing for addressing surge needs. The findings include: Record review on 6/8/2022 evidenced an agency policy updated 6/7/2022, titled Disaster/Emergency Preparedness which failed to include use of volunteers or other emergency staffing procedures. During an interview on 6/8/2022 at 2:34 PM, administrator A indicated the agency does not use volunteers. When queried how the agency would handle a surge of patients, administrator A stated, & depending on the staff we could go down on staffing, like a nurse could become an aide & we would use a triage system and use all available staff & we would communicate with the patient s and the family members to see if they can provide their own care or if we need, we could collaborate with another agency &. Administrator A indicated the emergency staffing was not addressed in the emergency preparedness policy.			
E0031	Emergency Officials Contact Information 403.748(c)(2),482.15(c)(2),485.625(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an	E0031	**E0031** 1. Update Emergency contact information toinclude Federal, State, regional, and local emergency preparedness staff. 2. Update Emergency contact information toinclude Federal, State, regional, and	2022-07-14

	emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on record review and interview, the agency failed to develop and maintain an emergency preparedness communication plan which included contact information for federal emergency preparedness staff. The findings include: Record review on 6/8/2022 evidenced an		staff. 3. Update Emergency contact information toinclude Federal, State, regional, and local emergency preparedness staff. AdministrativeStaff will be in-serviced on contacting procedures and updated information asit occurs. 4. Monthly, the Administrator, ordesignee, will attend the local emergency preparedness meeting and review andupdate the communication plan which includes the contact information forfederal emergency preparedness staff. The binder will be reviewedquarterly by the administrator.	

	to include contact information for federal emergency preparedness staff. During an interview on 6/8/2022 at 2:40 PM, registered nurse B stated, when queried if the communication plan includes contact information for federal emergency preparedness staff, & we don t contact FEMA [federal emergency management agency], we call local emergency preparedness officials, and they call the department of homeland security & we have FEMA s website in there [the emergency preparedness binder] &.			
E0037	EP Training Program 403.748(d)(1),482.15(d)(1),485.625(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures.	E0037	**E0037** 1. Emergency preparedness training programwill be updated to include training for staff through online classes and in-services. 2. Training will be documented throughsign-in sheets and electronic documentation to demonstrate staff knowledge ofemergency procedures. 3. Records will include EmergencyPreparedness training for the new hire staff process and annually for allstaff. 4. Monthly, the clinicaldirector will monitor all new hires for EPP training and assess the need forin-service for current staff. Quarterly the administrator will review	2022-07-14

	(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency		thistraining.	

	preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The			

	CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.			

	(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the agency failed to maintain documentation of all emergency preparedness training and failed to demonstrate staff knowledge of emergency procedures. The findings include: Record review on 6/8/2022 evidenced an agency policy updated 6/7/2022, titled Disaster/Emergency Preparedness which stated, & Employees will be oriented on the emergency plan during the new hire process and annually &. Record review on 6/9/2022 of employee records failed to evidence documentation of any staff emergency preparedness training. During an interview on 6/10/2022 at 2:00 PM, administrator A indicated the agency conducts emergency preparedness training for all staff but was not sure where it was documented or how frequently the training was conducted. Administrator A requested the documentation from the employee C. Surveyor requested staff emergency preparedness training on 6/10/2022 at 2:00 PM, and no further information was provided upon exit.			

E0039	EP Testing Requirements 403.748(d)(2),482.15(d)(2),485.625(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or	E0039	**E0039** 1. HHA will conduct Emergency PreparednessPlan exercise test with all staff at least annually. 2. Training will be documented throughsign-in sheets and electronic documentation to demonstrate staff knowledge ofemergency procedures. 3. Develop plans, but not limited to tabletop workshops, mock disasters, facility based-functional exercises. 4. Yearly the administrator will reviewthe EP testing requirement to ensure the facility participated, documented andanalyzed the agency's and staff's responses.	2022-07-14

	(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.			

	(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not			

	accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the			

	emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is			

	community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an			

	emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.			

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.

(ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed.

*[RNCHIs at §403.748]:

(d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following:

(i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.

Based on record review and interview, the agency failed to maintain documentation of all drills, tabletop exercises, and emergency events.

	The findings include: Record review on 6/8/2022 evidenced a document dated 11/14/2019, titled Funnel Vision Full Scale Exercise which indicated the agency participated in a full-scale emergency preparedness exercise in 2019. Record review on 6/8/2022 evidenced a Certificate of Participation for a 2021 Great Central U.S. ShakeOut Multi-State Earthquake Drill. Record review failed to evidence the agency participated in a full-scale emergency preparedness exercise every 2 years. Record review on 6/8/2022 failed to evidence the agency conducted an additional emergency preparedness exercise at least every 2 years, in the opposite year of the full-scale exercise. During an interview on 6/8/2022, at 2:53 PM, when queried if the agency conducted emergency preparedness exercises, administrator A indicated in 2020 the agency and staff participated in a phone tree drill. When queried about documentation of this drill, and specifics of the 2021 drill, administrator A stated, & We have a copy of the blank review form from the earthquake drill, all the staff participated if they were working during it & we don t have documentation of the calls or what happened and don t have documentation in the book of what happened during the earthquake drill or who was there &.			
G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment.	G0374	**G374** 2 100% of current patient's comprehensiveassessment was reviewed and updated for accurate referral dates, incontinencestatus, use of standardized fall risk tool,	2022-07-14

	Based on observation, record review, and interview, the agency failed to ensure the OASIS [outcome and assessment information set] accurately reflected patient s status at time of assessment in 5 of 7 clinical records reviewed. (#2, 3, 4, 6, 7) The findings include: 1. Record review on 6/14/2022 evidenced an agency policy updated 6/10/2021, titled Comprehensive Assessment of Patients [OASIS] which stated, & The OASIS [outcome and assessment information set] data collected must accurately reflect the patient s status at the time of the assessment &. 2. Clinical record review for patient #2 was completed on 6/13/2022, for certification period 4/14/2022 6/12/2022. Record review evidenced an OASIS start of care/comprehensive assessment dated 4/14/2022 which included a section titled [M0104] Date of Referral which was incomplete. This document contained a section titled [M1610] Urinary Incontinence or Urinary Catheter Presence: which indicated patient #2 was not incontinent due to a urinary catheter. This document contained a section titled [M1620] Bowel Incontinence Frequency which indicated patient very rarely or never had bowel incontinence. This document also included a fall risk assessment which stated, & Incontinence: & Yes &. The comprehensive assessment/OASIS start of care failed to accurately reflect the patient s incontinent status at time of assessment. This document contained a section titled [M1910] Has this patient had a multi-factor Fall Risk Assessment using a standardized, validated assessment tool? which stated, & No &. This document did have a standardized fall risk assessment tool which was completed, and rated patient at a score of 6, which indicated a risk for falling. This document failed to accurately reflect the assessment of fall risk completed on this patient. During an interview on 6/13/2022 at 12:09 PM,		accurate pain documentation, properOASIS transfer documentation that would have included the appropriate risk forhospitalization at time of assessment. 3 One on one in-service was provided forthe SN staff, as well as assigned OASIS training class to ensure the accuracyof the comprehensive assessment data collected at the time of the assessment. EachOASIS will be QA reviewed prior to export for this documentation. 4 The clinical manager will review 100%of comprehensive assessment for 4 weeks to ensure the accuracy of the datacollected. Once the 100% threshold is met, then 50% of all comprehensiveassessments will be reviewed quarterly. Once this 100% threshold foraccuracy is met, then 25% of all active patients clinical records will bereviewed quarterly to ensure this established threshold is maintained Every OASISwill have a QA review prior to being exported to ensure the 100% compliance.	

	care/comprehensive assessment section M0104 was incomplete, registered nurse B indicated it should have been completed, and was not sure how that section was skipped. When queried why the OASIS start of care/comprehensive assessment indicated a standardized fall assessment was not completed, administrator/clinical manager A indicated it was an error in charting. When queried why the OASIS start of care/comprehensive assessment indicated patient was not incontinent but the fall risk assessment indicated incontinence, administrator/clinical manager A indicated it was probably an error in charting. 3. Observation of a home visit for patient #3 was conducted on 6/10/2022 at 8:45 AM to observe a routine home health aide visit. The patient lived in city F. Patient #3 indicated the correct zip code was for city F. Clinical record review for patient #3 was completed on 6/13/2022 for certification period 4/13/2022 6/11/2022. Record review evidenced a start of care/comprehensive assessment dated 4/13/2022 which indicated the patient lived in city G. This document contained a section titled M0060 Patient ZIP code which indicated the patient s zip code was for city H. During an interview on 6/13/2022 at 12:40 PM, administrator/clinical manager A indicated the address and zip code on the comprehensive assessment was incorrect and would need to be corrected. 4. Clinical record review for patient #4 was completed on 6/13/2022 for certification period 4/22/2022 6/20/2022. Record review evidenced an OASIS recertification/comprehensive re-assessment dated 4/19/2022 which indicated patient had intermittent pain to lower extremities which medication improved. This document contained a section titled [M1242] Frequency of Pain Interfering with patient s activity or			

movement which stated, & 0 Patient has no pain &.

During an interview on 6/13/2022 at 3:01 PM, when queried if OASIS assessment of pain on recertification was accurate, administrator/clinical manager A indicated the nurse probably misinterpreted the question and thought it meant is the patient currently having any pain.

5. Clinical record review for patient #6 was completed on 6/13/2022 for certification period 10/10/2021 12/8/2021. Record review evidenced an OASIS transfer document dated 12/4/2021 which stated, & [M2016] Patient/Caregiver Drug Education Intervention: & NA Patient not taking any drugs &.

Record review evidenced a medication list dated 12/6/2021 which indicated the patient was taking the following medications: loperamide (for diarrhea), senna-docusate (for constipation), midodrine (for low blood pressure), albuterol (for wheezing), Apixaban (blood thinner), Keppra (for seizures), pregabalin (for nerve pain), trazadone (anti-psychotic/for sleep), and Auryxia (to lower phosphorus levels).

Record review evidenced an OASIS discharge document dated 12/6/2021, which stated, & [M2410] To which Inpatient Facility has the patient been admitted? & NA No inpatient facility admission & Comments: went into hospital &.

During an interview on 6/13/2022 at 3:54 PM, when queried why the OASIS transfer document stated patient was not taking any drugs, administrator/clinical manager A indicated it was not accurate and must have been an error. At 4:00 PM, when queried why the OASIS discharge document indicated the patient was not admitted to an inpatient facility, when he was admitted to the hospital,

	administrator/clinical manager A indicated it was a mistake on their part. 6. Clinical record review for patient #7 was completed on 6/13/2022 for certification period 1/22/2022 3/22/2022. Record review evidenced an OASIS recertification/comprehensive re-assessment dated 1/20/2022 which included a section titled [M1033] Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization [Mark all that apply] &. This document failed to mark the option which indicated the patient had a history of falls or reported exhaustion. Clinical record review evidenced a patient communication note dated 1/20/2022 which indicated the patient fell during the skilled nurse visit this day, and stated, & the patient has an increase in weakness & The patient stated he feels weak, not sleeping well at night &. During an interview on 6/13/2022 at 4:09 PM, when queried why the OASIS recertification did not include exhaustion or falling as risk factors for hospitalization, administrator/clinical manager A indicated they should have been included.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the agency failed to ensure the comprehensive assessment accurately reflected the patient s current health status in 4 of 7 clinical records reviewed. (#2, 4, 5, 6)	G0528	**G0528** 1. Patient #2 assessment of the catheter,including size, site assessment and type of device has been added. Patient no longer has wounds to lower legs. Patient #4 assessment of the catheter, including size, site assessment and typeof device	2022-07-14

