STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K118	A. BUILDING B. WING	10/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMETOWN HOME HEALTHCARE INC	302 E NORTH B STREET, GAS CITY, IN, 46933

(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 of a home health Provider. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Survey Dates: October 17, 18, 19, 20, and 21, 2022 Current Census: 20	N0000		2022-11-16
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey of a home health agency Provider.	G0000		2022-11-16

	Survey Dates: October 17, 18, 19, 20, and 21, 2022 Current Census: 20 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. During this Federal Recertification Survey, Hometown Home Healthcare was found to be out of compliance with Conditions of Participation 484.65 Quality assessment and performance improvement (QAPI) and 484.70 Infection prevention and control. Based on the Condition-level deficiencies during the **October 21, 2022,** survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on October 18, 2022. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from providing its own home health aide training and competency evaluation programs for a period of two years beginning October 21, 2022 and continuing through			

	October 20, 2024. QR: Area 2 11/02/22			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must:	N0464	N-0464 Clinical Director & Administrator has educated/in-serviced office and TB certified staff on CFR 410. IAH 17-12-1 (i) and reviewed policy 1.65. All records cited at survey have been corrected All expired TB were discarded and new replaced Agency generated a new process (medication refrigerator record) will log weekly checks for TB opened and discard date to ensure compliancy. Any adverse effects will be reported to QAPI monthly 100% of tuberculin screening form will be audited for evidence adhering to this deficiency and reported to QAPI monthly The Clinical director and Administrator will be responsible for monitoring these corrective actions to ensure this deficiency does not	2022-11-16

	(A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on observation, record review, and interview, the home health agency failed to ensure its supply of medication used to perform Mantoux tuberculin skin testing was stored according to agency policies and best medication storage practices for 1 of 1 medication vial observed, which had the potential to affect all patients and employees. Findings included: 1. An observation of the agency's medication fridge was conducted on 10/18/22 at 3 PM. During the observation, 1		recur	

	used to perform Mantoux tuberculin (TB) skin testing) was observed. The vial's manufactures cap was off and the bottle failed to evidence the date the vial was opened. 2. Policy 1.65 titled "Maintaining Tuberculosis Solution," dated 07/03/2019, indicated but not limited to "... TB solution will be dated when opened and discarded after 30 days of opening..." 3. During an interview on 10/18/22 beginning at 3:38PM, the clinical supervisor indicated multi-use vials are kept until the expiration date on the vial.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment accurately reflected the patient's current health and psychosocial status for 2 of 5 active records reviewed (Patients #2 and 5).	G0528	G-0528 Administrator educated/In-serviced all nursing staff on G-0528 and policy 2.05 to list the current health, psychosocial functional, and cognitive a comprehensive assessment. The CM whom completed this assessment which failed to contain all of the patients current health status as sited in finding was counseled in writing to include all information regarding the patients current health status. All patients cited at survey have been corrected	2022-11-15

	Findings included: 1. Policy 2.05 titled "Comprehensive Assessment," dated 12/10/2019, indicated but was not limited to "the clients current health, psychosocial, functional and cognitive status…the assessment should paint a picture of the clients status to assist the HHA in developing the care plan… assessment of the clients current health status include… all active health and medical problems." 2. The clinical record of Patient #2 was reviewed on 10/18/22 and included plans of care for the certification periods of 07/31/22 to 09/28/22 and 09/29/22 to 11/27/22. The plans of care indicated the patient's initial start of care was 06/11/2020, due to the agency's change of electronic medical record (EMR) system, Patient #2 was discharged and readmitted on 09/29/22 with a new start of care date of 09/29/22. The patient's diagnoses included, but not limited to, Chronic Obstructive Pulmonary Disease (COPD), Borderline Personality Disorder, and anxiety. The		100% clinical records were reviewed and verbal orders obtained if needed 25% of all clinical charts will be audited quarterly to ensure 100% adherence to this deficiency and any adverse effect will be reported to the QAPI Clinical Director/Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency is corrected and will not recur	

comprehensive assessment completed on 09/29/22 by the Clinical Manager that failed to evidence a complete and thorough assessment of Patient #2's COPD, Borderline Personality Disorder, and anxiety disorder, including the presence or absence of symptoms of these diseases/disorders.

A home visit observation was conducted on 10/18/22 at 11:34 AM with Patient #2. During the visit, Patient #2 was observed to have a dry hacking cough which produced sputum (color and consistency not observed). When queried if the cough was new or chronic, the patient relayed the cough was chronic. The comprehensive assessment failed to evidence the presence of a chronic cough.

3. The clinical record of Patient #5 was reviewed on 10/19/22 and included a plan of care for the certification period 09/26/22 to 11/24/22 which indicated a start of care of 09/26/22 and diagnoses included, but not limited to, high blood pressure, heart failure, edema (swelling), atrial

	rhythm), COPD, pulmonary fibrosis, low blood sugar, and cystitis (bladder inflammation). The record indicted a comprehensive assessment was completed on 09/26/22 by the Clinical Manager. The comprehensive assessment failed to evidence an assessment of Patient #5's respiratory system including the current status of the patient's COPD and pulmonary fibrosis and failed to evidence the current status of Patient #5's high blood pressure, heart failure, edema, and atrial fibrillation. The assessment included documentation, not limited to, "... [Patient #5] states, 'I have my own glucose monitor, not because I'm diabetic, but because I'm hypoglycemia [sic] ...'," however the assessment failed to evidence an assessment of the patient's hypoglycemia status (symptoms patient experienced of low blood sugar, frequency of low blood sugar episodes, how often did patient check their blood sugar, etc). The plan of care included, but not limited to, "Summary ...			

	[Patient #5] continues on prophylactic treatment of Cipro [antibiotic] that client states that she has been taking for + 15 years … Client has a history of cystitis." The comprehensive assessment indicated the patient had urinary incontinence (unable to control urination) however failed to evidence the type of incontinence (stress, urge, etc) and failed to evidence the presence or absence of cystitis symptoms. 4. An interview was conducted on 10/19/22 at 3:53 PM with the Administrator and Clinical Manager. During the interview, the Clinical Manager confirmed the comprehensive assessment should include an assessment of the patient's current health and psychosocial status. 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,	G0536	G-0536 Administrator has educated/in-serviced nursing staff on G536 & policy 2.05 to ensure the comprehensive assessment contained a medication list which included indication for the administration for as needed (PRN) medications.	2022-11-15

	duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the home health agency failed to ensure the comprehensive assessment contained a medication list which included indication for administration for as-needed (PRN) medications for 1 of 5 active records reviewed (Patient #2). Findings include: An agency policy #2.05 titled "Comprehensive Assessment," dated 12/10/2019, indicated but was not limited to "... Procedure ... The clients clinical record should identify all medications client is taking (both prescription and OTC [over-the-counter]) ...." The clinical record of Patient #2 was reviewed on 10/18/22 and included a plan of care for the certification period of 09/29/2022 to 11/27/2022 with start of care on 09/29/22. The record included a medication list, reviewed and signed by the Clinical Manager, on 09/29/22, which indicated the patient was currently prescribed Albuterol (medication given to treat shortness of breath and/or wheezing) nebulizer every 4-6 hours as needed, Tylenol (OTC		All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physician to clarify. 100% of new admissions and 50% of recertification assessments will be audited for review of all current medications and reported to QAPI monthly Clinical director and Administrator will review audits to implement any changes To ensure 100% adherence to this deficiency and any adverse effect will be reported to the QAPI monthly Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	

	medication given to treat pain and/or fever) every 6 hours as needed, and Albuterol inhaler every 4 hours as needed. The medication list failed to evidence the indication for administration for the as needed medications. An interview was conducted on 10/18/22 at 3:38 PM with the Administrator and Clinical Manager. When queried if the medication list should include indications for administration of the as needed medications, the Clinical Manager stated "we could put that on there."			
G0550	At discharge 484.55(d)(3) At discharge. Based on record review and interview, the home health agency failed to ensure the comprehensive assessment completed at the time of discharge accurately reflected the patient's current wound status for 1 of 1 discharge records reviewed of a patient with a wound (Patient #6). Findings included: An agency policy #2.05 titled	G0550	G-0550 Administrator has educated/in-serviced nursing staff on G550 & policy 2.05 to ensure the comprehensive assessment accurately reflects the patients status at discharge. All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physician to clarify. 100% of discharged charts will be audit by Administrator or administrator designee for review of accurately reflecting patients status at discharge for six months and reported to QAPI monthly	2022-11-15

	"Comprehensive Assessment," dated 12/10/2019, indicated, but not limited to, "Procedure: ... The clients current health ... status ... update of the comprehensive assessment at discharge." The clinical record of Patient #6 was reviewed on 10/20/22 and included a plan of care for the certification period 03/06/22 to 05/04/22 with a start of care 07/09/2021. The record indicated the patient was discharged on 04/13/22 per patient request. The plan of care included physician orders for skilled nursing visits 1-3 hours per visit, 1-3 visits per day, 5-7 days per week for 8 weeks then 2-4 days per week for 1 week and nursing interventions included, but not limited to, "complete wound care daily." The record included skilled nursing visits completed by Former Registered Nurse (RN) #1 on 04/08/22 at 5 PM, 04/09/2022 at 5 PM, 04/10/22 at 5 PM, 04/11/22 at 9 AM, 04/12/22 at 2 PM, and 04/13/22 at 5 PM which indicated Patient #6's pressure ulcer to the left ischium (lower back portion of the hip bone) was closed and healed and the pressure ulcer		Clinical Director & Administrator or administrator designee will be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	

	wound to the right buttock measured 5.5 centimeters (cm) in length by 3.5 cm in width by 1.0 cm in depth. The record included a discharge assessment, completed on 04/13/22 by Former Clinical Manager #1, which indicated the patient's left ischium pressure ulcer measured 0.25 cm in length by 0.25 in width by 0.25 cm in depth and the right buttock pressure ulcer measured 5.5 cm in length by 4.5 cm in width by 1.0 cm in depth. The discharge comprehensive assessment failed to evidence an accurate status of Patient #6's wounds. An interview was conducted on 10/21/22 at 3:32 PM with the Administrator and Clinical Manager. During the interview, the Clinical Manager confirmed the wound measurements documented on a discharge comprehensive assessment should align with the measurements documented on recent skilled nursing visits.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi)	G0574	G-0574 Clinical Director has educated/in-serviced nursing staff on G574 including all pertinent	2022-11-15

	The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure and follow their own policy and include within the Plan of Care all required elements for 7 of 7 patient records reviewed (Patient #1, 2, 3, 4, 5, 6, and 7).		diagnoses, treatments and measurable outcomes assessments for accurate documentation. All records cited at survey have been corrected. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physician to clarify any missing pertinent diagnoses, treatments and measurable goals. Measurable outcomes and goals will be discussed with patient at each skilled nursing encounter and documented. 100% of new admissions and 50% of recertification comprehensive assessments and Plan of Care will be audited for missing pertinent diagnoses, treatments and measurable goals to ensure that this deficiency does not recur. Clinical director and Administrator will review audits to implement any changes and report to QAPI monthly To ensure 100% adherence to this deficiency and any adverse effect will be reported to the QAPI monthly Clinical Director & Administrator will be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	

Findings include:

1. Policy 2.06 titled "Care Planning," dated 12/11/2019, included, but not limited to, "... the individualized plan of care must include the following: ... all medications and treatments ... safety measures to protect against injury ... description of the clients risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors ... any additional items the HHA or doctor may choose to include."

2. The clinical record of Patient #2 was reviewed on 10/18/22 and included plans of care for the certification periods of 07/31/22 to 09/28/22 and 09/29/22 to 11/27/22 that indicated the patient's initial start of care [SOC] was 06/11/2020 and due to the agency's change of electronic medical record (EMR) system, Patient #2

	was discharged and then readmitted on 09/29/22 with a new SOC date of 09/29/22. The record included a comprehensive assessment completed on 09/29/22 by the Clinical Manager. The plan of care [POC] for the certification period 09/29/22 to 11/27/22 failed to evidence safety measures which followed the safety measures indicated on the comprehensive assessment and failed to evidence hospitalization risk factors which followed the hospitalization risk factors indicated on the comprehensive assessment. The plan of care also included two separate sets of vital sign call parameters, one of which did not follow the vital sign call parameters indicated on the comprehensive assessment. Patient #2's clinical record included a document titled "Indiana Health Care Representative Appointment," signed by the patient and Clinical Manager on 09/28/22, which indicated the patient named a health			

	care representative. The plan of care failed to evidence Patient's #2 health care representative. 3. The clinical record of Patient #3 indicated a SOC date of 10/07/22. The POC for certification period 10/07/22 to 12/05/22 failed to include risk for hospitalization and emergency department visits. 4. The clinical record of Patient #4 indicated a start of care date of 03/20/2020. The POC for certification period 09/06/22 to 11/04/22 failed to include risk for hospitalization and emergency department visits. 5. The clinical record of Patient #5 was reviewed on 10/19/22 and included a POC for the certification period 09/26/22 to 11/24/22 which indicated a SOC of 09/26/22 and patient diagnoses included, but not limited to, high blood pressure and iron deficiency			

anemia. The record included a comprehensive assessment completed on 09/26/22 by the Clinical Manager. The POC failed to evidence hospitalization risk factors which followed the hospitalization risk factors indicated on the comprehensive assessment.

