STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157662	A. BUILDING B. WING	11/08/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ONE HOME HEALTH, LLC	833 W LINCOLN HWY, SUITE 300, SCHERERVILLE, IN, 46375

(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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102 for Home Health Providers and Suppliers. Survey Dates: October 24, 25, 26, 27, 30, and November 8, 2023. Census: 62 At this Emergency Preparedness survey, One Home Health, LLC was found to be out of compliance with Conditions of Participation 42 CFR 484.102: Emergency Requirements for Medicare and Medicaid Participating Providers and Suppliers	E0000	INITIAL COMMENTS VIEWED	
E0001	Establishment of the Emergency Program (EP)	E0001	EMERGENCY PREPAREDNESS PROGRAM WAS ESTABLISHED AND COMPLIES WITH ALL APPLICABLE FEDERAL, STATE, AND LOCAL	2023-12-06

	483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §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		EMERGENCY PREPAREDNESS REQUIREMENTS. EPP BOOKLET WAS UPDATE AS OF 12/5/23.	

include, but not be limited to, the following elements:

Based on record review and interview, the home health agency failed to include complete individualized emergency plans (see tag E0017); failed to include the procedure to address the agency's responsibility in contacting local and state officials of patients in need of evacuation (see tag E0019); failed to include the procedure to locate on-duty staff and patients that are unable to be contacted during an emergency (see tag E0021); failed to include the use of emergency staffing or volunteers (see tag E0024); failed to include a communication plan that complied with federal, state and local laws (see tag E0029); failed to include in the communication plan contact information for entities providing services under arrangement, and patients' physicians (see tag E0030); failed to include primary and alternate means of communicating with staff and federal, state, regional and local emergency officials (see tag E0032); and failed to include procedures for sharing medical

	documentation for patients under the agency's care with other health care providers during an emergency (see tag E0033) for 1 of 1 agency.			
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 record review and interview, the agency failed to ensure each patient had an individualized emergency plan in 12 of 14 records reviewed. (Patient #1, 3, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14)	E0017	Clinicians were educated on 11/9/23, 11/29/23and 12/5/23 on completing individualized emergency plan, and on eachindividualized emergency plan including if applicable: hemodialysis, Port a Cath, weekly intravenousinfusions, cardiac pacemakers, feeding tube, wounds, CPAP, oxygen,transportation and evacuation address and instructions. EPP documentation willbe audited 100% of active patients by Clinical Director/Administrator andIntake manager until 100% compliance is met. Once the threshold is met the audit will bereduced to 10% quarterly.	2023-12-08

The findings include:

*On 10/27/23 starting at 11:39 AM, during home visit observation, Patient # 4's home folder contained Patient Individualized Emergency Plan that failed to evidence all safety precautions for patient that include bleeding precautions.

* On 10/26/23, record review evidenced Patient #4 taking Eliquis (a medication used to treat and prevent blood clots and to prevent stroke). Eliquis can cause bleeding, which can be serious, and may rarely lead to death and bleeding precautions should be included for patients taking Eliquis. Safety precautions failed to evidence bleeding precautions for Patient #4's Individualized Emergency Plan.

*During review, the clinical record failed to evidence documentation of plans for evacuation location of Patient #8 if evacuation due to emergency or disaster is needed.

##. A review of an agency policy revised April 2020, titled, "Emergency Management Plan,"

for patients during a disaster would be included as part of the comprehensive patient assessment.

##. A review of the initial assessment for patient #6, dated 07/06/2023, indicated the patient had a port a cath (implanted device for access to patient's veins).

A review of the plan of care for certification period 07/06/2023-09/03/2023 indicated the patient had weekly intravenous infusions.

A review of the patient's individualized emergency plan dated 07/06/2023, failed to evidence the patient's port a cath or the intravenous infusions ordered.

##. A review of the initial assessment for patient #9, dated 08/29/2023, indicated the patient had an cardiac pacemaker (an implantable device that sends electrical pulses to the heart to regulate the heart rate).

A review of the patients individualized emergency plan dated 08/28/2023, failed to

pacemaker.

##. A review of the initial assessment for patient #11, dated 04/03/2023, indicated the patient required hemodialysis (a process in which a machine filters blood when the kidneys are no longer healthy).

A review of the patient's individualized emergency plan dated 04/03/2023, failed to evidence the patient's hemodialysis.

##. A review of the initial assessment for patient #14, dated 08/02/2023, indicated the patient required hemodialysis and a had a feeding tube (tube into the stomach for nutrition).

A review of the patient's individualized emergency plan dated 08/02/2023, failed to evidence the patient's hemodialysis or the feeding tube.

##. During an interview on 11/08/2023, at 1:50 PM, the Administrator indicated dialysis, pacemakers, feeding tubes, port a cath, intravenous infusions, diabetic care, wounds and oxygen use should all be

	individualized emergency plan. XX. A review of the start of care assessment dated 10/19/2023 evidenced Patient #3 had a surgical wound and required wound care. A review of the individualized emergency plan dated 10/19/2023 failed to evidence Patient #3 required wound care as well as transportation / evacuation plans. XX. A review of the individualized emergency plan for Patient #5 dated 10/17/2023 failed to evidence transportation / evacuation plans. XX. A clinical record review for Patient #10, start of care 10/25/2023 failed to evidence a completed individualized emergency plan. *. Observation of a home visit for patient #1, on 10/24/2023, at 4:15 PM, to observe a routine physical therapy assistant visit. During the visit, a home health			

folder contained an undated document titled "Patient Individualized Emergency Plan" which failed to specify an evacuation location and instructions and failed to include wound care instructions.

A clinical record review for patient #1, evidenced a start of care assessment dated 8/25/2023 which evidenced the patient had wounds. This document failed to evidence an evacuation address and instructions.

A review of Patient #1's Individualized Emergency Plan failed to evidence an evacuation address and instructions and failed to include wound care instructions.

* A clinical record review for patient #7, evidenced a start of care assessment dated 8/30/2023 which evidenced Patient #7 went to Dialysis on Tuesday Thursday Saturday at Entity 2 (Dialysis Center). This document failed to evidence an emergency evacuation address.

A review of Patient #11's Individualized Emergency Plan failed to evidence an evacuation

	dialysis days and location. * A clinical record review for patient #11, evidenced a start of care assessment which evidenced Patient #11 used oxygen and a CPAP machine (for sleep apnea). This document failed to include an evacuation address and instructions. A review of Patient #11's Individualized Emergency Plan failed to evidence an evacuation address and instructions, oxygen, and CPAP machine. * A clinical record review for patient #12, evidenced a start of care assessment dated 10/6/2023 This document failed to evidence Patient #12's evacuation location was home. The document failed to evidence an evacuation location and instructions. A review of Patient #12's Individualized Emergency Plan failed to evidence an evacuation address and instructions.			
E0019	Homebound HHA/Hospice Inform EP Officials 418.113(b)(2)	E0019	Emergency Preparednessprocedure for informing state and local officials about patients' needs	2023-12-08

	§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 home health agency failed to ensure they included the procedures to inform state and local emergency preparedness officials about patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical, psychiatric, and home environment conditions for 1 of 1 agency. Findings include: A record review of an agency		of evacuation from their residences due to emergency situation based on their medical, psychiatric, and home environment conditions were updated and put into EPP Binder. The policies and procedures for informing state and local officials will be reviewed and updated at least every 2years by Clinical Director/Administrator. QAPI will be auditing quarterly to ensure this deficiency does not recur.	

	policy revised April 2020, titled, "Emergency Management Plan," indicated the agency would have a means of informing state and local emergency preparedness officials of patients in need of evacuation due to their medical, behavioral health or conditions of the home environment. A review of the emergency preparedness binder on 11/08/2023, failed to evidence documentation of the procedure to inform state and local emergency preparedness officials about patients in need of evacuation from their residence due to an emergency situation. During an interview on 10/07/2023, at 2:20 PM, the Administrator indicated the agency did not have documentation of a procedure to notify state and local emergency preparedness officials about patients in need of evacuation.			
E0021	HHA- Procedures for Follow up Staff/Pts. 484.102(b)(3)	E0021	Emergency Preparedness procedure was updated on12/5/23 and put into EPP Binder. Radiocommunication obtained on 12/5/23. Procedures to inform state and local	2023-12-08

	§484.102(b)(3) Condition of 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:] (3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact. Based on record review and interview, the home health agency failed to ensure procedures were included to inform the state and local emergency official of any on-duty staff or patients that the agency were unable to contact for 1 of 1 agency. Findings include: A record review of an agency policy revised April 2020, titled, "Emergency Management Plan," indicated the agency would maintain an emergency preparedness communication plan that would include a		emergency officials of any on duty staff or patient that agency are unable to contact have been revised as of 12/5/23. EPP Binder will be reviewed and updated annually by Clinical Director/Administrator to ensure compliance and that deficiency will not recur.	

	local emergency officials of patients and on-duty staff that the agency were unable to contact. The policy failed to address what actions would be required due to the inability to make contact with staff or patients and reporting capabilities to the local and state emergency officials. A review of the emergency preparedness binder on 11/08/2023, failed to evidence documentation of a communication plan that would include a means of informing state and local emergency officials of patients and on-duty staff that were unable to be contacted. During an interview on 11/08/2023, at 2:20 PM, the Administrator indicated the agency did not have a communication plan to contact local and state emergency officials of their patients or on-duty staff that the agency was unable to contact.			
E0024	Policies/Procedures-Volunteers and Staffing	E0024	Policy updated for use of volunteers in case of emergency. EPP Binder was updated to include use of volunteers.	2023-12-08

	483.73(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), §485.542(b)(6), §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 integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and		QAPI will review management EPP binder quarterly to ensure volunteers are addressed and any updated information is added as needed to binder.	

	agency failed to evidence the process for the use of volunteers or other emergency staff strategies to address surge needs during an emergency for 1 of 1 agency. FIndings include: A record review of an agency policy revised April 2020, titled, "Emergency Management Plan," indicated the agency would define their role to the emergency management program related to the use of volunteers and other emergency staffing to address the agency's surge needs. A review of the emergency preparedness binder on 11/08/2023, failed to evidence documentation of the agency's procedure to define their role related to the use of volunteer and other emergency staffing to address the agency's surge needs. During an interview on 11/08/2023, at 12:28 PM, the Administrator indicated the agency did not have a procedure to address volunteer and emergency staffing during an agency's surge needs.			

E0029	Development of Communication Plan 483.73(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.542(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an 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]. Based on record review and interview, the home health agency failed to develop and maintain a communication plan that complies with federal, state and local laws and that was reviewed every 2 years for 1 of 1 agency. Findings include: A record review of an agency policy revised April 2020, titled, "Emergency Management Plan," indicated the agency would maintain an emergency preparedness communication plan that complied with federal, state, and local laws that would include name and contact information for patients'	E0029	EPP plan was reviewed as of 12/5/23: Updated Employee contact list, vendor list,and communication plan. Clinical Director/Administrator will update employee contact list, vendor list and communication plan as changes occur. Will maintain an emergency preparedness communication plan that complies with Federal, State and locallaws and will be reviewed and updatedat least every 2 years by Clinical Director/Administrator. QAPI will be auditing quarterly the employee contact list, vendor list, and communication plan ensuring information is up to date and deficient practice does not recur.	2023-12-05

	providing care under arrangement, primary and alternate means for communication with staff, federal, state, tribal, and local emergency officials, a method for sharing medication documentation for patients, a means for informing state and local emergency officials with patients that agency were unable to reach, patients in need of evacuation, or on-duty staff that the agency were unable to contact. A review of an agency document dated 06/01/2022, titled, "Review Record," indicated the Administrator reviewed and updated the employee contact list. A review failed to evidence documentation the communication plan was reviewed every 2 years. A review of the agency's emergency preparedness binder on 11/08/2023, failed to evidence documentation of the agency's communication plan that complied with the federal, state and local laws to include name and contact information for patients' physicians and entities providing care under			

	arrangement, primary and alternate means for communication with staff, federal, state, tribal, and local emergency officials, a method for sharing medication documentation for patients, a means for informing state and local emergency officials with patients that agency were unable to reach, patients in need of evacuation, or on-duty staff that the agency were unable to contact. During an interview on 11/08/2023, at 2:20 PM, the Administrator indicated the agency did not have documentation the communication plan was reviewed every 2 years and complied with the federal, state and local laws.			
E0030	Names and Contact Information 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1).	E0030	EPP Binder updated with entities providingservices under arrangement and patients physicians as of 12/5/23. ClinicalDirector/Administrator willl maintain anemergency preparedness communication plan that complies with Federal,	2023-12-05

	[(c) The [facility must develop and maintain an 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:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement.		State and locallaws and will be reviewed and updatedat least every 2 years. Clinical Director/Administrator will update/revise communication plan as changes occur. QAPI will audit communication plan quarterly to ensure deficient practice will not recur.	

