POC unacceptable on 10-18-2022
Deborah Franco, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200231350A	A. BUILDING B. WING	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED HOME HEALTH CARE, INC	6920 PARKDALE PLACE, SUITE 110, INDIANAPOLIS, IN, 46254

(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 a Home Health Provider and Supplier. Survey Date: 6/1/22, 6/2/22, 6/3/22, 6/6/22, 6/7/22, 6/8/22, and 6/9/22 Census: 453 At this Emergency Preparedness survey, Preferred Home Care was found to be out of compliance at 42 CFR 484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies. QR: Area 3 June 23, 2022	E0000	***Please note - Survey report wasn't received until 7/5/22 due to technical system issue. Spoke with Survey supervisor who adjusted due dates and completion dates.*** HHA has formulated a POC that addresses all citations summarized in E0000. Please see remaining subsections for POC.	2022-11-30
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey of a Home Health Provider. Survey Dates: 6/1, 6/2, 6/3, 6/6, 6/7, 6/8, and 6/9/22.	G0000	HHA has formulated a POC that addresses all citations summarized in G0000.	2022-11-30

	This deficiency report reflects State Findings cited in accordance with 410 IAC 17. During this Federal Recertification Survey, Preferred Home Health Care, INC, was found to be out of compliance with Conditions of Participation 484.65 Quality Assessment and Performance Improvement and 484.70 Infection Prevention and Control. Based on the Condition-level deficiencies during the June 09, 2022 survey, your HHA was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 6/07/22. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills competency, and / or competency evaluation program for a period of two years beginning June 09, 2022 and continuing through June 08, 2024. QR: Area 2 June 23, 2022			
E0001	Establishment of the Emergency Program (EP) 403.748,482.15,485.625 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §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	E0001	1.Describe what the agency did to correct the deficient practice for each client cited in the deficiency. failed to ensure the comprehensive emergency preparedness program met all requirements to meet the health, safety, and security needs of their staff and patient population for 1 of 1 agency	2022-08-31

	maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on record review and interview, the agency failed to ensure the comprehensive emergency preparedness program met all requirements to meet the health, safety, and security needs of their staff and patient population for 1 of 1 agency (E0001); failed to ensure an Emergency Preparedness Plan was in place and reviewed		(E0001). The newly appointed compliance officer will be reviewing and ensuring that each section of the EP program's deficiencies (E0004, E0009, E0017, E0021, E0030, E0031, E0037, and E0039) is corrected and comprehensive so that the agency's EP program meets all health, safety and security requirements. A compliance consultant was hired and began working with the new compliance officer appointed on 7/1/2022. The first meeting was a two-hour consultation on 7-19-22 which identified agency deficiencies. The next meeting to review Summit's EP plan is scheduled for 7-26-22 and a mock survey is scheduled for 8-9-22. This incremental plan of correction will ensure a comprehensive EP program will be in place by August 31, 2022 for all current clients along with all future clients. failed to ensure an Emergency Preparedness Plan was in place and reviewed every 2 years, at minimum (E0004) The newly appointed compliance officer has assembled a compliance committee and governing body,	

	(E0004); failed to ensure the Emergency Plan included a process for cooperation and collaboration with the local, regional, State, and Federal emergency preparedness official in the districts which the agency provides services (E0009); failed to ensure patients had written and individualized Emergency Preparedness plans, included as part of their comprehensive assessments, in 17 of 17 clinical records reviewed (E0017), failed to ensure the agency had a plan for the subsistence needs for staff and patients, whether they evacuated or sheltered in place; failed to ensure access to a plan or a system / defined procedure to track the location of on-duty staff and sheltered patients under the agency s care during an emergency (E0021); failed to ensure that an emergency preparedness communication plan included all staffing addresses and phone numbers, entities providing services under arrangements, and patient physicians for all districts/ territories that the agency provided services to (E0030); failed to evidence the contact numbers for local emergency management agencies and local officials who support the Incident Command System (E0031); failed to ensure all staff providing services in all districts / territories were trained in emergency preparedness and failed to ensure the agency maintained documentation of the training provided (E0037); and failed to		which includes management personnel from each branch. This committee is scheduled to meet quarterly and will ensure the comprehensive EP is in place and accessible to patients and staff members. The compliance committee will review the EP plan at the 4th quarter meeting every other year. The compliance committee will meet in 8/23/22. failed to ensure the Emergency Plan included a process for cooperation and collaboration with the local, regional, State, and Federal emergency preparedness officials in the districts which the agency provides services (E0009). Summit's compliance officer will research and identify the appropriate officials in the 40 Indiana counties of service, local Indianapolis EP officials, Indiana region 5 officials, Indiana state officials and Federal officials. The contact information will be placed in the agency's EP binder as well as on Summit's internal site as a subpage under Compliance. With the guidance of the compliance consultant, this will be in place by 8-15-22.	

	ensure the agency conducted a full-scale exercise that was community or individual-based exercise to test the emergency plan for all staff in all districts/ territories, failed to ensure a tabletop exercise that included a group after action discussion was conducted, and failed to maintained documentation of any drills, tabletop exercises, and emergency events (E0039). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies. at 42 CFR 484.102. Findings include: 1. Review of the agency's Emergency Preparedness Binder revealed a document titled 'Cooperation and Collaboration with EP Officials' with the contact number for FEMA and 911, was then followed by 32 pages of emergency contact numbers for the state of Ohio. Page 33 revealed a contact number for Indianapolis Emergency Services and a web address for additional 'Indiana County EM Numbers', but not the contact numbers themselves (the agency services 40 counties within the state of Indiana). A separate document, printed from a web-based internet site with the header 'DHS / Contact Us' evidenced contact information for the Indiana Department of Homeland Security. Within another binder, a document printed titled 'Statewide Contacts' evidenced one County Emergency Management Agency contact		failed to ensure patients had written and individualized Emergency Preparedness plans, included as part of their comprehensive assessments, in 17 of 17 clinical records reviewed (E0017). Summit's administrator and regional director have placed in each admission packet a comprehensive plan for emergency preparedness. This includes the 17 patients identified in the survey and all admission packets dispersed since 7-14-22. At time of admission, clinicians have been instructed to review the EP plan pertaining to each client and their preparedness needs. Local government/emergency services/emergency resources are now being reviewed with patients, along with identifying the disaster triage code each client falls under and identifying this in OASIS documentation and admission notes. failed to ensure the agency had a plan for the subsistence needs for staff and patients, whether they evacuated or sheltered in place; failed to ensure access to	