The comprehensive assessment indicated Patient #5's pain goal was a 6 out of 10 on a 0-10 numeric pain scale (used to objectively assess a patient's pain, with 0 meaning no pain and 10 meaning the most severe pain). The POC indicated goals for patient care included, but were not limited to, "[Patient #5] will remain functionally independent within limitation of pain within 60 days as evidenced by pain level of [less than] 7 ... [Hemoglobin, a blood test used to test for anemia and other blood disorders] will remain within normal limits as evidenced by lab draws within 60 days ... [Home Health Aide (HHA)] will meet the clients

	hygiene and personal care needs this cert period with the assistance of the home health aide as evidenced by [Registered Nurse] assessment." 6. The clinical record of Patient #6 was reviewed on 10/20/22 and included a POC for the certification period 03/06/22 to 05/04/22 which indicated a SOC date of 07/09/2021. The record indicated the patient was discharged on 04/13/22 per patient request. The POC included orders for skilled nursing visits 1-3 hours per visit, 1-3 visits per day, 5-7 days per week for 8 weeks then 2-4 days per week for 1 week, nursing interventions included but were not limited to "complete wound care daily," and the patient's medications included "Allevyn" (type of wound dressing) and "boarded foam [dressing]," both with the frequency of "change daily." The record included a discharge assessment completed on 04/13/22 which indicated			

	the patient had one pressure to the left ischium (lower back portion of the hip bone) and one pressure ulcer to the right buttock. The POC failed to evidence specific orders for the patient's wound care for their two pressure ulcers. 7. The clinical record of Patient #7 indicated a start of care date of 12/02/2020. The POC for certification period 03/27/22 to 05/25/22 failed to include patient's risk for hospitalization and emergency department visits. 8. During an interview on 10/18/22 beginning at 3:38PM, the clinical manager (CM) confirmed the vital sign parameters on the POC should match the vital sign parameters in the comprehensive assessment and confirmed PRN medications on the POC should have indications. 9. During an interview on 10/19/22 beginning at 3:53PM, the CM confirmed			

	the Plan of Care should include all safety measures identified in the comprehensive assessment and confirmed the POC should include risk for emergency department (ED) visits and hospitalization and should also include interventions for those assessed as high risk for ED visits and hospitalizations. 10. During an interview on 10/20/22 beginning at 4:08PM, the CM confirmed goals on the POC should be measurable. 410 IAC 17-13-1(a)(1)(C)(x)(xiii)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) 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 home health agency failed to notify the patient's physician of missed visits according to agency policy and failed to promptly obtain	G0590	G-0590 Clinical Director has educated/in-services nursing staff on promptly alerting relevant physician of changes CFR 484.60 (c)(1) and policy 3.06 & 2.56 100% of clinical charts were audited for compliance. Omissions, clarifications and verbal orders obtained if needed. All records cited at survey have been corrected. The Administrator or administrator Designee will audit 100% of re-certifications within 5 days of cert period for medication	2022-11-15

	clarification orders for discrepancies regarding the patient's medications for 2 of 5 active records reviewed (#2, 5). Findings include: 1. An agency policy #3.05 titled "Missed Visit Documentation," dated 05/21/2020, indicated but was not limited to "... Procedure: ... 5. The Clinical Manager will complete a notification to the MD, informing the MD of the missed visit." 2. An agency policy #2.55 titled "Medication Set Up Policy," last revised 06/29/2019, indicated but was not limited to "... Instructions ... 3. The medication list is current and updated with physician orders as changes occur ... 10. The nurse will document and report any issues noted in regard to noncompliance ... involving medication/drugs." 3. The clinical record of Patient #2 was reviewed on 10/18/2022 and included plans of care [POC] for the certification periods of 07/31/22 to 09/28/22 and 09/29/22 to 11/27/22. The POC's indicated the patient's initial start of care		reconciliation and Missed visits to prevent this deficiency from recurring and reported to QAPI monthly to continue for one year Clinical Director and Administrator or Administrator designee will be responsible for monitoring these corrective actions to ensure this deficiency does not recur.	

	[SOC] was 06/11/2020 and due to the agency's change of electronic medical record (EMR) system, Patient #2 was discharged then readmitted on 09/29/22 with a new SOC date of 09/29/22. The POC for the certification period of 07/31/22 to 09/28/22 included orders for home health aide visits for 2 hours per visit, 3 visits per week, and included, but was not limited to, "Orders for Discipline and Treatments ... Visits may be altered due to weather, MD appointments and per patient request. No need to notify the MD of these types of changes to the [plan of care] …." The record indicated aide visits were missed on 08/31/22 (no reason noted), 09/23/22 (no reason noted), and 09/26/22 (no reason noted). The record failed to evidence the patient's physician was notified of the missed visits according to agency policy. A. The record included a physician order, dated 10/02/22 and signed by the Clinical Manager, which included, but was not limited to, "During medication reconciliation, it was noted that the medication in the home that client is taking			

	do not match MD's medication list. Please see medication list sent with order for all current medications. Please clarify and verify medications. Please let us know if any changes? Yes or No ...." The record included medical records for Patient #2's visit with their primary care provider (PCP) on 08/23/22. The visit note included a medication list which, when compared with the agency's medication list completed and signed by the Clinical Manager on 09/29/22, differed in the following ways with the following medications: B. The agency's medication list did not include medications which were included on the PCP's medication list: Cyclobenzaprine (given to relax muscles and treat a variety of musculoskeletal conditions), EpiPen (given to treat emergency allergic reaction), Lipitor (given to treat high cholesterol), Magnesium Citrate (supplement given to treat a variety of conditions resulting from low magnesium blood levels), Multivitamin, Nicoderm C-Q Clear (given to treat cravings for tobacco while quitting smoking), Nitrostat			

typically as needed), Sertraline (given to treat depression, anxiety, and other psychological conditions), Ventolin HFA (inhaler given to treat shortness of breath and/or wheezing), and Vitamin B6 (OTC supplement).

C. The agency's medication list indicated the patient was taking an Albuterol inhaler, however this medication was not included on the PCP's medication list.

D. The dose of the medication on the agency's list differed from the PCP's medication list for the following medications: Mucinex Extended Release (OTC medication given to treat a cough) listed as 1200 milligrams (mg), 1 tablet daily on the agency list and 600 mg, 1 tablet twice a day on the PCP list.

Omeprazole (given to treat acid reflux) was listed as 1 capsule once a day on the agency list and 1 capsule once a day as needed on the PCP list.

Vitamin C (OTC supplement) listed as 500 mg, 2 tabs twice a day, on agency list and 250 mg, 1 tab once a day on the PCP list.