	The findings include: 1. Record review on 6/14/2022 evidenced an agency policy updated 6/10/2021, titled Comprehensive Assessment of Patients [OASIS] which stated, & Components of a comprehensive assessment include & Head to Toe assessment & Integumentary status & Elimination status &. 2. Clinical record review for patient #2 was completed on 6/13/2022 for certification period 4/14/2022 6/12/2022. Record review evidenced a start of care/comprehensive assessment dated 4/14/2022, which indicated the patient had a urinary catheter but failed to specify if it was a suprapubic catheter (tube inserted directly into the bladder to drain urine) or Foley catheter (tube inserted into the urethra to drain urine). This document failed to include an assessment of the catheter, including size, site assessment, or type of device. This document indicated patient had 2 wounds to left and right lower legs but failed to include measurements or any site assessment including color, drainage, or odor. During an interview on 6/13/2022 at 12:10 PM, administrator/clinical manager A indicated a full catheter site assessment should include what type of catheter, size, color of urine, and amount of output. Administrator/clinical manager A indicated a full wound assessment included measurements, color, drainage, and if any odor was present. Administrator/clinical manager A indicated wounds should be measured every visit. 3. Clinical record review for patient #4 was completed on 6/13/2022, for certification period 5/13/2022 7/11/2022. Record review evidenced a recertification/comprehensive re-assessment dated 5/9/2022 which indicated the patient had a left heel wound. This document failed to include a wound assessment including wound type, measurement, color, or type of dressing applied. The comprehensive re-assessment		has been added. Patient nolonger has wounds to left heel. Patient #5 assessment of tracheostomy and peg tube, including size, dressing tobe applied, and skin condition has been added. Patient #6 - patient has been discharged prior to survey; however any patientwith a dialysis catheter, AV fistula or graph will have documentationidentifying access type and site of access. 2. Each currentpatient's comprehensive assessments were reviewed and updated to include size,location, site assessment and type of device used on all urinary catheters,tracheostomies, peg tubes and dialysis catheters. 3 One on one in-service was provided tothe SN staff, as well as assigned OASIS education, to ensure the accuracy ofthe comprehensive assessment documentation of all catheters and wounds at thetime of the assessment. Each OASIS will be QA reviewed prior to export for thisdocumentation.	

	failed to include an assessment of patient s suprapubic catheter (a tube inserted directly into the bladder to drain urine) site including size, insertion date, indication, site assessment, or dressing applied. During an interview on 6/13/2022 at 2:25 PM, when queried when wounds should be measured and documented on, administrator/clinical manager A indicated every visit wounds should be measured. Registered nurse B indicated wounds should be measured when dressing was changed, but did not include measurements for patient #4 s wound because it was less than a centimeter. When queried what wound documentation should include, registered nurse B indicated the type of dressing, drainage amount, odor, and color. At 2:27 PM, registered nurse B stated, when queried what type of sterile dressing was applied to patient #4 s left heel wound, & a sterile 2x2 gauze dressing. Why is it sterile, because that s me, he didn t order it &. At 2:35 PM, when queried what should be included in a full assessment of a suprapubic catheter, registered nurse B indicated it should include a site assessment, type of dressing applied, urine color and output. 4. Clinical record review for patient #5 was completed on 6/13/2022, for certification period 4/22/2022 6/20/2022. Record review evidenced a comprehensive re-assessment/recertification dated 4/22/2022, which indicated patient had a peg tube (tube inserted into stomach for feedings) and a tracheostomy (tube inserted into airway to assist with breathing), but failed to include a site assessment of tracheostomy or peg tube, including size, dressings to be applied, skin condition, or any other information. During an interview on 6/13/2022 at 3:05 PM, when queried what should be included on the comprehensive assessment regarding peg/tracheostomy, administrator/clinical manager A indicated it should have included type of dressing, if there was an inner cannula,		4 The clinical manager will review 100%of comprehensive assessments for 4 weeks to ensure the accuracy of the datacollected. Once 100% threshold is met, then 50% of all comprehensiveassessments will be reviewed quarterly. Once this 100% threshold foraccuracy is met, then 25% of all active patients clinical records will bereviewed quarterly to ensure this established threshold is maintained. EveryOASIS will have a QA review prior to being exported to ensure the 100%compliance.	

	sputum, size, and an assessment of the skin around the site. 5. Clinical record review for patient #6 was completed on 6/13/2022 for certification period 10/10/2021 12/8/2021. Record review evidenced a comprehensive re-assessment/recertification dated 10/6/2021, which included a wound graph which indicated patient had a dialysis catheter (central venous access site) to right chest. This same document indicated the patient had an arteriovenous graft/fistula site instead of a central venous catheter access site. This document failed to document any assessment of the dialysis access site, and failed to accurately reflect the specific type of dialysis access. During an interview on 6/13/2022 at 3:40 PM, when queried what a comprehensive assessment should include regarding dialysis access, administrator/clinical manager A indicated the assessment should have included the type of access, size, location, if the patient has a graft or a shunt, and the status of the dressing. Administrator/clinical manager A did not know if this patient had an arteriovenous graft/fistula or a central access dialysis catheter. 410 IAC 17-14-1(a)(1)(B)			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review and	G0536	**G0536** 1. Patient #1 – medication record has beencorrected to reflect the physician notification for duplicate therapy andinteractions. Patient #3 - - medication record has been corrected to address patient'snon-compliance with drug therapy.	2022-07-14

	interview, the home health agency failed to review all medications patients were taking to identify significant drug interactions, duplicative drug therapy, and/or noncompliance with drug therapy in 4 of 5 active clinical records reviewed. (#1, 3, 4, 5) The findings include: 1. Record review on 6/14/2022, evidenced an agency policy updated 6/10/2022, titled Medication Profile , which stated, & Nursing staff check all drug therapy a patient may be taking to identify & actual or potential interactions, side effects & duplicate drug therapy & and promptly report any problems to the physician &. 2. Record review on 6/14/2022, evidenced an agency policy updated 6/10/2022, titled Adverse Drug Reactions , which stated, & drug to drug reactions listed as potentially moderate or severe are reported to the prescribing physician prior to administration &. 3. Observation of a home visit for patient #1 was conducted on 6/8/2022, at 8:00 AM, to observe a routine home health aide (HHA) visit. During the visit, the patient s medication list was reviewed. The medication list included the following medications: Aspirin-Dipyridamole (medication to prevent platelets from sticking together), Aspirin (to prevent heart attack and stroke), Simvastatin (to lower cholesterol), Lisinopril (to lower blood pressure), hydralazine (to lower blood pressure), and metformin (to lower blood sugar).		Patient #4 - medication record has been corrected to remove a duplicatemedication order. Patient #5 – Physician notified of possible drug interactions. 2. All clients' medications have beenreviewed to identify significant drug interactions, duplicative drug therapy,and or non-compliance with drug therapy. 3. Skilled nurses have been in-serviced on identifyingpotential adverse effects and drug reactions, including ineffective drugtherapy, significant side effects, significant drug interactions, duplicatedrug therapy, and noncompliance with drug therapy. 4. The clinical directorwill review 100% of all medication profiles for 4 weeks to ensure thedocumentation of any medication interactions, drug duplication and patientscompliance with drug therapy. Once the 100% threshold is met, themedication profiles will be reviewed every 60 days.	

	Clinical record review for patient #1 was completed on 6/13/2022, for certification period 4/12/2022 6/10/2022. Record review evidenced a document titled Patient Medication Record dated and electronically signed on 6/7/2022, which stated, & Physician notified of severe medication interactions? & NA (no interactions) &. Review on 6/13/2022 of a web-based reference, https://www.drugs.com/interactions-check.php , evidenced evidenced duplicative drug therapy between aspirin and aspirin-dipyridamole. 4. Observation of a home visit for patient #3 was conducted on 6/10/2022, at 8:45 AM, to observe a routine home health aide visit. During the visit, the patient s medications were reviewed. Patient #3 indicated they were only taking Amaryl (to lower blood sugar) 2 times per week, instead of daily as ordered. Clinical record review for patient #3 was completed on 6/13/2022, for certification period 4/13/2022 6/11/2022. Record review evidenced a medication list dated 4/21/2022, which included the following medications: Baclofen (to treat muscle spasms), Amaryl (to lower blood sugar), Ibuprofen (for pain), and Clobetasol (steroid to decrease inflammation). This document stated, & All medications the patient is currently using have been reviewed for & noncompliance with drug therapy &. During an interview on 6/13/2022 at 1:00 PM, administrator/clinical manager A indicated the medication review should have address patient s noncompliance with Amaryl. 5. Clinical record review for patient #4 was completed on 6/13/2022, for certification period 5/13/2022 7/11/2022. Record review evidenced a medication list dated 5/8/2022,			

	Levaquin (antibiotic), doxycycline (antibiotic), emergenC (vitamin C), Oxybutynin (for bladder spasms), baclofen (muscle relaxer), Megestrol Acetate (to increase appetite), Klonopin (anti-anxiety), and Desitin (diaper rash cream). This document stated, & All medications the patient is currently using have been reviewed for & duplicate drug therapy &. This document included a duplicate order for Oxybutynin. During an interview on 6/13/2022 at 2:40 PM, when queried why Oxybutynin was included twice on the medication list, registered nurse B indicated it was accidentally entered twice and needs to be corrected. 6. Clinical record review for patient #5 was completed on 6/13/2022 for certification period 4/22/2022 6/20/2022. Record review evidenced a medication list dated 4/19/2022 which included but was not limited to the following medications: Potassium Chloride (electrolyte), Topamax (anti-seizures), and Robinul (to decrease respiratory secretions). This document stated, & Physician notified of severe medication interactions? & NA [No interactions] &. Review on 6/13/2022 of a web-based reference, https://www.drugs.com/interactions-check.php , evidenced 2 major drug-to-drug interactions between the following medications: potassium chloride and Robinul and Robinul and Topamax. 7. During an interview on 6/13/2022 at 10:55 AM, when queried why the medication reviews all say no interactions, registered nurse B stated, & when I put the meds [medications] in, it will tell me if there are any drug interactions & I don t notify the physician unless they have an adverse reaction or have new medications .... Administrator/clinical manager A indicated the medication review should identify the major drug-to-drug			

	non-compliance with drug therapy. 410 IAC 17-14-1(a)(1)(B)			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment included the patient s primary caregiver or other available supports including their willingness/ability to provide care and availability/schedules in 1 of 3 home visits conducted. (#2) The findings include: Record review on 6/14/2022 evidenced an agency policy updated 6/10/2021, titled Comprehensive Assessment of Patients [OASIS] which stated, & Components of a comprehensive assessment include, but is not limited to: & Identification of an emergency contact & Availability and capability of caregivers &. Observation of a home visit for patient #2 was conducted on 6/9/2022 at 2:00 PM to observe a routine skilled nurse visit. During the home visit, it was noted that the patient lived in a group home, and registered nurse B indicated the group home staff prepare all meals and assist patient with incontinent care or other needs.	G0538	G0538 1. Patient#2- Oasis has been updated to specify name, availability of the group homesupport. 2. All clients have been reviewed toinclude the names and availability of caregivers to provide care. 3. One on one in-service was provided to the SN staff,as well as assigned OASIS education, to ensure the accuracy of thecomprehensive assessment documentation to include the patient's primarycaregiver or other available supports including their willingness/ability toprovide care. Each OASIS will be QA reviewed prior to export for thisdocumentation. 4. The clinical director will review 100% of allcomprehensive assessments for 4 weeks to ensure the documentation of caregiversand other supports	2022-07-14