	(iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.			

	*[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on record review and interview, the home health agency failed to maintain an emergency preparedness communication plan which included names and contact information for patients' physicians and other entities providing services under arrangement to patients for 1 of 1 agency. Findings include: A review of an agency policy revised April 2020, titled, "Emergency Management Plan," indicated the agency would maintain an emergency preparedness communication plan that would include name and contact information for entities providing services under arrangement and patients' physicians.			

	A review of the emergency preparedness binder on 11/08/2023, failed to evidence documentation of a communication plan that included entities providing services under arrangement and patients' physicians. During an interview on 11/08/2023, at 2:20 PM, the Administrator indicated the agency did not have an communication plan that included entities providing services under arrangement and patients' physicians.			
E0032	Primary/Alternate Means for Communication 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.542(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an 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: (3) Primary and alternate means for	E0032	EPP Binder update 12/5/23: primary and secondary means of communicationwere updated and filed in EPP binder. Clinical Director/Administrator willmaintain an emergency preparedness communication plan that complies with Federal, State and locallaws and must be reviewed and updatedat least every 2 years. QAPI will be auditing quarterly primary and secondary means of communication to ensure deficient practice does not recur.	2023-12-05

communicating with the following:

(i) [Facility] staff.

(ii) Federal, State, tribal, regional, and local emergency management agencies.

*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.

Based on record review and interview, the home health agency failed to develop and maintain an emergency preparedness communication plan that included primary and alternate means for communication with the facility, staff, federal, state, tribal, regional, and local emergency management for 1 of 1 agency.

Findings include:

A review of an agency policy revised April 2020, titled, "Emergency Management Plan," indicated the agency would maintain an emergency preparedness communication plan that would include primary and alternate means for communication with the staff, federal, state, tribal, regional and local emergency management agencies.

A review of the emergency

	11/08/2023, failed to evidence a communication plan that included primary and alternate means for communication with staff, federal, state, tribal, regional and local emergency management agencies. During an interview on 11/08/2023, at 1:50 PM, the Administrator indicated the agency did not have an emergency preparedness communication plan that included primary and alternate means for communication with the staff, federal, state, tribal, regional and local emergency management agencies.			
E0033	Methods for Sharing Information 483.73(c)(4)-(6) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.542(c)(4)-(6), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an 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	E0033	EPPbinder updated as of 12/5/23 with communication plan including a method for sharing information, medicaldocumentation, and provide information about the general condition and locationof the patients under the agency's care. Updated 12/5/23. Clinical Director/administrator will develop and maintain an emergency preparedness communication plan that complies with Federal, State and locallaws and must be reviewed	2023-12-05

	communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Based on record review and interview, the home health agency failed to a method for sharing information and medical documentation for patients under the agency's care with other health care providers to maintain continuity of care, and in the event of an		and updatedat least every 2 years. QAPI will be auditing emergency preparedness communication and methods of sharing information quarterly to ensure deficient practice does not recur.	

evacuation, a means of releasing patient information about the general condition and location of the patient for 1 of 1 agency.

Findings include:

A record review of an agency policy revised on April 2020, titled, "Emergency Management Plan," indicated the agency's communication plan would include a method for sharing information, medical documentation, and provide information about the general condition and location of the patients under the agency's care.

A review of the emergency preparedness binder on 11/08/2023, failed to evidence the procedure to include a method to share information, medication documentation, and provide information about the general condition and location of the patients under the agency's care.

During an interview on 11/08/2023, at 2:20 PM, the Administrator indicated the agency did not have a procedure to share patient

	provide information of the general condition and location of the patients under the agency's care.			
G0000	INITIAL COMMENTS This visit was for a Federal Complaint survey of a Deemed Home Health Agency provider. Survey Date: 10/24/2023, 10/25/2023, 10/26/2023, 10/27/2023, 10/30/2023, and 11/8/2023 Complaint # IN102340 Federal and State deficiencies were cited. Census: 680 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. During this survey One Home Health was found to not meet 1 Conditions of Participation at 42CFR 484.102 Organization and Administration of Services.	G0000	INTIAL COMMENTS VIEWED	
G0572	Plan of care	G0572	**Clinicians were educated on**	2023-12-08

	484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure care was provided as established in the plan of care in 4 of 10 active clinical records reviewed. (Patient #1, #4, #7, #10). The findings include: 1. A review of an agency policy titled, "Care Planning Process", revised 4/2020, indicated the agency shall provide services based on the needs of the patient as directed in the plan of care. 2. Review of Job Description No. C-210 "Position: Registered Nurse", included but not limited to, "Performs comprehensive assessments of client status,		**11/27, and 12/5 topain parameters and when to notify physician of pain rating greater than 6.** **Clinicians educated on use of assistive devices and appropriateness of thedevice to ensure patient safety.** **Clinicians educated on reporting to physicianthe Patient's systolic blood pressure (BP) greater than 165 and diastolicgreater than 95.** **Education provided to clinicians on proper auscultation ofbreath sounds and apical pulse.** 100% review of all current/active charts were audited by Clinical director/administrator and intake manager until 100%percent of compliance is met, specifically: - pain and blood pressure parameters arefollowed, and physician was notified	

	and/or follows an individualized Plan of Care…" 3. A review of the plan of care for Patient #10, certification period 10/25/2023 to 12/23/2023, indicated the licensed professional was to report a pain rating greater than 6. The plan of care indicated physical therapy was to provide gait training and use of an appropriate assistive device to ensure patient safety. In a visit note dated 10/26/2023, OT (Occupational Therapist) 2 indicated the patient complained of pain rating a 7. A clinical record review failed to evidence OT 2 informed the physician of the patient's pain. In an initial visit note dated 10/25/2023, PT (Physical Therapist) 1 indicated they did not instruct the patient on the basic use of assistive devices to ensure the patient was safe until next visit because it was not applicable.		-Therapists were educated on 11/27 and 12/5/23on DME/ assistive devices to ensure safety. - Nurses were in serviced on 11/27/23 and 12/5/23 on the appropriate technique to auscultate lung sounds and how to take an apical pulse. Ongoing education will be provided to clinicians annually. Any deficiencies that were cited during chartreviews clinicians were educated on said deficiency. Clinicianswere notified via HIPPA compliant message and were educated on compliance incited area to prevent deficiency from recurring.	

	During an interview on 10/27/2023 at 2:52 PM, Patient #10 indicated they were not used to using a walker, and they did not use one before surgery. During an interview on 10/30/2023 at 12:25 PM, the administrator indicated the clinician should notify the physician for a pain rating outside of the parameters. When informed of the findings, the administrator indicated PT 1 should have assessed the patient's use of the walker in order to ensure their safety at the initial visit and ongoing. 4. A clinical record review for patient #7, start of care 8/30/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 8/30/2023 -10/28/2023. This document evidenced the nurse was to notify the physician if the Patient's systolic blood pressure (BP) was greater than 165 and diastolic greater than 95. A review of Patient #7's electronic record evidenced an RN Visit Note dated 9/8/2023. During this visit, Patient #7's BP was 172/98. There failed to be			

	evidence the RN contacted the Physician as indicated in the plan of care. 5. A clinical record review for Patient #1, start of care 9/25/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 9/25/2023 to 11/23/2023. This document evidenced the RN was to notify the nurse of a pain level of greater than 6 on a scale of one to ten (one being less pain 10 being the most pain). A clinical record review for Patient #1, start of care 9/25/2023, evidenced an agency document for an RN visit on 9/29/2023. This document evidenced Patient #1 had a pain level of 6-7. There failed to be evidence the nurse notified the Physician of the Patient pain as ordered in the plan of care. 6. During a home observation visit of RN 3 providing care for Patient #4 on 10/27/23 beginning at 11:39 AM, observed RN 3 auscultate apical heart rate for approximately 5 seconds then auscultate all			

	posterior breath sounds bilaterally. The registered nurse (RN) failed to auscultate any of the patient's anterior breath sounds and failed to auscultate an apical pulse for a full 60 seconds. 7. On 10/26/23, the clinical record review for Patient #4 evidenced a POC for the period 10/23/23 through 12/21/23 that included "skilled nurse to...assess cardiovascular system..." and "SN (skilled nurse) for assessment of lung sounds..." 8. During an interview on 10/27/23 at 3:31 PM, Administrative Staff 1 reported the expectation was for nurse to check apical pulse for full 60 seconds every patient visit and all lung fields should be auscultated, back-to-back, front, for every patient visit.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and	G0574	The Rn and Therapy field staff were in-serviced on11/27/23 and 12/5/23 to the following CFR: 484.60(a)(2)(i-xvi) . Education included items listed on the individualized plan ofcare, but not limited to: -All pertinent diagnosis -Documenting blood sugar parameters for diabetic patients -The types of services, supplies, and equipment required. IE: ice	2023-12-08

	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, supplies, safety precautions, equipment, and treatments in 8 of 14 clinical records reviewed. (Patient #1, 2, 3, 4, 7, 10, 11, 14) The findings include: 1. A review of an agency policy		machine,glucometer -All Medications and treatments includingprescription and supplements -care coordination Note in HCHB to becompleted if patient on hemodialysis to include what dialysis center and thedates of dialysis treatment. -Wound care should include what wound care wasto be done, by whom, and what frequency as well as what supplies are needed. - Patient specific clinical plan of care:precautions, supplies, and safety equipment that is used or needed. The Clinical Director/administrator and Intakemanager will audit 100% of all current/active charts until 100% compliance ismet, specifically: - Every patient chart contains anindividualized plan of care -Wound care to be performed and at whatfrequency. Patient/Caregiver if able to demonstrate ability to perform woundcare. -Patient specific precautions -All DME in the home will be documented -Complete and accurate medications, dose, frequency, and routes -Any PRN medications and supplements will list quantity and frequency -Supplies and equipment required to promotesafety and protect against injury. Any deficiencies thatwere cited during chart reviews clinicians were educated on saiddeficiency. Clinicians were notified via HIPPA compliant messageand were educated on compliance in cited area to prevent deficiency fromrecurring.	

revised 4/2020, indicated the agency would create an individualized plan of care for each patient which included all medications and treatment for the patient.

2. A review of the plan of care for Patient #3, certification period 10/19/2023 to 12/17/2023, indicated the nurse was to perform / teach wound care to the incision on the right hip. The plan of care evidenced a goal that the patient / caregiver will demonstrate the ability to perform wound care. The plan of care failed to evidence what wound care was to be performed and at what frequency. A review of the list of supplies on the plan of care evidenced the patient required alginate dressing (a specialized wound care dressing). A clinical record review failed to evidence an order or instruction for the patient to use alginate dressing.

