STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200497560	A. BUILDING B. WING	07/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL CARE HOME HEALTH SERVICES	9721 PRAIRIE AVENUE, HIGHLAND, IN, 46322

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This was a State re-licensure survey for a home health agency, conducted by the Indiana Department of Health. Survey Dates: 7/13/2022, 7/14/2022, 7/15/2022, 7/18/2022, and 7/19/2022. Facility ID: 004076	N0000		2022-08-31
G0000	INITIAL COMMENTS This was a Federal Re-certification, and State re-licensure survey for a home health agency, conducted by the Indiana Department of Health. Survey Dates: 7/13/2022, 7/14/2022, 7/15/2022, 7/18/2022 and 7/19/2022. Facility ID: 004076 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Quality Review Completed 08/02/2022	G0000		2022-08-31

E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 7/13/2022, 7/14/2022, 7/15/2022, 7/18/2022, and 7/19/2022 Facility ID: 004076	E0000		2022-08-31
E0006	Plan Based on All Hazards Risk Assessment 403.748(a)(1)-(2),482.15(a)(1)-(2),485.625(a)(1)-(§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment.	E0006	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: 1. failureof the agency to evidence an all-hazard, community and facility-based riskassessment. 2. Failure of the agency to include strategies for addressingemergency events identified by the risk assessment. including the management ofthe consequences of power failures, natural disasters, and other emergenciesthat would affect the hospice's ability to provide care. **To correct this deficiency:** TheDON reviewed and **revised** the Emergency Plan to include a current documented,facility-based, and community-based risk	2022-08-09

	* [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the home health agency failed to ensure the emergency preparedness plan was based on		assessment, utilizing an all-hazards approachconducted with agency staff members. **To prevent the deficiency fromrecurring:** the agency has added the following to the patient binder/folder a. "At-risk patient evaluation form" b. Emergency evacuation plan c. "Hazard Vulnerability Assessment" to be performed by the clinician at the start of care and updated as necessary. d. Strategies for addressing emergency events. The DON had scheduled home visits to verify that the above revisionshave been implemented by the visiting clinician. **(**See attachment: At risk Evaluationform, Emergency evacuation plan, Hazard Vulnerability Assessment, Strategies foraddressing emergency events) The **DON and/or the alternateclinical manager** shall	

	community-based risk assessment utilizing an all-hazards approach and failed to include strategies for addressing emergency events identified by the risk assessment. The findings include: Record review on evidenced an undated agency policy obtained 7/13/2022, titled Home Care Emergency Preparedness Program for Professional Care Home Health Services which stated, & the Director of Nursing will conduct a meeting amongst staff members to conduct a hazard vulnerability analysis to identify possible emergencies that could affect the agency s ability to provide services or patient s need for services [See minutes of the meetings, all hazards vulnerability assessments] &. Record review evidenced an undated agency policy obtained 7/13/2022, titled Emergency Action Plan which stated, & The emergency plan is based on an all hazards approach which analyzes a broad range of emergencies and identifies situations that are likely to impact the agency, it s staff and clients &. Record review on 7/13/2022, evidenced an emergency preparedness binder, which failed to evidence an all-hazard, community and facility-based risk assessment was conducted. During an interview on 7/14/2022, at 12:57 PM, when queried if the agency emergency preparedness plan utilized a community and facility-based, all-hazard risk assessment, alternate clinical manager #2 stated, & No, we only do COVID, at the time of the pandemic, it was decided upon that it would be COVID because it was an emergency situation &.		be responsible for ensuring that this deficient practicedoes not recur. The correction of the deficiencies had beenimplemented on 08-09-22 by informing all clinicians of the document changes.All clinicians will be provided the updated forms to be inserted in the patientbinder and filled out. The DON and had startedhome visits and will be able to attain 100 % by mid **Sept, 2022.**	
E0017	HHA Comprehensive Assessment in Disaster	E0017	The DON conducted a meeting on **08-09-22** with all	2022-08-09

484.102(b)(1)

§484.102(b)(1) Condition for Participation:

[(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years.

At a minimum, the policies and procedures must address the following:]

(1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55.

Based on observation, record review, and interview, the agency failed to include individual emergency preparedness plans for each patient as part of the comprehensive assessment in 5 of 5 active clinical records reviewed. (#1, 2, 3, 4, 5)

The findings include:

1. Record review evidenced an undated agency policy obtained 7/13/2022, titled Home Care Emergency Preparedness Program for Professional Care Home Health which stated, & All home health patients are provided an admission booklet at the start of care which contains: & Essential patient information & Patient risk levels & hazard vulnerability analysis & Steps to preparing for an emergency & list of medications & Patients and caregivers are educated on the importance of the above information during an emergency and instructed on how to prepare an emergency kit during nursing visits & Patients and caregivers are instructed on what the Home health agency will do during

the staff to discuss corrections on the deficiencies particularly: the failure of the agency to set policies and procedures based on the emergency plan based on the risk assessment and a communication plan which must be updated at least every 2 yrs. 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.