	Clinical record review for patient #2 was completed on 6/13/2022 for certification period 4/14/2022 6/12/2022. Record review evidenced a start of care/comprehensive assessment dated 4/14/2022, which failed to include available group home supports, including their willingness and ability to provide care and availability. This document indicated patient received assistance from family/friends for activities of daily living, psychosocial support, assistance with medical appointments, delivery of medications and management of finances, but failed to specify names, availability, or capability of these family/friends to assist. During an interview on 6/13/2022 at 12:09 PM, when queried who patient #2 s caregiver/emergency contact was, registered nurse B indicated the patient did not have an emergency contact but lived in the group home. Administrator/clinical manager A indicated the caregiver should be included on the comprehensive assessment.		are noted. Once the 100% threshold is met, the documentationof caregivers will be reviewed every 60 days.	
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on record review and interview, the agency failed to update and revise the comprehensive assessment due to a major decline in the patient's health status in for 2 of 2 patients who experienced a	G0544	**G0544** 1. Patient #4 - Oasis has been updated to includethe reassessment of an assessment of a new wound. Patient #6 - patient has been discharged prior to survey. 2. All patients have been review forevidence of a significant change in the patient's health status. A revised comprehensive assessment has beencompleted. 3. One on one in-servicewas provided to the SN staff, as well	2022-07-14

	decline in health status. (#4, 6) The findings include: 1. Record review on 6/14/2022 evidenced an agency policy updated 6/10/2021, titled Comprehensive Assessment of Patients [OASIS] which stated, & A comprehensive assessment incorporating the Outcomes and Assessment Information Set [OASIS] utilizing the most current approved version will be performed on qualified patients at: & When the patient s condition warrants due to major decline or major improvement & A follow-up OASIS assessment will also be used to collect information as frequently as the condition of the patient warrants due to an unexpected major decline or improvement in the patient s health status &. 2. Clinical record review for patient #4 was completed on 6/13/2022 for certification periods 3/14/2022 - 5/12/2022 and 5/13/2022 7/11/2022. Record review evidenced a recertification/comprehensive re-assessment completed 3/11/2022, which indicated patient did not have any wounds. Review of a skilled nurse visit dated 4/28/2022 indicated patient had developed a left heel wound. Record review evidenced a skilled nurse visit note dated 5/6/2022, which stated, & Dressing to left heel removed & Small amount of drainage noted & Wound decreasing in size & Wound was cleaned and sterile dressing applied &. Record review failed to accurately document when onset of left heel wound occurred. Record review failed to evidence the home health agency performed a comprehensive re-assessment of patient due to significant change in condition/development of new wound. During an interview on 6/13/2022 at 2:28 PM, when queried what the agency considers a significant change in condition, registered nurse B stated, & any change in vital signs, mental status, pain level & Any change in output or bowel movements &. When queried when the agency performs re-assessments,		as assigned OASIS education, to ensurethat if there is a major change in patients health status, a follow up OASIS,SCIC, is completed. Each OASIS will be QA reviewed prior to export forthis documentation. 4 The clinical director will review 100%of all comprehensive assessments for 4 weeks to ensure the proper documentationhas been completed. Once the 100% threshold is met, the documentation ofany changes in the patient health status will be reviewed every 60 days.	

	administrator/clinical manager A stated, & if there s a change in status & patient is hospitalized & we send a nurse out to do another comprehensive assessment &. Administrator/clinical manager A indicated a comprehensive re-assessment should have been completed for a patient who developed a new wound. 3. Clinical record review for patient #6 was completed on 6/13/2022 for certification period 10/10/2021 12/8/2021. Review of a comprehensive re-assessment/recertification dated 10/6/2021 indicated patient was alert and oriented, with a history of lung disease and high blood pressure, wore oxygen at 3 liters per minute at night, was on dialysis (artificial kidney filtration), and a 1500 milliliter fluid restriction. The blood pressure measurement on 10/6/2021 was 96/61, and the oxygen was 90% on room air. Clinical record review evidenced a skilled nurse visit note dated 11/23/2022 which indicated the patient s blood pressure was 169/118. This document stated, & Noted oxygen level at 77 % when oximeter first placed on finger & Instructed patient to put his oxygen on, 02 saturation increased to 85 90% with 02 on. Instructed patient to keep his oxygen on the rest of the day and check his saturation with his portable oxygen sensor. Oxygen in use at 3LPM [liters per minute] at night &. Record review evidenced patient was hospitalized on 12/4/2022 for hypervolemia (fluid overload), weakness, hypoxia (low oxygen saturation), and high blood pressure. Record review failed to evidence a comprehensive re-assessment was completed due to a change in condition. During an interview on 6/13/2022 at 3:50 PM, administrator/clinical manager A stated, & yes that was a status change & I would have the home health aide take vitals and send a nurse out to do a PRN [as needed visit] or another assessment &.			

	410 IAC 17-14-1(a)(1)(B)			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the agency failed to ensure the discharge summary included all information pertinent to patient s current course of illness and treatment, post-discharge goals of care and treatment preferences in 2 of 2 discharge records reviewed. (#6, 7) The findings include: 1. Record review on 6/14/2022 evidenced an agency policy updated 6/10/2021, titled Discharge/Transfer from Service which stated, & Upon transfer, the physician will receive via fax a transfer summary or discharge summary & containing at least the following: & diagnosis related to transfer & summary of care & care coordination & Discharge summary is written and in the chart. Include the patient s health status at discharge and a summary of activities for each discipline, which served the patient &. 2. Clinical record review for patient #6 was completed on 6/13/2022 for certification period 10/10/2021 12/8/2021, discharged 12/6/2021. Record review evidenced a comprehensive assessment dated 10/6/2021, which included the following diagnoses: hypertension (high blood pressure), end stage	G0564	**G0564** 1. Patient #6 - patient has been dischargedprior to survey. Patient #7 - patient has been discharged prior to survey. 2. All current pending discharged summaries havebeen reviewed to ensure they included all information pertinent to patient’s currentcourse of illness and treatment, post-discharge goals of care and treatment andsent to the receiving facility or healthcare practitioner. 3 One on one in-service was provided tothe SN staff, as well as assigned OASIS education, to ensure that if there is amajor change in patients health status, a follow up OASIS, SCIC, iscompleted. Each OASIS will be QA reviewed prior to export for thisdocumentation . 4 The clinical director will review 100%of all comprehensive assessments for 4 weeks to ensure the proper documentationhas been completed. Once the 100%	2022-07-14

	renal disease (kidney failure requiring artificial kidney filtration), and chronic obstructive pulmonary disease (a chronic lung disease which leads to low oxygen levels). This document indicated the patient used 3 liters of oxygen at night, received dialysis 3 times weekly, was on a 1500 milliliter fluid restriction, and was taking 5 or more medications. Clinical record review evidenced a discharge summary dated 12/6/2021 which failed to include any diagnoses, medical requirements such as dialysis requirements, nutritional information, oxygen use, or dialysis access type. This document failed to include any post-discharge goals of care or treatment preferences. During an interview on 6/13/2022 at 3:56 PM, administrator/clinical manager A indicated the discharge summary should have included information like oxygen use, dialysis access, nutritional requirements, and diagnoses. 3. Clinical record review for patient #7 was completed on 6/13/2022. Record review evidenced a plan of care for certification period 1/22/2022 3/22/2022 which indicated the patient had diagnoses of Parkinson s disease, dementia, falls, high blood pressure, weakness, and constipation. Record review evidenced a discharge summary dated 3/22/2022 which indicated the patient was discharged per patient/family request, but failed to include post-discharge goals of care, diagnoses, or treatment preferences. During an interview on 6/13/2022 at 3:55 PM, when queried what information should be included in a discharge summary, administrator/clinical manager A stated, & the reason for discharge & goals that were met & any necessary medical information and a medication list &.		threshold is met, the documentation ofany changes in the patient health status will be reviewed every 60 days.	

G0570	Care planning, coordination, quality of care 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 observation, record review and interview, the home health agency failed to ensure: they were able to meet the patient needs (see tag G0570); failed to ensure each patient received home health services written in their plan of care and the plan of care was individualized (see tag G0572); the plan of care contained all medications, diagnoses, type and frequency of services, measurable goals and outcomes, interventions to address underlying risk factors for hospitalization, medical equipment and patient-specific interventions and goals for their patients (see tag G0574); all orders were recorded in the plan of care (see tag G0576); services and treatments were administered only as ordered by a physician (see tag G0580); the home health agency staff promptly alerted the primary care physician to changes in the patient s condition (see tag G0590); and there was coordination of care amongst the different disciplines / entities that provided care to agency patients (see tag G0606).	G0570	**G0570** 1. Patient #3 –patient does not receive SNPT or OT from this agency. Referral has been updated to reflect Home HealthAide services only. 2. All referrals for service have beenreviewed to ensure that the agency is able to meet the patient’s needs. 3 One on one in-service was provided tothe SN staff to ensure that when accepting a patient referral, the agency isable to meet the patients needs that are ordered. If there are circumstancesthat prevent our agency from providing a service-such as the patient already isreceiving the referred service or we cannot provide the service requested, thismust be documented and communicated to the physician. 4 Administrator will review 100% ofreferrals for the ability of the agency to provide the services requested.	2022-07-14

The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care.

A standard citation was also evidenced at this level as follows:

Based on record review and interview, the agency failed to accept patients only on the expectation that the home health agency could meet the patient s rehabilitative and nursing needs in his or her place of residence in 1 of 3 home visits conducted. (#3)

The findings include:

Record review on 6/14/2022 evidenced an agency policy updated 6/10/2021, titled Admission Criteria which stated, & The agency must accept a client for home health services based on a reasonable expectation that the client s medical, nursing, and social needs can be met adequately in the client s residence &.

Clinical record review for patient #3 was completed on 6/13/2022 for certification period 4/13/2022 6/11/2022. Record review evidenced a face-to-face document dated 4/13/2022 which stated, & Provide a summary of clinical findings that support the patient s eligibility for home health services, including specific need for intermittent skilled nursing and/or therapy services & SN [skilled nurse] required to monitor vital signs, administer medications, and educated on disease process, fall/home safety, and importance of medications, side effects, and complications & PT/OT [physical therapy/occupational therapy] for assistance in improving strength, bed mobility, balance, transfer, and gait and to

	increase of motion and home safety training &. Record review failed to evidence the patient received skilled nursing interventions or physical or occupational therapy referral or treatment. Clinical record review evidenced a plan of care for certification period 4/13/2022 6/11/2022 which indicated patient was to receive skilled nursing supervisory visits every 30 days, home health aide visits 5 7 days per week and failed to evidence any physical or occupational therapy visits, and failed to evidence skilled nursing for education, vital sign monitoring or administration of medication was ordered. During an interview on 6/13/2022 at 12:34 PM, when queried if therapy services were provided to this patient, administrator/clinical manager A indicated the agency does not provide therapy services and was not aware of this therapy or skilled nursing referral order. Registered nurse B indicated the patient received skilled nursing from her physician s office for any skilled care. Registered nurse B and administrator/clinical manager A were unsure of the frequency or what interventions the physician s office skilled nurse provided to patient #3. Registered nurse B indicated she was unaware of patient #3 receiving any therapy services or which agency would provide those services. 410 IAC 17-13-1(a) 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(ii) 410 IAC 17-13-1(a)(1)(D)(iii) 410 IAC 17-13-1(a)(1)(D)(ix) 410 IAC 17-13-1(a)(1)(D)(x) 410 IAC 17-13-1(a)(1)(D)(xi)			

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 observation, record review, and interview, the agency failed to ensure patients received the home health services which were written in an individualized plan of care in 5 of 7 clinical records reviewed. (#1, 2, 4, 5, 6) The findings include: 1. Record review on 6/13/2022, evidenced an agency policy updated 6/10/2022, titled Care Planning which stated, & It is the policy of this Agency to provide individualized, planned, appropriate care, treatment, and/or service based on the patient s needs and goals & Care planning is performed to ensure that care and services are appropriate to each patient specific needs and problems &. 2. Observation of a home visit for patient #1 was conducted on 6/8/2022, at 8:00 AM, to observe a routine HHA (home health aide) visit. During the visit, the patient was observed several times coughing forcefully. Clinical record review for patient #1 was	G0572	G0572 1. Patient #1 –Plan of care hasbeen updated to include any precautions or interventions to prevent aspiration. Patient #2 - Received order for missed visit for week of 5/1/22. Patient #4 - Received a SN visit on 5/12/22 and documentation is complete. Patient #5 - SN was re-educated on notifying physician when vital signs areoutside of parameters Patient #6 - patient has been discharged prior to survey. SN wasre-educated on notifying physician when vital signs are outside of parameters. 2. All patients have beenreviewed to ensure each patient received home health services written in theirplan of care and the plan of care is individualized. 3 One on one in-service wasprovided to the SN staff to ensure that the patients received the home healthservices which were written in the plan of care and to document any missedvisits. Instructed to individualize the	2022-07-14

	period 4/12/2022 6/10/2022. Review evidenced a comprehensive assessment/recertification dated 4/8/2022, which stated, & Sometimes it is difficult for the patient to swallow, has aspirated food in the past due to stroke &. Clinical record review evidenced a plan of care for certification period 04/12/2022 6/10/2022 which failed to be individualized to include any precautions or interventions to prevent aspiration (food or liquid entering the airway instead of the stomach). During an interview on 6/13/2022, at 11:31 AM, when queried how patient #1 s plan of care should be individualized, administrator/clinical manager A indicated they did not know the patient had any problems swallowing or aspirating, but swallowing safety measures should be included in the plan of care. Registered nurse B indicated the plan of care should be individualized to include proper positioning for aspiration prevention, and any other safety measures. 3. Clinical record review for patient #2 was completed on 6/13/2022. Record review evidenced a plan of care for certification period 4/14/2022 6/12/2022, which indicated the patient was to receive a home health aide visit 6-7 days a week for assistance with activities of daily living. Record review evidenced patient #2 received only 5 home health aide visits the week of 5/1/2022. The home health agency failed to follow the physician signed plan of care.		plan of care to include risksassessments, interventions and safety measures and of need to notify physiciansof vital signs that are out of the ordered parameters. 4 Clinicalmanager will review 100% of Plans of Care for 4 weeks to ensure that thepatients are receiving the services ordered, include risk assessments,intervention and safety measures and of notification of physicians when needed.Once threshold of 100% is met, will continue to audit 25% of plan of caresquarterly	