	number for Adams County, Indiana, Region 3 (the agency is located in Marion County, Region 5) and on this page was an email address for 'Hazmat' with the Indiana Department of Health. The agency binder failed to evidence any other Indiana-specific local emergency management contact numbers. 2. Review of the agency's 'Emergency Preparedness' binder document with the header, "SUMMIT INTERNAL SITE - Testing and Training" evidence a partial first line that was not legible. The second line stated, "will be addressed twice annually for management/leadership (one tabletop exercise and one live community exercise) and once annually for field staff and other office personnel (alternating years of 1. self-learning and testing and 2. live exercise)...All emergency preparedness training will be documented and memorialized on Summit's internal site under the Compliance page and will demonstrate staff knowledge of emergency preparedness program plans, policies, and procedures. This documentation will include the specific training completed as well as the methods used to demonstrate knowledge of the training program (ie. testing)." 3. Review of an agency document dated April 2015, titled 'Emergency Management Plan 6-037.1' page 1 stated, "Policy ... The organization's role and command structure will be identified in relation to those of regional or county emergency response agencies ... Procedure ... 6. In the event of a prolonged emergency situation, the CEO/Administrator or designee will: ... F. Notify attending physicians regarding recommendations for continued care for patients on caseloads .... 8. In all emergency situations, the CEO/Administrator or designee will maintain communications and		procedure to track the location of on-duty staff and sheltered patients under the agency's care during an emergency (E0021). The compliance committee will ensure a plan is formulated and accessible that describes meeting the needs for staff and patients in an emergency situation. The plan will include the procedure to track staff and sheltered patients. This plan will be placed in the agency's EP binder as well as on Summit's internal site as a subpage under Compliance. The compliance officer, is scheduled to work with the compliance consultant on 7-26-22 to create this procedure and ensure it is in place by the date of the mock survey on 8-9-22. failed to ensure that an emergency preparedness communication plan included all staffing addresses and phone numbers, entities providing services under arrangements, and patient physicians for all districts/ territories that the agency provided services to (E0030). The compliance committee, with the assistance of Summit's HR department, will compile a list of staff	

	,... community, and safety authorities. & 11. An annual evaluation of the organization's hazard vulnerability analysis and emergency management plan, including its objectives and scope, functionality, and effectiveness will be conducted. The annual evaluation may be based on the drill evaluation or actual implementation of the emergency management plan. & Patient Preparedness: Detailed written instructions will be given to patients and/or family members to ensure an appropriate and timely response in the event of an emergent event that may cause interruptions of service. Information provided may include 1. Emergency contact telephone numbers 2. Names of contact persons 3. Local resources for civil preparedness. 4. Evacuation routes 5. Availability of local shelters and other community resources 6. Maintenance of backup systems for medical equipment when indicated 7. Methods to obtain needed medication and supplies 8. Necessity of having a plan for obtaining food/water, caring for pets, and obtaining important documents. & Planning Process: Personnel will work with regional or county emergency management planning agencies...in planning priorities among the potential emergencies identified in the hazard s vulnerability analysis that mitigation, preparation, response, and recovery activities will need to be undertaken. 12. Organization leadership will provide for orientation and education of all personnel regarding participation in the emergency management plan. Education will be provided during orientation and annually." & " 4. Review of an undated agency document titled 'Summit Home Care and Hospice Emergency Preparedness Plan' stated, "Planning...Administration 1. Each office will keep and maintain a current list of...vendors, emergency services, hospitals and other appropriate community resources." On page 5 stated, "...Patient and Care Planning 1. Upon SOC/admission, the admitting nurse will assign each patient a priority/disaster risk/triage code, dictating that patient's emergency rating. The admitting nurse will obtain a list of		members', physicians, contract partners, and facilities' addresses and phone numbers for all areas that Summit services. This will be included in the communication plan and placed in the agency's EP binder as well as on Summit's internal site as a subpage under Compliance. Summit's HR department began organizing the list week of 7-18-22 and will be completed by 7-29-22. failed to evidence the contact numbers for local emergency management agencies and local officials who support the Incident Command System (E0031). The compliance officer will compile the list of contact numbers for Indianapolis emergency management agencies and local officials who support the Incident Command System, which will be placed in the agency's EP binder as well as on Summit's internal site as a subpage under Compliance. The compliance officer began work on this list on 7-19-22 and will be completed by 7-29-22. failed to ensure all staff	

	contact numbers and discuss emergency planning options with both the patient and family. This information is documented on admission in Well Sky and on paper kept in the patient's home as a reference to. The admitting nurse works with the patient, preparing a list of items that will be available for use in an emergency situation, this is patient specific. a. Any patients requiring special equipment such as power for life support will be registered with the local utility companies and with local emergency offices. This admitting Summit nurse will educate both patients and families on managing and emergency situation. b. a list of medical vendors who supply patient supplies will be noted in the chart in Well Sky and in the patient's home." The Plan failed to evidence a process for coordinating with and informing local and state officials of any on-duty staff and of any patients the agency was unable to contact and failed to evidence the inclusion of documentation of names and contact information for entities providing services under arrangement to the agency's patients and failed to include names and contact numbers for the patients' physicians (or allowed practitioner). 5. A review of the clinical records for patients 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, and 17 failed to evidence a completed, individualized Emergency Preparedness Plans were in place. 6. In an interview on 6/3/22 at 8:45 AM, the Administrator in training [AIT], the former Administrator, and the Regional Clinical Manager [RCM] (from Ohio) When asked about Emergency Preparedness training provided to staff, the RCM relayed the training was done upon hire, at orientation, but was not been conducted after orientation and relayed that this training was not		providing services in all districts / territories were trained in emergency preparedness and failed to ensure the agency maintained documentation of the training provided (E0037). The compliance committee will schedule training for all staff servicing the 40 Indiana counties, will document the training, and memorialize the training on Summit's internal site as a subpage under Compliance. This training date will be scheduled at the compliance committee's by 8/23/22 failed to ensure the agency conducted a full-scale exercise that was community or individual-based exercise to test the emergency plan for all staff in all districts/ territories, failed to ensure a tabletop exercise that included a group after action discussion was conducted, and failed to maintained documentation of any drills, tabletop exercises, and emergency events (E0039). The compliance committee, on the 8/23/22 meeting, will schedule an individual-based exercise in quarter 4 2022 to	

	documented. The AIT confirmed additional Emergency Preparedness training was not currently being conducted. When queried about the contents of the Emergency Preparedness binder provided, that the emergency contacts were Ohio-centric, the RCM indicated there was an internet 'link' to click and would have led to Indiana-specific information. This additional information was not provided for review and was not included in the agency's binder. The RCM acknowledged shortcomings in the agency's Emergency Preparedness plan and relayed can be better. When asked if the agency s emergency plan included a process and cooperation and collaboration with local state and federal emergency preparedness officials and included documentation of attempts to contact officials in an effort for collaborative planning, the AIT and the former administrator did not answer and deferred to the RCM who indicated that if there was an emergency situation, patients would be instructed to call 911, and the agency could also call the police for a 'wellness check'. When queried as to when the Emergency Plan was updated, the RCM indicated the Emergency Plan was not updated and referred to the purchase of Preferred by Summit in October of 2020. The administrators jointly acknowledged Emergency Preparedness was an area where the agency failed and indicated that a staff meeting would be arranged in order to educate staff on completing an individualized Emergency Preparedness plan for patients and ensuring a copy of same remained in the home. The agency was unable to provide documentation of an Emergency Preparedness Plan nor an evaluation of a previous or current plan. As of survey exit on June 09, 2022, no other documents were provided by the agency.		test the emergency plan for all staff in all 40 counties as well as a tabletop exercise and after action discussion for management. The committee will document the training, and memorialize the training in the EP binder and on Summit's internal site as a subpage under Compliance. 2. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. Because 17 of 17 charts failed to evidence a completed, individualized Emergency Preparedness Plan, the compliance committee is assuming all clients are affected by this deficiency. Ongoing, the committee will perform and document annual audits to ensure compliance. The first mock survey is scheduled on 8-9-22. 3. Describe the steps or	

			systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Summit Homecare appointed a new Director of Compliance effective July 1, 2022. The compliance officer has assembled a compliance committee (7/15/22), which includes management personnel from each branch and a governing body. This committee is scheduled to meet quarterly on the 4th Tuesday in the 2nd month of the quarter and will ensure the comprehensive EP is in place and accessible to patients and staff members. The compliance committee will review the EP plan at the 4th quarter meeting every other year. A compliance consultant was hired and began working with the new compliance officer. The first meeting was a two-hour consultation on 7-19-22 which identified agency deficiencies. The next meeting to review Summit's EP plan is scheduled for 7-26-22 and a mock survey is scheduled for 8-9-22. This incremental plan of correction	

			will ensure a comprehensive EP program will be in place by August 31, 2022 for all current clients along with all future clients. 4. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. The corrective actions will be monitored by the compliance committee performing bi-annual audits (mock surveys) for each branch. The audits will include review of client charts and a comprehensive review of the EP plan. The compliance officer will be responsible for ensuring that the aforementioned deficiencies will not recur. The first mock survey is scheduled for 8-9-22. 5. By what date are you going to have the deficiency corrected? E0001 8-31-22	

			E0004 8/23/22 E0009 8-15-22 E0017 7-14-22 E0021 8-9-22 E0030 7-29-22 E0031 7-29-22 E0037 8/23/22 E0039 8/23/22	
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the agency failed to conduct an initial assessment within 48 hours of discharge in 1 of 7 home visits conducted with a record review (Patient #11). Findings include: 1. A review of an agency s policy titled, INTAKE PROCESS Policy No. 4-066.1-4-066.2 revealed, PURPOSE to establish the process for acceptance and entry of a patient into the	G0514	Describe what the agency did to correct the deficient practice for each client cited in the deficiency. HHA wrote a delayed SOC order to cover the delay with initiating HH services for this patient. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. HHA has an internal QA team that reviews every new SOC (and ongoing episodes) to ensure our orders are accurate.	2022-08-01

	organization. POLICY Referrals will be accepted 24 hours a day, seven (7) days per week. Personnel will be available 24 hours a day to accept patients into home care service &PROCEDURE &6. After scheduled business hours (weekends and evenings) the organization can be accessed through the answering service &B. The on-call nurse will complete the initial intake information from the referral source and relay the information as follows: 1. If the referral is on Saturday or Sunday, the on-call nurse will determine if the patient needs to be seen, or if he / she can wait until Monday morning for a follow-up by the Clinic Manager. 2. If the patient must be seen, the on-call nurse schedule an initial visit & 2. A home visit was scheduled on 6/3/22 at 9:30 AM with Patient #11. When Patient was queried about the quality of care, they stated the agency was supposed to start on Monday [5/30/22], but "someone called from the agency" and indicated since it was a Holiday [5/30/22] , they would come on Tuesday [5/31/22] for the admission." 3. A review of the clinical record of Patient #11, with a start of care date of 5/31/22, revealed a 'Home Health Certification and Plan of Care' for the certification period of 5/31/22 to 7/29/22, with diagnoses, but not limited to Right leg cellulitis with abscess (dog bite). The patient was to receive SN (skilled nursing) 2 times a week for 1 week, then 3 times a week for 8 weeks for wound care / wound vacuum to right calf with the frequency of wound vacuum dressing changes was 3 times a week. A. The record included in Miscellaneous Files a form titled, Referral to Home Care (Order 399138074) dated 5/27/22, with a fax date of 5/27/22 and time of 12:13 PM, with physician orders for Home Care Services and Specific Nursing Care for wound care. B. The clinical record of Patient #11 evidenced		If they are not, the QA team would reach out to the Administrator as well as the ADON, allowing us the opportunity to contact the physician for an updated order if needed. QA director re-educated the entire QA team on this process on 7/8/2022. Describe the steps or systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. HHA has been working on and plans to implement a brand new intake process which includes formal tracking that begins when accepting a patient. HHA has been working on this process since Feb of 2022, as we brought in a third party to review our current intake process and make recommendations. HHA has been meeting with clinical leadership over the last 90 days in preparation for implementation. This new process includes a patient access center that will review every referral, looking to see if	

	the start of care (SOC). 4. On 6/6/22 at 9:35 AM the administrator presented emails dated 5/30/22, at 5:59 PM, that relayed that the patient s spouse called the agency, the weekend prior to admission, inquiring about home services and that the patient had a wound vacuum. A staff member documented that the patient was discharged on Friday, 5/27/22, from [hospital] per the agency's on-call RN. 5. On 6/6/22 at 8:08 AM, a phone interview was conducted with MD #3. When queried about the agency starting care on Tuesday 5/31/22, MD #3 relayed that they were not aware at the time. MD #3 relayed that after aware that Patient #11's wound care was not completed, as ordered, on 5/30/22, the doctors office requested Patient #11 come to office for assessment of wound; the visit with the doctor was completed on 6/4/22 to be assured there was no harm to the patient since Patient #11 had gone from Friday 5/27/22 to Tuesday 5/31/22 without the dressing / wound vacuum being changed. MD #3 relayed their orders were for nurse care visits with wound vacuum changes every Monday, Wednesday, and Friday." 410 IAC 17-14-1(a)(1)(A)		we can accept or decline. From there it will go to a designated SOC order center, where they will place the patient on a tracker and note every attempt made to obtain the order until successful. Once SOC order is obtained, the referral will be sent to an intake center who will put the patient in our EMR, which will cue our scheduling team to begin staffing. There will be one tracker that everyone works off of and this will ensure compliance, by decreasing the risk of any patient being delayed.	

			Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. There will be one tracker that everyone works off of and this will ensure compliance, by decreasing the risk of any patient being delayed. Our intake team will be responsible to monitor this tracker daily and report any issues to clinical and operations leadership. By what date are you going to have the deficiency corrected? August 1, 2022 is the anticipated go live date for Indiana with this new process.	
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the comprehensive assessment failed to contain all information about the current	G0528	Describe what the agency did to correct the deficient practice for each client cited in the deficiency. All clinicians educated and instructed to complete a full head to toe assessment upon next scheduled visit. For those being seen by a therapy	2022-08-25