To correct this deficiency:
The DON has updated the Emergency Preparedness Plan to include an individualized patient emergency plan which is documented in the patient folder/binder that is left in the patients' home. Individualized patient plan is included as part of the comprehensive patient assessment, which must be conducted according to the

	an emergency & Patients and caregivers are instructed to call and inform the agency if they are relocated during an emergency &. 2. Observation of a home visit for patient #1 was conducted on 7/14/2022, at 10:00 AM, to observe a routine physical therapy visit. The patient ambulated with a moderate assist using a walker. Patient #1 indicated she did not ambulate unless the therapist was present. During the visit, the patient s home folder was reviewed, which contained an emergency plan. This plan failed to be individualized to include patient s mobility needs, risk level, or evacuation location in case of emergency. Clinical record review for patient #1 was completed on 7/14/2022, for certification period 6/29/2022 8/27/2022. Record review evidenced a start of care comprehensive assessment dated 6/29/2022, which indicated no evacuation location had been identified and patient could not evacuate independently. This document failed to indicate who would assist patient to evacuate, or where they would evacuate in an emergency. 3. Observation of a home visit for patient #2 was conducted on 7/15/2022, at 10:00 AM, to observe a routine skilled nurse visit. During the visit, the patient was observed to be immobile, bedbound, and non-responsive, with multiple wounds and tube feeding infusing. The patient s home folder was reviewed which contained an emergency plan. This plan failed to be individualized to address patient s mobility needs, evacuation location, or plan for ensuring patient had necessary medical equipment and supplies during an emergency. Clinical record review for patient #2 was completed on 7/15/2022, for certification period 5/20/2022 7/18/2022. Record review evidenced a start of care comprehensive assessment dated 5/20/2022, which indicated the patient could not evacuate independently, and was not able to take responsibility for services normally provided by the home health		be reviewed every 2 years. This will provide the following information a. risk level b. Patient Mobility needs, c. Person who will help the patient in case of an emergency, d. Necessary medical equipment and supplies, e. evacuation location in case of an emergency f. Arrangements for alternative home health services should Professional Care home health services due to unforeseen circumstances be unable to provide the necessary services. (See attachment: At risk Evaluation form, Emergency evacuation plan, Hazard Vulnerability Assessment**)** **To prevent the deficiency from recurring:** The agency updated patient information page in the patient home folder now titled as At-risk patient evaluation form which includes the emergency	

	agency. This document failed to identify an evacuation location, method of evacuation, or how patient would receive necessary services in the event of emergency. 4. Observation of a home visit for patient #3 was conducted on 7/15/2022, at 1:30 PM, to observe a routine home health aide visit. During the visit, the patient was observed to be wheelchair-bound. The patient was able to stand using a walker. Patient #3 indicated he used oxygen as needed during the day, and continuously at night. Patient #3 had a wound to right leg with large amount of drainage. A home folder was reviewed, which contained an emergency preparedness plan. This plan failed to address patient s mobility needs, evacuation location, or how oxygen and wound care would be provided in the event of emergency. Clinical record review for patient #3 was completed on 7/18/2022, for certification period 6/22/2022 8/20/2022. Record review evidenced a start of care comprehensive assessment dated 6/22/2022, which included an emergency evacuation plan. This plan indicated the patient was unable to evacuate independently. This plan failed to identify an evacuation location and person who would assist patient to evacuate. This plan failed to address patient s need for oxygen, wound care, or medical supplies. 5. Clinical record review for patient #4 was completed on 7/18/2022, for certification period 6/8/2022 8/6/2022. Record review evidenced a start of care comprehensive assessment dated 6/8/2022, which indicated the patient required assistance for ambulation and was dependent for most activities of daily living. This document indicated the patient was confused and incontinent. This document contained an emergency preparedness plan which indicated the patient could not evacuate independently, but failed to indicate who would assist patient to evacuate, and failed to identify an evacuation location.		evacuation plan, risk level, patient mobility needs, identity of persons who may assist the patient, necessary medical supplies, evacuation location and arrangements for alternative services should Professional Care home health services due to unforeseen circumstances be unable to provide the necessary services. The DON scheduled home visits to verify that the above revisions have been implemented by clinicians in the patient binder/folder. The **DON and/or the alternate clinical manager** shall be responsible for ensuring that this deficient practice does not recur. The correction of the deficiencies had been implemented on 08-09-22 by informing all clinicians of the document changes. All clinicians had been provided the updated forms to be inserted in the patient binder and filled out. The DON had started home visits and will be able to attain 100% by	

	6. Clinical record review for patient #5 was completed on 7/18/2022, for certification period 6/1/2022 7/30/2022. Record review evidenced a start of care comprehensive assessment dated 6/1/2022, which indicated patient was bedbound, non-responsive, and had multiple wounds and tube feeding requirements. This document contained an emergency preparedness plan, which indicated patient could not evacuate independently and nobody would be able to assist patient to evacuate. This document failed to include where patient would evacuate, and failed to address wound care, mobility, and tube feeding requirements in case of emergency. During an interview on 7/14/2022, at 1:03 PM, when queried how the agency addresses individual emergency preparedness plans, administrator/clinical manager #1 indicated the agency would make phone calls to the patients in an emergency situation. Alternate clinical manager #2 indicated the agency provided all patients with general emergency preparedness information on admission. Alternate clinical manager #2 indicated the agency did not include evacuation locations, provision for medical supplies or equipment, or person responsible for evacuating patients in individual emergency plans. Administrator/clinical manager #1 indicated the agency would include evacuation locations and plans for individual patient needs in emergency plans in the future. Alternate clinical manager #2 indicated all patients were a high risk in case of emergency due to their co-morbidities.			
E0019	Homebound HHA/Hospice Inform EP Officials 484.102(b)(2) §418.113(b)(2), §460.84(b)(4), §484.102(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency	E0019	The DON conducted a meeting on 08-09-22 with all the staff to discuss corrections on the deficiencies particularly: the failure of the agency to set procedures to inform State	2022-08-09

preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:]