During an interview on 10/30/2023 at 11:10 AM, the administrator indicated the plan of care should include specific orders for what wound care was to be done, by whom, and at what frequency. The

	dressing was not currently used by the patient and should not have been on the plan of care. 3. A clinical record review for patient #7, start of care 8/30/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 8/30/2023 -10/28/2023. This document evidenced Patient #7 had end-stage kidney failure and was dependent on Renal Dialysis. The plan of care failed to include Patient #7's Dialysis Center and the dates of his dialysis treatments. The document evidenced Patient #7 was diabetic and received insulin twice daily. The document failed to include blood sugar parameters for physician notification. During an interview on 10/20/2023 at 2:31 PM, the Administrator indicated the plan of care should include where and when the Patient goes to dialysis, She also indicated there should be blood sugar parameters on the plan of care for diabetic patients. 4. A clinical record review for			

	9/25/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 9/25/2023 to 11/23/2023. This document evidenced the patient was taking the following medications: Atorvastatin (for high cholesterol), Calcium (supplement), Furosemide (for fluid retention) levothyroxine (for thyroid), lidocaine topical cream (for pain), methylprednisolone (for inflammation), metoprolol (For high blood pressure), Montelukast (for asthma), tramadol (for pain) Valsartan (for high blood pressure), Xarelto (prevents blood clots). The plan of care failed to include Patient #1's complete list of medications. During a home visit on 10/24/2023 at 4:15 PM, Patient #1's home folder was reviewed. The medication list in Patient #1's home folder evidenced Patient #1 was taking Turmeric (supplement). During an interview with Patient #1 on 10/24/2023 at 4:45 PM, Patient #1 when reviewing the current medications taken,			

takes Klor Con (for low potassium) and Turmeric. These medications failed to be included in the medications on the plan of care.

During an interview on 10/27/2023 at 2:17 PM, the Administrator indicated all medications and supplements the Patient is taking should be listed on the plan of care.

5. A review of a plan of care for patient #2 for certification period 10/21/2023-12/19/2023, evidenced the patient had a right knee replacement.

During an observation of a home visit for patient #2 on 10/25/2023, starting at 9:30 AM, registered nurse (RN) 1 instructed the patient to use an ice machine to the right knee in 20-minute increments.

A review of the plan of care failed to evidence the use of the ice machine to the right knee.

During an observation of the home visit the patient indicated the use of supplements magnesium 400 micrograms one tablet twice a day and Iron 65mg one tablet twice a day.

	A review of the plan of care failed to evidence the magnesium and iron supplements. During an interview on 10/26/2023, at 2:15 PM, the Administrator indicated the use of the ice machine should have been included on the plan of care and magnesium and iron should have been verified with the physician and added to the plan of care medication list. 6. A review for patient #11 evidenced an initial RN admission note, dated 04/03/2023, which indicated patient was receiving hemodialysis (a process to filter wastes from the blood when the kidneys are no longer healthy). A review of the plan of care for certification period 04/03/2023-06/01/2023, failed to evidence the patient's dialysis center or frequency of treatments. 7. A review for patient #14 evidenced an initial RN admission note, dated 08/02023, which indicated patient was receiving hemodialysis.			

	A review of the plan of care for certification period 08/02/2023-09/30/2023, failed to evidence the patient's dialysis center or frequency of treatments. 8. During an interview on 10/30/2023, at 11:19 AM, the Administrator indicated the dialysis location center name and days of the week of dialysis should be included on the plan of care. 9. Review of Policy 4-001 "Care Planning Process," revised April 2020, included but not limited to, "the patient-specific clinical plan of care includes:...safety measures to protect against injury...supplies and equipment required..." 10. During a home visit observation on 10/27/23 beginning at 11:39 AM, Patient # 4 reported use of a glucometer to monitor blood sugar levels being performed by Patient # 4's children every few days. 11. Review of Patient #4's clinical record evidenced a POC for certification period 10/23/23 through 12/21/23 which failed to include the patient's			

glucometer and failed to include bleeding precautions as the patient takes an oral anticoagulant (Eliquis).

12. A review of the plan of care for Patient #10, certification period 10/25/2023 to 12/23/2023 indicated the patient was to receive OT (Occupational Therapy) services but failed to evidence specific interventions for what was to be done at patient visits.

During an interview on 10/27/2023 at 3:30 PM, Occupational Therapist Assistant (OTA) 1 indicated the Occupational Therapist did not give them specific instructions for what to do in the patient's home. OTA 1 indicated the therapist would write the goals, but it was up to her to come up with the interventions.

13. During interviews conducted on 10/26/23 at 2:21 PM and 10/27/23 at 3:31 PM, Administrative Staff 1 failed to demonstrate evidence of glucometer equipment as well as bleeding precautions listed in Patient # 4's POC for certification period 10/23/23 through 12/21/23.

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 agency failed to alert the physician to changes in the patient's condition in 2 of 2 clinical records reviewed in which the Patients experienced a change in condition (Patient #1, #5). The findings include: 1. A review of the agency's Registered Nurse job description, revised 12/10/2012, evidenced the nurse shall report changes in patient status to the physician in a timely manner. 2. A review of the agency's Occupational Therapy Assistant job description, dated 2017, evidenced the OTA (Occupational Therapy Assistant) shall report any changes to the therapist and / or nursing supervisor.	G0590	Clinicians educated on 11/27/23 and12/5/23 to promptly alert physicians on any changes in the patient's conditionor outcomes that are not being achieved and if the plan of care should bealtered. Physician should becontacted to obtain a new order and order should be entered. Assistants shall be reporting any changes to the therapist or nursing supervisor. 100% of chartswill be reviewed by clinicalmanager/administrator and intake manager until 100% compliance is met to ensurecare coordination between clinicians and physicians onany change of status. Once threshold is met, a 10% audit will be conductedquarterly.	2023-12-08

	3. A review of the start of care assessment dated 10/17/2023 by RN (Registered Nurse) 2, indicated Patient #5 had bruising. A clinical record review failed to evidence the nurse informed the physician of the bruising. In a skilled nurse visit note dated 10/19/2023, RN 2 indicated the patient had a new skin tear to the left inner arm. A clinical record review failed to evidence the nurse informed the physician of the new wound. In a visit note dated 10/24/2023, OTA 1 indicated the patient had hemoptysis (coughing up blood). A review of all prior visit notes (skilled nurse 10/17/2023 and 10/29/2023; occupational therapy 10/18/2023 and 10/20/2023; physical therapy 10/20/2023) failed to evidence hemoptysis. A clinical record review failed to evidence the physician was informed of the patient's hemoptysis. During an interview on 10/27/2023 at 3:09 PM, the administrator indicated the nurse should inform the physician if a patient has			

	bruising or a new wound. If a new patient symptom or complaint is found by an OTA, the administrator indicated they should inform the OT who would contact the physician and document the communication in the patient's record. 4. A clinical record review for Patient #1, start of care 9/25/2023, evidenced an agency document for an RN visit on 9/29/2023. This document evidenced Patient #1 had a pain level of 6-7 on a scale of 1-10 (1 less pain 10 most pain) but did not want to take his/her tramadol due to potential constipation. RN 3 educated the patient to increase fluids and take a stool softener every day. A review of the patient's medical record failed to evidence RN 3 notified the Physician of the patient's pain and concern with taking the pain medication and failed to obtain an order for the stool softener. A review evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 9/25/2023 to 11/23/2023. This			

	patient was taking the following medications: Atorvastatin (for high cholesterol), Calcium (supplement), Furosemide (for fluid retention) levothyroxine (for thyroid), lidocaine topical cream (for pain), methylprednisolone (for inflammation), metoprolol (For high blood pressure), Montelukast (for asthma), tramadol (for pain) Valsartan (for high blood pressure), Xarelto (prevents blood clots). This document failed to evidence the patient was prescribed Tylenol or a stool softener. A review of the patient medication list failed to evidence the patient was prescribed a stool softener or Tylenol. A review for patient #1 evidenced a Client Note Report dated 10/10/2023. This document evidenced Patient #1 was experiencing diarrhea. The document evidenced RN 3 educated the patient to eat yogurt several times a day as antibiotics can cause diarrhea. RN 3 also informed the Patient to start a daily probiotic. There			

	called the Physician about the diarrhea and failed to evidence an order for a probiotic. During an interview on 10/30/2023 at 3:15 PM, the Administrator indicated the Physician should have been called and the medications should have been added to the plan of care.			
G0606	Integrate all services 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 record review and interview, the home health agency failed to ensure they coordinated care with other health care providers that provided care to agency patients in 3 of 3 clinical records reviewed of patients who received dialysis (Patient #7, #11, #14) and 1 of 1 patient discharged to hospice care. The findings include: 1. Review of an agency policy titled "Coordination of Services with Other Providers," revised	G0606	Education was provided to clinicians on11/27/23 and 12/5/23 regarding coordinating care documentation with patientsreceiving Integrated services, whether services are provided directly or underarrangement. IE: Hospice, Hemodialysis Agency will show coordination of care documentationwith health care providers that provide care to agency patients. 100 % of current and active charts have beenreviewed by clinical director/administrator and Intake manager to ensuredocumentation supports integrated services. Once 100% compliance is met to showevidence of communication or coordination of care with other health careproviders a 10% audit will be conducted quarterly by QAPI.	2023-12-08

April 2020, indicated the case manager will act as a liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related service."

2. A clinical record review for patient #7, start of care 8/30/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 8/30/2023 -10/28/2023. This document evidenced Patient #7 had end-stage kidney failure and was dependent on Renal Dialysis.

A review of Patient #7's electronic medical record (EMR) failed to evidence coordination with the dialysis center.

During an interview on 10/20/2023 at 12:20 PM, the Administrator indicated Patients usually have been on dialysis for a while when they come onto service. She indicated they know their schedule and have transportation, so the agency does not coordinate with the dialysis centers.

3. A review on 11/08/2023, for patient #9 of the patient's electronic medical records

	evidenced the patient was last seen on 10/25/2023, and the patient was discharged to hospice on 10/30/2023. Review of the electronic medical records failed to evidence any communication or coordination with the hospice agency related to the patient discharge. During an interview on 11/08/2023, at 2:18 PM, Administrative Staff 2 indicated the patient was discharged to hospice on 10/30/2023, and there was not documentation of coordination of care with the hospice agency to take over patient care. 4. A review of a visit note dated 04/11/2023, for patient #11, indicated the patient received hemodialysis (a process to filter wastes from the blood when the kidneys are no longer healthy) 3 days per week. A review of the patient's electronic medical records failed to evidence coordination with the dialysis center.			

	5. A review of the initial registered nurse assessment dated 08/02/2023, for patient #14, indicated the patient received hemodialysis 3 days per week. A review of the patient's electronic medical records failed to evidence coordination with the dialysis center. 6. During an interview on 10/30/2023, at 11:19 AM, the Administrator indicated the agency does not coordinate patient care with the dialysis centers.			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation and interview, the agency failed to ensure their patients received a written schedule of visits in 3 of 5 home visits conducted (Patient #1, 3, 10). The findings include: *. Observation of a home visit for Patient #1 on 10/24/2023 at	G0614	Education was provided to clinicianson 11/27/23 and 12/5/23 to complete a writtenschedule, including frequency to be left in the patient'shome. Clinicians will be sending in pictures via HIPPA compliant message in real time of completed calendar at end of SOC, EVAL to ensure evidence that patient received a written schedule of visits to be performed by clinicians. A random 10 % of home visits will be conducted to ensure compliance of completed calendars in the home. If	2023-12-08

	4:15 PM failed to evidence a completed visit schedule. During the home visit for Patient #1 on 10/24/2023 at 4:21 PM, Physical Therapy Assistant (PTA) 2, indicated Patients were informed what day their visit would be, and the patient would get a call the night before to give them an approximate visit time. During an interview at a home Visit for Patient #1 on 10/24/2023 at 5:02 PM, Patient #1 indicated there was not a calendar filled out by staff. Patient #1 indicated Staff usually comes either Tuesdays or Wednesdays, and they will call the night before to give an approximate visit time. During an interview on 11/8/2023 at 1:56 PM, The Administrator indicated there is a calendar in the Patient's booklet in their home. By the end of the evaluation visit the frequency is put on the calendar. The Administrator indicated the days of the Patients next visit should be added to the calendar. The times are not given until the night before.		adjustments are neededcalendar will be updated at the following home visit so patient is aware. 100% of active/current patient'scharts will be reviewed by intake manager and clinical director/administrator until100% compliance is met to ensure calendars are completed in the home. Oncethreshold is met, a 10% audit will be conducted quarterly by Clinical Director/Administrator and intake manager to ensure deficiency does not recur.	