	4. Clinical record review for patient #4 was completed on 6/13/2022, for certification period 5/13/2022 7/11/2022. Record review evidenced a plan of care dated 5/9/2022, which indicated a frequency of skilled nurse visits of every other day for 3 hours. Record review failed to evidence patient #4 received a skilled nurse visit on 5/12/2022, which would have been every other day. During an interview on 6/13/2022 at 12:03 PM, when queried how the agency met patient needs if the patients didn t receive all visits as ordered, administrator/clinical manager A stated, & I try to always put an order in & but we were short hours in May &. 5. Clinical record review for patient #5 was completed on 6/13/2022, for certification period 4/22/2022 6/20/2022. Record review evidenced a plan of care dated 4/19/2022, which stated, & Notify physician of: Systolic BP [blood pressure] greater than 160 & Diastolic BP [blood pressure] greater than 90 &. Clinical record review evidenced a nursing flow sheet shift assessment dated 5/26/2022, which indicated the patients blood pressure at 4:00 PM, was 162/101, and at 10:00 PM, was 157/101. This document stated, & Concerns about elevate BP at MD [doctor] visit. BP remains elevated at this time. No distress noted from elevated BP &. Record review failed to evidence the clinician notified the physician as ordered on the plan of care for blood pressure outside of parameters. During an interview on 6/13/2022 at 3:21 PM, when queried why the physician wasn t notified of the elevated blood pressure as ordered on the plan of care, administrator/clinical manager B stated, & my thought on that is [person E {family member}] was the boss and probably took care of that & but the nurse should have notified the physician &.			

	6. Clinical record review for patient #6 was completed on 6/13/2022. Record review evidenced a plan of care for certification period 10/10/2021 12/8/2021, which stated, & Notify physician of: & systolic BP [blood pressure] greater than 160 & diastolic BP greater than 90 & Report to physician o2 saturation less than 85% &. Clinical record review evidenced a skilled nurse visit note dated 11/23/2022, which indicated the patient s blood pressure was 169/118. This document stated, & Noted oxygen level at 77 % when oximeter first placed on finger & Instructed patient to put his oxygen on, 02 saturation increased to 85 90% with 02 on. Instructed patient to keep his oxygen on the rest of the day and check his saturation with his portable oxygen sensor. Oxygen in use at 3LPM [liters per minute] at night &. Record review failed to evidence the physician was notified of the patient s abnormal vital signs as ordered on the plan of care. During an interview on 6/13/2022 at 3:50 PM, administrator/clinical manager A indicated the nurse should have followed up on the low oxygen and elevated blood pressure and called the physician per the plan of care. Administrator/clinical manager A indicated patient was non-compliant and missed dialysis sometimes. 410 IAC 17-13-1(a)			
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;	G0574	**G0574** 1. Patient #1 – the plan of care was updatedto include Tylenol to the medication list, prostate cancer and high cholesterolto the diagnosis and the frequency of physical	2022-07-14

	(ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the agency failed to ensure the plan of care included all medications, diagnoses, type and frequency of services, measurable goals and outcomes, interventions to address underlying risk factors for hospitalization, medical equipment and patient-specific interventions and goals for their patients in 7 of 7 clinical records reviewed. (#1, 2, 3, 4, 5, 6, 7) The findings include: 1. Record review on 6/13/2022 evidenced an agency policy updated 6/10/2022, titled Care		therapy visits. Patient #2 – The plan of care was updated to include additional DMEs,medications, patient specific interventions and goals, risk for falls,diagnosis of heart failure, chronic kidney disease, edema, and care related toan indwelling urinary catheter. Patient #3- The plan of care was updated to be individualized to include patientspecific interventions and goals and to include Eloquis. Patient #4 - The plan of care was updated to include all current medications,diagnosis of depression. Patient #5 - The plan of care was updated to include rate of tube feeding,flush frequency and amount. Medicationprofile updated to include indication, frequency, and location of PRNmedication. Hoyer lift was added to theplan of care. Patient #6 – patient has been discharged prior to survey. Patient #7 – patient has been discharged prior to survey. 2. All patients plan of care	

	developed in accordance with the referring physician s orders, may include, but not limited to: & Principle diagnosis and other pertinent diagnoses & Medications: dose/frequency/route & Orders for therapy services, include specific procedures and modalities to be used & safety measures & Problems/needs, interventions, treatments/orders, instructions, if any, to patient/patient representative and/or family &. 2. Observation of a home visit for patient #1 was conducted on 6/8/2022, at 8:00 AM, to observe a routine HHA (home health aide) visit. During the visit, person A (family member) indicated the patient had diagnoses of prostate cancer, diabetes, and arthritis. Person A indicated they check patient #1 s blood sugar at least 1 time per day, and indicated the patient sees a urinary specialist for the prostate cancer. Patient #1 indicated he was getting physical therapy, but the last physical therapy visit was 5/1/2022. Clinical record review for patient #1 was completed on 6/13/2022, for certification period 4/12/2022 6/10/2022. Review evidenced a comprehensive assessment/recertification dated 4/8/2022, which indicated patient was taking Tylenol for arthritis pain to his lower back. Clinical record review on 6/13/2022, evidenced a face to face document dated 3/2/2022, which listed diagnoses of diabetes (problem regulating blood sugar), prostate cancer, and high cholesterol. Clinical record review evidenced a plan of care for certification period 04/12/2022 6/10/2022, which failed to evidence Tylenol in the medication list. This document stated, & Patient s mobility will be improved with assistance of physical therapist &. The plan of care failed to include frequency or duration of physical therapy visits, or any therapy		have beenreviewed to ensure plan of care, contained all medications, diagnoses, type andfrequency of services, measurable goals and outcomes, interventions to addressunderlying risk factors for hospitalization, medical equipment andpatient-specific interventions and goals for their patients. 3 One on one in-service was provided tothe SN staff to ensure that the patient's plan of care is individualized toinclude all current medication, diagnoses, type and frequency of services,measurable goals and outcome, interventions to address underlying risk factorsfor hospitalization, medical equipment and patient specific interventions andgoals for their patients. Educated to ensure that any other agency thatmight be providing services should be documented along with the frequencies andduration of treatment that is being rendered. 4 Clinical manager will review 100% ofPlans of Care for 4 weeks to ensure that the patient's plan care isindividualized. Once threshold	

	a physical therapy plan of care. This document failed to include pertinent diagnoses of prostate cancer, arthritis, diabetes, and high cholesterol. During an interview on 6/13/2022 at 11:05 AM, when queried why the plan of care did not include diagnosis of arthritis, prostate cancer, high cholesterol, or diabetes, registered nurse B indicated they were not aware patient had a diagnosis of prostate cancer. Administrator/clinical manager A indicated they use the history and physical to add diagnoses to the plan of care, and all pertinent diagnosis should be added to the plan of care. At 11:08 AM, registered nurse B indicated she was not sure how frequently physical therapy was seeing patient #1, or when his last therapy session was. Administrator/clinical manager A indicated the plan of care should include the agency providing therapy services along with the frequency and duration of treatments, and a copy of the therapy care plan. At 1:05 PM, administrator/clinical manager A indicated the plan of care should include all medications the patient was taking. 3. Observation of a home visit for patient #2 was conducted on 6/9/2022 at 2:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to have a grabber, cane, and a trapeze bar (a bar the patient uses to assist with positioning in bed). The following medication bottles were observed, but not limited to: diazepam (anti-anxiety medicine) 5mg (milligrams) orally daily as needed for dizziness (prescription dated 5/17/2022), and doxazosin (medicine for high blood pressure) mesylate 1mg orally twice a day (prescription dated 5/25/2022). Patient #2 indicated he was taking Tylenol for aching pain to his knee and feet. Clinical record review for patient #2 was completed on 6/13/2022, for certification period 4/14/2022 6/12/2022. Record review evidenced a start of care/comprehensive assessment dated 4/14/2022, which included but was not limited to the following diagnoses:		of 100% is met, will continue to audit 25% ofplan of cares quarterly.	

heart failure, chronic kidney disease, urinary incontinence, and cerebral infarction (lack of blood flow to the brain/stroke). This document indicated the patient had a wound to his right leg and left leg. This document indicated the patient was a risk for falling and had 3 + pitting edema (swelling which when pressed, demonstrates an indentation in the skin of 5 6 millimeters, which lasts for 60 seconds) to bilateral lower extremities. This document indicated the patient had an indwelling urinary catheter (tube inserted in urethra which allows urine to drain).

Clinical record review evidenced a plan of care for certification period 4/14/2022 6/12/2022, which failed to be individualized to include any patient-specific interventions and/or goals addressing risk for falls, diagnoses of heart failure, chronic kidney disease, edema, wounds, or cerebral infarction. Plan of care failed to evidence any wound measurement orders or treatment for the wounds. This document stated, & Goals and Outcomes & Patient will be free of skin breakdown during this episode of care &. This document failed to be individualized to include any patient-specific interventions and/or goals related to care of an indwelling urinary catheter. This document failed to include a grabber, cane or trapeze bar in the DME (durable medical equipment section. The plan of care failed to include diazepam, doxazosin, and Tylenol on the medication list.

Clinical record review evidenced a face-to-face document dated 4/7/2022, which included but was not limited to the following diagnoses, which were not included on the plan of care: hypertension (high blood pressure), left sided weakness, and left foot drop (difficulty lifting the front of foot).

During an interview on 6/13/2022 at 11:53 AM, administrator/clinical manager A indicated the plan of care should have included diagnoses of hypertension, left sided weakness, and left foot drop. When queried what DME (durable medical equipment) should be included on the

plan of care, administrator/clinical manager A indicated all durable medical equipment should be included. Administrator/clinical manager A indicated the plan of care should include all medications the patient was taking. During an interview on 6/13/2022 at 12:06 PM, when queried how patient #2 s plan of care should have been individualized, and which patient-specific interventions/education it should have included, registered nurse B indicated it should have included education regarding slow transfers, ensuring all obstructions are cleared, instruction to use assistive devices to ambulate, assessing for swelling, diet education, monitoring blood pressure and urine output, foley care instructions. When queried how the goal of being free of skin breakdown was patient-specific and measurable, if patient #2 already had wounds upon start of care, registered nurse B stated, & they aren t wounds to me, so I would just take the wounds off for the next visit & I shouldn t have put them on there as a wound &. When queried what a wound was, registered nurse B stated, & I consider a wound something that s open, draining & I don t think that it s a wound so to speak &.

4. Observation of a home visit for patient #3 was conducted on 6/10/2022, at 8:45 AM, to observe a routine home health aide visit. During the visit, the patient s medications were reviewed. Patient #3 indicated they were taking Eliquis (blood thinner) for a blood clot, which was not included on the plan of care. Patient #3 indicated they had never taken Lasix (water pill) or a multivitamin.

Clinical record review for patient #3 was completed on 6/13/2022, for certification period 4/13/2022 6/11/2022. Record review evidenced a start of care/comprehensive assessment dated 4/13/2022, which indicated the patient was a fall risk. This document included, but was not limited to the following diagnoses: multiple sclerosis (a disease in which nerve damage impairs the communication between the brain and the body), edema (swelling), chronic kidney disease, and diabetes (a problem regulating

blood sugars). The comprehensive assessment indicated patient #3 had 5/10 pain to lower back which interfered with patient s activity or movement daily. This document stated, & evidence of cellulitis rt. [right] lower extremity &.

Clinical record review evidenced a plan of care for certification period 4/13/2022 6/11/2022. This document indicated the patient had the following risks for hospitalization: difficulty complying with medical instructions in the past 3 months and currently reports exhaustion. This document failed to include interventions to address these underlying risk factors such as education on medical instructions or energy conserving techniques. The plan of care failed to be individualized to include patient-specific interventions/education and/or measurable outcomes and goals to address cellulitis, fall risk status, diabetes, edema, multiple sclerosis, pain, or chronic kidney disease. This document included the following medications: Baclofen (muscle relaxer), Amaryl (to lower blood sugar), Ibuprofen (for pain), multivitamin, and Lasix. The plan of care failed to include the Eliquis patient was taking, or the diagnosis of blood clot.