*[For homebound Hospice at §418.113(b)(2), PACE at §460.84(b)(4), and HHAs at §484.102(b)(2):] The procedures to inform State and local emergency preparedness officials about [homebound Hospice, PACE or HHA] patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.

Based on record review and interview, the agency failed to develop and implement emergency preparedness policies and procedures which included procedures to inform state emergency preparedness officials about patients in need of evacuation from their residences based on patient s medical condition and home environment.

The findings include:

Record review evidenced an undated agency policy obtained 7/13/2022, titled Maintaining or Expanding Patient Care During Emergency Operations which stated, & If continued care is not possible in the patient s home, transfer of patient from the home to a facility nearby will be facilitated by the staff. Staff will call the local Red Cross agency or the Lake County Homeland Security and Emergency Management Agency &. This policy failed to include procedure to inform state emergency preparedness officials about patients in need of evacuation from their residences based on patient s medical condition and home environment.

During an interview on 7/14/2022, at 1:11 PM, when queried if the agency s emergency preparedness policy addressed the agencies

and local emergency preparedness officials about homebased patients in need of evacuation from their residences at any time due to an emergency based on the patient's medical and psychiatric condition and home environment.

To correct this deficiency
Professional Care Home Health Services endeavored to contact these various agencies to inquire on the procedure. The results are as follows:

Call emergency: 911

Then call the LOCAL (TOWN) emergency preparedness for example: Highland tel: 219-923-9876

REGIONAL:

Lake County Homeland Security/EMA – 219-755-3549 contact person Paul Petrie Deputy Director

Red Cross- 219-756-5360

Lake County Department of

	responsibility to call state and local officials and inform them of patients needing evacuation, alternate clinical manager #2 indicated the agency provided each patient with a list of numbers to call if they need evacuation. Administrator/clinical manager #1 indicated the policies should have included the procedure to contact state officials to notify of patient s who needed evacuation.		Health 219-755-3655 Vavilala head officer 219-755-3656 219-755-3657 The Home health Agency may call: District 1 Coalition: contact person Paul Petrie Deputy Director, Andrew Carlay -at large · STATE o Indiana Department of Homeland Security- 317-238-1750 o Indiana State Department of Health Division of Emergency Preparedness: 317-473-677 Doug Farmwald -Coordinator o Indiana State Department of Health Division of Emergency Preparedness- District 1 (317-741-8527) Elizabeth Ashley coordinator · FEDERAL: o FEMA 1-800-621-3362 o FEMA region 5 (Indiana)	

312-408-5500.

tribal affairs: 312-408-4427

The agency will instruct all clinicians and patients to call 911 so that they can be directed to the proper evacuation site and for patients to call back the agency when they are situated.

(See attachment: Communication Plan: other sources of assistance)

To prevent the deficiency from recurring: The agency will contact the above agencies yearly to verify if the numbers and contact persons are still accurate

The **alternate clinical manager** shall be responsible for ensuring that this deficient practice does not recur.

The correction of the deficiencies had been implemented on 08-09-22 by revising the emergency evacuation plan and

			changes.	
E0030	Names and Contact Information 403.748(c)(1),482.15(c)(1),485.625(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), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(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.	E0030	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: thefailure of the agency to develop a communication plan that must include all thefollowing: (1) Names andcontact information for the following: (i) Staff. (ii) Entitiesproviding services under arrangement. (iii)Patients' physicians. (iv)Volunteers. To correct this deficiency ProfessionalCare Home Health Services has updated the list of the following: (1) Names andcontact information for the following: (i) Staff. (ii) Entitiesproviding services under arrangement. (iii)Patients' physicians.	2022-08-09

	(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. (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.		(iv)Volunteers. (**(See attachment: CommunicationPlan, Staff addresses, entities providing services, physicians)** **To prevent the deficiency from recurring:** The agency willupdate above data yearly. The **alternate clinical manager**shall be responsible for ensuring that this deficient practice does not recur. The correction of the deficiencies had beenimplemented on 08-09-22 by updating the above list.	

*[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 agency failed to maintain an emergency preparedness communication plan which included names and contact information for staff and patient s physicians.