	health status for 8 of 17 records reviewed (Patient's #4, 5, 9, 10, 12, 13, 14, and 17). Findings include: 1. An agency policy titled "INITIAL AND COMPREHENSIVE ASSESSMENT," Policy No. 4-018.1 and 4018.2, dated April 2015, stated "POLICY: &The assessment will be patient-specific and comprehensive to include the patient s need for home care &PROCEDURE &2. The comprehensive assessment for each patient must be completed in its entirety by a single clinician &3 &B. A physical assessment including blood pressure &and other relevant data related to pertinent physical findings of common symptoms such as constipation &(Head-to-toe assessment.) &I. An evaluation of the home environment &and assessment of emergency preparedness of the patient..." 2. A review of the closed clinical record of Patient #4, with the start of care date (SOC) of 5/16/22, included a 'Home Health Certification and Plan of Care', dated 5/16/22, for the certification period of 5/16/22 to 7/14/22, with diagnoses, that included, but not limited to, Chronic Kidney Disease with heart Failure (Chronic kidney disease is common in heart failure, and shares many risk factors with such as age, hypertension, diabetes, and coronary artery disease and Congested Heart Failure (a chronic progressive condition that affects the pumping power of your heart muscle). The plan of care included orders for skilled nurse [SN] to instruct Patient #4 on a daily weight self-monitoring program where the patient utilized the same scales on a hard, flat surface each morning before breakfast and after urination. Patient to report to SN a weight gain of 3 pounds (lbs) per day or more or 5 lb in one week. SN was to assess the patient s weight log every visit. The record included the comprehensive		assistant (therapy only cases), HHA plans to have evaluating therapist complete full head to toe assessment within the next 30 days. Assigned case manager educated and instructed to document comprehensive assessment findings within a communication note. It is mandatory that the admitting clinician performs a comprehensive assessment at admission. A full system assessment is to be performed at every nursing visit. In addition, it is mandatory for all clinical staff to perform specific assessment measures every visit based on patient's diagnoses. (ie. bowel movement for post-surgical patients, blood sugar for diabetes, weights and edema for CHF, lung sounds for COPD, etc.) Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected.	

	assessment document, "Outcome and Assessment Information Set" (OASIS) (a patient-specific, standardized assessment used in Medicare home health care to plan care, determine reimbursement, and measure quality), which failed to include a list of parameters for the patient to call physician with weight changes. 3. A review of the clinical record of Patient #9, with a SOC of 10/29/21, revealed a 'Home Health Certification and Plan of Care', dated 4/22/22, for the certification period of 4/27/22 to 6/25/22, with diagnoses, that included, but not limited to, Malignant neoplasm of frontal lobe (a cancerous growth in the brain which may cause impaired judgment, motivation or inhibition; impaired sense of smell or vision loss; paralysis on one side of the body; reduced mental abilities and memory loss), Hemiplegia (paralysis of one side of the body), unspecified affecting right dominant side, and Aphasia (loss of ability to understand or express speech), age-related nuclear cataract, bilateral (a major cause of blindness, which is characterized by opacification and coloration in the center of the lens), and hypertensive retinopathy, bilateral (retinal vascular damage caused by hypertension which can cause reduced vision, eye swelling, bursting of a blood vessel, double vision accompanied by headaches). Clinical record # 9 included the comprehensive recertification assessment, dated 4/22/22, that failed to evidence an assessment of Patient's bowel and lung sounds, and failed to assess peripheral pulses and capillary refill. 4. A review of the clinical record of Patient #12, with a SOC date of 3/6/22, revealed a 'Home Health Certification and Plan of Care', dated 5/4/22 and signed by employee RN 1, for the certification period of 5/5/22 to 7/3/22, with diagnoses, but not limited to Necrotizing fasciitis (an acute disease in which inflammation of the fasciae of muscles or other organs results in rapid destruction of overlying tissues), Cellulitis of the abdominal		Based on the survey findings of 8/17 missing full comprehensive assessment, HHA plans to address entire census by having all nurses and evaluating therapists complete a full head to toe assessment within the next 30 days. Describe the steps or systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Clinical staff in-services were performed on 6/14 (nursing) and 6/23 (therapy) to educate / review comprehensive assessment, full system assessment, and specific assessment measures based on patient's diagnoses. Emails were also sent to all clinical staff to review the information that was provided during the in-services. The administrator, regional	

	wall (deep infection of the skin caused by bacteria), and Type 2 Diabetes mellitus (is an impairment in the way the body regulates and uses sugar [glucose] as a fuel). Treatments ordered but not limited to were Insulin Lispro (0.5 unit dial) Subcutaneous 100 unit/ML sliding sc per sliding scale subcutaneous 3 x daily if BS (blood sugar) is less than 70 call MD. If blood sugar is 150-179 give 1 unit, if BS is 180 209 give 2 units, BS 210-239, give 3 units, if BS 240-269 give 4 units, BS 270-299 give 5 units, BS 300-359 give 7 units, BS 360-400 give 8 units, If BS is greater than 400 give 9 units BS greater than 400 call MD. Physician orders and treatments included, but not limited to, SN to instruct Patient / Caregiver on all aspects of diabetic management to include the disease process, foot assessments, signs and symptoms of hypo / hyperglycemia, glucometer use and preparation and administration of diabetic medications ordered by the physician . The clinical record included a recertification assessment dated 5/4/22 and signed by employee RN 1, with documentation that Patient had a Surgical Wound and that the wound was not addressed during the assessment. The documentation indicated the patient was independent with glucometer use, and documented in the comment section, Pt (patient) does not have a meter to check BS (blood sugar) . Interventions documented as provided included, but were not limited to, SN to instruct Patient / Caregiver on all aspects of diabetic management to include the disease process, foot assessments, signs and symptoms of hypo / hyperglycemia, glucometer use and preparation and administration of diabetic medications ordered by physician . 5. A review of the clinical record of Patient #14, with a start of care date of 5/30/22, revealed a 'Home Health Certification and Plan of Care', dated 5/30/22, for the certification period of 5/30/22 to 7/28/22, with diagnoses, but not limited to Aftercare following joint replacement surgery, Presence of left artificial knee joint, and Chronic Respiratory Failure and physician orders for physical therapy 3 times a week, for 2 weeks and 2 times a week for 2		director, and ADON will conduct quarterly in-services focused on comprehensive assessments to ensure current staff maintains skills to do so, as well as any new hires joining the HHA. The administrator, regional director, ADON or office nurse will review 20 random charts each week for 60 days to ensure comprehensive assessments, full system assessments and specific assessment measures are being performed. Spot checking will occur thereafter to ensure compliance or need for further education. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. The QA department will continue to audit documentation. The administrator, regional director, ADON or office nurse will	

	weeks. The clinical record included a comprehensive assessment, dated 5/30/21, which failed to evidence an assessment of patient's Integumentary Status, respiratory status and lung sounds, cardiac status and peripheral pulses and capillary refill, digestion, bowel sounds, elimination status, and the date of the patient's last bowel movement. 6. In an interview with the administrator on 6/7/22 at 12:40 PM, stated, "there are bullet points in OASIS that need to be answered, physical assessments have to be completed, and if areas are being left blank, that would be a quality review issue and QR will return documents for corrections." 7. In an interview with the former administrator on 6/7/22 at 1:30 PM, stated that they expected a full assessment at each visit. 8. A review of the clinical record for Patient #5, with SOC date of 5/17/22, revealed a 'Home Health Certification and Plan of Care' for the certification period of 5/17/22 to 7/15/22 with diagnoses that included, but were not limited to, Aftercare following joint replacement surgery, right total knee arthroplasty (a surgical procedure to restore the function of a joint) on 5/11/22. The SOC assessment, dated 5/17/22, failed to document an assessment of patient's last bowel movement, the area was left blank, and 'interventions' and 'goals' were left blank. 9. A review of the clinical record for Patient #10, with SOC date of 4/29/22, revealed a 'Home Health Certification and Plan of Care' for the certification period of 4/29/22 to 6/27/22 with diagnoses that included, but were not limited to, Congestive Heart Failure (a chronic progressive condition that affects the pumping power of your heart muscle, specifically referring to the stage in which fluid builds up within the heart and causes it to pump inefficiently). The admission assessment, dated 4/29/22, failed to evidence a Fall Risk Assessment, was blank. 10. A review of the clinical record for Patient		review 20 random charts each week for 60 days to ensure comprehensive assessments, full system assessments and specific assessment measures are being performed. Spot checking will occur thereafter to ensure compliance or need for further education. By what date are you going to have the deficiency corrected? Initiated 6/14/22 and to be completed by 8/25/22.	