During an interview on 6/13/2022 at 12:44 PM, registered nurse B indicated interventions to address patient #3's risk factors for hospitalization would be education about quitting smoking. Administrator/clinical manager A indicated there were no interventions to address the underlying risk factors for hospitalization on patient #3 s plan of care. Administrator/clinical manager A indicated the plan of care does not include any patient-specific interventions/education or goals related to the patient s diagnoses or risk factors, but they would add patient-specific interventions in the future. At 12:53 PM, registered nurse B stated, when asked what patient-specific interventions should be included on patient #3 s plan of care, & for pain management, see what relieves the pain, non-pharmacological measures for pain, what makes pain worse & If medication relieves pain, follow-up on medication &. At 12:56 PM,

	when queried which patient-specific interventions/education the plan of care should include for a diabetic patient, registered nurse B indicated it should include diet education, instruction on medications, foot care, and assessing the patient s knowledge of blood sugar measurements. At 1:05 PM, when queried which medications the plan of care should include, administrator/clinical manager A indicated it should include all the medications the patient was taking. When queried why patient #3 s medication list on the plan of care was not accurate, administrator/clinical manager A indicated they did not know since it should auto-populate from the comprehensive assessment medication reconciliation. 5. Clinical record review for patient #4 was completed on 6/13/2022, for certification period 5/13/2022 7/11/2022. Record review evidenced a plan of care dated 5/9/2022, which included the following medications: Levaquin (antibiotic), doxycycline (antibiotic), emergenC (vitamin C), Oxybutynin (for bladder spasms), baclofen (muscle relaxer), Megestrol Acetate (to increase appetite), Klonopin (anti-anxiety), and Desitin (diaper rash cream). The plan of care included but was not limited to the following diagnosis: quadriplegia (paralysis from the neck down), neurogenic bowel (loss of normal bowel function), and neuromuscular dysfunction of bladder (loss of normal bladder function). This document stated, & Goals and Outcomes & Patient skin integrity will remain intact during this episode &. Clinical record review evidenced a medication list which stated, & Doxycycline & daily x 5 days & start date: 1/6/2022 &. Record review failed to evidence the plan of care included all current medications patient was taking. Clinical record review evidenced a comprehensive re-assessment/recertification dated 5/9/2022, which indicated the patient had a wound to the left heel.			

Clinical record review evidenced a history and physical dated 10/5/2021, which included a diagnosis of depression which was not included on the plan of care.

During an interview on 6/13/2022 at 2:41 PM, when queried why depression was not included on the plan of care, administrator/clinical manager A indicated they needed to add it, it probably didn t get added since the patient had been on service for several years. At 2:42 PM, when queried why the plan of care included a medication which was supposed to be taken only for 5 days in January, registered nurse B indicated they didn t put the discontinue date in. At 2:52 Pm, when queried how the goal of skin remaining intact was measurable if patient already had a wound, administrator/clinical manager A indicated it was not measurable and needed to be updated.

6. Clinical record review for patient #5 was completed on 6/13/2022, for certification period 4/22/2022 6/20/2022. Record review evidenced a plan of care dated 4/19/2022, which indicated the patient was receiving tube feeding Osmolite 1000 cubic centimeters per day via a feeding pump continuously, but failed to evidence the rate of tube feeding or flush frequency or amount. The plan of care included but was not limited to the following medication orders: wound wash cleanse affected area as ordered and PRN (as needed), Santyl (wound treatment to remove dead tissue from wound bed) apply ointment to affected area as ordered and PRN, Pepto-Bismol every 4-6 hours PRN, Robitussin (cough medicine) every 4-6 hours PRN, Normal Saline Flush Intravenous (through the vein) inhale via trach (a tube inserted in the airway to help with breathing) PRN, Desitin apply topically to peri area PRN, Triamcinolone Acetonide (medicine to decrease irritation to skin) apply topically to peri area PRN, A & D Zinc Oxide apply topically to affected peri area PRN, Bacitracin (antibiotic) apply topically to affected areas PRN, Hydrocortisone Acetate (steroid cream) apply topically PRN,

	Ketoconazole (antifungal cream) apply topically PRN, Flonase Allergy Relief 1 spray in each nostril PRN, Artificial tear solution place 1 drop in both eyes every 6 hours PRN, Dulcolax (laxative) rectally daily PRN, and vitamin D 1 tab crushed via feeding tube. The plan of care failed to include indications for PRN medication, failed to include location to apply topical medication, and failed to include frequency of vitamin D. Plan of care failed to include Hoyer lift under durable medical equipment. Clinical record review evidenced a nursing flow sheet shift assessment dated 4/24/2022, which stated, & Diaper changed, up to w/c [wheelchair] with Hoyer lift &. Clinical record review evidenced a comprehensive re-assessment/recertification dated 4/22/2022, which indicated patient did not have any wounds to apply wound cleanser or Santyl to. Plan of care failed to be individualized to include only medications pertinent to patient. During an interview on 6/13/2022 at 3:11 PM, when queried if the plan of care should include rate of tube feeding in nutritional requirements, administrator/clinical manager A indicated the plan of care should include the rate and flush amount. During an interview on 6/13/2022 at 3:13 PM, registered nurse B indicated patient #5 did not have a wound. When queried why Santyl was ordered on the plan of care, administrator/clinical manager A indicated it was probably an old order from a previous certification period. At 3:15 PM, when queried what should be included in a complete medication order on the plan of care, administrator/clinical manager A indicated an indication for PRN medications, frequency of administration, and location for topicals to be applied. At 3:18 PM, when queried if a Hoyer lift should be included on the plan of care under durable medical equipment, administrator/clinical manager A indicated it should be included.			

7. Clinical record review for patient #6 was completed on 6/13/2022 for certification period 10/10/2021 12/8/2021. Record review evidenced a plan of care dated 10/13/2021, for certification period 10/10/2021 12/8/2021, which failed to be individualized to include patient-specific interventions/orders/education, or measurable outcomes/goals related to patient s oxygen use, hypertension (high blood pressure), end stage renal disease requiring dialysis (kidney failure requiring blood filtration), and/or chronic obstructive pulmonary disorder (COPD/type of chronic lung disease). This document indicated patient had the following risk factors for hospitalization or emergency visits: history of difficulty complying with medical instructions in the last 3 months and currently taking 5 or more medications. This document failed to include all necessary interventions to address the risk factors for hospitalization or emergency room visits.

During an interview on 6/13/2022 at 3:37 PM, when queried how this patient s plan of care should have been individualized for his diagnosis and risk factors, administrator/clinical manager A indicated it should have included information/education on oxygen use such as rate of oxygen flow, if the patient uses a cannula or mask, education not to smoke, and education on storage of oxygen. Administrator/clinical manager A indicated patient #6 s plan of care should have been individualized to include patient-specific interventions such as monitoring intake and output, monitoring blood pressure, diet compliance education, and assessing the extremities for edema.

8. Clinical record review for patient #7 was completed on 6/13/2022, for certification period 1/22/2022 3/22/2022. Record review evidenced a face-to-face document dated 8/31/2021, which included but was not limited to the following diagnoses as the primary reasons for home care: history of benign prostatic hyperplasia (prostate enlargement)

	right shoulder). Clinical record review evidenced a recertification/comprehensive re-assessment dated 1/20/2022, which stated, & [Family member] applies biofreeze [a pain relief topical medication] &. Clinical record review evidenced a plan of care for certification period 1/22/2022 3/22/2022, which indicated patient was taking Tamsulosin (medication for enlarged prostate), and Finasteride (medication for enlarged prostate), but failed to include diagnosis of benign prostatic hyperplasia. This document also failed to include the diagnosis of right shoulder osteoarthritis. This document failed to include interventions to address the patient s risks for hospitalization including taking 5 or more medications, and a decline in mental, emotional, or behavioral status in the last 3 months. The plan of care failed to include Biofreeze on the medication list. During an interview on 6/13/2022 at 4:17 PM, when queried how the plan of care should address underlying risk factors for hospitalization, administrator/clinical manager A indicated it should include education on medication, reminding patient to use assistive devices, and caregiver education. When queried if the plan of care should include diagnoses of benign prostatic hyperplasia and osteoarthritis, administrator/clinical manager A indicated it should. When queried which medications should be included on the plan of care, administrator/clinical manager indicated all medications the patient was taking. When queried why biofreeze was not included, registered nurse B stated, & yeah, the [family member] just said she applied it wherever to whatever hurts & so I didn t know how to enter that in there [the plan of care] &. 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C)			

	410 IAC 17-13-1(a)(1)(D)(ii, iii, ix, x, xi)			
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the agency failed to ensure all patient care orders were recorded in the plan of care in 1 of 5 active clinical records reviewed. (#3) The findings include: Record review on 6/14/2022 evidenced an agency policy updated 6/10/2021, titled Care Planning which stated, & The plan of care is based upon the physician s orders and encompasses the equipment, supplies, disciplines, and services required to meet the patient s needs &. Clinical record review for patient #3 was completed on 6/13/2022, for certification period 4/13/2022 6/11/2022. Record review evidenced a face-to-face order signed by physician B on 4/26/2022, which stated, & SN [skilled nursing] required to monitor vital signs, administer medications, and educate on disease process, fall/home safety, and importance of medications, side effects, and complications & PT/OT [physical therapy/occupational therapy] for assistance in improving strength, bed mobility, balance, transfer, and gait and to establish a home exercise program and increase of motion and home safety training &. Clinical record review evidenced a plan of care for certification period 4/13/2022 6/11/2022 which failed to include skilled nursing orders for monitoring vital signs, administering	G0576	**G0576** 1. Pt. #3 – Order received for home healthaide services only. This Plan of Care has been updated to reflect this order. 2. Reviewed all patients to ensure allorders were included in the plan of care. 3. Skilled nurses will be in-serviced toensure that all orders are included in the plan of care. 4. All patient records are reviewed by casemanager to ensure the plan of care has been followed.	2022-07-14

	process, fall/home safety, and importance of medications, side effects and complications. This document failed to evidence any occupational therapy or physical therapy orders or referrals. During an interview on 6/13/2022 at 12:34 PM, administrator/clinical manager A indicated the agency was not aware of the skilled nursing or therapy orders, so did not include them on the plan of care. Registered nurse B indicated the patient s physician s office was providing skilled nursing for the patient, but did not know what services they were providing or how frequently they were seeing the patient. Administrator/clinical manager A indicated all orders should be recorded in the plan of care.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the agency failed to ensure all services and treatments were administered only as ordered by a physician in 1 of 5 active clinical records reviewed. (#4) The findings include: Record review on 6/14/2022 evidenced an agency policy updated 6/10/2021, titled Physician Orders/Plan of Care which stated, & The physician sets up a plan of care, which includes the diagnosis, prognosis, goals to be accomplished, and order for each service, item of drugs, and equipment to be provided by the Agency & Verbal orders may be received by the RN [registered nurse] & Verbal orders are put into writing, signed, and dated by the person receiving the order &.	G0580	**G0580** 1. Pt. #4 – plan of care has been updated toonly include treatments and services as ordered by physician. 2. Agency reviewed patient's plan of care toensure all services and treatments were administered as ordered by a physician. 3 One on one in-service was provided tothe SN staff to ensure that all services and treatments are administered onlyas ordered by physician, prior to the service and orders for all disciplinesinclude the amount, frequency and duration of the service provided and all PRNorders for medication and	2022-07-14