The findings include:

Record review evidenced an undated agency policy obtained 7/13/2022, titled Home Care Emergency Preparedness Program for Professional Care Home Health Services which stated, & The Agency prepares the following lists that will be updated regularly: & staff members with their addresses, telephone numbers, emergency contact persons and email address & Active patients that contain their addresses, telephone numbers,

	emergency contact persons, patient risk level and the presence of any DME & Physicians with their addresses and telephone numbers &. Record review on 7/14/2022, evidenced an emergency preparedness communication plan which included a list of staff contact information which was updated 8/15/2019. This document failed to include names and contact information for home health aide #1, home health aide #2, and social worker #8. This document failed to be updated every 2 years. The communication plan failed to evidence names and contact information for patient s physicians. During an interview on 7/14/2022, at 1:20 PM, when queried if the communication plan included names and contact information for staff and patient s physicians, alternate clinical manager #2 failed to answer. Administrator/clinical manager #1 indicated they would update the lists to include the physicians and current staff.			
E0037	EP Training Program 403.748(d)(1),482.15(d)(1),485.625(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following:	E0037	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: thefailure of the agency to provide emergency preparedness training to all staffat least every 2 years and failed to document emergency preparedness training. **To correct this deficiency:**The agency had a table-top exercise on Winter Storm on 08-12-22 based on the HazardVulnerability Assessment	2022-08-12

	(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the		and documented training. **To prevent recurrence of thisdeficiency**, the DON updated the policy on Emergency preparedness to ensurethat the agency will take part in a facility based functional exercise every 2years and conduct an additional exercise every 2 years opposite the year thefull scale or the functional exercise is done and that will be documented. The **DON** shall beresponsible for ensuring that this deficient practice does not recur. The agency had performed a tabletop exercise on08-12-22.	

following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

(ii) After initial training, provide emergency preparedness training every 2 years.

(iii) Demonstrate staff knowledge of emergency procedures.

(iv) Maintain documentation of all emergency preparedness training.

(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least every 2 years.

(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.

(iv) Maintain documentation of all training.

(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:

(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under

	arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under			

arrangement, and volunteers, consistent with their expected roles.

(ii) Provide emergency preparedness training at least every 2 years.

(iii) Maintain documentation of the training.

(iv) Demonstrate staff knowledge of emergency procedures.

(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.

Based on record review and interview, the agency failed to provide emergency preparedness training to all staff at least every 2 years and failed to document emergency preparedness training.

The findings include:

Record review evidenced an undated agency policy obtained 7/13/2022, titled Home Care Emergency Preparedness Program for Professional Care Home Health which stated, & All staff members will be oriented to the agency s Emergency Action Plan which is reviewed annually & Initial training in Emergency Preparedness policies and procedures to all new and existing staff, consistent with their expected roles & Training procedure is documented &.

Record review on 7/14/2022, evidenced an emergency preparedness binder which failed

	to evidence documented staff training on emergency preparedness within last 2 years. Employee record review on 7/14/2022, failed to evidence documentation of annual or biennial emergency preparedness training for staff. During an interview on 7/14/2022, at 1:28 PM, when queried if the agency provided and documented emergency preparedness training, administrator/clinical manager #1 stated, & at the start of the year we brief them & Every year there is a briefing for emergency preparedness with infection control &. Administrator/clinical manager #1 indicated the training should have been documented.			
E0039	EP Testing Requirements 403.748(d)(2),482.15(d)(2),485.625(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional	E0039	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: thefailure of the agency to provide emergency preparedness training to all staffat least every 2 years and failed to document emergency preparedness training. To correct this deficiency: The agencyhad a table-top exercise on Winter Storm on 08-12-22 based on the Hazard VulnerabilityAssessment and documented training. The Agency performed a HazardVulnerability Assessment amongst staff members on the	2022-08-12

	exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or		the result showed that the group considered the COVIDpandemic as the event that puts the group at the most vulnerable state despite precautionsand vaccinations. The Winter storm was the 3rd hazard which was consideredto put the group in a vulnerable state. (**See attachment: Tabletop exercise)** To prevent recurrence of thisdeficiency, the DON updated the policy on Emergency preparedness to ensure thatthe agency will take part on a community based full scale exercise every 2 yearsand conduct an additional exercise every 2 years opposite the year the fullscale or the functional exercise is done and that will be documented. The **DON** shall beresponsible for ensuring that this deficient practice does not recur.	

	(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or		The agency had performed a tabletop exercise on08-12-22. The agency is also scheduled to take part on a community-basedexercise on 09-15-22 conducted by Senior First Connect	

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

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

	*[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following:			

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

	exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise			

needed.

*[RNCHIs at §403.748]:

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

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

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

Based on record review and interview, the agency failed to participate in a full-scale exercise or functional exercise every 2 years and failed to conduct an additional exercise every 2 years, on years opposite the year the full-scale or functional exercise was conducted.

The findings include:

Record review evidenced an undated agency policy obtained 7/13/2022, titled Home Care Emergency Preparedness Program for Professional Care Home Health Services which stated, & Professional Care Home Health Services must participate in a full scale exercise that is community-based or when not accessible, an individual, facility based & Conduct an additional exercise that may include, but is not limited to the following: & A second full scale exercise that is community based or individual, facility-based & A table top exercise & Analyze the home health agency s response to and maintain documentation of all drills, tabletop exercises, emergency events, and revise the agency s emergency plan as needed &.