Vitamin D3 (OTC supplement)

	listed as 10,000 international units once a day on agency list and 5,000 international units once a day on the PCP list. The record failed to evidence the agency had received the physician order back from the PCP clarifying the above discrepancies. An interview was conducted on 10/18/2022 at 3:38 PM with the Administrator and Clinical Manager. During the interview, the Clinical Manager was unsure of the specific medications which differed from the PCP's medication list nor if the agency had received a clarification order back from the PCP. When queried how the patient was to know which medications or dosages to take, the Clinical Manager stated Patient #2 would take or not take whichever medications they wanted to, regardless of if and how they were ordered. 4. The clinical record of Patient #5 was reviewed on 10/19/22 and included plans of care for the certification periods of 08/02/22 to 09/30/20 and 09/26/22 to 11/24/22. The POC for the certification period			

	08/02/22 – 09/30/22 indicated the SOC was 12/16/2019 and due to the agency's change of electronic medical record (EMR) system, Patient #5 was discharged then readmitted on 09/26/22 with a new SOC date of 09/26/22. The POC for the certification period 08/02/22 to 09/30/22 included orders for home health aide visits for 2 hours per visit, 3-5 visits per week, and included, but was not limited to, "Orders for Discipline and Treatments … Visits may be altered due to weather, MD appointments and per patient request. No need to notify the MD of these types of changes to the [plan of care]." The record indicated aide visits were missed on 08/12/22 (no reason for missed visit noted), 09/14/22 (per patient request), and 09/16/22 (no reason for missed visit noted) and visits were conducted for less than the ordered duration on 08/24/22 (1.75 hours), 09/03/22 (1.25 hours), 09/04/22 (1.5 hours), and 09/12/22 (1.75 hours). The record failed to evidence the physician was notified of the missed visits per agency policy. 5. An interview was conducted			

	the Administrator and Clinical Manager. During the interview, the Administrator indicated the agency was advised by the previous clinical manager there was no requirement to notify the physician of a missed visit since the POC indicated physician notification was not required for missed visit which occurred due to weather changes, doctor appointments, or patient request, therefore the agency had not been sending missed visit notifications to the attending physician. 410 IAC 17-13-1(a)(2)			
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	G0640	G-0640 Responded to under G0642, G0656, G0658 and G0660 In regards to G-0640 and its standards 100% of staff were called into office for re-education on QAPI & PIP programs and the responsibility of the Governing Body All staff in-serviced on what to report to the agency missed visit, falls, patient going to ER or was in ER, if patient is sick Staff will be in-serviced on hire and annual on	2022-11-15

	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 home health agency failed to ensure its quality assessment and performance improvement (QAPI) program measured, analyzed, and tracked quality indicators and failed to evidence measurable improvement in quality indicators which would improve patient health outcomes, safety, and quality of care (see G642), failed to ensure its QAPI program took actions aimed at performance improvement which focused on high risk, high volume, or problem-prone areas (see G656), failed to ensure its QAPI program conducted at least one performance improvement project (PIP) each calendar year depending on the scope, complexity, and past performance of the agency's services and operations, which included documenting the PIP(s) undertaken, the reason for conducting the project, and the measurable progress achieved on the project (see G658). Based on record review and interview, the governing body failed to ensure an ongoing program for its quality improvement and patient safety was maintained, failed to ensure the agency-wide QAPI efforts addressed priorities for improved quality of care and patient safety, and failed to ensure the QAPI program evaluated improvement actions for effectiveness (see		QAPI & PIP policies and the responsibility of the Governing Body. New QAPI form implemented (11-15-2022) will track the following a New & Old PIP projects, Incidents/Occurrences, Unmet Care, Patient chart review, Employee chart review, Employee Infection , Patient infection, Missed visits, COVID-19, OSHA, Emergency Preparedness, Complaints, Hospitalizations to prevent these deficiency from recurring and adhere to the corrective actions to ensure A data driven QAPI program. this will be the responsibility of the Administrator or Administrator Designee QAPI Committee will meet monthly to review data and trends and decide if corrective actions are needed for one year and the Governing Body will meet every Quarter for review of the QAPI & PIP committee meetings for one year to prevent this deficiency from recurring. New PIP form implemented (11-15-22) will track the following Expected outcomes, interventions monitor for issues that may arise, any barriers for trends notes and what the monitor plan will be along with an Audit log to show monthly percentage to reach compliance and goals. This will be the responsibility of the Administrator or Administrator Designee PIP Committee will meet monthly to review PIP tracking and improvements on the PIP Project this will continue for one year Governing Body will be responsible for ensuring that these deficiency does not recur	

	G660). The cumulative effects of these systemic problems resulted in the agency failing to maintain an effective, ongoing, agency-wide, data drive QAPI program, which resulted in the agency being found out of compliance with Condition of Participation 42 CFR 484.65 Quality assessment and performance improvement.			
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 home health agency failed to ensure its quality assessment and performance improvement (QAPI) program measured, analyzed, and tracked quality indicators and failed to	G0642	G 0642 Responded to under G0642, G0656, G0658 and G0660 In regards to G-0642 and its standards 100% of staff were called into office for re-education on QAPI & PIP programs and the responsibility of the Governing Body All staff in-serviced on what to report to the agency missed visit, falls, patient going to ER or was in ER, if patient is sick Staff will be in-serviced on hire and annual on QAPI & PIP policies and the responsibility of the Governing Body. New QAPI form implemented (11-15-2022) will track the following a New & Old PIP projects, Incidents/Occurrences, Unmet Care, Patient chart review, Employee chart review, Employee Infection , Patient infection, Missed visits,	2022-11-15

	evidence measurable improvement in quality indicators which would improve patient health outcomes, safety, and quality of care, which had the potential to affect all agency patients and employees. Findings included: 1. An agency policy #5.51 titled "QAPI Program & PIP [Performance Improvement Project]," last revised 07/15/2021, indicated but was not limited to "... Procedure: ... 1. Be able to show measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, client safety, and quality of care. 2. Measure, analyze, and track quality indicators ...." 2. Agency documents titled "Agency Monthly Management Meeting Agenda," confirmed by the Alternate Administrator as the agency's monthly QAPI quality indicator tracking for the months of October 2021 through September 2022, were reviewed on 10/21/2022. The documents failed to evidence the agency tracked any quality indicators for the months of May 2022, June 2022, July 2022,		COVID-19, OSHA, Emergency Preparedness, Complaints, Hospitalizations to prevent these deficiency from recurring and adhere to the corrective actions to ensure A data driven QAPI program. this will be the responsibility of the Administrator or Administrator Designee QAPI Committee will meet monthly to review data and trends and decide if corrective actions are needed for one year and the Governing Body will meet every Quarter for review of the QAPI & PIP committee meetings for one year to prevent this deficiency from recurring. New PIP form implemented (11-15-22) will track the following Expected outcomes, interventions monitor for issues that may arise, any barriers for trends notes and what the monitor plan will be along with an Audit log to show monthly percentage to reach compliance and goals. This will be the responsibility of the Administrator or Administrator Designee PIP Committee will meet monthly to review PIP tracking and improvements on the PIP Project this will continue for one year Governing Body will be responsible for ensuring that these deficiency does not recur	

	and August 2022. The September 2022 documents failed to evidence the agency tracked all of the quality indicators for the month. 3. An interview was conducted on 10/21/2022 at 1:27 PM with the Alternate Administrator. During the interview, the Alternate Administrator confirmed they were responsible for obtaining and documenting the agency's quality indicators as part of its QAPI program and reported they had been unable to obtain the quality indicators for the above months due to multiple changes in electronic medical record (EMR) systems and several different people in the role of the clinical manager. 4. The agency's Governing Body minutes for meetings held 02/29/2021 – 08/31/2022, confirmed by the Administrator as both the agency's Governing Body meeting minutes and QAPI meeting minutes, were reviewed on 10/21/2022. The minutes indicated meetings were held on 02/29/2021, 07/27/2021, 08/29/2021, 12/15/2021, 03/01/2022, 05/16/2022, 05/26/2022,			