	Record review on 6/14/2022 evidenced an agency policy updated 6/10/201, titled Wound Care Management which stated, & staff will obtain specific physician orders to perform wound care for Agency patients & Orders shall at a minimum contain the specific protocol, technique to be observed, supplies, frequency, duration and any adverse events to report to the physician & Agency RN [registered nurse] to perform/teach wound care as ordered by the physician &. Clinical record review for patient #4 was completed on 6/13/2022 for certification periods 3/14/2022 - 5/12/2022 and 5/13/2022 7/11/2022. Record review evidenced skilled nurse visit notes for dates 5/6/2022, 5/16/2022, 5/20/2022, 5/26/2022, 6/3/2022, 6/7/2022, and 6/9/2022 which all stated, & Dressing to left heel removed. Small amount of drainage noted. Wound decreasing in size. Wound was cleaned and sterile dressing applied &. Record review failed to evidence physician orders for wound care, including type/frequency, of cleansing or dressing to be applied. During an interview on 6/13/2022 at 2:24 PM, when queried what the wound care orders were for patient #4, administrator/clinical manager A stated, & we didn t amend the plan of care & we need to say if there s an order from the physician &. Registered nurse B indicated the physician said to keep the wound clean, but didn t specify any wound care orders, and no wound care orders were documented. 410 IAC 17-13-1(a)		treatments have specific numbers and reasons. 4 Clinical manager will review 100% ofPlans of Care for 4 weeks to ensure that all services and treatments areadministered only as ordered by the physician. Once the threshold of 100% ismet, will continue to audit 25% of plan of cares quarterly.	
G0590	Promptly alert relevant physician of changes 484.60(c)(1)	G0590	**G0590** 1. Patient #2 – Communication	2022-07-14

	The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to ensure they promptly alerted the physician to any change in patients condition in 5 of 7 clinical records reviewed. (#2, 3, 4, 6, 7) The findings include: 1. Record review on 6/14/2022, evidenced an agency policy updated 6/10/2021, titled Coordination of Client Care which stated, & The agency staff: & Notifies the physician, patient and family and other staff of significant events or revisions in the plan &. 2. Record review on 6/14/2022, evidenced an agency policy updated 6/10/2021, titled Care Planning which stated, & Clinicians will inform the patient s physician of any changes that suggest a need to alter the plan of care & If person-to-person contact was not completed or if awaiting a return response, all contacts and interactions shall be documented & All orders shall contain sufficient information to carry out the order, name of the physician, intermediate care provider and, if appropriate, representative conferring the order to the agency &. 3. Clinical record review for patient #2 was completed on 6/13/2022, for certification period 4/14/2022 6/12/2022. Record review evidenced a skilled nurse visit noted dated 5/12/2022, which indicated the patient s blood pressure was 135/100. This document stated, & patient c/o [complains of] lightheadedness and dizziness & Physician was called to notify of the elevated BP [blood pressure] & I was referred to the NP [nurse practitioner] who was busy with patients and was unable to speak to		documentationadded to record Patient #3 - Communication documentation added to record Patient #4 - Communication documentation added to record Patient #6 - patient has been discharged prior to survey. Patient #7 - patient has been discharged prior to survey. 2. Reviewed all patients' plan of cares to ensurethat staff promptly alerted the physician to any change in patients' condition. 3 One on one in-service was provided tothe SN staff to ensure that physicians are alerted promptly to any change inthe patient's condition and to document the follow-up, including providers nameand if there is a need to revise the plan of care. 4 Clinical manager will review 100% ofPlans of Care for 4 weeks to ensure that all services and treatments areadministered only as ordered by the physician. Once the threshold of 100% ismet, will continue to audit 25% of plan of cares quarterly.	

return call to patient &. Record review failed to evidence which physician was contacted. Record review failed to evidence any physician or NP was made aware of elevated blood pressure, dizziness, and lightheadedness.

Clinical record review evidenced a skilled nursing visit note dated 5/26/2022, which stated, & Patient c/o lightheadedness and dizziness & Physician was called to notify of the elevated BP & I was referred to the NP who was busy with patients and was unable to speak to her & message was left and the NP was to return call to patient &.

During an interview on 6/13/2022, at 12:18 PM, when queried which physician was made aware of change in patient s condition, lightheadedness, and dizziness on 5/12/2022 and 5/26/2022, administrator/clinical manager A indicated it was not documented. Registered nurse B indicated the office never called her back regarding the lightheadedness or dizziness, but the physician ordered the patient valium (anti-anxiety medication). Administrator/clinical manager A indicated when the physician is notified, it should be documented which physician was called, on what date, at what time, and what the notification was regarding.

4. Clinical record review for patient #3 was completed on 6/13/2022, for certification period 4/13/2022 6/11/2022. Record review evidenced a start of care/comprehensive assessment dated 4/13/2022, which stated, & Evidence of cellulitis [an infection in the skin] rt. [right] lower extremity &. Review failed to evidence physician notification of cellulitis, which could have indicated the need for a change in the plan of care.

During an interview on 6/13/2022 at 1:00 PM, when queried if the physician was made aware of the cellulitis, registered nurse B indicated there was a nurse practitioner in the patient s home during the comprehensive assessment who knew about the cellulitis, but did not

document the name of the nurse practitioner or notify the patient s physician.

5. Clinical record review for patient #4 was completed on 6/13/2022, for certification periods 3/14/2022 - 5/12/2022 and 5/13/2022 7/11/2022. Record review evidenced a recertification/comprehensive re-assessment completed 3/11/2022, which indicated patient did not have any wounds. Record review evidenced a skilled nurse visit note dated 5/6/2022, which stated, & Dressing to left heel removed & Small amount of drainage noted & Wound decreasing in size & Wound was cleaned and sterile dressing applied &. Record review failed to accurately document when onset of left heel wound occurred. Record review failed to evidence orders for wound care, or documentation the physician was notified of new wound to left heel, which suggested the plan of care should be revised.

During an interview on 6/13/2022 at 2:24 PM, when queried if the physician was notified of the change in patient condition/new wound to left heel, registered nurse B stated, & I called [physician C] and notified of new wound, and he just said to keep it clean & It was like a blister like thing, and when it comes off you have a little wound &. Registered nurse B indicated the physician notification was not documented and could not recall the date of onset of wound, or date physician was notified.

6. Clinical record review for patient #6 was completed on 6/13/2022, for certification period 10/10/2021 12/8/2021. Review of a comprehensive re-assessment/recertification dated 10/6/2021, indicated patient was alert and oriented, with a history of lung disease and high blood pressure, wore oxygen at 3 liters per minute at night, was on dialysis (artificial kidney filtration), and a 1500 milliliter fluid restriction. The blood pressure measurement on this visit was 96/61, and the oxygen was 90% on room air.

Clinical record review evidenced a skilled nurse

	visit note dated 11/23/2022, which indicated the patient s blood pressure was 169/118. This document stated, & Noted oxygen level at 77 % when oximeter first placed on finger & Instructed patient to put his oxygen on, 02 saturation increased to 85 90% with 02 on. Instructed patient to keep his oxygen on the rest of the day and check his saturation with his portable oxygen sensor. Oxygen in use at 3LPM [liters per minute] at night &. Record review failed to evidence the physician was notified of the change in patient s condition which suggested the plan of care may need to be altered. During an interview on 6/13/2022 at 3:50 PM, administrator/clinical manager A stated, & yes that was a status change & I would have the home health aide take vitals and send a nurse out to do a PRN [as needed visit] or another assessment &. Administrator/clinical manager A indicated the physician should have been notified of the change in patient s status and abnormal vitals. 7. Clinical record review for patient #7 was completed on 6/13/2022 for certification period 1/22/2022 3/22/2022. Record review evidenced a patient communication note dated 1/20/2022 which stated, & As he got to the doorway, lost his grip and we eased him to the floor & we stood him up and put him in the wheelchair & my administrator and patient s [family member] were notified of the above I informed them that the patient has an increase in weakness &. Review failed to evidence the physician was notified of patient s fall on 1/20/2022. During an interview on 6/13/2022 at 4:03 PM, administrator/clinical manager A stated, & we needed to notify the doctor for the fall &. 410 IAC 17-13-1(a)(2)			
G0606	Integrate all services	G0606	G0606	2022-07-14

	484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on observation, record review, and interview, the agency failed to integrate and coordinate services to assure the identification of patient needs or factors that could affect treatment effectiveness in 4 of 7 clinical records reviewed. (#1, 2, 4, 6) The findings include: 1. Record review on 6/13/2022, evidenced an agency policy updated 6/10/2021, titled Coordination of Client Care which stated, & All service providers involved in the care of a client, including contracted health care professionals or another Agency, will be engaged in an effective interchange, reporting, and coordination of care regarding the client. All such coordination of care will be documented in the client record. Each client will be assessed upon admission as to identify any other agencies providing services to the client &. 2. Observation of a home visit for patient #1 was conducted on 6/8/2022, at 8:00 AM, to observe a routine home health aide visit. Patient #1 was observed sitting in a wheelchair. The patient was able to stand, by holding on to the walker, and with assistance of the home health aide. Patient #1 indicated he had previously received physical therapy, and the last visit was 5/1/2022, but he would like to receive physical therapy to improve his ambulation. He indicated he was told by the therapist he couldn t receive any more physical therapy visits until he went to his next doctor appointment.		1. Patient #2 – Plan of care updated to reflectcoordination with physician regarding foley catheter. Patient #3 - Communication documenting Patient #6 - patient has been discharged prior to survey. 2. All plans of cares were reviewed toensure there was coordination of care amongst disciplines/entities thatprovided care to agency patients. 3. One onone in-service was provided to the SN staff to ensure that any services thepatient receives from another provider are integrated in the plan of care andcommunication indicating these services are coordinated and documented. Thisincludes SN or home health aide services provided, therapy services and all otheragencies that provide services.	

	Clinical record review for patient #1 was completed on 6/13/2022, for certification period 4/12/2022 6/10/2022. Record review evidenced a plan of care for certification period 4/12/2022 6/10/2022, which stated, & Patient s mobility will be improved with assistance of physical therapist &. Record review failed to evidence integration of physical therapy services to ensure coordination of care, failed to evidence the name of the physical therapy agency which provided services, and failed to evidence any communication between the therapy agency and the home health agency regarding frequency of visits or services to be provided. Record review failed to evidence the home health agency communicated with the physician regarding the patient s therapy needs, or interruption of therapy services. During an interview on 6/13/2022 at 11:17 AM, when queried how the agency integrates physical therapy services and coordinates care, administrator/clinical manager A stated, & we don t have any care coordination on him yet &. When queried how the agency is meeting this patient s needs if he requires physical therapy, but therapy is not being provided, administrator/clinical manager A stated, & we need to communicate with the doctor for new script or new order &. 3. Observation of a home visit for patient #2 was conducted on 6/9/2022, at 2:00 PM, to observe a routine skilled nurse visit. During the visit, the patient was observed to have a urinary catheter (tube inserted into the bladder or urethra to drain urine). The registered nurse failed to assess the catheter during the home visit. Clinical record review for patient #2 was completed on 6/13/2022, for certification period 4/14/2022 6/12/2022. Record review evidenced a skilled nurse visit note dated 5/26/2022, which indicated the patient had a Foley catheter (tube inserted into the urethra to drain urine), which was last changed 4/11/2022. This document indicated the Foley		4. Clinicalmanager will review 100% of Plans of Care for 4 weeks to ensure that allservices and treatments are administered only as ordered by the physician. Oncethe threshold of 100% is met, will continue to audit 25% of plan of caresquarterly.	

	catheter was changed by a physician, but failed to indicate which physician, at what intervals, or to evidence care coordination to ensure the patient s catheter was changed at appropriate intervals. A plan of care was reviewed for certification period 4/14/2022 6/12/2022, which failed to evidence any care coordination note or instructions/orders regarding the patient s Foley catheter. During an interview on 6/10/2022 at 1:43 PM, administrator/clinical manager A indicated several of the agency s patients received only home health aide services, and another home health agency provided skilled nursing due to staffing issues with nurses. Administrator/clinical manager A indicated there was no agreement between the agencies sharing patients. When queried how the agency coordinates the patient s care between agencies, administrator/clinical manager A indicated the agency completes a care coordination note every 30 days with the other agency. Registered nurse B did not know how frequently the Foley changes were ordered for patient #2. 4. Clinical record review for patient #4 was completed on 6/13/2022, for certification period 3/14/2022 5/12/2022. Record review evidenced a physician order dated and signed on 4/15/2022. This order stated, & Request physical therapy evaluation for upper extremity strengthening and bilateral feet ROM [range of motion] &. Record review failed to evidence a physical therapy evaluation was completed or coordinated. Record review failed to evidence communication between the home health agency and the therapy agency. During an interview on 6/13/2022 at 2:18 PM, when queried whether the physical therapy referral was completed, administrator/clinical manager A stated, & we called [Entity D/physical therapy agency] and they needed the order directly from the physician, not us, so [registered nurse B] went directly to the physician s office and let [physician C] know to			

	send an order directly to [entity D] &. When queried if the patient received physical therapy services, registered nurse B indicated the home health agency never received any information from the physical therapy agency and did not know if therapy saw patient #4 or evaluated the patient. 5. Clinical record review for patient #6 was completed on 6/13/2022 for certification period 10/10/2021 12/8/2021. Record review evidenced a comprehensive re-assessment/recertification dated 10/6/2021 which indicated patient was receiving skilled nursing services from agency D (home health agency). No care coordination or plan of care outlining what type and frequency of services agency D was providing was evidenced. Clinical record review evidenced a plan of care for certification period 10/10/2021 12/8/2021 ,which indicated patient was receiving skilled nurse visits every 15 days and a home health aide daily. During an interview on 6/10/2022 at 1:43 PM, when queried how some patients receive skilled nursing from 2 home health agencies, administrator/clinical manager A stated, & we sometimes have patients who we provide HHA [home health aide] services to, since we didn t have a nurse except for myself and registered nurse I & The other agency [home health] provides skilled nursing and we provide the aide, but don t bill for duplicate services & We don t have an agreement or anything & If the aide is in the home, and notices something, we call the doctor & and we do a care coordination note every 30 days with the other agency &. Administrator/clinical manager A indicated, when queried why there was no care coordination note for patient #6, that most of the time the other home health agency doesn t provide the information requested such as a plan of care or frequency of visits.			