Record review on 7/14/2022, evidenced an

	emergency preparedness binder which indicated the agency participated in a tabletop emergency preparedness exercise on 9/18/2019. This binder indicated the agency participated in a full-scale emergency preparedness exercise on 11/7/2018. The emergency preparedness binder failed to evidence documentation of any training and testing exercised for 2020, 2021, or 2022. During an interview on 7/14/2022, at 1:28 PM, when queried what training and testing exercises the agency participated in, alternate clinical manager #2 stated, & we do table top exercises, the most recent was 2017 & We weren t able to do one during COVID, but we go to coalition meetings &.			
N0472	Q A and performance improvement 410 IAC 17-12-2(a) Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on record review and interview, the home health agency failed to ensure they utilized relevant objective data in design of their Quality Assessment and Performance Improvement (QAPI) program and failed to track adverse patient events, analyze their causes and implement preventative actions.	N0472	The DON conducted a meeting on 8-9-22_withall the staff to discuss corrections on the deficiencies particularly: the failure to evidence utilizationof any OASIS [outcome and assessment information set] measures, or otherrelevant data such as falls, hospitalizations, new wounds, or catheterassociated urinary tract infections in the QAPI program. **To correct this deficiency theDON**: Has instructed the QAPI team to updatethe QAPI goals by re-assessing the home health services and track down problemareas where improvement can be done. The	2022-08-15

	The findings include: Record review on 7/14/2022, evidenced an undated QAPI binder, which stated, & QAPI Goals 2022 & to continue to educate all clinicians and patients on the prevention of the COVID-19 infection & To keep abreast with the new developments and updates on COVID-19 and be able to disseminate the information to all staff and patients &. This QAPI binder, also stated, & to continue to educate all clinicians and patients on the prevention of the COVID-19 infection & To keep abreast with the new developments and updates on COVID-19 and be able to disseminate the information to all staff and patients &. Review of the agency s QAPI binder failed to evidence utilization of any OASIS [outcome and assessment information set] measures, or other relevant data such as falls, hospitalizations, new wounds, or catheter associated urinary tract infections in the QAPI program. The QAPI binder evidenced tracking for COVID infections, but failed to evidence tracking of other adverse patient events such as hospitalizations, other infections, or increase in wounds. Record review on 7/14/2022, evidenced an agency fall log for dates 1/1/2022 7/14/2022, which indicated the agency had 1 fall without injury, and 7 falls with injuries out of 88 total active patients during this time period. This document indicated 6.82% of active patients during this period experienced falls. The fall log failed to evidence the agency analyzed or implemented preventative action regarding falls. Record review failed to evidence the agency analyzed the cause of or implemented preventative actions for other adverse events including hospitalizations, wounds, or other infections. Record review on 7/14/2022, evidenced an OASIS outcome report for period 05/2021 - 04/2022. This report indicated the agency had 30.8% or 8 out of 26 eligible patients with acute care hospitalizations within the first 60 days of home health care. This report		QAPI team had stated 3 goals and hasbeen able to tackle the first goal on medications which is being submitted. Theother goals will be worked on until the end of the year (2022). (see attachment: QAPI) **To prevent the recurrence of thisdeficiency** the DON as member of the QAPI team will look into the servicesprovided by the agency and will make use of reports from Home Health Compare, iQIESand other data to improve home health services. The **DON** shall beresponsible for ensuring that this deficient practice does not recur. The Agency has done the first QAPI goal (which is being submitted)and will work on the other goals till the end of the year.	

	evidenced the national average for acute care hospitalizations within the first 60 days of home health was 13.5%. On 7/13/2022 and 7/14/2022 a hospitalization log was requested, and not provided. During an interview on 7/14/2022, at 1:35 PM, when queried which quality indicator data, including measures from OASIS, the QAPI program collected, alternate administrator #2 indicated the agency was tracking COVID infections for QAPI, and no other measures currently. Alternate clinical manager #2 indicated the QAPI program should collect data from OASIS quality measures. During an interview on 7/14/2022, at 1:42 PM, when queried which adverse events were the biggest issues for the agency, administrator/clinical manager #1 indicated hospitalizations were the biggest problem across the agency. Administrator/clinical manager #1 indicated the agency should have documented, tracked, analyzed, and implemented preventative actions based on adverse events.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must 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	N0488	The DON conducted a meeting on 08-09-22_withall the staff to discuss corrections on the deficiencies particularly: failure of the agency to develop and implement a policyrequiring at least 15 calendar days of notice to patient or caregiver beforeservices were stopped (j) The fifteen (15) day period described in subsection (i)of this rule does not apply in the following circumstances: 1) The	2022-08-16

	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 interview, the agency failed to develop and implement a policy requiring at least 15 calendar days of notice to patient or caregiver before services were stopped in 1 of 2 discharge clinical records reviewed. (#6) The findings include: Record review evidenced an undated agency policy obtained 7/19/2022, titled Discharge and Transfer of Patients which stated, & The patient and/or family is notified of discharge and the reason at least 5 days in advance of		health,safety, and/or welfare of the home health agency's employees would be atimmediate and significant risk if the home health agency continued to provideservices 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 reimbursementrequirements and the home health agency informs the patient of communityresources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatorycriteria, such as lack of physician's order, and the home health agency informsthe patient of community resources to assist the patient following discharge **To correct this deficiency theagency updated t**he policy on discharge and transfer of patients. The DONinformed and provided the clinicians a copy of the updated policy **To prevent the deficiency fromrecurring** the QA shall monitor and review all	