	06/29/2022, and 08/31/2022. Each meeting minute documentation included, but was not limited to, "... QAPI Update: Board received update from [Alternate Administrator] on QAPI activities. We will continue the same as we have been with no changes ...." The meeting minutes failed to evidence the agency analyzed and/or investigated any trends in quality indicators and failed to evidence measurable improvement in indicators. 5. An interview was conducted on 10/21/2022 at 3:32 PM with the Administrator and Clinical Manager. During the interview, the Clinical Manager reported they are new to the role and had not been trained on QAPI yet. 410 IAC 17-12-2(a)			
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	G0656	G 0656 Responded to under G0642, G0656, G0658 and G0660 In regards to G-0656 and its standards 100% of staff were called into office for re-education on QAPI & PIP programs and the responsibility of the Governing Body	2022-11-15

	interview, the home health agency failed to ensure its quality assessment and performance improvement (QAPI) program took actions aimed at performance improvement which focused on high risk, high volume, or problem-prone areas, which had the potential to affect all agency patients and employees. Findings included: 1. An agency policy #5.51 titled "QAPI Program & PIP [Performance Improvement Project]," last revised 07/15/2021, indicated but was not limited to "... Procedure: ... 7. The data collected must ... identify opportunities for improvement ... 9. Performance improvement activities must have: a. Focus on high risk, high volume, or problem-prone areas. 2. The agency's Governing Body minutes for meetings held 02/29/2021 – 08/31/2022, confirmed by the Administrator as both the agency's Governing Body meeting minutes and QAPI meeting minutes, were reviewed on 10/21/2022. The minutes indicated meetings were held on 02/29/2021, 07/27/2021, 08/29/2021, 12/15/2021, 03/01/2022,		All staff in-serviced on what to report to the agency missed visit, falls, patient going to ER or was in ER, if patient is sick Staff will be in-serviced on hire and annual on QAPI & PIP policies and the responsibility of the Governing Body. New QAPI form implemented (11-15-2022) will track the following a New & Old PIP projects, Incidents/Occurrences, Unmet Care, Patient chart review, Employee chart review, Employee Infection , Patient infection, Missed visits, COVID-19, OSHA, Emergency Preparedness, Complaints, Hospitalizations to prevent these deficiency from recurring and adhere to the corrective actions to ensure A data driven QAPI program. this will be the responsibility of the Administrator or Administrator Designee QAPI Committee will meet monthly to review data and trends and decide if corrective actions are needed for one year and the Governing Body will meet every Quarter for review of the QAPI & PIP committee meetings for one year to prevent this deficiency from recurring. New PIP form implemented (11-15-22) will track the following Expected outcomes, interventions monitor for issues that may arise, any barriers for trends notes and what the monitor plan will be along with an Audit log to show monthly percentage to reach compliance and goals. This will be the responsibility of the Administrator or Administrator Designee PIP Committee will meet monthly to review PIP tracking and improvements on the PIP Project this will continue for one year	

	05/16/2022, 05/26/2022, 06/29/2022, and 08/31/2022. Each meeting minute documentation indicated but was not limited to "... QAPI Update: Board received update from [Alternate Administrator] on QAPI activities. We will continue the same as we have been with no changes ...." The meeting minutes failed to evidence the agency took actions aimed at performance improvement which focused on high risk, high volume, or problem-prone areas. 3. An interview was conducted on 10/21/2022 at 3:32 PM with the Administrator and Clinical Manager. During the interview, the Clinical Manager reported they are new to the role and had not been trained on QAPI yet. 410 IAC 17-12-2(a)		Governing Body will be responsible for ensuring that these deficiency does not recur	
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects.	G0658	G 0658 Responded to under G0642, G0656, G0658 and G0660 In regards to G-0658 and its standards 100% of staff were called into office for re-education	2022-11-15

	(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 ensure its quality assessment and performance improvement (QAPI) program conducted at least one performance improvement project (PIP) each calendar year depending on the scope, complexity, and past performance of the agency's services and operations, which included documenting the PIP(s) undertaken, the reason for conducting the project, and the measurable progress achieved on the project, which had the potential to affect all agency patients and staff. Findings included: 1. An agency policy #5.51 titled "QAPI Program & PIP [Performance Improvement Project]," last revised 07/15/2021, indicated but was not limited to "... Performance Improvement Projects. 1. Hometown must take actions		on QAPI & PIP programs and the responsibility of the Governing Body All staff in-serviced on what to report to the agency missed visit, falls, patient going to ER or was in ER, if patient is sick Staff will be in-serviced on hire and annual on QAPI & PIP policies and the responsibility of the Governing Body. New QAPI form implemented (11-15-2022) will track the following a New & Old PIP projects, Incidents/Occurrences, Unmet Care, Patient chart review, Employee chart review, Employee Infection , Patient infection, Missed visits, COVID-19, OSHA, Emergency Preparedness, Complaints, Hospitalizations to prevent these deficiency from recurring and adhere to the corrective actions to ensure A data driven QAPI program. this will be the responsibility of the Administrator or Administrator Designee QAPI Committee will meet monthly to review data and trends and decide if corrective actions are needed for one year and the Governing Body will meet every Quarter for review of the QAPI & PIP committee meetings for one year to prevent this deficiency from recurring. New PIP form implemented (11-15-22) will track the following Expected outcomes, interventions monitor for issues that may arise, any barriers for trends notes and what the monitor plan will be along with an Audit log to show monthly percentage to reach compliance and goals. This will be the responsibility of the Administrator or Administrator Designee PIP Committee will meet monthly to review PIP tracking and improvements on the PIP Project this will continue for one year	

	aimed at performance improvement and, after implementing those actions, must measure its success and track performance to ensure that improvements are sustained … 6. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the agency's services and operations. a. Hometown must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. b. Have at least one performance project either in development, ongoing, or completed each calendar year …." 2. An interview was conducted on 10/21/2022 at 1:27 PM with the Alternate Administrator. During the interview, the Alternate Administrator stated they had never heard of a PIP prior to the survey and confirmed the agency had no current performance improvement activities or projects. 3. The agency's Governing Body		Governing Body will be responsible for ensuring that these deficiency does not recur	