	410 IAC 17-12-2(h)			
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: Based on record review and interview, the agency failed to measure, analyze and track quality indicators such as adverse patient events, and other aspects of performance which would enable the agency to assess processes of care, services and operations (see tag G642); utilize quality indicator data to monitor effectiveness and safety of services and quality of care and identify opportunities for improvement (see tag G644); focus on high-risk, high-volume, or problem-prone areas (see tag G648); ensure the performance improvement activities considered incidence, prevalence, and severity of problems (see tag G650); to ensure the performance improvement activities lead to an immediate correction of any identified problem that directly or potentially threatens the health and safety of patients (see tag G652); ensure the performance improvement	G0640	**G0640** 1. The agency will update, evaluate andmaintain an ongoing agency-wide QAPI program. 2. The agency will maintain documentaryevidence of its QAPI program and be able to demonstrate its operation usingEMR. 3 Use of the Smart QAPI Program in theagency's EMR will be used to draw data to assist in measuring, analyzing andtracking quality indicators from the comprehensive assessments, plan of cares,and clinical notes to revise the current clinical review of measures beingdone. Upon review of the data, the QAPI committee will update and revisethese measures for development of additional process improvement plan. 4 The clinical director is responsible tomonitor the day to day QI activities and at least quarterly the QAPI committeewill review the plan and revise as needed. The	2022-07-14

	activities analyzed the causes of adverse patient events and implemented preventive actions (see tag G654); measure the success of the performance improvement activities and track performance to ensure that improvements are sustained (see tag G656); and document and conduct a performance improvement project (see tag G658). This practice had the potential to affect all agency patients. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 484: 65 Condition: Quality Assessment / Performance Improvement.		governing body will ensure thatthe program reflects the complexity of its organization and services quarterly.	
G0642	Program scope 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. Based on record review and interview, the agency failed to measure, analyze and track quality indicators such as adverse patient events, and other aspects of performance which would enable the agency to assess processes of care, services and operations. The findings include:	G0642	**G0642** 1. Patient#4 patient new wound to left heel was measured and treatment documented innursing visit. Patient #6 patient has been discharged prior to survey Patient #7 patient has been discharged prior to survey. This was not a fall. 2. Allpatients will be included in QAPI program. 3 Use of the Smart QAPIProgram in the agency's EMR will be used to draw data to assist in measuring, analyzingand tracking quality indicators from the comprehensive assessments, plan ofcares, and clinical notes	2022-07-14

	Record review evidenced an agency policy updated 6/8/2022, titled Quality Assessment & Performance Improvement Plan which stated, & The QAPI [quality assessment and performance improvement] committee will review at least the following: & Infection control activities and communicable diseases & Negative client care outcomes &Medication administration and errors & Adverse Drug Reactions & Outcome-Based Quality Monitoring & Outcome-Based Quality Improvement Report &. Review of the agency s QAPI program on 6/13/2022 evidenced a Quarterly Infection Log dated 6/9/2022, which indicated 2 urinary tract infections, and 1 patient with urinary tract infection was hospitalized on 6/8/2022. Record review failed to evidence any tracking or analysis of hospitalizations, falls, wounds, or other quality indicators. Clinical record review for patient #4 was completed on 6/13/2022. Record review evidenced the patient developed a new wound to left heel during certification period 3/14/2022 5/12/2022. Clinical record review for patient #6 was completed on 6/13/2022. Record review evidenced the patient was admitted to the hospital on 12/04/2021 for shortness of breath and hypervolemia (fluid overload). Clinical record review for patient #7 was completed on 6/13/2022. Record review indicated on 1/20/2022, during a home visit, the patient fell, and was assisted to the floor by home health staff and placed in the wheelchair. Record review on 6/13/2022 evidenced a document titled Quality Assessment and Performance Improvement Committee Minutes of Member Meeting dated December 2021, which stated, & Negative Client Care		events and other aspectsof performance which would enable the agency to assess the processes of care,services and operations. Upon review of the data, the QAPI committee willupdate and revise these measures for development of additional processimprovement plan. 4 The clinical director is responsible tomonitor the day to day QI activities and at least quarterly the QAPI committeewill review the plan and revise as needed. The governing body will ensure thatthe program reflects the complexity of its organization and services quarterly.	

	Outcomes & None & Review of all incidents & None & This document failed to measure, analyze, and track hospitalizations, including patient #6 s hospitalization. Record review on 6/13/2022 evidenced a document titled Quality Assessment and Performance Improvement Committee Minutes of Member Meeting dated March 2022, which stated, & Negative Client Care Outcomes & None & Review of all incidents & None & This document failed to measure, analyze, and track patient falls, to include patient #7 s fall. During an interview 6/13/2022 at 10:30 AM, administrator A stated, when queried which quality indicators the agency is tracking for QAPI, & none right now & Administrator A indicated the agency looks at hospitalizations due to infections but were more focused on documentation and updating OASIS. Registered nurse B indicated the agency did not consider patient #7 as a fall because they were assisted to the ground and did not track or analyze this fall. 410 IAC 17-12-2(a)			
G0644	Program data 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to-	G0644	**G0644** 1. Agency is updating the quality indicatordata including measures derived from OASIS.	2022-07-14

	(i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and interview, the agency failed to utilize quality indicator data to monitor effectiveness and safety of services and quality of care and identify opportunities for improvement. The findings include: Record review on 6/13/2022 evidenced an agency policy updated 6/8/2022, titled Quality Assessment & Performance Improvement Plan which stated, & Assessment of these measures will be through data collection, which at a minimum will consist of clinical record review, patient interviews, and patient satisfaction reports & Each performance improvement activity/study includes the following items: & A description of indicator(s) to be monitored/activities to be conducted & Methods of data collection &. Review on 6/13/2022 of the QAPI [Quality Assessment and Performance Improvement] program, failed to evidence any quality indicator data used to measure effectiveness and safety of services and quality of care to identify opportunities for improvement. During an interview on 6/13/2022 at 10:16 AM, when queried how the QAPI program utilizes data to measure effectiveness and safety of services, administrator A stated, & I ve not calculated the data & we are going to start using a program in Kinnser [electronic medical record] to calculate the data percentages straight out of the OASIS [Outcome and Assessment Information Set] program ... that s our goal, I put in a few goals, and never followed it up &.		2. All patients will be included in thequality program. Data will be utilized to monitor the effectiveness and safetyof services, quality of care, and identify opportunities for improvement. 3 Use of the Smart QAPI Program in theagency's EMR will be used to draw data to assist in measuring, analyzing andtracking quality indicators from the comprehensive assessments, plan of cares,and clinical notes to monitor effectiveness and safety of services and qualityof care and identify opportunities for improvement. Upon review of the data,the QAPI committee will update and revise these measures for development ofadditional process improvement plan. 4 The clinical director is responsible tomonitor the day to day QI activities and at least quarterly the QAPI committeewill review the plan and revise as needed. The governing body will ensure thatthe program reflects the complexity of its organization and services quarterly.	

	410 IAC 17-12-2(a)			
G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview, the home health agency failed to ensure the performance improvement activities analyzed the causes of adverse patient events and implemented preventive actions. The findings include: Record review on 6/13/2022 evidenced an agency policy updated 6/8/2022, titled Quality Assessment & Performance Improvement Plan which stated, & The QAPI committee will review at least the following: & negative client care outcomes & Each performance improvement activity/study includes the following items: & A description of indicator(s) to be monitored/activities to be conducted & Methods of data collection & Acceptable limits for findings & Plans to re-evaluate if findings fail to meet acceptable limits &. Review on 6/13/2022 of the agency s QAPI program failed to evidence tracking or analysis of adverse patient events such as falls, hospitalization, and wounds in the performance improvement activities. Review failed to evidence the agency implemented any preventative actions or performance improvement activities. Review of the agency s QAPI program on 6/13/2022 evidenced a Quarterly Infection Log dated 6/9/2022, which indicated 2 urinary tract	G0654	**G0654** 1. Patient #4 – used clinical documentationto track the adverse patient event, analyzed its cause, and implementpreventative action. Patient #6 - patient has been discharged prior to survey. Patient #7 patient has been discharged prior to survey. This was not a fall. 2. All patients will be included in the QAPIprogram.	2022-07-14

	infection was hospitalized on 6/8/2022. Record review failed to evidence tracking of wounds, falls, or hospitalizations, and failed to evidence performance improvement activities which led to an immediate correction of any identified problems. Clinical record review for patient #4 was completed on 6/13/2022. Record review evidenced the patient developed a new wound to left heel during certification period 3/14/2022 5/12/2022. Clinical record review for patient #6 was completed on 6/13/2022. Record review evidenced the patient was admitted to the hospital on 12/04/2021 for shortness of breath and hypervolemia (fluid overload). Clinical record review for patient #7 was completed on 6/13/2022. Record review indicated on 1/20/2022, during a home visit, the patient fell, and was assisted to the floor by home health staff and placed in the wheelchair. During an interview on 6/13/2022 at 10:39 AM, when queried how the agency uses performance improvement activities to track, analyze, and implement preventative actions, administrator A indicated the agency had not implemented any performance improvement activities, and just started tracking infections. Administrator A indicated the agency did not have any wound, hospitalization, or fall tracking information currently. Administrator A indicated the agency discussed adverse events and determined contributing factors verbally. Administrator A stated, & we would look at falls, like a patient not using assistive devices and ensuring aides are reminding patients to use their assistive devices and doing patient education &. 410 IAC 17-12-2(a)		3 Use of the Smart QAPI Program in theagency's EMR will be used to draw data to assist in measuring, analyzing andtracking quality indicators from the comprehensive assessments, plan of cares,and clinical notes to track adverse patient events such as falls,hospitalizations and wounds to be included in the performance improvementprocess to identify opportunities for improvement. Upon review of the data, the QAPI committeewill update and revise these measures and implement preventive actions. 4 The clinical director is responsible tomonitor the day to day QI activities and at least quarterly the QAPI committeewill review the plan and revise as needed. The governing body will approve thefrequency and detail of the data collection quarterly	

G0656	Improvements are sustained 484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained. Based on record review and interview, the home health agency failed to measure the success of the performance improvement activities and track performance to ensure that improvements were sustained. The findings include: Record review on 6/13/2022 evidenced an agency policy updated 6/8/2022, titled Quality Assessment & Performance Improvement Plan which stated, & The following elements are considered within the plan: & Monitoring to determine effectiveness of the action & Documentation of the review of its own program & An agency must document corrective action to ensure that improvements are sustained over time &. Review of the agency s QAPI program on 6/13/2022, failed to evidence any performance improvement actions were implemented, and failed to evidence measurement or tracking of performance to ensure improvements were sustained. During an interview on 6/13/2022 at 10:40 AM, administrator A indicated because the agency had not implemented any performance improvement activities, they did not measure or track performance. 410 IAC 17-12-2(a)	G0656	**G0656** 1. Agency is updating the qualityimprovement program to ensure that improvements are sustained. 2. All patients will be included in the QAPIprogram. 3 Use of the Smart QAPI Program in theagency's EMR will be used to draw data to assist in measuring, analyzing andtracking quality indicators from the comprehensive assessments, plan of cares,and clinical notes to measure and track performance to ensure that improvementswere sustained. 4 The clinical director is responsible tomonitor the day to day QI activities and at least quarterly the QAPI committeewill review the plan and revise as needed. The governing body will reviewquarterly to ensure that improvements are sustained.	2022-07-14