	discharge &. Clinical record review for patient #6 was completed on 7/19/2022, for certification period 3/25/2022 5/23/2022, discharged 5/18/2022. Record review evidenced a skilled nurse visit note dated 5/6/2022, which indicated the patient was first notified of discharge on this date, 12 days prior to discharge. The agency failed to provide the patient with a 15 day discharge notice. During an interview on 7/19/2022, at 1:50 PM, when queried how much discharge notice the agency provided patients, administrator/clinical manager #1 indicated the agency provided 5 days discharge notice.		discharges and transfers. **(see updated policy on dischargeand transfer of patients)** The **QA** shall beresponsible for ensuring that this deficient practice does not recur. The agency has updated the policy on08-09-22 QA had reviewed 100% of the planned discharged/transfer patient's chartssince 08-09-22 and implemented the policy on 15 calendar day notice to patient/or caregiver prior to discharge.	
G0526	Content of the comprehensive assessment 484.55(c) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment accurately reflected the patients status in 2 of 3 home visits conducted. (#2, 3) The findings include: 1. Record review evidenced an undated agency	G0526	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: the failure of the agency to ensure the comprehensiveassessment accurately reflected the patients' status. 1. Instructed all clinicians to review skills on history taking, systems review and complete physical exam especially on skin assessment, use of oxygen, and history of	2022-08-16

	policy obtained 7/19/2022, titled Updated Initial and Comprehensive Assessment which stated, & The comprehensive assessment must accurately reflect the patient s status and must include at a minimum, the following: & The patient s current health, psychosocial, functional and cognitive status &. 2. Observation of a home visit was conducted for patient #2 on 7/15/2022, at 10:00 AM, to observe a routine skilled nurse visit and a recertification assessment. During the visit, a new, quarter sized, blister/wound to patient s right hip was observed. The wound was covered by tape from a wound dressing, and skin ripped off surface of blister when tape was removed. Clinical record review for patient #2 was completed on 7/19/2022, for certification period 5/20/2022 7/18/2022. Record review evidenced a referral order/history and physical dated 5/17/2022, which indicated patient had recently had a complicated urinary tract infection. Record review evidenced a start of care comprehensive assessment dated 5/20/2022, which evidenced patient had a foley catheter (tube inserted in urethra to drain urine), but failed to evidence when it was inserted. Record review evidenced a plan of care for certification period 5/20/2022 7/18/2022, which indicated the skilled nurse was to change the patient s catheter every month. The comprehensive assessment failed to accurately reflect patient s health status at the time of the assessment, including all necessary information regarding catheter such as insertion date. Record review evidenced a recertification comprehensive assessment dated 7/15/2022, which failed to include measurement or assessment of new right hip wound. During an interview on 7/18/2022, at 12:28 PM, when queried when the patient s last foley change was when they were admitted, administrator/clinical manager #1 stated, & we went from the admit date because we didn t know &. Administrator/clinical manager #1		catheter insertions, 2. that all clinicians should answer all assessment items in the software as this provides a comprehensive view of the patient. 3. QA will review all clinician entries. **(See attachment: QA form)** To prevent the deficiency from recurring, the QA will reviewand query all clinician entries as they are submitted to the agency using theupdated QA form. The **QA** shall beresponsible for ensuring that this deficient practice does not recur. **QA has reviewed 70 % of active charts since 08-09-22and queried clinicians on the accuracies of their entries and will be attaining100% mid-September 2022.**	

	indicated the date should have been included in the comprehensive assessment. At 12:19 PM, when queried why the recertification comprehensive assessment didn t include any assessment of the new wound, administrator/clinical manager #1 indicated it should have been documented with the other wound. 3. Observation of a home visit for patient #3 was conducted on 7/15/2022, at 1:30 PM, to observe a routine home health aide visit. During the visit, oxygen equipment was observed in the patient s home. The patient indicated he wore 3 liters of oxygen as needed during the day, and 2 liters of oxygen at night with a Bi-Pap (machine to help with sleep apnea). Clinical record review for patient #3 was completed on 7/19/2022, for certification period 6/22/2022 8/20/2022. Record review evidenced a start of care comprehensive assessment dated 6/22/2022, which indicated the patient did not use oxygen. During an interview on 7/19/2022, at 12:27 PM, when queried why the comprehensive assessment indicated the patient did not use oxygen, administrator/clinical manager #1 indicated they must have forgotten to put that in the assessment. Administrator/clinical manager #1 indicated the assessment did not reflect patient s status accurately. 410 IAC 17-15-1(a)			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any	G0536	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: thefailure to complete a review of all medications the patients	2022-08-15

	potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review and interview, the agency failed to complete a review of all medications the patients were using to identify drug reactions, including significant drug interactions and ineffective drug therapy in 4 of 5 active clinical records reviewed. (#1, 3, 4, 5) The findings include: 1. Record review evidenced an undated agency policy obtained 7/19/2022, titled Drug Regimen Review which stated, & To identify any potential significant drug interactions & Any major interactions will be brought to the attention of the physician &. 2. Observation of a home visit for patient #1 was conducted on 7/14/2022, at 10:00 AM, to observe a routine physical therapy visit. During the visit, a home medication list was reviewed, which included an order for Eliquis (blood thinner) 5 milligrams 2 times per day. Clinical record review for patient #1 was completed on 7/19/2022. Record review evidenced a plan of care for certification period 6/29/2022 8/27/2022, which included a medication list with orders for iodine tincture (disinfectant) daily external, ammonium lactate (cream for dry skin) twice a day external, and Tylenol (for pain) 650 milligrams every 6 hours as needed. The medication list failed to indicate location of application for ammonium lactate and iodine tincture and failed to include an indication for patient to take Tylenol. The medication list included an order for Eliquis (blood thinner) 5 milligrams every 2 hours orally. During an interview on 7/18/2022, at 11:12 AM, administrator/clinical manager #1		were using, toidentify drug reactions, including significant drug interactions and ineffectivedrug therapy **To correct this deficiency:** The DON instructed all cliniciansto perform Drug Regimen review after entry of medication and to re-check accuracyof each medication's, dose, route, and location (of where to apply in terms oftopical medication), frequency, drug interaction and indication for use. Shouldthere be an interaction noted, clinician shall inform physician as noted in theDrug Regimen review policy. **To prevent the deficiency fromrecurring, DON and** QA will review clinician notes submitted with closeattention to medication entries and drug interactions**.** The DON and QA shall be responsible for ensuring that thisdeficient practice does not recur. DON and QA reviewed clinician notes with attention todeficiencies identified during this survey which started week of 08-15-22 andwill continue as	

	indicated a complete medication order should have included a location of application for topical medication, and an indication for as needed medication. At 11:14 AM, when queried why the medication list included an order for Eliquis every 2 hours, administrator/clinical manager #1 indicated it was an error, and should have been twice per day, as on patient s medication list. 3. Clinical record review for patient #3 was completed on 7/19/2022, for certification period 6/22/2022 8/20/2022. Record review evidenced a medication list dated 6/22/2022, which included an order for Colace (stool softener) 100 milligrams as needed orally. This medication list failed to include an indication. Record review evidenced a comprehensive assessment dated 6/22/2022, which identified 1 major drug interaction between aspirin (to prevent stroke/heart attack) and Xarelto (blood thinner). Review on 7/19/2022, of a web-based source at https://www.drugs.com/interactions-check.php , indicated the following major drug-drug interactions between medications on patient s medication list: potassium chloride (electrolyte) and losartan (to lower blood pressure) - losartan may increase levels of potassium in blood, causing high potassium levels, which can result in kidney failure, irregular heart beat, or death; ciprofloxacin (antibiotic) and hydrocodone (pain medication) - ciprofloxacin may increase blood levels of hydrocodone, causing dizziness, drowsiness, low blood pressure, or respiratory distress; ciprofloxacin and Lexapro (antidepressant) - increased risk for an irregular possibly fatal heart rhythm; and hydrocodone and gabapentin (for nerve pain) - may cause respiratory depression, coma, and/or death. During an interview on 7/19/2022, at 12:35 PM, when queried which drug-drug interactions should be identified in the drug		clinician submit visit notes.	

	#1 indicated all major drug interactions should be identified. During an interview on 7/19/2022, at 12:17 PM, administrator/clinical manager #1 indicated all as needed medication should include indications for use. 4. Clinical record review for patient #4 was completed on 7/19/2022, for certification period 6/8/2022 8/6/2022. Record review evidenced a medication list dated 6/8/2022, which included acetaminophen (for pain or fever) 325 milligrams 2 tabs every 4 hours as needed. This document failed to include an indication for use. 5. Clinical record review for patient #5 was completed on 7/19/2022, for certification period 6/1/2022 7/30/2022. Record review evidenced a medication list dated 6/1/2022, which included, but was not limited to the following medications: promethazine (used for nausea) 10 milliliter every 6 hours as needed per gastrostomy tube, Medihoney (wound ointment) dressing external daily, and Neosporin (antibiotic ointment) external ointment as needed. This document failed to include indication for promethazine and Neosporin, and a location of application for Medihoney and Neosporin. Clinical record review evidenced a start of care comprehensive assessment dated 6/1/2022, which included a drug regimen review, which indicated there were no drug-drug interactions noted. Review on 7/19/2022, of a web-based source at https://www.drugs.com/interactions-check.php , indicated the following major drug-drug interaction for medications included on patient #5 s medication list: propranolol (to regulate blood pressure and heartrate) and albuterol (to open the airways) can each reduce the effect of the other medication, and propranolol can narrow airways, decreasing the effect of albuterol.			