	XX. Observation of a home visit on 10/27/2023 at 8:05 AM failed to evidence a complete written visit schedule in Patient #3's home. XX. Observation of a home visit on 10/27/2023 at 2:37 PM failed to evidence a complete written visit schedule in Patient #10's home. At 3:27 PM, OTA (Occupational Therapy Assistant) 1 documented their upcoming visits in the patient's calendar and indicated the physical therapist failed to document their upcoming visits in the calendar.			
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 record review and interview, the home health agency failed to implement policies and procedures for the control of communicable diseases in 1 of 1 patients records reviewed with antibiotics prescribed while on	G0682	100 % of current/active charts were reviewed by Clinical Director/administrator for the next 30 days to ensure allpatients with a new or suspected infection will have a patient infection reportcompleted within 24 hours of discovery. This will include any new, actual, orsuspected infection is clinically observed by personnel, or a new antibiotic isordered. Clinical Director/Administrator will be monitoring new or suspected infection during case conference and having clinician entering QI report if needed. Target threshold is 100%, once 100% compliance is met then QAPI will be performing quarterly chart audits to ensure deficiency does not recur on any new, actual, or suspected infection or new antibiotic that is ordered. Education was provided to staff on 11/27/23 and 12/5/23 on infection control and documenting a infection report on any new, actual, or suspected infection as well as if new antibiotic is ordered.	2023-12-08

service with the home health agency (Patient # 6).

The findings included:

A review of an agency policy dated April 2020, titled, "Evaluating and Maintaining Records of Infections Among Patients," indicated all patients with a new or suspected infection will have a patient infection report completed within 24 hours of discovery. The policy indicated the patient report form would be completed when a new, actual, or suspected infection is clinically observed by personnel, or a new antibiotic is ordered, and the form will be sent to the Performance Improvement Coordinator to analyze the reports and the information will be used as part of the organization's risk analysis for the organization's infection prevention activities.

A clinical record review for patient #6, start of care 07/06/2023, evidenced a coordination note dated 10/11/2023, which indicated the patient had a boil (skin infection) to the right arm that

	(fluid from wound that could be sign of infection). The coordination note indicated the patient was started on Keflex (antibiotic). A review of the Quality Improvement Event Summary for 10/24/2022-10/24/2023, failed to include the infection report for the patient. During an interview on 10/26/2023, at 2:18 PM, the Administrator indicated the infection for the patient should have been included on the Quality Improvement Event Summary.			
G0724	Supervise skilled professional assistants 484.75(c) Standard: Supervision of skilled professional assistants. Based on record review and interview, the therapist failed to direct the activities of the therapy assistant in 1 of 1 Occupational Therapy Assistant Visits conducted (Patient #10). The findings include: The review of an agency policy titled “Scope of Services”,	G0724	All fieldtherapists and assistants were educated at staff meeting on 11/27/23 and 12/5/23 toensure that skilled professionals assume responsibility for supervising the therapy assistants. Therapist will develop and revise a planof care for each patient and supervise that the assistant is providing servicesthat are planned, delegated, and supervised by the therapist. Goals will be developed by Therapist and interventions will	2023-12-08

	revised 4/2020, indicated the therapists shall develop and revise a plan of care for each patient as well as supervise therapy assistants. The policy indicated therapy assistants shall provide services that are planned, delegated, and supervised by the therapist. A review of the plan of care for Patient #10, certification period 10/25/2023 to 12/23/2023 indicated the patient was to receive OT (Occupational Therapy) services but failed to evidence specific interventions for what was to be done at patient visits. During an interview on 10/27/2023 at 3:30 PM, Occupational Therapist Assistant (OTA) 1 indicated the Occupational Therapist did not give them specific instructions for what to do in the patient's home. OTA 1 indicated the therapist would write the goals, but it was up to her to come up with the interventions.		be determined by therapy assistants during care in home to make sure goals are being reached/achieved. 100% of charts will be reviewed by theClinical Director/administrator toensure the supervision of skilled professional assistants. The Scheduler/Intake Manager will assign asupervisory visit code on the patient's schedule in the EMR, i.e. RN10, PT10,OT10, no less frequently than every 14 days. Once 100% complianceis met, a 10% audit will be conducted quarterly by QAPI.	
G0940	Organization and administration of services 484.105	G0940	**Org chartwas updated with direct lines of authority which clearly establish responsibilityand**	2023-12-08

	Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on record review and interview, the agency failed to ensure the administrative and supervisory functions were not delegated to another agency or organization and the organizational structure was set forth, in writing, including lines of authority and services furnished; failed to ensure a clinical manager was available during all operating hours (See G950); and failed to ensure failed to ensure a qualified individual was available to assume the responsibilities and obligations as the administrator in the Administrators absence (See G954) in 1 of 1 agency. The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe		**accountability within theorganization. Clinical Director/Administrator will update the ORG chart whenchanges occur within the agency. Audit of ORG chart will be** reviewed, revised and dated **quarterly with any changes by Clinical Director/**Administrator. A 100%review of all contracted staff contracts were reviewed by Clinical Director/administratorto ensure all contracted staff are in compliance. QAPI will be auditing quarterly to ensure this deficiency does not recur. Updated policy and procedure to include business associate agreements (BAA) agreements prior to the individuals being permittedto providing services on behalf of the organization.	

	environment for the condition of participation 42 CFR 484.105 Organization and Administration of Services. The findings include: 4. A review of an agency policy revised in April 2020, titled "Use of Organizational Chart," indicated, There will be defined lines of authority, which clearly establishes responsibility and accountability for all organization personnel. Organizational charts will be used to define relationships and the lines of authority within the organization. Organizational charts will be reviewed revised and dated as changes occur. 5. A review of the agency organizational chart, which was revised on 8/17/23023, indicated the organization chart was for the Indiana location. A review of this chart evidenced Corporate Staff was the QAPI Coordinator and that Corporate Staff 5 was the Nurse Educator. Review evidence Corporate Staff was not an employee of the Indiana Agency but was a corporate employee. Review evidenced Corporate Staff 5 was not an employee of the Indiana agency and did not have an Indiana Nursing License and			

Corporate Staff 5's Indiana Nursing license expired in 2021. These positions were to report to Corporate Staff 1.

A review of the Indiana license verification website (https://mylicense.in.gov) evidenced Corporate Staff 3 did not have an Indiana Nursing License, and Corporate Staff 5 had an Indiana Nursing License which expired on 10/31/2021.

A review of the Organizational chart indicated clinical staff was to report to the clinical manager.

A review of the Organizational chart for the Indiana agency failed to ensure only agency employees and failed to ensure the line ensure responsibility and lines of authority were not delegated to an outside agency.

During an interview on 10/25/2023 at 12:01 PM, the Administrator indicate they do not have a clinical manager we don't have a clinical manager. She indicated the previous Clinical Manager left in 2021.

During a home visit on 10/24/2023 at 4:15 PM, PTA 1

	have a clinical manager.			
G0950	Ensure clinical manager is available 484.105(b)(1)(iii) (iii) Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours; The agency failed to ensure there was a Clinical Manager available during all operating hours. The findings include: A review of an agency Policy titled "Branch Control," revised 4/2020 indicated a clinical supervisor shall be available during all operating hours and when the clinical supervisor was unavailable a health professional with experience, education, and qualifications to see all care and services provided would be available. During the entrance conference on 10/24/2023 at 10:38 AM, the Administrator indicated the Agency did not have a Clinical Manager. During an interview on	G0950	The agency has always had a clinical manager. The administrator is theclinical manager/clinical director and has held this role for 3 years. When interviewed it was stated Clinical Director/Administrator did hold the role of the clinical manager. Education was provided to clinicians on 11/27/23 and 12/5/23 as well as staff on getting completeinformation on clarification of set roles i.e.: clinical manager/clinical director VS clinical supervisor so the correct information can beprovided. QAPI will be auditing quarterly to ensure this deficiency does not recur.	2023-11-29

	10/24/2023 at 12:01 PM, the administrator indicated the Clinical Manager left in 2021. A review of the State Agencies Home Health Agency Report, received from the Administrator on 10/25/2023 at 12:45 AM, failed to evidence a Clinical Manager nor an interim or an alternate Clinical Manager. During an interview on 10/25/2023 at 10:36 AM, the Administrator indicated the form was correct and there was not a current Clinical Manager; that the agency was trying to hire someone. During an interview on 10/30/2023 at 2:23 PM, the Administrator indicated the agency did not have a clinical manager, nor a was there a current backup clinical manager. The administrator indicated the previous clinical manager left in 2021.			
G0954	Ensures qualified pre-designated person 484.105(b)(2) When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and	G0954	Corporate Staff #1 : National Background check was completed as of 11/29/23. 100% of all active/current personnel records were audited to ensure 100% compliance. Policies and procedures were updated to include all new hires and current employees	2023-11-29

	the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. Based on record review and interview the administrator failed to ensure that a qualified person was authorized to act in the administrator's absence (Corporate Staff 1). Findings include: A review of an agency policy dated 12/2018, titled, "Personnel Records," indicated the employee personnel record would include criminal history and background checks as required by law. A review of an agency job description titled, "Alternate Administrator," received on 10/26/2023, indicated that the alternate administrator would ensure that a clinical manager was available during all operating hours. A review of the agency governing body minutes dated 03/01/2022 indicated corporate staff 1 was approved and appointed to the role of alternate administrator. A review of personnel records for corporate staff 1 evidenced		will have national background checks present in personnel files at date of hire. QAPI will work with HR to audit 10% of personnel records quarterly to ensure deficiency does not recur.	

	a job description signed on 03/07/2022, titled, "Alternate Administrator," which indicated in the absence of the administrator the alternate administrator is responsible for planning, coordinating, and directing all activities and programs of the home health agency at all times during operating hours. The job description indicated the position qualification would be a licensed physician, a registered nurse (RN) or hold an undergraduate degree. A review of the personnel records indicated corporate staff 1 held an Illinois RN license and did not have an Indiana RN license where the agency was located. The personnel records reviewed evidenced a limited background check for the state of Illinois dated 09/16/2019 and did not include a national background check or an Indiana background check. During an interview on 10/26/2023, at 2:23 PM the Administrator indicated she does what the clinical manager would do as the agency did not have a current clinical manager. The Administrator indicated that if he/she was not available			

	Corporate Staff 1 would have to come in. During an interview on 10/30/2023, at 11:00 AM, the Administrator indicated he/she had direct patient contact and would see patients if required. During an interview on 10/30/2023, at 12:17 PM, the Administrator confirmed corporate staff 1 did not have an Indiana RN license or a National Criminal Background Check.			
G1012	Required items in clinical record 484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders; Based on record review and interview, the agency failed to maintain a clinical record with all pertinent patient information in 1 of 1 patient with a Do Not Resuscitate order (Patient #5). The findings include: A review of an agency policy titled “Advanced Directives”, revised 4/2020, indicated if a patient has completed an Advance Directive or DNR (Do not resuscitate) order, a copy of the document should be	G1012	Field staff, and office staff were in serviced on 11/27/23 and 12/5/23 on therequirements of maintaining a clinical record with all pertinent patientinformation including but not limitedto -Advanced Directives -DNR 100% of chartsand Admission Consentswill be audited by Clinical Director/administratorand Intake Manager to ensure compliance with every active patient until 100%compliance is met. Once threshold is met 10% of all charts will be auditedquarterly.	2023-12-08

	entered in the patient's clinical record. If a copy is not immediately available, the clinician will discuss the contents of the Advance Directive with the patient and / or their representative and document the contents of the directive in the patient record. A review of an agency document titled "Home Health Updated Plan of Care Report", for certification period 10/17/2023 to 12/15/2023 evidenced Patient #5 had a Do Not Resuscitate order, and the document was in the patient's home. The area of the form where content of the Advance Directive was to be documented stated "NA". A clinical record review failed to evidence a copy of the DNR order or any discussion of contents of the Advance Directive as stated in the agency's policy. During an interview on 10/27/2023 at 2:47 PM, the administrator indicated the admitting clinician should request a copy of the DNR order from the patient or physician to enter into the patient's chart.			