G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the home health agency failed to conduct and document a performance improvement project. The findings include: Record review on 6/13/2022 evidenced an agency policy updated 6/8/2022, titled Quality Assessment & Performance Improvement Plan which stated, & The annual QAPI report includes & Summary of all PI activities, findings, and corrective actions & Each performance improvement activity/study includes the following items: & A description of indicator(s) to be monitored/activities to be conducted & methods of data collection & Plans to re-evaluate if findings fail to meet acceptable limits in addition to any other activities required &. Review on 6/13/2022 of the agency s QAPI program failed to evidence documentation of	G0658	**G0658** 1. Performanceimprovement will be updated to reflect scope, complexity and performance of theagencies performance and operations. 2. Allpatients will be included in the QAPI program. 3 The agency will document the qualityimprovement projects undertaken and the reasons for conducting these projectsand the measurable progress achieved on the projects by ensuring the clinicalreview is completed quarterly and upon this assessment tool the PIP may bereevaluated for additional activities 4 The clinical director is responsible tomonitor the day to day QI activities and at least quarterly the QAPI committeewill review PIP and revise as needed. The governing body will review quarterlyto review performance improvement project findings to ensure improvements aresustained	2022-07-14

	any performance improvement projects. During an interview on 6/13/2022 at 10:29 AM, administrator A indicated the agency had not developed or documented a performance improvement project.			
G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement.	G0687	**G0687** 1. All employees, including Employee F havefull vaccination documentation or exemption on file. 2. All employees were reviewed and theirvaccination status is documented. 3 Policies have been updated to reflectthat all employees with patient contact are fully vaccinated, except for thestaff that has been granted exemption and they have been provided additionalprecautions to follow. Policies have been updated to include thecontingency plan for those employees who would refuse the vaccine, which wouldinclude removing staff from their assignments immediately. All staff havefull vaccination documentation since 06/14/2022 and have not needed to beremoved from their assignment. All new hires are required to provide	2022-07-14

	(2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;		fullvaccination records prior to any patient contact. 4 Administrator reviewed 100% of currentand new applicants' employee records for full vaccination documentation.	

	(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains			

	(A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Based on record review and interview, the home health agency failed to ensure policies and procedures were developed and implemented to ensure all staff were fully vaccinated for COVID-19. This practice had the potential to affect all agency patients. The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.70 Infection Control. The findings include: Record review on 6/9/2022 evidenced an			

	agency policy updated 6/8/2022, titled COVID-19 Policy which failed to evidence any information regarding COVID-19 vaccination requirements for staff, a process for tracking and documenting vaccination status, and contingency plans for staff who were not vaccinated. Record review on 6/9/2022 of the agency s COVID-19 Employee Vaccination Log, updated 6/8/2022, indicated 2 employees did not have COVID-19 vaccination documentation on file, and 3 employees refused COVID-19 vaccination without an exemption (19% of staff). 1 employee had an approved medical exemption on file. During an interview on 6/9/2022 at 11:20 AM, administrator A stated, when queried about why all staff was not vaccinated, & I didn t know they had to all be vaccinated because a few staff are young, and against the vaccine and refused & we don t have exemptions on file for them & one staff member has a medical exemption &. Administrator A indicated the agency received home health aide E s vaccination documentation on 6/8/2022 and will keep in on file now. At 11:25 AM, administrator A called home health aide D, and requested the employee s exemption to keep on file. At 11:45 AM, administrator A called home health aide F and asked if they had an exemption. Administrator A indicated the policies would be revised to reflect the 100% COVID-19 vaccination requirements. Administrator A indicated she would find out about HHA [home health aide] F, G and H s COVID-19 vaccination status. On 6/10/2022 at 10:30 AM, administrator A provided further COVID-19 vaccination documentation, including an exemption for home health aide D and vaccination documentation for HHA E, G, and H. No exemption or vaccination documentation was provided for HHA F by end of survey.			

G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on observation, record review, and interview, the agency failed to ensure skilled professionals accurately and completely prepared clinical notes in 4 of 7 clinical records reviewed. (#2, 3, 4, 7) The findings include: 1. Record review on 6/14/2022 evidenced an agency policy updated 6/10/2021, titled Registered Nurse which stated, & be responsible for the ill, injured or infirm, and the maintenance of health and prevention of illness of others as well as & Prepares clinical and progress notes &. 2. Observation of a home visit for patient #2 was conducted on 6/9/2022 at 2:00 PM to observe a routine skilled nurse visit. During the visit, the patient s right and left shins were observed to have 5-10 small areas of pink skin each, which appeared to be scar tissue. Clinical record review for patient #2 was completed on 6/13/2022 for certification period 4/14/2022 6/12/2022. Record review evidenced a start of care/comprehensive assessment dated 4/14/2022, which stated, & Patient states had multiple blisters that burst to both lower extremities & areas are scabbed over now &. This document indicated the patient had wounds to bilateral shins. This document indicated pain did not interfere with movement or daily activities. Clinical record review evidenced a plan of care for certification period 4/14/2022 6/12/2022 which stated, & Patient skin integrity will remain intact during this episode &.	G0716	**G0716** 1. Patient #2 – Plan of care has beenupdated to reflect skin condition and the frequency of pain. Patient #3 – Documentation has been updated to reflect an accurate BradenScale. Patient #4 – Wound has healed. Documentation regarding supra pubic catheter wasupdated to include supplies used, how procedure was performed and how patienttolerated. Patient #7 - Patient #7 has beendischarged prior to survey. This was not a fall. 2. All patients were reviewed to ensureskilled professionals accurately and completely prepared clinical notes. 3 One on one in-service was provided tothe SN staff to ensure the frequency of pain interfering with patientsactivity, skin integrity, Braden scale, wound measurements, color of drainage,type of dressing and wound cleanser used is accurately documented in both thecomprehensive assessment and the plan of care. Educated to ensure that thedate, time and name of physician notified of	2022-07-14

	Clinical record review evidenced a skilled nurse visit note dated 5/12/2022 which stated, & Frequent of pain interfering with patient s activity or movement: & All of the time & Patient has been suffering with joint pain since stroke which caused inability for him to move, walk &. During an interview on 6/13/2022 at 12:00 PM, when queried about how patient #2 could meet goal of being free from skin breakdown if he already had wounds on start of care, registered nurse B stated, & they aren t wounds to me, so I would just take the wounds off for the next visit & I shouldn t have put them on there as a wound &. Registered nurse B indicated documenting the patient had wounds was an error. At 12:16 PM, when queried why the comprehensive assessment indicated pain does not interfere with daily activities, and the nurse visit note indicated pain interferes daily, registered nurse B stated, & he has pain all the time, but it doesn t interfere with his daily activities & maybe it was mistake &. 3. Observation of a home visit for patient #3 was conducted on 6/10/2022 at 8:45 AM to observe a routine home health aide visit. The patient was observed to be alert and oriented, and able to ambulate with a walker as needed. Patient had the ability to feel pain and discomfort and voice such discomfort. Clinical record review for patient #3 was completed on 6/13/2022 for certification period 4/13/2022 6/11/2022. Record review evidenced a start of care/comprehensive assessment dated 4/13/2022, which included a Braden scale which stated, & Very limited & Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness or has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body &.		changes in patients health status aredocumented. Supplies used, procedure for catheter change and patients responseto procedure, wound assessment including measurements, type of dressing,drainage amount, odor and color also need to be documented. Fall riskassessments need to be accurate and the signature date of all documentationneeds to be accurate' 4 The clinical director will review 100%of all comprehensive assessments and plan of cares for 4 weeks to ensure theproper documentation and proper signature dates have been completed. Oncethe 100% threshold is met, the comprehensive assessment and plan of cares willbe reviewed every 60 days.	

During an interview on 6/13/2022 at 12:55 PM, when queried why the comprehensive assessment indicated patient has inability to communicate or feel pain, registered nurse B stated, & I think I meant to put 3 for that one & She is capable &.

4. Clinical record review for patient #4 was completed on 6/13/2022 for certification periods 3/14/2022 - 5/12/2022 and 5/13/2022 7/11/2022. Record review evidenced skilled nurse visit notes for dates 5/6/2022, 5/16/2022, 5/20/2022, 5/26/2022, 6/3/2022, 6/7/2022, and 6/9/2022 which all stated, & Dressing to left heel removed. Small amount of drainage noted. Wound decreasing in size. Wound was cleaned and sterile dressing applied &. Review of these skilled nurse visit notes failed to evidence documentation of wound measurements, color of drainage, type of sterile dressing applied, or type of wound cleanser used. Skilled visit note dated 5/6/2022 indicated date of onset of left heel wound was 5/6/2022. Skilled visit note dated 5/16/2022 indicated the date of onset of left heel wound was 5/16/2022. Skilled visit note dated 5/20/2022 indicated the date of onset of left heel wound was 5/20/2022. Skilled visit note dated 5/26/2022 indicated the date of onset of left heel wound was 5/26/2022. Skilled visit note dated 6/3/2022 indicated the date of onset of left heel wound was 6/3/2022. Skilled visit note dated 6/7/2022 indicated the date of onset of left heel wound was 6/7/2022. Skilled visit note dated 6/9/2022 indicated the date of onset of left heel wound was 6/9/2022. Record review failed to accurately evidence the correct date of onset of left heel wound.

Clinical record review evidenced skilled nurse visit notes for 6/3/2022, 6/7/2022, and 6/9/2022 which all stated, & patient c/o [complains of] bronchitis like symptoms & physician notified &. Record review failed to evidence which physician was notified, on what date and time.

Clinical record review evidenced a skilled nurse

patient s suprapubic catheter (a tube inserted directly into the bladder to drain urine) was changed during the 6/7/2022 visit but failed to include any documentation of catheter change such as supplies used, how procedure was performed, or how patient tolerated procedure.

During an interview on 6/13/2022 at 2:25 PM, when queried when wounds should be measured and documented on, administrator/clinical manager A indicated every visit wounds should be measured. Registered nurse B indicated wounds should be measured when dressing is changed but did not include measurements for patient #4 s wound because it was less than a centimeter. When queried what wound documentation should include, registered nurse B indicated the type of dressing, drainage amount, odor, and color. At 2:27 PM, registered nurse B stated, when queried what type of sterile dressing was applied to patient #4 s left heel wound, & a sterile 2x2 gauze dressing. Why is it sterile, because that s me, he didn t order it &. When queried how the onset date of left heel wound should be documented, administrator/clinical manager A indicated the onset date should be the date the wound was first assessed. Registered nurse B indicated they thought the onset date was supposed to be the date of visit for wound care. At 2:33 PM, when queried what should be documented when a catheter is changed, registered nurse B stated, & that I changed it under sterile conditions and a new one was inserted & the size & dressing applied & how urine is draining & color & external area around site & that the patient tolerated it well &. At 2:48 PM, when queried why 6/7/2022, 6/3/2022, and 6/9/2022 visit notes all say the same thing, registered nurse B stated, & probably because I copy and pasted &.

5. Clinical record review for patient #7 was completed on 6/13/2022 for certification period 1/22/2022 3/22/2022. Record review evidenced a patient communication note dated 1/20/2022 which stated, & As he got to the doorway, lost his grip and we eased him to the floor &. This document indicated it was

	electronically signed by registered nurse B on 1/20/2021, but the date of contact was 1/20/2022. Clinical record review evidenced a recertification/comprehensive re-assessment dated 1/20/2022 which included a fall risk assessment tool. The clinician failed to mark Yes under the option which stated, & Prior history of falls within 3 months: Fall definition: An unintentional change in position resulting in coming to rest on the ground or at a lower level &. During an interview on 6/13/2022 at 4:12 PM, when queried why the fall assessment did not include the fall patient had on 1/20/2022, administrator/clinical manager A indicated it should have been included. When queried why the patient communication note was for a visit 1/20/2022, but electronically signed on 1/20/2021, administrator/clinical manager A indicated it was a mistake in charting. 410 IAC 17-14-1(a)(1)(E)			

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

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