	#13, with a SOC date of 3/11/22, revealed a 'Home Health Certification and Plan of Care' for the certification period of 5/10/22 to 7/8/22 with diagnoses that included, but were not limited to, progressive supranuclear ophthalmoplegia (an uncommon brain disorder that causes serious problems with walking, balance and eye movements, and later with swallowing) and dysphagia (difficulty swallowing). The SOC assessment dated 3/11/22 was incomplete and failed to evidence an assessment of Patient's Height and Weight, Last bowel movement, and any weight loss or gain. In a section titled 'Nutrition,' 'Dysphagia' was documented. The Depression Screening assessment included that the patient had, "experienced little interest or pleasure in doing things, felt down, depressed, or hopeless, 2-6 days" in the last two weeks. The record failed to evidence whether the patient was on an antidepressant and symptoms were well-controlled, or whether symptoms were not controlled while on an antidepressant, and whether the physician was notified of the same. 11. A review of the closed clinical record for Patient #17, with a SOC dated 4/26/22, revealed a 'Home Health Certification and Plan of Care' for the certification period of 4/26/22 to 6/24/22 with diagnoses that included, but were not limited to, Aftercare following abdominal surgery for neoplasm (an abnormal mass of tissue that forms when cells grow and divide more than they should or do not die when they should. Neoplasms may be benign [not cancer] or malignant [cancer]), and cancer of the left kidney. The Comprehensive Assessment dated 4/26/22 failed to evidence a complete assessment that included the date of the patient's last bowel movement. 12. In an interview on 6/7/22 at 1:00 PM with the Administrator in training and former Administrator, who indicated the agency's expectation of clinicians was to document the last bowel movement in all post-surgical patients.			

	410 IAC 17-14-1(a)(1)(A)			
G0602	Communication with all physicians 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. Based on interview and record review, the agency failed to notify the physician of not completing the SOC (start of care) assessment/treatment when it was ordered by the physician in 1 patient of 17 record reviews (Patient #11). Findings include: 1. During a home visit observation, on 6/3/22 at 9:30 AM with Patient #11, when queried about the care Patient received, Patient #11 stated, "The agency was supposed to start on Monday (5/30/22), someone called from the agency and relayed that since Monday was a Holiday, they (staff) would arrive on Tuesday for the admission." The Clinical record revealed in Miscellaneous Files a form titled, 'Referral to Home Care (Order 399138074), dated 5/27/22, with a fax date of 5/27/22 and time of 12:13 PM, that evidenced physician orders for Home Care Services and specific Nursing Care and wound care. The clinical record included a physician order, dated 5/31/22 for a delay in SOC, with SOC to begin on 5/31/22. The clinical record included a Start of Care admission assessment, dated 5/31/22, with the	G0602	Describe what the agency did to correct the deficient practice for each client cited in the deficiency. HHA wrote a delayed SOC order to cover the delay with initiating HH services for this patient. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. HHA has an internal QA team that reviews every new SOC (and ongoing episodes) to ensure our orders are accurate. If they are not, the QA team would reach out to the Administrator as well as the ADON, allowing us the opportunity to contact the physician for an updated order if needed. QA director re-educated the entire QA team on this process on 7/8/2022. Describe the steps or systemic	2022-08-01

	date of referral as 5/30/22. 2. On 6/6/22 at 8:08 AM, a phone interview was conducted with MD #3. MD #3 relayed that after made aware that Patient #11 was not assessed and wound care provided on 5/30/22, as ordered, they were concerned for Patient and scheduled an appointment to be seen in the office on 6/4/22, to be assured there was no harm to Patient as Patient had gone from Friday (5/27/22) to Tuesday (5/31/22) without the dressing / wound vacuum changed. MD #3 relayed, when asked, that they were not made aware that Patient was not assessed and care provided on 5/30/22 until 6/3/22, and stated, "my orders were for the wound vacuum to be changed every Monday, Wednesday, and Friday." 3. On 6/6/22 at 9:35 AM, the administrator provided emails, dated 5/30/22, that begin at 5:59 PM, where staff documented that Patient #' s spouse phoned the agency twice, over the weekend, inquiring about the services and that Patient had a wound vacuum. Another email documented, the patient was DC d (discharged) Friday from (hospital) per the on-call RN. 4. A review of an agency's policy titled, 'Care Planning Process' Policy No. 4-001.1 to 4-001.4, dated April 2015 revealed, "PURPOSE To provide clinical direction to the clinician providing direct patient care. POLICY A written plan of care will be initiated...PROCEDURE 1. At the time of the initial assessment, the clinician...will develop the patient plan of care based upon the patient's identified needs and will review it with the patient...10. Clinicians will inform the patient's physician of any changes..." 5. An agency policy titled MONITORING PATIENT S RESPONSE/REPORTING TO PHYSICIAN Policy No. 4-012.1 to 4-012.3 dated April 2015 revealed, PURPOSE To provide guidelines for monitoring the patient s response to care and for reporting to the		changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. HHA has been working on and plans to implement a brand new intake process which includes formal tracking that begins when accepting a patient. HHA has been working on this process since Feb of 2022, as we brought in a third party to review our current intake process and make recommendations. HHA has been meeting with clinical leadership over the last 90 days in preparation for implementation. This new process includes a patient access center that will review every referral, looking to see if we can accept or decline. From there it will go to a designated SOC order center, where they will place the patient on a tracker and note every attempt made to obtain the order until successful. Once SOC order is obtained, the referral will be sent to an intake center who will put the patient in our EMR, which will cue our scheduling team to begin staffing. There will be one tracker that	

	patient s physician. POLICY Clinician will monitor, document, and report the patient s response to care and treatment provided on each home visit &Clinicians will establish and maintain ongoing communication with the physician to ensure safe and appropriate care for the patient. PROCEDURE 1. During each home visit, the clinician will monitor the patient s response to care &A. Care interventions and treatments B. Medications &3. The patient s physician will be contacted on the same day when any of the following occur: A significant changes &E. Changes that have occurred regarding &treatment &F. When there is any problem implementing the plan of care..." 6. A review of an agency's policy titled, 'Physician Participation in Plan of Care' Policy no. 4-002.1 to 4-002.3, dated April 2015 revealed, "PURPOSE To provide guidelines...POLICY A physician will direct the care of every home health care patient...PROCEDURE...7...A. Changes in the care or service provided..." 410 IAC 17-14-1(a)(1)(G)		everyone works off of and this will ensure compliance, by decreasing the risk of any patient being delayed. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. There will be one tracker that everyone works off of and this will ensure compliance, by decreasing the risk of any patient being delayed. Our intake team will be responsible to monitor this tracker daily and report any issues to clinical and operations leadership. By what date are you going to have the deficiency corrected? August 1, 2022 is the anticipated go live date for Indiana with this new process.	
G0640	Quality assessment/performance improvement 484.65	G0640	Describe what the agency did to correct the deficient practice for each client cited in the	2022-08-01

	Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the agency failed to use measurable indicators to improve outcomes, patient safety, and quality of care (G 642); failed to use data derived from OASIS (Outcome and Assessment Information Set) assessments to monitor services and quality of care and failed to obtain governing body approval for the frequency and detail of data collection (G 644); failed to ensure the QAPI (Quality Assessment and Performance Improvement) program focused on high-risk, high-volume, or problem-prone areas (G 648); failed to document the agency had considered the incidence, prevalence, and severity of problems to select indicators and performance improvement efforts (G 650); failed to ensure performance improvement activities documented correction of identified problems related to the health and safety of patients (G 652) failed to ensure the agency tracked and analyzed adverse patient events and implemented actions to prevent adverse events (G 654); failed to measure and track performance improvement projects to determine if improvement occurred and was sustained (G 656); failed to ensure the QAPI Program included at least 1 performance improvement project, either in development or ongoing, that was based on the agency's QAPI program activities and data obtained through		deficiency. failed to use measurable indicators to improve outcomes, patient safety, and quality of care (G 642). The compliance officer will be using the following measurable indicators to identify QAPI opportunities: OASIS outcome measures, MCR Compare scores, and HHCAHPS results. failed to use data derived from OASIS (Outcome and Assessment Information Set) assessments to monitor services and quality of care and failed to obtain governing body approval for the frequency and detail of data collection (G 644). As stated above, OASIS outcome date will be used to monitor services and quality of care. Summit’s governing body has agreed that this data can be accessed as needed to improve quality of care. failed to ensure the QAPI (Quality Assessment and Performance Improvement) program focused on high-risk, high-volume, or problem-prone	

	tracking, measuring, and analyzing high-risk, high-volume, problem-prone areas (G 658); and failed to document governing body oversight of an ongoing program for quality improvement to include a requirement to identify and address possible fraud or waste (G 660), with the potential to affect all 453 active patients. The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care, thus resulting in non-compliance with Condition of Participation CFR 484.65 Quality Assessment/Performance Improvement. Findings include: A review of an agency's policy titled, 'IMPROVING ORGANIZATIONAL PERFORMANCE' Policy No. 5-001.1 to 5-001.4, dated April 2015 revealed, "PURPOSE To establish patient outcomes as the primary focus of the organizations' performance improvement activities. POLICY Senior management will have the responsibility: to guide the organization's efforts in improving...to define expectations of the performance improvement activities; and to generate the plan and processes the organization will utilize...Performance improvement results will be utilized to address problem issues, improve the quality of care and patient safety, and will be incorporated into program planning and process design and modifications. All personnel will be active participants...The Governing Body is responsible for ensuring...PROCEDURE 1. Senior management will: A. Participate in educational activities to increase their level of understanding and ability to implement performance improvement activities...B. Adopt a structured framework for performance improvement....C. Identify and set specific outcomes for measurable improvement and acceptable limits for findings...D. Identify and participate in benchmarking activities that utilize: 1. Internal standards:...2.Processes and		areas (G 648) and failed to document the agency had considered the incidence, prevalence, and severity of problems to select indicators and performance improvement efforts (G 650). . The compliance committee at the 1st quarter each year will identify high-risk, high-volume, or problem-prone areas for each branch as QAPI opportunities. These opportunities will be documented at time of the meeting. failed to ensure performance improvement activities documented correction of identified problems related to the health and safety of patients (G 652) and failed to ensure the agency tracked and analyzed adverse patient events and implemented actions to prevent adverse events (G 654). Also failed to measure and track performance improvement projects to determine if improvement occurred and was sustained (G 656) The compliance officer will ensure QAPI projects and	

	Allocate resources for performance improvement activities by: 1. Assigning organization personnel to participate...2. Providing adequate time for organization personnel...3. Creating and maintaining information systems and data management processes...4. Utilizing appropriate statistical techniques...F. Assure that each performance improvement activity contains the following elements: 1. Description of the indicator(s)/activities to be conducted 2. Frequency of activities 3. Designation of responsible party 4. Method(s) of data collection 5. Acceptable limits for findings 6. Who will receive the report 7. Follow-up plans if findings fail to meet acceptable limits including plan(s) of correction 2. provide organization personnel training...3. All other organization personnel will: A. Be involved in performance improvement teams and activities B. Promote communication and coordination of performance improvement activities as well as contribute to those activities. C. Forward relevant information...D. Take action on recommendations...4. Trends identified through performance improvement measurement and analysis will be reported to the Governing Body on a quarterly basis. 5. Results of performance improvement activities will be communicated with all staff via intranet..." In an interview with the former administrator on 6/6/22 at 3:40 PM, the former administrator presented the QAPI binder, and stated, "I know we have quite a few deficits here. We plan on doing one every quarter on tracking falls and start-of-care times. The organization groups Ohio and Indiana together". In an interview with the former administrator on 6/9/22 at 3:50 PM, the former administrator stated they were not sure where to get all the information required for QAPI, and that the prior administrator had completed the QAPI.		outcomes of these projects will be documented and memorialized on Summit's internal site. QAPI projects will be completed and documented during quarter 4 of each year. Quarter 2 compliance committee meeting each year will cover the sustainability of improvement of the previous years QAPI project. failed to ensure the QAPI Program included at least 1 performance improvement project, either in development or ongoing, that was based on the agency's QAPI program activities and data obtained through tracking, measuring, and analyzing high-risk, high-volume, problem-prone areas (G658). Although Summit has been undergoing the process of improvement of quality star ratings in all branches through 1 on 1 individual OASIS training in CY 2022, this education was not formally structured as a QAPI project. The newly appointed compliance officer will formally structure and document the QAPI to meet standards.	

			failed to document governing body oversight of an ongoing program for quality improvement to include a requirement to identify and address possible fraud or waste (G 660). The compliance officer will ensure documented governing body oversight of internal audits that identify and address possible fraud or waste. Audits are planned for quarter 3 of each CY. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. Randomized internal audits are now planned for quarter 3 each year to prevent these possibilities. Describe the steps or systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any	

			system changes you made. The compliance officer will assemble a compliance committee by 7/15/22, which will include management personnel from each branch. This committee will meet quarterly with QAPI projects being the focus of Q1 and Q2 meetings each year. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. The QAPI corrective actions will be monitored by the compliance committee at the Q2 meeting each year. The compliance officer will be responsible for ensuring that the aforementioned deficiencies will not recur. By what date are you going to have the deficiency corrected? August 1, 2022 is the anticipated go live date for Indiana with this new process.	