	During an interview on 10/27/2023 at 2:53 PM, Administrative Staff 2 indicated the patient's clinical record failed to evidence a copy of their Advance Directive.			
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: 10/24/2023, 10/25/2023, 10/26/2023, 10/27/2023, 10/30/2023, and 11/8/2023 Complaint # IN102340 deficiencies were cited. Census: 680	N0000	INITIAL COMMENTS VIEWED	
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and	N0440	Org Chart establishes responsibility andaccountability for all organization personnel and defines relationships and the linesof authority within theorganization as of 12.5.23 . Organizational chart will be reviewed revised anddated as changes occur by Clinical Director/Administrator	2023-12-05

	(2) readily identifiable. Organization, administrative control, and lines of authority for the delegation of responsibility down to the patient care level failed to be clearly identified in writing in 1 of 1 agency. The findings Include: 1. A review of an agency policy revised in April 2020, titled "Use of Organizational Chart," indicated, There will be defined lines of authority, which clearly establishes responsibility and accountability for all organization personnel. Organizational charts will be used to define relationships and the lines of authority within the organization. Organizational charts will be reviewed revised and dated as changes occur. 2. A review of the agency organizational chart, which was revised on 8/17/23023, indicated the organization chart was for the Indiana location. A review of this chart evidenced Corporate Staff was the QAPI Coordinator and that Corporate Staff 5 was the Nurse Educator.			

	Review evidence Corporate Staff was not an employee of the Indiana Agency but was a corporate employee. Review evidenced Corporate Staff 5 was not an employee of the Indiana agency and did not have an Indiana Nursing License and Corporate Staff 5's Indiana Nursing license expired in 2021. These positions were to report to Corporate Staff 1. 3. A review of the Indiana license verification website (https://mylicense.in.gov) evidenced Corporate Staff 3 did not have an Indiana Nursing License, and Corporate Staff 5 had an Indiana Nursing License which expired on 10/31/2021. A review of the Organizational chart indicated clinical staff was to report to the clinical manager. A review of the Organizational chart for the Indiana agency failed to ensure only agency employees and failed to ensure the line ensure responsibility and lines of authority were not delegated to an outside agency. During an interview on 10/25/2023 at 12:01 PM, the Administrator indicate they do			

	not have a clinical manager we don't have a clinical manager. She indicated the previous Clinical Manager left in 2021.			
N0441	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Administrative and supervisory responsibilities shall not be delegated to another agency or organization, and all services not furnished directly, including services provided through a branch office, shall be monitored and controlled by the parent agency. Based on record review and interview, the home health agency failed to ensure administrative and supervisory responsibilities were not delegated to another agency or organization and all services not furnished directly, including services provided through a branch office, would be monitored and controlled by the parent agency in 1 of 1 agency. Findings include: 1. A review of an agency policy dated 04/2020, titled, "Branch Control," indicated branch	N0441	CONTRACTIS AVAILBLE FOR CORPORATE STAFF 3 Contracted services will have writtenagreements prior to the individuals being permitted to providing services on behalf of the organization. A 100% review of all contracted staff willhave contracts reviewed by Clinical Director/Administrator until 100% compliance is met. Updated policy/procedure to make sure all new hires have signed business associate agreements (BAA) contracts in personnel records.	2023-12-08

clinical/service records in the identical manner as the parent location including protection of protected health information. The policy indicated the administrator would maintain agreements and vendor contracts.

2. A review of an agency policy revised on 04/2020, titled, "Home Health Contracted Services," indicated the policy would define the nature and scope of services provided by clinicians and others not directly employed by the organization. The policy indicated the contracted services would be defined by a written agreement prior to the individuals being permitted to provide services on behalf of the organization.

3. A review of personnel records for corporate staff 3 evidenced a job description signed on 11/09/2022, titled, "Position: Quality Improvement Registered Nurse [RN]," which indicated qualifications included a Registered Nurse with a current license to practice in states of operation.

A review of the personnel

	records indicated corporate staff 3 held an Illinois RN license and did not have an Indiana RN license where the agency was located. The job description indicated the RN implemented and monitored the agency's Quality Improvement Program by preparing reports, identifying trends, and monitored the SHP (Strategic Healthcare Programs) scorecards and outcome and star rating reports at least quarterly. A review failed to evidence corporate staff 3 had a contract with the Indiana home health agency. During an interview on 10/26/2023, at 2:00 PM, the Administrator indicated corporate staff 3 collected the quality assessment and performance improvement data from the Strategic Healthcare Programs for the Indiana agency.			

	During an interview on 10/27/2023, at 12:22 PM, the Administrator indicated the Indiana agency did not have a contract with corporate staff 3. During an interview on 10/30/2023, at 12:17 PM, the Administrator confirmed corporate staff 3 did not hold an Indiana RN license.			
N0447	Home health agency administration/management 410 IAC 17-12-1(c)(4) Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on observation, record review and interview, the home health agency failed to ensure accurate information to the public in accordance with established services provided by	N0447	CURRENTLYHAVE ACTIVE POSTING ON INDEED FOR HHA- IT IS A SERVICE AGENCIE PROVIDES MEDICALSOCIAL WORKER CONTACTED FROM BONNES AND ASSOCIATES, P.C. CONFIRMEDTHEY CAN PROVIDE SERVICES IN INDIANA AWAITING FOR FINAL CONTRACT COMPLETION. -Contract signed 12/8/23 QAPI will be conducting quarterly audits of all	2023-12-08

	the agency in 1 of 1 agency. The findings include: 1. Review of the agency website (https://onehhc.com) on 10/23/2023 at 11:01 AM, evidenced the services provided on the home page. The services included Nursing, Therapy, and Medical Social Worker. 2. A review of the agency handbook on 10/24/2023 at 10:42 AM evidenced services the agency offers on page 2 of the handbook The services included Skilled Nursing, Physical, Occupational, and Speech Therapy, Medical Social Services, and Home Health Aide. 3. A review of the agency brochure on 10/24/2023 at 10:50 AM, evidenced the services provided by the agency were Skilled Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Medical Social Work, Certified Nursing Assistants, and Home Health Aides. 3. Review of an agency document titled "Employee List" on 10/25/2023, evidenced all		and job postings to ensure deficient practice does not recur and all agency specified services are being provided by agency.	

	and their titles. This list failed to include a medical social worker and a home health aide. 4. During the entrance conference on 10/24/2023 at 10:38 AM, the administrator indicated they do not have a Medical Social Worker and do not currently have any home health aides, but they are looking to hire someone. 5. During an interview on 10/26/2023 at 11:07 AM, the Administrator indicated the home health aide was terminated on 6/13/2023, her last patient contact was 5/25/2023. She indicated they have been trying to hire another aide, but they have not been able to hire one yet. When queried as to how they are recruiting, the Administrator indicated she would reach out to HR to find out. No further information was provided.			
N0451	Home health agency administration/management 410 IAC 17-12-1(c)(8) Rule 12 Sec. 1(c)(8) The administrator, who may also be the supervising physician or registered nurse required by subsection (d),	N0451	Corporate Staff 1: received NationalBackground check -completed 11/29/23. 100% of all active/current personnel records were audited to ensure 100% compliance.	2023-11-29

	shall do the following: (8) Ensure that a qualified person is authorized in writing to act in the administrator's absence. Based on record review and interview the administrator failed to ensure that a qualified person was authorized to act in the administrator's absence (Corporate Staff 1). Findings include: A review of an agency policy dated 12/2018, titled, "Personnel Records," indicated the employee personnel record would include criminal history and background checks as required by law. A review of the agency governing body minutes dated 03/01/2022 indicated corporate staff 1 was approved and appointed to the role of alternate administrator. A review of personnel records for corporate staff 1 evidenced a job description signed on 03/07/2022, titled, "Alternate Administrator," which indicated in the absence of the administrator the alternate administrator is responsible for		Policies and procedures were updated to include all new hires and current employees will have national background checks present in personnel files at date of hire. QAPI will work with HR to audit 10% of personnel records quarterly to ensure deficiency does not recur.	

	planning, coordinating, and directing all activities and programs of the home health agency at all times during operating hours. The job description indicated the position qualification would be a licensed physician, a registered nurse (RN) or hold an undergraduate degree. A review of the personnel records indicated corporate staff 1 held an Illinois RN license and did not have an Indiana RN license where the agency was located. The personnel records reviewed evidenced a limited background check for the state of Illinois dated 09/16/2019 and did not include a national background check or an Indiana background check. During an interview on 10/26/2023, at 2:23 PM the Administrator indicated he/she does what the clinical manager would do as the agency did not have a current clinical manager. The Administrator indicated that if he/she was not available Corporate Staff 1 would have to come in. During an interview on 10/30/2023, at 11:00 AM, the Administrator indicated he/she			

	had direct patient contact and would see patients if required. During an interview on 10/30/2023, at 12:17 PM, the Administrator confirmed corporate staff 1 did not have an Indiana RN license or a National Criminal Background Check.			
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	N0464	Agency ensured that all employeeshaving direct patient contact have been evaluated for tuberculosis anddocumented annually in personnel records. 100% compliance was obtained and allclinicians with patient contact were evaluated for TB and documentation hasbeen filed. Clinical Director/administrator will conduct a 100% audit that each clinicianwill have TB screening completed and in HR paperwork. Audit will be conducted annually.	2023-12-08

	(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: (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 record review and interview, the home health agency failed to ensure that all employees having direct patient contact are evaluated for tuberculosis and documented annually in 1 of 1 administrative personnel records reviewed (Administrator), and 1 of 1 occupational therapist personnel records reviewed (occupational therapist (OT) 1).			

	Findings include: 1. A review of an agency policy revised April 2020, titled, "Tuberculosis Exposure Control Plan," indicated the agency would conduct an annual tuberculosis (TB) risk assessment to determine the type and frequency of testing and assessment for direct care personnel. 2. A review of the Administrator's personnel file, date of first patient contact 05/21/2016, evidenced an agency document dated 08/11/2022, titled, "Tuberculosis Screening Tool," which was blank for the questions regarding the symptoms of cough, fever, night sweats, shortness of breath, weight loss, unexplained fatigue, exposure to anyone with TB and if travelled outside the United States. A review of the personnel file failed to evidence an annual tuberculosis risk assessment was completed. 3. A review of OT 1's personnel records, date of first patient contact 02/20/2023, evidenced a TB skin test performed on			

	03/10/2022. A review of the personnel file failed to evidence an annual tuberculosis risk assessment or TB skin test was completed after 03/10/2022. 4. During an interview on 10/30/2023, at 11:45 AM, the Administrator indicated TB assessments were scheduled to be completed in November of 2023, and there was not further documentation of TB evaluation for the Administrator or OT 1.			
N0470	Home health agency administration/management 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on record review and interview, the home health agency failed to implement policies and procedures for the control of communicable diseases in 1 of 1 patients records reviewed with	N0470	100 % of current/active charts were reviewed by Clinical Director/administrator for the next 30 days to ensure all patients with a new or suspected infection will have a patient infection report completed within 24 hours of discovery. This will include any new, actual, or suspected infection is clinically observed by personnel, or a new antibiotic is ordered. Clinical Director/Administrator will be monitoring new or suspected infection during case conference and having clinician entering QI report if needed. Target threshold is 100%, once 100% compliance is met then QAPI will be performing quarterly chart audits to ensure deficiency does not recur on any new, actual, or suspected infection or new antibiotic that is ordered. Education was provided to staff on 11/27/23 and 12/5/23 on infection control and documenting an infection report on any new,	2023-12-08

	antibiotics prescribed while on service with the home health agency (Patient # 6). Findings include: A review of an agency policy dated April 2020, titled, "Evaluating and Maintaining Records of Infections Among Patients," indicated all patients with a new or suspected infection will have a patient infection report completed within 24 hours of discovery. The policy indicated the patient report form would be completed when a new, actual, or suspected infection is clinically observed by personnel, or a new antibiotic is ordered, and the form will be sent to the Performance Improvement Coordinator to analyze the reports and the information will be used as part of the organization's risk analysis for the organization's infection prevention activities. A clinical record review for patient #6, start of care 07/06/2023, evidenced a coordination note dated 10/11/2023, which indicated the patient had a boil (skin		actual, or suspected infection as well as if new antibiotic is ordered.	