	minutes for meetings held 02/29/2021 – 08/31/2022, confirmed by the Administrator as both the agency's Governing Body meeting minutes and QAPI meeting minutes, were reviewed on 10/21/2022. The meeting minutes failed to evidence performance improvement projects were conducted by the agency. 4. An interview was conducted on 10/21/2022 at 3:32 PM with the Administrator and Clinical Manager. During the interview, the Clinical Manager reported they are new to the role and had not been trained on QAPI yet.			
G0660	Executive responsibilities for QAPI 484.65(e)(1)(2)(3)(4) Standard: Executive responsibilities. The HHA's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained; (2) That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and	G0660	G 0660 In regards to G-0660 and its standards 100% of staff were called into office for re-education on QAPI & PIP programs and the responsibility of the Governing Body All staff in-serviced on what to report to the agency missed visit, falls, patient going to ER or was in ER, if patient is sick Staff will be in-serviced on hire and annual on QAPI & PIP policies and the responsibility of the Governing Body. New QAPI form implemented (11-15-2022) will	2022-11-15

	patient safety, and that all improvement actions are evaluated for effectiveness; (3) That clear expectations for patient safety are established, implemented, and maintained; and (4) That any findings of fraud or waste are appropriately addressed. Based on record review and interview, the home health agency's governing body failed to ensure an ongoing program for its quality improvement and patient safety was maintained, failed to ensure the agency-wide quality assessment and performance improvement (QAPI) efforts addressed priorities for improved quality of care and patient safety, and failed to ensure the QAPI program evaluated improvement actions for effectiveness, which had the potential to affect all patients and employees. Findings included: 1. An agency policy #5.51 titled "QAPI Program & PIP [Performance Improvement Project]," last revised 07/15/2021, indicated but was not limited to "... The Board of Directors [Governing Body] is responsible for ensuring the following. That an ongoing program for quality improvement and client safety is defined, implemented, and		track the following a New & Old PIP projects, Incidents/Occurrences, Unmet Care, Patient chart review, Employee chart review, Employee Infection , Patient infection, Missed visits, COVID-19, OSHA, Emergency Preparedness, Complaints, Hospitalizations to prevent these deficiency from recurring and adhere to the corrective actions to ensure A data driven QAPI program. this will be the responsibility of the Administrator or Administrator Designee QAPI Committee will meet monthly to review data and trends and decide if corrective actions are needed for one year and the Governing Body will meet every Quarter for review of the QAPI & PIP committee meetings for one year to prevent this deficiency from recurring. New PIP form implemented (11-15-22) will track the following Expected outcomes, interventions monitor for issues that may arise, any barriers for trends notes and what the monitor plan will be along with an Audit log to show monthly percentage to reach compliance and goals. This will be the responsibility of the Administrator or Administrator Designee PIP Committee will meet monthly to review PIP tracking and improvements on the PIP Project this will continue for one year Governing Body will be responsible for ensuring that these deficiency does not recur	

	maintained. Agency wide quality assessment and performance improvement efforts address priorities for improved quality of care and client safety, and all improvements actions are evaluated for effectiveness." 2. The agency's Governing Body minutes for meetings held 02/29/2021 – 08/31/2022, confirmed by the Administrator as both the agency's Governing Body meeting minutes and QAPI meeting minutes, were reviewed on 10/21/22. The minutes indicated meetings were held on 02/29/21, 07/27/21, 08/29/21, 12/15/21, 03/01/22, 05/16/22, 05/26/22, 06/29/22, and 08/31/22. Each meeting minute documentation indicated but was not limited to "… QAPI Update: Board received update from [Alternate Administrator] on QAPI activities. We will continue the same as we have been with no changes …." The meeting minutes failed to evidence the governing body ensured its QAPI program was maintained and all federal regulations related to QAPI, including the QAPI efforts needing to address priorities for improved quality			

	of care and patient safety and evaluating improvement actions for effectiveness, were being met. The governing body meeting minutes also failed to evidence the body was aware and attempting resolution to the inability to obtain complete quality indicator data for the months of May 2022, June 2022, July 2022, August 2022, and September 2022. 3. An interview was conducted on 10/21/2022 at 3:32 PM with the Administrator and Clinical Manager. During the interview, the Clinical Manager reported they are new to the role and had not been trained on QAPI yet. The Administrator reported the Alternate Administrator was responsible for obtaining quality indicator data and the previous clinical manager had not done any work toward the agency's QAPI program.			
G0680	Infection prevention and control 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal	G0680	G 680 Responded to under G682 and G684 All staff was re-educated/In-serviced on the proper way to wash hands, and for how long hands should be washed.	2022-11-15

	the prevention and control of infections and communicable diseases. Based on observation, record review, and interview, the home health agency failed to ensure all staff followed accepted standard precautions and agency policies and procedures to prevent the transmission of infectious and communicable diseases (see G682) and failed to maintain an agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable disease infection tracking (see G684). The cumulative effect of these problems resulted in the agency failing to maintain and document an infection control program and being found out of compliance with Condition of Participation 42 CFR 484.70 Infection Prevention and Control.		All staff will be in-serviced on handwashing policy 2.82 and infection control yearly and at hire to prevent this deficiency from recurring Clinical Director will monitor staff at Supervisor visits and recertification for hand washing technique and report to QAPI monthly for any adverse effects New QAPI form implemented (11-15-2022) will track the following a New & Old PIP projects, Incidents/Occurrences, Unmet Care, Patient chart review, Employee chart review, Employee Infection , Patient infection, Missed visits, COVID-19, OSHA, Emergency Preparedness, Complaints, Hospitalizations to prevent these deficiency from recurring and adhere to the corrective actions to ensure A data driven QAPI program. this will be the responsibility of the Administrator or Administrator Designee QAPI will continue to monitoring and track infection control to determine any cross contamination between patients and employees monthly for one year The Clinical Director and Administrator or administrator will be responsible for monitoring these corrective actions to ensure	

			that this deficiency is corrected and will not recur (G-684) In regards to G-0684 and its standards 100% of staff were called into office for re-education on QAPI & PIP programs and the responsibility of the Governing Body All staff in-serviced on what to report to the agency missed visit, falls, patient going to ER or was in ER, if patient is sick Staff will be in-serviced on hire and annual on QAPI & PIP policies and the responsibility of the Governing Body. New QAPI form implemented (11-15-2022) will track the following a New & Old PIP projects, Incidents/Occurrences, Unmet Care, Patient chart review, Employee chart review, Employee Infection , Patient infection, Missed visits, COVID-19, OSHA, Emergency Preparedness, Complaints, Hospitalizations to prevent these deficiency from recurring and adhere to the corrective actions to ensure A data driven QAPI program. this will be the responsibility of the Administrator or Administrator Designee QAPI Committee will meet monthly to review data and trends and decide if corrective actions are needed for one year and the Governing Body will meet every Quarter for review of the QAPI & PIP committee meetings for one year to prevent this deficiency from recurring. New PIP form implemented (11-15-22) will track the following Expected outcomes, interventions monitor for issues that may arise,	