G0680	Infection prevention and control 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. Based on observation, record review, and interview the agency failed to ensure staff implemented infection prevention measures, including hand hygiene, while providing patient care in 2 of 7 home visit observations (G682) and failed to ensure their Covid-19 Vaccine Mandate policy and procedures were implemented from December 29, 2021 through a period of 6 months, during a pandemic, and failed to ensure that the agency met the Covid-19 Vaccine Mandate at 100% compliance for 1 of 1 agency, with the potential of negative outcome for the agency's current 453 patients (G687). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment, resulting in non-compliance with Condition of Participation CFR 484.70 Infection Prevention and Control.	G0680	Describe what the agency did to correct the deficient practice for each client cited in the deficiency. On 6/10/22 a spreadsheet was started to track COVID vaccination or exemption status for each Indiana Summit employee. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. Emails were sent out the week of 6/12/22 to every employee who we did not have record of vaccine / exemption status. Each employee emailed their vaccination card or exemption form to the Administrator, Regional Director, and HR. Staff in-services were performed on 6/14 and 6/23 to educate / review infection control and	2022-07-08

			proper hand hygiene. Emails were also sent to all clinical staff to review the information that was provided during the in-services. Describe the steps or systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The Administrator, Regional Director, ADON or office RN will receive a daily phone call/text from each COVID exempt employee (symptom check, temperature) prior to seeing a patient. The Administrator and/or Regional Director will be tracking all employee COVID positives and/or exposures. All clinical staff will continue to receive instruction on proper hand hygiene / infection control. Shadowing of every clinical employee during a home visit will occur at a minimum of once per year. In addition, monthly, quarterly,	

			and yearly in-services / skills check for all clinical staff (which will include hand hygiene). Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. HR will obtain vaccination card or exemption forms during the onboarding process. The Administrator, Regional Director, ADON or office RN will update the COVID Exempt Daily tracker for each exempt employee. The Administrator, Regional Director, ADON, Rehab Coordinator or office RN will educate / monitor infection control and proper hygiene of staff. By what date are you going to have the deficiency corrected?	

			COVID vaccination / exemption of 100% of Indiana Summit employees was completed on 7/8/22. The COVID Exempt Daily tracker will be initiated on 7/13/22 and will be ongoing.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview the agency failed to ensure staff implemented infection prevention measures, including hand hygiene, while providing patient care in 2 (Home health aide # 1 and physical therapy assistant #1) of 7 home visits observations. Findings include: On 6/2/22 at 12:30 PM, during a home visit for Patient 1, Home Health Aide 1 was observed performing a bed bath. The aide proceeded to the bathroom, performed hand hygiene at the sink, obtained a plastic bowl and placed the bowl into the sink, then donned gloves, and filled the bowl with water, then carried it to the bedside to begin the bath. After washing the patient's face, the aide added liquid soap to the bowl of water, wet the washcloth into the soapy water, and proceeded to wash the patient's entire body, including the feet and peri area, with the same washcloth, water, and while wearing the same pair of gloves throughout the visit, doffed the gloves at the end of the visit. On 6/2/22 at 3:00 PM, during a home visit for	G0682	Describe what the agency did to correct the deficient practice for each client cited in the deficiency. HHA immediately developed and implemented updated certified aide/bathing tech competency evaluation and skills checklist. DIrector of nursing provided skilled education to each aide/bathing tech via hands on training, handouts approved by CDC, utilized the method of teach back from each certified aide/tech to evaluate understanding of appropriate and proper technique. Staff in-services were performed on 6/14 and 6/23 to educate / review infection control and proper hand hygiene. Emails were also sent to all clinical staff to review the information that was provided during the in-services. Describe how the agency reviewed all clients in the	2022-07-14

	Patient 2, Physical Therapy Assistant #1 was observed to remove a beverage from Patient #2's refrigerator, unscrewed the cap at the mouth of the container, and then handed the beverage to Patient #2 to drink, without performing hand hygiene before obtaining the beverage. Review of an agency document dated April 2015, titled 'HAND HYGIENE Policy No. 6-006.1' stated, "PURPOSE...To prevent cross-contamination and home care-acquired infections...POLICY...Personnel providing care in the home care setting will regularly wash their hands, per the most recently published CDC regulations and guidelines in healthcare settings...PROCEDURE...3. hand decontamination using an alcohol-based hand rub should be performed: A. Before having direct contact with patients...C. After contact with patient's intact skin (when taking pulse, blood pressure, or lifting a patient) &E. When moving from a contaminated body site to a clean body site during patient care. F. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient...At any time, personnel may choose to wash their hands with soap and running water in addition to using an alcohol-based hand rub, especially if personnel feel there is a "build-up" on the hands after repeated use of the alcohol-based hand rub. An online document titled 'How to Give a Bed Bath from Medline Plus, outlined how to perform a bed bath while maintaining excepted infection control practices. The following steps should be followed when giving a bed bath: &While the patient is lying on their back, begin by washing their face and move toward their feet. Then, roll your patient to one side and wash their back &Bring fresh, warm water to the patient's bedside with a clean washcloth to wash private areas. First, wash the genitals, then move toward the buttocks, always washing from front to back. A.D.A.M. Medical Encyclopedia [Internet]. Johns Creek (GA): Ebix, Inc., A.D.A.M.; c1997-2020. Bathing a patient in bed;		agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. HHA reviewed the current roster of certified aide/bathing tech clients, reviewed each client with certified aide/bathing tech and reinforced education provided in the immediate correction plan. HHA immediately developed and implemented updated certified aide/bathing tech competency evaluation and skills checklist. DIrector of nursing provided skilled education to each aide/bathing tech via hands on training, handouts approved by CDC, utilizing methods of teach back from each certified aide/tech to evaluate understanding of appropriate and proper technique. Staff in-services were performed on 6/14 and 6/23 to educate / review infection control and proper hand hygiene. Emails were also sent to all clinical staff to review the information that was provided during the in-services	