	infection) to the right arm that ruptured with purulent drainage (fluid from wound that could be sign of infection). The coordination note indicated the patient was started on Keflex (antibiotic). A review of the Quality Improvement Event Summary for 10/24/2022-10/24/2023, failed to include the infection report for the patient. During an interview on 10/26/2023, at 2:18 PM, the Administrator indicated the infection for the patient should have been included on the Quality Improvement Event Summary.			
N0486	Q A and performance improvement 410 IAC 17-12-2(h) Rule 12 Sec. 2(h) The home health agency shall coordinate its services with other health or social service providers serving the patient. Based on record review and interview, the home health agency failed to ensure they coordinated care with other health care providers that provided care to agency	N0486	Education was provided to clinicianson 11/27/23 and 12/5/23 regardingcoordinating care documentation with patients receiving Integrated services,whether services are provided directly under arrangement. Clinicians were educated to show communication with any and all services providing care to patients. Any active patients that are receiving any integrated services	2023-12-08

	patients in 3 of 3 clinical records reviewed of patients who received dialysis (Patient #7, #11, #14) and 1 of 1 patients discharged to hospice care (Patient #9). The findings include: 1. Review of an agency policy titled "Coordination of Services with Other Providers," revised April 2020, indicated the case manager will act as a liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related service" 2. A clinical record review for patient #7, start of care 8/30/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 8/30/2023 -10/28/2023. This document evidenced Patient #7 had end-stage kidney failure and was dependent on Renal Dialysis. A review of Patient #7's electronic medical record (EMR) failed to evidence coordination with the dialysis center. During an interview on 10/20/2023 at 12:20 PM, the		communication was documented in patients record showing coordination of care. Agency will show coordination of care with health care providers that provide care to agency patients. 100% of charts will be reviewed by Clinicaldirector/administrator and Intake Manager until 100% compliance is met to show evidence of communication or coordinationof care with other health care providers. IE: Hospice, Hemodialysis. Once threshold is met, a 10% audit will be conducted quarterly by QAPI to ensure deficiencies do not recur.	

	Administrator indicated Patients usually have been on dialysis for a while when they come onto service. She indicated they know their schedule and have transportation, so the agency does not coordinate with the dialysis centers. #. A review of a visit note dated 04/11/2023, for patient #11, indicated the patient received hemodialysis (a process to filter wastes from the blood when the kidneys are no longer healthy) 3 days per week. #. A review of the initial registered nurse assessment dated 08/02/2023, for patient #14, indicated the patient received hemodialysis 3 days per week. #. During an interview on 10/30/2023, at 11:19 AM, the Administrator indicated the agency does not coordinate patient care with the dialysis centers.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must	N0488	Patients were given advanceddischarge notice in accordance with state regulations except in a	2023-12-08

	develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and		emergency.Patient will be notified within 15 days of discharge. Education was provided toclinicians on 11/27/23 and 12/5/23 giving patients 15-day notice prior todischarge. Clinicians will verballynotify patient of the decision to terminate services and the decision toterminate services would be documented in the clinical record the patient willbe notified. 100% of allactive patients' charts will be audited by Clinical Director/administrator and IntakeManager until 100% compliance is met toshow patient were given 15 days' notice prior to discharge service to thepatient, the patient's legal representative,or other individual responsible for the patient's care at least fifteen (15)calendar days before the services are stopped. Once threshold is met, a 10% audit will be conductedquarterly.	

interview, the home health agency failed to develop and implement a policy requiring a notice of discharge of at least 15 calendar days before services are discontinued in 1 of 1 agency.

The findings include:

A review of an agency policy titled "Discharge Criteria and Process," revised April 2020, indicated, " ... The organization will verbally notify the patient of the decision to terminate or reduce services within one (1) visit prior to the change in service to occur (i.e., prior to the last scheduled visit...."

A review of the agency's patient handbook indicated Patients would be given advance discharge notice in accordance with state regulations except in an emergency.

During an interview on 10/27/2023 at 3:27 PM, the Administrator indicated she was unaware Patients were required to receive 15 days' notice for discharge.

#. A review of an agency policy revised April 2020, titled,

	Process," indicated the agency would verbally notify the patient of the decision to terminate services, the decision to terminate services would be documented in the clinical record and the patient would be notified. The policy indicated efforts to resolve problems would be documented in the patient's record. The policy indicated if the decision to terminate services was due to the patient's behavior the clinical record would reflect the identification of the problems encountered, assessment of the situation, and a plan to resolve the issues would be the responsibility of the Clinical Supervisor. #. A review of a registered nurse (RN) visit note dated 04/11/2023, for patient #11, start of care 04/03/2023, indicated the patient received hemodialysis (a process to filter wastes from the blood when the kidneys are no longer healthy) on Monday, Wednesday, and Friday every week. A review of the plan of care for certification period 04/03/2023-06/01/2023			

	services to be provided 1 time a week for 1 week then 2 times a week for 1 week and then 1 time a week for 3 weeks. A review indicated the patient was seen by the agency 0n 04/03/2023, 04/11/2023, and 04/13/2023. A review of coordination notes dated Wednesday 04/19/2023 and Wednesday 04/26/2023 indicated the reason for the patient's missed visit was no answer to the patient's phone. A review of coordination notes dated Thursday 04/20/2023 indicated the visit was missed due to patient complaints of fatigue. A review of a discharge order due to non-compliance was dated 04/28/2023. A review of the clinical record failed to evidence documentation the situation was assessed to establish a plan to resolve the issues by the Clinical Supervisor. A review of the clinical record failed to evidence a 15 day notice of discharge was provided to the patient.			

	During an interview on 10/27/2023 at 3:15 PM, the Administrator indicated if a patient was noncompliant with home visits the patient would be provided 2 warnings prior to discharge. The Administrator indicated on 10/30/2023 at 11:17 AM, there was no documentation the patient was provided warning of discharge.			
N0520	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on record review and interview, the home health agency failed to meet the needs of the patient in their place of residence in 1 of 1 active patient discharged from the hospital (Patient #7) The Findings Included: 1. An agency policy titled "Admission Criteria and Process," revised April 2020, indicated a patient will be	N0520	Hospital Hold reportwill be ran by Clinical Director/administrator weekly and 100 percent of active patients whoare on hold will be followed up on weekly by Marketer/Liaison and coordinationnotes will be entered into chart to show coordination with facilities,patients, and discharge planners. Weekly reports willcontinue to be ran to ensure follow up with hospitalized patients.	2023-12-08

accepted for care based on consideration. Consideration will be given to the adequacy and suitability of organization personnel, resources to provide the required services and the reasonable expectation that the patient's medical, nursing, rehabilitative, and social needs can be adequately met in the patient's place of residence.

2. A clinical record review for patient #7, start of care 8/30/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 8/30/2023 -10/28/2023. This document evidenced Patient #7 was receiving Skilled Nursing and Physical Therapy.

Review evidenced Patient #7 was admitted to the hospital on 9/21/2023 with a PE (Pulmonary Embolism). The documentation indicated patient #7's services were put on hold due to the Patient going to the hospital, he was not discharged from the agency.

Record review of Agency emails obtained on 10/30/2023 from the Administrator, evidenced

	Administrator, Administrative Staff 2 (Intake Manager), and Corporate Staff 4 (Regional Account Manager). These documents evidenced on 10/18/2023 Corporate Staff 4 to reached out to Entity 1, to about patient #7. Patient #7 was no longer at Entity 1. Corporate Staff 4 called and left a message on the Patient's voicemail. On 10/26/2023 Administrative Staff 2 emailed Corporate Staff 4 to find out she had heard back from the Patient. Corporate Staff 2 indicated a message was left on 10/19/2023, and there was no return call. During an interview on 10/27/2023 at 11:55 AM, the Administrator was queried as to why Patient #7 was an active patient on hold with no visits since 9/21/2023. The Administrator indicated he/she had recently been discharged from the hospital and their sales marketer had been in touch with the patient. She indicated they had emails but they did not update the patient chart, but he/she would be resuming care soon. During a phone interview on			

	10/27/2023 at 12:37 PM Patient #7 indicated he/she had been home from the hospital for a few weeks, maybe a month. He/She was not certain of how long he/she had been in the hospital. Patient #7 indicated medications were adjusted and received several consecutive days of dialysis, which led to improved discharge from Entity 1. Prior to hospitalization, Patient #7 was receiving Skilled Nursing services (SN) and Physical Therapy (PT) from the agency. He/She was evaluated by OT, but they didn't think he/she needed it. Patient #7 ambulates with 2 canes now and wants to start back on physical therapy. Patient #7 indicated it was building strength and wanted to continue. Patient #7 indicated someone from the agency contacted him/her to see if he/she came home, but Patient #7 couldn't remember when. Patient #7 thought they were trying to get therapy back for him/her again, and hopes they do because Patient #7 would love to do it again. Record review on 10/30/2023 at 1:15 PM evidenced Documents from Entity 1 (Hospital)			

	evidenced the Patient was admitted on 9/21/2023 and discharged home on 9/24/2023. There failed to be evidence that the agency had resumed services after discharge from the hospital in the electronic medical record. Patient #7 was readmitted to the hospital on 10/11/2023 and discharged on 10/13/2023. There failed to be evidence the agency resumed services. During an interview on 10/30/2023 at 2:25 PM, the Administrator indicated they never received information from Entity 1 about Patient #7's discharge, so the Agency was unaware he/she had returned home. The Administrator indicated the Patient was going to see Patient #7 between 1-3 PM. No further information was given as of exit at 4:10 PM			
N0522	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows:	N0522	Clinicians were educated on 11/27, and 12/5 to pain parameters and when to notifyphysician of pain rating greaterthan 6. Clinicians educated onuse of assistive devices and appropriateness of the device to ensure	2023-12-08

	Based on record review and interview, the agency failed to ensure care was provided as established in the plan of care in 4 of 10 active clinical records reviewed. (Patient #1, #4, #7, #10). The findings include: *Review of Job Description No. C-210 "Position: Registered Nurse", included but not limited to, "Performs comprehensive assessments of client status, including physical...develops and/or follows an individualized Plan of Care..." *During a home observation visit of RN 3 providing care for Patient #4 on 10/27/23 beginning at 11:39 AM, observed RN 3 auscultate apical heart rate for approximately 5 seconds then auscultate all posterior breath sounds bilaterally. The registered nurse (RN) failed to auscultate any of the patient's anterior breath sounds and failed to auscultate		patientsafety. Clinicians educatedon reporting to physician the Patient's systolic blood pressure (BP) greaterthan 165 and diastolic greater than 95. Education provided to clinicians onproper auscultation of breath sounds and apical pulse. The Clinical Director/administrator and Intake manager audited 100% of all active/current charts and will continue to audit until 100% compliance is met if deficiencies were cited clinicians were educated via HIPPA compliant tiger connect on said deficiency with corrected additions needed to show compliance specifically: - pain and blood pressureparameters are followed, and physician was notified -Therapists were educated on 11/27and 12/5/23 on DME/ assistive devices to ensure safety. -Nurses were in-servicedon 11/27/23 and 12/5/23 on the appropriate technique to auscultate lung sounds and howto take a apical pulse. Annually education will be provided to clinicians to ensure deficiency does not recur.	

	an apical pulse for a full 60 seconds. *On 10/26/23, the clinical record review for Patient #4 evidenced a POC for the period 10/23/23 through 12/21/23 that included "skilled nurse to...assess cardiovascular system..." and "SN (skilled nurse) for assessment of lung sounds..." *During an interview on 10/27/23 at 3:31 PM, Administrative Staff 1 reported the expectation was for nurse to check apical pulse for full 60 seconds every patient visit and all lung fields should be auscultated, back-to-back, front, for every patient visit. 1. A review of an agency policy titled, "Care Planning Process", revised 4/2020, indicated the agency shall provide services based on the needs of the patient as directed in the plan of care. 2. A review of the plan of care for Patient #10, certification period 10/25/2023 to 12/23/2023, indicated the licensed professional was to report a pain rating greater than 6. The plan of care indicated		Once 100% off all charts are in compliance quarterly audits will be conducted by QAPI to ensure deficiency will not recur.	