			monitor plan will be along with an Audit log to show monthly percentage to reach compliance and goals. This will be the responsibility of the Administrator or Administrator Designee PIP Committee will meet monthly to review PIP tracking and improvements on the PIP Project this will continue for one year Governing Body will be responsible for ensuring that these deficiency does not recur	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the home health agency failed to ensure all staff followed accepted standard precautions and agency policies and procedures to prevent the transmission of infectious and communicable diseases for 1 of 3 staff members observed during a home visit (Home Health Aide #2).	G0682	G 0682 (G-682) All staff was re-educated/In-serviced on the proper way to wash hands, and for how long hands should be washed. All staff will be in-serviced on handwashing policy 2.82 and infection control yearly and at hire to prevent this deficiency from recurring Clinical Director will monitor staff at Supervisor visits and recertification for hand washing technique and report to QAPI monthly for any adverse effects New QAPI form implemented	2022-11-15

	Findings include: An agency policy #2.82 titled "Hand Washing / Hand hygiene," last revised 02/08/2019, indicated but was not limited to "... Hand Hygiene Technique ... 7. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by manufacturer to hands and rub hands together vigorously for at least twenty (20) seconds ...." A home visit observation was conducted on 10/18/2022 at 11:34 AM with Patient #2 (start of care 09/29/2022 due to change in agency's electronic medical record (EMR) system, previous start of care 06/11/2022) and Home Health Aide (HHA) #2. During the home visit, HHA #2 was observed performing hand hygiene using soap and water twice, scrubbing their hands for 16 seconds and 18 seconds respectively. During the home visit at 11:42 AM, Patient #2 asked HHA #2 how long the aide was instructed to wash their hands and the aide responded, "20		(11-15-2022) will track the following a New & Old PIP projects, Incidents/Occurrences, Unmet Care, Patient chart review, Employee chart review, Employee Infection , Patient infection, Missed visits, COVID-19, OSHA, Emergency Preparedness, Complaints, Hospitalizations to prevent these deficiency from recurring and adhere to the corrective actions to ensure A data driven QAPI program. this will be the responsibility of the Administrator or Administrator Designee QAPI will continue to monitoring and track infection control to determine any cross contamination between patients and employees monthly for one year The Clinical Director and Administrator or administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

	seconds … or sing 'Happy Birthday' song two times." 410 IAC 17-12-1(m)			
G0684	Infection control 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview, the agency failed to maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases which is an integral part of the agency's quality assessment and performance improvement (QAPI) program, which had the potential to affect all patients and employees.	G0684	G 0684 In regards to G-0684 and its standards 100% of staff were called into office for re-education on QAPI & PIP programs and the responsibility of the Governing Body All staff in-serviced on what to report to the agency missed visit, falls, patient going to ER or was in ER, if patient is sick Staff will be in-serviced on hire and annual on QAPI & PIP policies and the responsibility of the Governing Body. New QAPI form implemented (11-15-2022) will track the following a New & Old PIP projects, Incidents/Occurrences, Unmet Care, Patient chart review, Employee chart review, Employee Infection , Patient infection, Missed visits, COVID-19, OSHA, Emergency Preparedness, Complaints, Hospitalizations to prevent these deficiency from recurring and adhere to the corrective actions to ensure A data driven QAPI program. this will be the responsibility of the Administrator or Administrator Designee QAPI Committee will meet monthly to review data and trends and decide if corrective actions are needed for one year and the Governing Body will meet every Quarter for review of the QAPI & PIP committee meetings for one year to prevent this deficiency from recurring. New PIP form implemented (11-15-22) will	2022-11-15

	Findings include: 1. An agency policy #2.52 titled "Infection Control," dated 12/13/2019, indicated but was not limited to "... Procedure ... the infection program must include: a program for the surveillance, identification, prevention, control and investigation of infections and communicable disease specific to care and services provided in the home setting ...." 2. Agency documents titled "Agency Monthly Management Meeting Agenda," confirmed by the Alternate Administrator as the agency's monthly QAPI quality indicator tracking for the months of October 2021 through September 2022, were reviewed on 10/21/2022. The documents failed to evidence the agency tracked patient infections for the months of May 2022, June 2022, July 2022, August 2022, and September 2022 and failed to evidence the agency tracked employee infections for all months reviewed. An interview was conducted on 10/21/2022 at 1:27 PM with the Alternate Administrator. During		interventions monitor for issues that may arise, any barriers for trends notes and what the monitor plan will be along with an Audit log to show monthly percentage to reach compliance and goals. This will be the responsibility of the Administrator or Administrator Designee PIP Committee will meet monthly to review PIP tracking and improvements on the PIP Project this will continue for one year Governing Body will be responsible for ensuring that these deficiency does not recur	

	the interview, the Alternate Administrator confirmed they were responsible for obtaining and documenting the agency's quality indicators, which included patient infections, as part of its QAPI program. The Alternate Administrator reported the number of infections were to be recorded monthly on the "Agency Monthly Management Meeting Agenda," however they had been unable to obtain the number of patient infections due to the multiple changes in electronic medical record (EMR) systems and several different people in the role of clinical manager. 3. The agency's Governing Body minutes for meetings held 02/29/2021 – 08/31/2022, confirmed by the Administrator as both the agency's Governing Body meeting minutes and QAPI meeting minutes, were reviewed on 10/21/2022. The meeting minutes failed to evidence the agency analyzed and/or investigated any trends in patient or employee infections. 4. An interview was conducted on 10/21/2022 at 3:32 PM with			

	the Administrator and Clinical Manager. During the interview, the Clinical Manager reported the agency was able to track patient infections in the new EMR system however both employees confirmed there could be a potential delay in tracking, analyzing, and investigating patient or employee infections during the agency's transition to the new EMR system and as the Clinical Manager finished orientation to their role.			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the Registered Nurse (RN) failed to prepare a detailed and patient-specific home health aide (HHA) care plan for 2 of 5 active records reviewed (Patient #2 and 5).	G0798	G-0798 Administrator educated/In-serviced all nursing staff on G-0798 & policy 2.49 how to prepare a detailed and patient-specific home health aide care plan. The Rn who failed to complete this documentation correctly was counseled in writing' All records cited at survey have been corrected 100% of clinical records were reviewed and verbal orders obtained if needed were sent to the physician for clarification. 50% of all clinical records will be audited to ensure this deficient practice does not recur findings reported to QAPI monthly The Administrator and Clinical Director shall be	2022-11-15