	[about 2 p.]. Available from: https://medlineplus.gov/ency/patient instructions/00427.htm In an interview on 6/3/22 at 2:53 PM the Former Administrator and Regional Manager (from Ohio), when discussing the home visit for Patient 1 with Aide 1, referred to the fact that the current Administer in training had been present for the visit and had witnessed the same breaches. They acknowledged the aide required further education. When discussing the visit for Patient 2 with PTA 1, they also acknowledged breaches in infection control had occurred. In an interview on 6/7/22 at 10:30 AM with the Administrator in training when discussing the home visit for Patient 1 with Aide 1, called the visit, "cringy" and stated that, "education was started immediately', "[Aide 1] is our only aide." 410 IAC 17-12-1(m)		Describe the steps or systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. HHA immediately developed and implemented updated certified aide/bathing tech competency, infection control, including hand hygiene, evaluation and skills checklist. DIrector of nursing provided skilled education to each aide/bathing tech via hands on training, handouts approved by CDC, utilized methods of teach back from each certified aide/tech to evaluate understanding of appropriate and proper technique. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. Beginning immediately, the Director of Nursing will hold quarterly, annual, and as	

			needed focused skill check off/education, and comprehensive skill check off/education in-services to ensure ongoing compliance with CDC and CMS guidelines for all clinical staff and client care. Director of nursing or nursing preceptor staff will perform quarterly/annual/random in person visits with clinical nursing/aide/bath-tech staff to monitor quality of care and adherence to CDC and CMS guidelines By what date are you going to have the deficiency corrected? HHA will have deficiency corrected and all implemented practices will be in place no later than 7/14/2022	
G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies	G0687	Describe what the agency did to correct the deficient practice for each client cited in the deficiency. On 6/10/22 a spreadsheet was started to track COVID vaccination or exemption status	2022-07-08

	and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components:		for each Indiana Summit employee. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. Emails were sent out the week of 6/12/22 to every employee who we did not have record of vaccine / exemption status. Each employee emailed their vaccination card or exemption form to the Administrator, Regional Director, and HR. Describe the steps or systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. The Administrator, Regional Director, ADON or office RN will	

	(i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;		receive a daily phone call/text from each COVID exempt employee (symptom check, temperature) prior to seeing a patient. In addition, the exempt employee will wear a fd and mask during all home visits. The Administrator and/or Regional Director will be tracking all employee COVID positives and/or exposures. Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. HR will obtain vaccination card or exemption forms during the onboarding process. The Administrator, Regional Director, ADON or office RN will update the COVID Exempt Daily tracker for each exempt employee. By what date are you going to have the deficiency corrected?	

	(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19.		COVID vaccination / exemption of 100% of Indiana Summit employees was completed on 7/8/22. The COVID Exempt Daily tracker will be initiated on 7/11/22 and will be ongoing.	

Based on record review and interview the agency failed to ensure their Covid-19 Vaccine Mandate policy and procedures were implemented from December 29, 2021 through a period of 6 months, during a pandemic, and failed to ensure that the agency met the Covid-19 Vaccine Mandate at 100% compliance for 1 of 1 agency, with the potential of negative outcome for the agency's current 453 patients.

Findings include:

1. A review of an undated and untitled agency document, an Excel Spreadsheet, included the names of staff and indicated 29 of the agency's 86 staff completed a COVID-19 vaccination series.

A. A review of 6 agency documents, titled 'Religious Accommodation Request Form' were complete and accompanied by approval letters, granting the 4 employees a religious exemption. Two of the six 'Religious Accommodation Request Forms' were submitted, and failed to evidence an accompanying agency approval.

B. A review of agency documents titled 'Medical Exemption from Vaccination Accommodation Request Form' were completed and with accompanying approval letters, granting the 2 employees a medical exemption of the COVID-19 vaccine requirement.

C. The agency records evidenced 35 employees or 41%, of the 86 total employees, received a vaccine series or received an approved exemption.

2. Review of an undated agency policy titled 'Summit Home Care COVID-19 Vaccination Policy' stated, "Purpose ... we are adopting this policy to safeguard the health of our employees and their families; our customers and patients; and the communities we serve from COVID-19, that may be reduced by vaccinations. This policy will comply with all applicable laws and base its guidance from the Centers for Medicare and Medicaid Services

	applicable. Scope ... All employees are required to receive vaccinations as determined by Summit Home Care unless a reasonable accommodation is approved. Employees not in compliance with this policy will be placed on unpaid leave until their employment status is determined by the Human Resources department. New hires will be required to provide proof of vaccination before beginning work to the Human Resources department. Failure to do this will result in the offer of employment being rescinded...Procedures ... Before the stated deadlines to be vaccinated have expired, employees will be required to provide proof of vaccination or an approved reasonable accommodation to be exempted from the requirements." 3. In a telephone interview on 6/9/22 at 12:55 PM, corporate staff member 1, Director of Human Resources, indicated the agency stopped requiring and tracking staff Covid-19 vaccinations and exemptions. He stated this decision was made by, "myself, [regional clinical manager], the CEO, and a regional director in Cincinnati", recalling they had, "discussed our interpretation" based on a blog entry produced by the American Hospital Association on 12/28/21. When queried as to whether they had used another source to verify that they were no longer required to abide by the mandate he stated, "no". He indicated this discussion among the group was not documented. When queried as to whether he was 'signed up' with CMS to get their alerts directly, he stated, "no" but that he, "would check weekly, or few times a week to check on.. what's the Medicare Medicaid...." (required prompting) "CMS" updates. He reported this hospital blog is what he, "kept up with" to stay informed about CMS updates. Also indicated he believed he may have also checked the Department of Labor or the Department of Insurance websites. When asked if he had followed the blog further and checked beyond 12/29/21, he stated he did not check again after that date. 4. In a telephone interview on 6/9/22 at 3:04 PM, corporate staff person 2, from the Human Resources (HR) Department in Ohio stated			

	vaccinations or exemptions of employees, stated they had stopped tracking, "once he [corporate staff person 1] received the article." She relayed when they were tracking, this was done in their payroll system and when a vaccine card was presented they could make a copy and file it. She relayed they still request, but are no longer required.			
G0772	Documentation of competency evaluation 484.80(c)(5) The HHA must maintain documentation which demonstrates that the requirements of this standard have been met. Based on record review and interview, the agency failed to maintain competency evaluations for 1 of 1 Home Health Aide personnel file reviewed (Employee home health aide #1). Findings include: Personnel file review was completed on 6/9/22. Personnel file for home health aide #1 failed to evidence a Skills Competency. During an interview with the former Administrator on 6/9/22 at 3:54 PM, stated, "the skills competency for HHA1 is lost in an email, and never was forwarded to human resources". 410 IAC 17-14-1(I)(2)	G0772	Describe what the agency did to correct the deficient practice for each client cited in the deficiency. HHA to find an accredited HHA program to administer training and skill competencies check. List of consultants/programs obtained from IAHHC on 7/20/2022. Agency will have a contract in place with an accredited program before hiring any new HHAs. Describe how the agency reviewed all clients in the agency that could be affected by the same deficient practice, and state, what actions the agency took to correct the deficiency for any client the agency identified as being affected. HHA reviewed all home health aide HR charts, assessing for up to date competency skills checklists. Once partnership is established with accredited HHA program,	2022-08-25

competency evaluations annually.

Describe the steps or systemic changes the agency has made or will make to ensure that the deficient practice does not recur, including any in-services, but this also should include any system changes you made. Once partnership is established with accredited HHA program, they will provide training and competency evaluations annually to ensure 100% compliance over the next two years.

Describe how the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place to ensure 100% compliance and who will be responsible for monitoring. By utilizing an outside source (accredited HHA program) to complete annual training and competency evaluations for our HHA staff, outside source will provide agency with real time feedback as well as tests to ensure compliance. New HR

			software will ensure proper tracking, to eliminate the risk for deficient practice. By what date are you going to have the deficiency corrected? Paycom (New HR software) to be implemented by 08/01/2022. Accredited HHA program partnership to be established and competency evaluations to occur by 08/25/2022	

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

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