	physical therapy was to provide gait training and use of an appropriate assistive device to ensure patient safety. In a visit note dated 10/26/2023, OT (Occupational Therapist) 2 indicated the patient complained of pain rating a 7. A clinical record review failed to evidence OT 2 informed the physician of the patient's pain. In an initial visit note dated 10/25/2023, PT (Physical Therapist) 1 indicated they did not instruct the patient on the basic use of assistive devices to ensure the patient was safe until next visit because it was not applicable. During an interview on 10/27/2023 at 2:52 PM, Patient #10 indicated they were not used to using a walker, and they did not use one before surgery. During an interview on 10/30/2023 at 12:25 PM, the administrator indicated the clinician should notify the physician for a pain rating outside of the parameters. When informed of the findings, the administrator indicated PT 1			

	patient's use of the walker in order to ensure their safety at the initial visit and ongoing. *. A clinical record review for patient #7, start of care 8/30/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 8/30/2023 -10/28/2023. This document evidenced the nurse was to notify the physician if the Patient's systolic blood pressure (BP) was greater than 165 and diastolic greater than 95. A review of Patient #7's electronic record evidenced an RN Visit Note dated 9/8/2023. During this visit, Patient #7's BP was 172/98. There failed to be evidence the RN contacted the Physician as indicated in the plan of care. *. A clinical record review for Patient #1, start of care 9/25/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 9/25/2023 to 11/23/2023. This document evidenced the RN was to notify the nurse of a pain level of greater than 6 on a scale of one to ten (one being			

	less pain 10 being the most pain). A clinical record review for Patient #1, start of care 9/25/2023, evidenced an agency document for an RN visit on 9/29/2023. This document evidenced Patient #1 had a pain level of 6-7. There failed to be evidence the nurse notified the Physician of the Patient pain as ordered in the plan of care.			
N0524	Patient Care 410 IAC 17-13-1(a)(1) Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations.	N0524	The Rn and Therapy field staff were in- serviced on11/27/23 and 12/5/23 to the following CFR: 484.60 (a)(2)(i-xvi). Educationincluded items listed on the individualizedplan of care, but not limited to: -Allpertinent diagnosis -Documenting blood sugar parameters for diabetic patients -Thetypes of services, supplies, and equipmentrequired. IE: ice machine,glucometer -All Medications and treatments including prescription and supplements	2023-12-08

	(vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. Based on observation, record review and interview, the agency failed to ensure the plan of care included all medications, supplies, safety precautions, equipment and treatments in 7 of 14 clinical records reviewed. (Patient #1, 2, 3, 4, 7, 11, 14) The findings include: *Review of Policy 4-001 "Care Planning Process," revised April 2020, included but not limited to, "the patient-specific clinical plan of care includes:...safety measures to protect against injury...supplies and equipment required..." *During a home visit observation on 10/27/23 beginning at 11:39 AM, Patient # 4 reported use of a		-care coordination Note inHCHB to be completed if patienton hemodialysis to include what dialysis center and thedates of dialysis treatment. -Wound care should includewhat wound care was to bedone, by whom, and what frequency as well as what supplies are needed. - Patientspecific clinical plan of care: precautions, supplies, and safetyequipment that is used or needed. TheClinical Director/administrator and Intake manager audited 100% of all active/current charts and will continue to audit until 100% compliance is met if deficiencies were cited clinicians were educated via HIPPA compliant tiger connect on said deficiency with corrected additions needed to show compliance specifically: - Every patient chartcontains an individualized plan of care -Wound care to be performed and at what frequency. Patient/Caregiver if ableto demonstrate ability to perform	

	sugar levels being performed by Patient # 4's children every few days. *Review of Patient #4's clinical record evidenced a POC for certification period 10/23/23 through 12/21/23 which failed to include the patient's glucometer and failed to include bleeding precautions as the patient takes an oral anticoagulant (Eliquis). *During interviews conducted on 10/26/23 at 2:21 PM and 10/27/23 at 3:31 PM, Administrative Staff 1 failed to demonstrate evidence of glucometer equipment as well as bleeding precautions listed in Patient # 4's POC for certification period 10/23/23 through 12/21/23. ###. A review of a plan of care for patient #2 for certification period 10/21/2023-12/19/2023, evidenced the patient had a right knee replacement.		wound care. -Patient specific precautions -All DME in the home will be documented -Complete and accurate medications, dose, frequency, and routes -AnyPRN medications and supplementswill listquantity and frequency -Supplies and equipment requiredto promote safety and protectagainst injury. Once threshold is met, a 10% audit will be conducted quarterly by QAPI to ensure deficiencies do not recur.	

During an observation of a home visit for patient #2 on 10/25/2023, starting at 9:30 AM, registered nurse (RN) 1 instructed the patient to use an ice machine to the right knee in 20-minute increments.

A review of the plan of care failed to evidence the use of the ice machine to the right knee.

During an observation of the home visit the patient indicated the use of supplements magnesium 400 micrograms one tablet twice a day and Iron 65mg one tablet twice a day.

A review of the plan of care failed to evidence the magnesium and iron supplements.

During an interview on 10/26/2023, at 2:15 PM, the Administrator indicated the use of the ice machine should have been included on the plan of care and magnesium and iron should have been verified with the physician and added to the plan of care medication list.

###. A review for patient #11 evidenced an initial RN admission note, dated

	patient was receiving hemodialysis (a process to filter wastes from the blood when the kidneys are no longer healthy). A review of the plan of care for certification period 04/03/2023-06/01/2023, failed to evidence the patient's dialysis center or frequency of treatments. ###. A review for patient #14 evidenced an initial RN admission note, dated 08/02023, which indicated patient was receiving hemodialysis. A review of the plan of care for certification period 08/02/2023-09/30/2023, failed to evidence the patient's dialysis center or frequency of treatments. ##. During an interview on 10/30/2023, at 11:19 AM, the Administrator indicated the dialysis location center name and days of the week of dialysis should be included on the plan of care.			

	1. A review of an agency policy titled, "Care Planning Process", revised 4/2020, indicated the agency would create an individualized plan of care for each patient which included all medications, treatment XXXXXXXXXXX for the patient. 2. A review of the plan of care for Patient #3, certification period 10/19/2023 to 12/17/2023, indicated the nurse was to perform / teach wound care to the incision on the right hip. The plan of care evidenced a goal that the patient / caregiver will demonstrate the ability to perform wound care. The plan of care failed to evidence what wound care was to be performed and at what frequency. A review of the list of supplies on the plan of care evidenced the patient required alginate dressing (a specialized wound care dressing). A clinical record review failed to evidence an order or instruction for the patient to use alginate dressing. During an interview on 10/30/2023 at 11:10 AM, the administrator indicated the plan of care should include specific orders for what wound care was			

	what frequency. The administrator indicated alginate dressing was not currently used by the patient, and should not have been on the plan of care. 3. A clinical record review for patient #7, start of care 8/30/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 8/30/2023 -10/28/2023. This document evidenced Patient #7 had end-stage kidney failure and was dependent on Renal Dialysis. The plan of care failed to include Patient #7's Dialysis Center and the dates of his dialysis treatments. The document evidenced Patient #7 was diabetic and received insulin twice daily. The document failed to include blood sugar parameters for physician notification. During an interview on 10/20/2023 at 2:31 PM, the Administrator indicated the plan of care should include where and when the Patient goes to dialysis, She also indicated there should be blood sugar parameters on the plan of care for diabetic patients.			

	4. A clinical record review for Patient #1, start of care 9/25/2023, evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 9/25/2023 to 11/23/2023. This document evidenced the patient was taking the following medications: Atorvastatin (for high cholesterol), Calcium (supplement), Furosemide (for fluid retention) levothyroxine (for thyroid), lidocaine topical cream (for pain), methylprednisolone (for inflammation), metoprolol (For high blood pressure), Montelukast (for asthma), tramadol (for pain) Valsartan (for high blood pressure), Xarelto (prevents blood clots). The plan of care failed to include Patient #1's complete list of medications. During a home visit on 10/24/2023 at 4:15 PM, Patient #1's home folder was reviewed. The medication list in Patient #1's home folder evidenced Patient #1 was taking Turmeric (supplement). During an interview with Patient #1 on 10/24/2023 at 4:45 PM, Patient #1 when reviewing the			

	current medications taken, Patient #1 indicated she takes Klor Con (for low potassium) and Turmeric. These medications failed to be included in the medications on the plan of care. During an interview on 10/27/2023 at 2:17 PM, the Administrator indicated all medications and supplements the Patient is taking should be listed on the plan of care.			
N0527	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review and interview, the agency failed to alert the physician to changes in the patient's condition in 2 of 2 clinical records reviewed in which the Patients experienced a change in condition (Patient #1, #5).	N0527	Clinicians were educated 11/27/23 and12/5/23 to promptly alert physicians on any changes in the patient's conditionor outcomes that are not being achieved and if the plan of care should bealtered. Physician should becontacted to obtain a new order and order should be entered. Assistants shall be reporting any changes to the therapist or nursing supervisor. 100% of chartswill be reviewed Clinical Director/Administratorand Intake Manager until 100% compliance is met to ensure carecoordinationbetween clinicians and physicianson any	2023-12-08

	The findings include: *. A clinical record review for Patient #1, start of care 9/25/2023, evidenced an agency document for an RN visit on 9/29/2023. This document evidenced Patient #1 had a pain level of 6-7 on a scale of 1-10 (1 less pain 10 most pain) but did not want to take her tramadol due to potential constipation. RN 3 educated the patient to increase fluids and take a stool softener every day. A review of the patient's medical record failed to evidence RN 3 notified the Physician of the patient's pain and concern with taking the pain medication and failed to obtain an order for the stool softener. A review evidenced an agency document titled "Home Health Certification And Plan Of Care" for certification period 9/25/2023 to 11/23/2023. This document evidenced the patient was taking the following medications: Atorvastatin (for		change of status. Once threshold is met 10% audit will be conductedquarterly	

	high cholesterol), Calcium (supplement), Furosemide (for fluid retention) levothyroxine (for thyroid), lidocaine topical cream (for pain), methylprednisolone (for inflammation), metoprolol (For high blood pressure), Montelukast (for asthma), tramadol (for pain) Valsartan (for high blood pressure), Xarelto (prevents blood clots). This document failed to evidence the patient was prescribed Tylenol or a stool softener. A review of the patient medication list failed to evidence the patient was prescribed a stool softener or Tylenol. A review for patient #1 evidenced a Client Note Report dated 10/10/2023. This document evidenced Patient #1 was experiencing diarrhea. The document evidenced RN 3 educated the patient to eat yogurt several times a day as antibiotics can cause diarrhea. RN 3 also informed the Patient to start a daily probiotic. There failed to be evidence the Nurse called the Physician about the			

	evidence an order for a probiotic. During an interview on 10/30/2023 at 3:15 PM, the Administrator indicated the Physician should have been called and the medications should have been added to the plan of care. 1. A review of the agency's Registered Nurse job description, revised 12/10/2012, evidenced the nurse shall report changes in patient status to the physician in a timely manner. 2. A review of the agency's Occupational Therapy Assistant job description, dated 2017, evidenced the OTA (Occupational Therapy Assistant) shall report any changes to the therapist and / or nursing supervisor. 3. A review of the start of care assessment dated 10/17/2023 by RN (Registered Nurse) 2, indicated Patient #5 had bruising. A clinical record review failed to evidence the nurse informed the physician of the bruising. In a skilled nurse visit note dated 10/19/2023, RN 2			

	indicated the patient had a new skin tear to the left inner arm. A clinical record review failed to evidence the nurse informed the physician of the new wound. In a visit note dated 10/24/2023, OTA 1 indicated the patient had hemoptysis (coughing up blood). A review of all prior visit notes (skilled nurse 10/17/2023 and 10/29/2023; occupational therapy 10/18/2023 and 10/20/2023; physical therapy 10/20/2023) failed to evidence hemoptysis. A clinical record review failed to evidence the physician was informed of the patient's hemoptysis. During an interview on 10/27/2023 at 3:09 PM, the administrator indicated the nurse should inform the physician if a patient has bruising or a new wound. If a new patient symptom or complaint is found by an OTA, the administrator indicated they should inform the OT who would contact the physician and document the communication in the patient's record.			
N0543	Scope of Services	N0543		2023-12-08

	410 IAC 17-14-1(a)(1)(D) Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on record review and interview, the registered nurse failed to initiate appropriate preventative and rehabilitative nursing measures in 1 of 10 active patient records reviewed (Patient #5). The findings include: A review of the agency's Registered Nurse job description, revised 12/10/2012, evidenced the nurse shall initiate appropriate preventative and rehabilitative nursing procedures. A review of an agency policy titled "Ongoing Assessments" revised 4/2020 evidenced the clinician shall reassess each patient for the following: vital signs, pain, breath sounds, skin integrity, elimination (bowel and bladder), mental status, functional status, home safety,		Education was provided to the clinicianson 11/27/23 and 12/5/23 on how they will reassess each patient for thefollowing at every visit: vital signs, pain, breath sounds, skin integrity,elimination (bowel and bladder),mental status, functional status, home safety, patient / caregiver support, progresstoward goals, and compliance. Goals will not be documented met at start of carethey should be ongoing. 100% of chart audits will be completed byClinical Director/administrator and Intake Manager until 100% compliance is metto ensure documentation is present that clinician completed assessment andgoals are ongoing throughout care. Once threshold ismet, a 10% audit will be conducted quarterly.	

patient / caregiver support, progress toward goals, and compliance.