	Findings included: 1. An agency policy #2.49 titled "Aide Assignments," revised 07/23/2021, indicated but was not limited to "... Purpose: Home Health Aides are assigned to a specific patient by a registered nurse ... with written patient care instructions for a home health Aide prepared by that registered nurse ... The duties of a home health Aide include ... 'Assistance in administering medications,' as referenced in this requirement, means that the [aide] may take only a passive role in this activity. Assistance may include items such as: Bringing a medication to the client either in a pill organizer or a medication container as request[ed] by the client or caregiver ... Reminding the client to take the medication." 2. The clinical record of Patient #2 was reviewed on 10/18/22 and include a plan of care [POC] for the certification period 09/29/22 to 11/27/22 with a start of care [SOC] date of 09/29/22. The POC included orders for home health aide for 2 hours per visit, 3 visits per		responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur	

	week. The record included a "Custom HH Aide Care Plan," signed by the Clinical Manager on 09/29/22, which indicated aide tasks included, but were not limited to, "... Medication Reminders. Instructions: Per shift ... Nail Care. Instructions: clean, file, and trim 1 [time a] week, as requested." The aide care plan failed to evidence the specific assistance the aide was to provide to Patient #2 with medication reminders (specific medication(s) versus the patient's routine scheduled medications, whether the aide was to bring the medication set or bottle to the client, etc) and failed to evidence a clear frequency the aide was to perform nail care. 3. The clinical record of Patient #5 was reviewed on 10/19/22 and included a POC for the certification period of 09/26/22 to 11/24/22 which indicated the SOC was 09/26/22. The POC included orders for home health aide visits for 2 hours per visit, 3-5 visits per week and indicated vital sign call parameters included but were not limited to "Systolic [blood pressure, BP, top number of BP			

	less than 90. Diastolic BP [bottom number of BP reading] greater than 95 or less than 60].” The record included a “HHA Care Plan,” signed by the Clinical Manager on 09/26/22, which indicated vital sign call parameters included but were not limited to systolic blood pressure greater than 120 or less than 50 and diastolic blood pressure greater than 160 or less than 90. The aide care plan indicated HHA tasks included but were not limited to “Assist with Chair Bath. Instructions: … 2 [times] a week … Shower with Chair. Instructions: … 3 [times] a week … Medication Reminders. Instructions: Per shift.” The care plan failed to evidence how the aide was to determine whether to perform a chair bath versus a shower and failed to evidence the specific assistance the aide was to provide to Patient #2 with medication reminders. 4. An interview was conducted on 10/17/22 at 3:38 PM with the Administrator and Clinical Manager. During the interview, the Clinical Manager confirmed the aide care plan should be detailed and patient-specific.			

	When asked how the aide was to perform the task "Medication Reminder," the Clinical Manager reported this was dependent on the patient. 410 IAC 17-13-2(a)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview, the agency failed to ensure home health aides provided services as ordered in the care plan for 3 of 5 active patient records reviewed (Patient #2, 3, 4). Findings include:	G0800	G-0800 Clinical director educated/in-service all home health aide staff on G-0800 providing services as ordered in the care plan and on policy # 2.49. Aide Assignment. 100% clinical records were reviewed and verbal orders obtained if needed were sent to Physician to clarify. The HHA staff sited at survey was counseled to adhere to tag G-0800 and policy 2.49 50% of clinical records will be audited to ensure that this deficient does not recue and findings will be reported to QAPI monthly The Clinical director & Administrator shall be responsible for monitoring these corrective actions and to ensure this deficiency does not recur	2022-11-15

1. Policy 2.49 titled "Aide Assignments," revised 07/23/2021, included, but not limited to, "a home health aide provides services that are... included in the plan of care."

2. The clinical record of Patient #2 was reviewed on 10/18/22 and include a plan of care [POC] for the certification period 09/29/22 to 11/27/22 with start of care date of 09/29/22. The POC included orders for home health aide for 2 hours per visit, 3 visits per week. The record included a "Custom HH Aide Care Plan," signed by the Clinical Manager on 09/29/22, which indicated aide tasks included, but were not limited to, "Safety Measures. Instructions: Keep pathways clear and well lighted [sic]. Applies to all Shifts ... Ask if Any Falls. Instructions: Call RN/ [Case Manager] if fallen to report. Applies to all Shifts ... Offer fluids (unless restricted). Instructions: Keep fluids beside client and encourage to drink. Applies to all shifts ... Antiplatelet Precautions. Instructions: Watch for bruising ... Applies to all shifts ... Incontinence Care. Instructions: Assist with washing perianal

area change depend – per request ... Assist with Ambulation. Instructions: Encourage to ambulate per shift ... Clean Bathroom. Instructions: After bathing 3 [times per] week."

The record included aide visit notes for visits completed by HHA #2 on 10/03/22, 10/05/22, 10/07/22, 10/10/22, 10/12/22, and 10/14/22, which failed to evidence the aide completed or the patient declined the above tasks.

3. Clinical record review for Patient #3 indicated a POC for the certification period 10/07/22 to 12/05/22 with orders for HHA (home health aide) services 2 hours per day, 2 days per week for tasks including but not limited to ask if any falls, offer fluids, tub bath, nail care, assist with dressing, assist with transfers as needed, and meal set up. The aide care plan tasks included but not limited to ask if any falls, offer fluids, tub bath, nail care, assist with dressing, assist with transfers as needed, and meal set up. The aide failed to perform the above tasks from

aide visits on the dates including 10/07/22, 10/11/22, 10/14/22, and 10/18/22.

4. Clinical record review for Patient #4 indicated a POC for the certification period 09/06/22 to 11/04/22 with orders for HHA services 6-8 hours per day, 5-7 days per week for tasks including but not limited to personal care such as assist with bathing and meal prep. The aide care plan tasks for the AM shift included a complete bed bath daily. The aide care plan tasks for the afternoon and PM shifts included meal prep daily. The aide failed to perform a complete bed bath during the AM shift on the dates including 09/07/22, 09/08/22, 10/17/22, and 10/19/22. The aide failed to perform meal prep during the afternoon shift on dates including 10/14/22 and 10/17/22. The aide failed to perform meal prep during the PM shift on dates including 09/06/22, 09/07/22, 09/08/22, 10/14/22, 10/15/22, 10/16/22, 10/17/22, 10/18/22, and 10/19/22.

5. During an interview on 10/18/2022 at 2:28 PM during a home visit with Patient #3, HHA #1 indicated she knows which tasks to do by the app on her phone. When asked if she offers fluids, a task from the aide care plan, HHA #1 indicated she offers fluids and it can be documented in the notes section. HHA #1 also indicated the notes section is where she would document patient refusal of a task. When asked about tub bath from the aide care plan, HHA #1 indicated that task was taken off the app because the patient's family preferred to give the bath at night.

6. During an interview on 10/18/2022 beginning at 3:38 PM, the clinical manager confirmed the aide should complete all tasks listed on the aide care plan or document patient refusal of a task, if applicable.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mitch Weaver	ADMIN	11/25/2022 3:23:19 PM