A review of the start of care note dated 10/17/2023 by RN (Registered Nurse) 2 indicated Patient #5 had chronic respiratory failure, pulmonary fibrosis (a lung disease that occurs when lung tissue becomes damaged and scarred), chronic obstructive pulmonary disease, recurrent pneumonia, and dependence on supplemental oxygen. A review of the start of care assessment and a skilled nurse visit note dated 10/19/2023 failed to evidence an assessment of the patient's breath sounds. A review of the start of care note indicated the patient understood education provided about one of 11 medications the patient was taking. The start of care assessment indicated the following goals were met: patient / caregiver demonstrates safe, appropriate use of medications, and patient verbalizes tolerance to treatments.

During an interview on

	administrator indicated a respiratory assessment including breath sounds should be completed at each nursing visit and goals cannot be reached at start of care, they should be ongoing.			
N0544	Scope of Services 410 IAC 17-14-1(a)(1)(E) Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on record review and interview, the Registered Nurse failed to document complete and accurate clinical notes in 3 of 12 patients receiving Skilled Nursing services (Patient #3, 5, 14). The findings include: 1. A review of an agency policy titled "Ongoing Assessments" revised 4/2020 evidenced the clinician shall reassess each patient for the following: vital	N0544	Clinician wereeducated on 11/27/23 and 12/5/23 on completing accurate clinical notes thatinclude: ongoing assessment of non removable dressings and documenting on thestatus of the dressing, any new wounds that are present after start of care,complete skin assessment at every visit and including any new bruisinglocation/cause and pegs/drains to include status of site, patency and who ismanaging care. 100% of charts will beaudited by Clinical Director/Administrator and Intake Manager until 100%compliance is met to ensure ongoing assessment is being completed. Once threshold is met, a 10% audit will be conducted quarterly.	2023-12-08

integrity, elimination (bowel and bladder), mental status, functional status, home safety, patient / caregiver support, progress toward goals, and compliance.

2. A review of the agency's Registered Nurse job description, revised 12/10/2012, evidenced the nurse shall perform comprehensive and re-assessments as well as prepare clinical and progress notes.

3. In the start of care assessment dated 10/19/2023, RN (Registered Nurse) 2 indicated Patient #3 had a surgical incision covered by a non-removable dressing. A review of the document failed to evidence an assessment of the dressing.

During an interview on 10/20/2023 at 11:10 AM, the administrator indicated if a non-removable dressing is in place, the clinician should document if the dressing is intact and if drainage is observed.

4. In a skilled nurse visit note dated 10/19/2023, RN 2 indicated Patient #5 had a new

	skin tear to their left inner arm. A review of the note failed to evidence an assessment of the new wound. A review of the start of care assessment dated 10/17/2023 and a skilled nurse visit note dated 10/19/2023 by RN 2 both indicated the patient had bruising, but failed to evidence where or from what. During an interview on 10/27/2023 at 2:54 PM, the administrator indicated if a patient was found to have bruising, the nurse should document the location and cause of the bruise. #. A review of a registered nurse initial assessment note dated 08/02/2023, for patient #14 indicated the patient had a peg tube (tube into stomach for nutrition/medications). A review of the initial assessment note failed to evidence assessment of the insertion site of the peg tube. During an interview on 10/30/2023, at 11:22 AM, the Administrator indicated the assessment note should have included the assessment of the			

	peg tube site to include location, patency and residual of the tube.			
N0566	Scope of Services 410 IAC 17-14-1(c)(5) Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (5) prepare clinical notes; Based on record review and interview, the Physical Therapist failed to document complete and accurate clinical notes in 1 of 7 active records reviewed receiving physical therapy (Patient #10). The findings include: 1. A review of the agency's Physical Therapist job description, revised 2017, evidenced the therapist shall document all patient findings, plans, interventions, and outcomes. 2. A review of the Start of Care assessment by PT (Physical Therapist) 1 indicated Patient	N0566	Education was provided on 11/27/23 and 12/5/23 to therapist on documenting all patientfindings, plans, interventions, and outcomes. Therapists will be educated onproper assessment of wounds, teaching of medication and patientresponse-understanding. 100% of charts will be reviewed by Clinical Director/administratorand Intake Manager until 100% compliance is met for all patient findings,plans, interventions, and outcomes. Once threshold ismet, a 10% audit will be conducted quarterly.	2023-12-08

	but failed to evidence an assessment of the wounds. A review of the start of care note indicated PT 1 did not assess the patient's understanding of the four medications they were taking. The start of care assessment indicated the following goals were met: patient / caregiver demonstrates safe, appropriate use of medications, and patient verbalizes tolerance to treatments. During an interview on 10/30/2023 at 12:23 PM, the administrator indicated the therapist should document an assessment of the wound and goals cannot be reached at start of care, they should be ongoing.			
N0567	Scope of Services 410 IAC 17-14-1(c)(6) Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (6) advise and consult with the family and other home health agency personnel; Based on record review and interview, the agency failed to ensure physical and	N0567	Education was providedon 11/27/23 and 12/5/23 to thetherapists that they shall review and update the patient's plan of careaccording to the patient's need and providedirection to other health team members on the updated need forclinicians needed in the home. 100 % ofall active patient will have case conferenceby Clinical Director until 100 % compliance is met on the need of disciplinesin the home. Once threshold is met, a 10% audit will beconducted quarterly.	2023-12-08

	occupational therapists consulted with other home health agency personnel responsible for the patient in 1 of 3 active patient records receiving physical therapy and occupational therapy (Patient #10). The findings include: A review of the agency's Physical Therapist job description, revised 2017, evidenced the therapists shall review and update the patient's plan of care according to the patient's need and provide direction to other health team members. A review of the agency's Occupational Therapist job description dated 12/2018 evidenced the therapists shall communicate plans and changes to the physician, nursing staff, and other agency members and participate in care coordination. A review of the plan of care for certification period 10/25/2023 to 12/23/2023 evidenced Patient #10 was receiving only			

	occupational therapy services. In the initial physical therapy assessment dated 10/25/2023, PT (Physical Therapist)1 indicated the only discipline reasonable and necessary for Patient #10 was physical therapy. A clinical record review failed to evidence PT 1 informed the clinical manager that they assessed the patient and they only required physical therapy. In the initial occupational therapy assessment dated 10/26/2023, OT (Occupational Therapist) 2 indicated the disciplines that were reasonable and necessary for the patient were skilled nursing, physical therapy, and occupational therapy. A clinical record review failed to evidence OT 2 informed the clinical manager that they assessed the patient to need skilled nursing. During an interview on 10/30/2023 at 12:35 PM, the administrator indicated care coordination should be documented in the patient's record; the agency was working on getting skilled nursing for the patient.			

N0570	Scope of Services 410 IAC 17-14-1(d) Rule 14 Sec. 1(d) In carrying out the responsibilities identified in subsection (c) of this rule the therapist may: (1) direct the activities of any therapy assistant; or (2) delegate duties and tasks to other individuals as appropriate. Based on record review and interview, the therapist failed to direct the activities of the therapy assistant in 1 of 1 Occupational Therapy Assistant Visits conducted (Patient #10). The findings include: The review of an agency policy titled "Scope of Services", revised 4/2020, indicated the therapists shall develop and revise a plan of care for each patient as well as supervise therapy assistants. The policy indicated therapy assistants shall provide services that are planned, delegated, and supervised by the therapist. A review of the plan of care for Patient #10, certification period	N0570	All field therapists and assistants were educated at staff meeting on 11/27/23 and 12/5/23 to ensure that skilled professionals assume responsibility for supervising the therapy assistants. Therapist will develop and revise a plan of care for each patient and supervise that the assistant is providing services that are planned, delegated, and supervised by the therapist. Goals will be developed by Therapist and interventions will be determined by therapy assistants during care in home to make sure goals are being reached/achieved. 100% of charts will be reviewed by the Clinical Director/administrator to ensure the supervision of skilled professional assistants. 100 % of charts will bereviewed by the Scheduler/Intake Manager Tiffany Varney to assign a supervisoryvisit code on the patient's schedule in the EMR, i.e., RN10, PT10, OT10, noless frequently than every 14 days to ensure services are being delegated and supervised by the therapist. Once 100% compliance is met,	2023-12-08

	10/25/2023 to 12/23/2023 indicated the patient was to receive OT (Occupational Therapy) services, but failed to evidence specific interventions for what was to be done at patient visits. During an interview on 10/27/2023 at 3:30 PM, Occupational Therapist Assistant (OTA) 1 indicated the Occupational Therapist did not give them specific instructions for what to do in the patient's home. OTA 1 indicated the therapist would write the goals, but it was up to her to come up with the interventions.		a10% audit will be conducted quarterly by QAPI to ensure deficiency will not recur.	
N0608	Clinical Records 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information. (2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel.	N0608	Field staff, and office staff were inserviced on 11/27/23 and 12/5/23 on the requirements of maintaining a clinicalrecord with all pertinent patient information including but not limited to -Advanced Directives -DNR 100% of charts and Admission Consentswill be audited by Clinical Director/administratorand Intake Manager to ensure compliance with every active	2023-12-08

	rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the agency failed to maintain a clinical record with all pertinent patient information in 1 of 1 patient with a Do Not Resuscitate order (Patient #5). The findings include: A review of an agency policy titled “Advanced Directives”, revised 4/2020, indicated if a patient has completed an Advance Directive or DNR (Do not resuscitate) order, a copy of the document should be entered in the patient’s clinical record. If a copy is not immediately available, the clinician will discuss the contents of the Advance Directive with the patient and / or their representative and document the contents of the directive in the patient record. A review of an agency document titled “Home Health Updated Plan of Care Report”,		patient until 100%compliance is met. Once threshold is met 10% of all charts will be auditedquarterly.	

10/17/2023 to 12/15/2023 evidenced Patient #5 had a Do Not Resuscitate order, and the document was in the patient's home. The area of the form where content of the Advance Directive was to be documented stated "NA". A clinical record review failed to evidence a copy of the DNR order or any discussion of contents of the Advance Directive as stated in the agency's policy.

During an interview on 10/27/2023 at 2:47 PM, the administrator indicated the admitting clinician should request a copy of the DNR order from the patient or physician to enter into the patient's chart.

During an interview on 10/27/2023 at 2:53 PM, Administrative Staff 2 indicated the patient's clinical record failed to evidence a copy of their Advance Directive.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robyn Vescovi	Administrator/Clinical Director	12/26/2023 1:10:44 PM