	During an interview on 7/19/2022, at 1:15 PM, administrator/clinical manager #1 indicated all topical medication orders should specify where they were to be applied and for what reason. When queried why the drug regimen review indicated no reactions, administrator/clinical manager #1 indicated she did not know, but it should identify all drug-drug reactions. 410 IAC 17-14-1(a)(1)(B)			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessments included patients primary caregiver, including their willingness and ability to provide care and their availability and schedules in 3 of 5 active clinical record reviewed. (#3, 4, 5) The findings include: 1. Record review evidenced an undated agency policy obtained 7/19/2022, titled Updated Initial and Comprehensive Assessment which stated, & The comprehensive assessment must include at a minimum the following & The patient s primary caregiver including: & their willingness and ability to provide care & Availability and schedule of caregiver &. 2. Observation of a home visit for patient #3 was conducted on 7/15/2022, at 1:30 PM, to	G0538	The DON conducted a meeting on 08-09-22 with all the staff todiscuss corrections on the deficiencies particularly: to include the names of patient'sprimary caregiver(s), if any, and other available supports, including their:(i) Willingness and ability to provide care, and (ii) Availability and schedules **To correct this deficiency:** 1. The DON instructed all clinicians to answer all the provisions under caregiver which includes the name, availability, and willingness in our Netsmart software. 2. QA will review all entries to prevent a recurrence of this deficiency.	2022-08-16

	observe a routine home health aide visit. During the visit, the patient was observed to live with person #2 (family member) 24/7, who assisted whenever needed, with transportation to doctor appointments, ambulation, and activities of daily living. Person #2 indicated they were willing and able to assist patient every day. Clinical record review for patient #3 was completed on 7/19/2022, for certification period 6/22/2022 8/20/2022. Record review evidenced a start of care comprehensive assessment dated 6/22/2022, which listed person #2 as patient s caregiver, but failed to document ability, willingness, availability, or schedule. During an interview on 7/19/2022, at 12:32 PM, when queried what information the comprehensive assessment should include regarding caregiver, administrator/clinical manager #1 indicated it should include their schedule, and if they were able to assist, and with what they could assist. 3. Clinical record review for patient #4 was completed on 7/19/2022, for certification period 6/8/2022 8/6/2022. Record review evidenced a start of care comprehensive assessment dated 6/8/2022, which indicated person #3 (family member) was the caregiver. This document failed to include caregiver s ability, willingness, availability, or schedule regarding assisting the patient at home. 4. Clinical record review for patient #5 was completed on 7/19/2022, for certification period 6/1/2022 7/30/2022. Record review evidenced a start of care comprehensive assessment dated 6/1/2022, which indicated person #4 (family member) was patient s primary caregiver, but failed to include their willingness, availability, schedule, or ability to assist patient in the home.		To prevent recurrence of this deficiency**QA** will review clinician notes which were submitted with close attentionto entries on caregivers, willingness, and ability to provide care, availability,and schedules. The **QA** shall beresponsible for ensuring that this deficient practice does not recur. QA had reviewed 100 % of active charts since 08-09-22 and had clinician correct their entries to answer this deficiency deficiency**.**	

G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview the agency failed to send all necessary information pertaining to patients current course of treatment, including medications, to the receiving facility or healthcare practitioner in 2 of 2 discharge records reviewed. (#6, 7) The findings include: 1. Record review evidenced an undated agency policy obtained 7/19/2022, titled Discharge and Transfer of Patients which stated, & Upon discharge, MD s office is notified of patient s discharge and the availability of discharge summary upon request & The nurse coordinates the preparation of the Transfer/Discharge Summary among the care into the patient record, including the date and reason for discharge &. 2. Clinical record review for patient #6 was completed on 7/19/2022, for certification period 3/25/2022 5/23/2022, discharged 5/18/2022. Record review evidenced a discharge summary dated 5/28/2022, which failed to include any medications patient was taking. This document failed to include all necessary medical information pertaining to the patient s current course of treatment During an interview on 7/19/2022, at 1:45 PM, when queried what information was included	G0564	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: thefailure to send all necessary information pertaining to patients' current courseof treatment, including medications, to the receiving facility or healthcarepractitioner **To correct this deficiency:** 1. The Policy on Discharge and Transfer of Patients was updated which would include list of medication in the documentation of services provided to the patient. 2. The DON informed and provided the clinicians on the update of the policy. **(See attachment: Updatedpolicy on discharge and transfer)** To prevent the deficiency from recurring, the policy onDischarge and transfer of patients was updated and clinicians were instructed toimplement the corrective action. QA will review all	2022-08-09

	in a discharge summary, administrator/clinical manager #1 indicated it should include goals of care, what services the patient received, the assessment of patient, and status at discharge. Administrator/clinical manager #1 indicated the discharge summaries did not include any medication information. 3. Clinical record review for patient #7 was completed on 7/19/2022, for certification period 5/17/2022 7/5/2022, discharged 6/7/2022. Record review evidenced a discharge summary dated 6/7/2022, which failed to include any medications patient was taking.		discharge/transfersummaries. The **QA** shall beresponsible for ensuring that this deficient practice does not recur. The agency updated the policy on 08-09-22.	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review and interview, the agency failed to ensure the patients received the services which were written in an individualized plan of care in 5 of 5 active clinical records reviewed. (#1, 2, 3, 4, 5) The findings include: 1. Record review evidenced an undated agency policy obtained 7/19/2022, titled Physician s Plan of Treatment which stated, & The	G0572	The DON conducted a meeting on 08-09-22 with all the staff to discuss corrections on the deficiencies particularly the failure of the agency to ensure that patients receive the services which were written in an individualized plan of care. **To correct this deficiency the agency**: a. will have the Physical Therapy assessment be computerized to be able to capture individualized plan of care accurately. b. Will obtain patient's	2022-08-16

	individualized plan of care and treatment prepared by the client s physician with assistance from the nurse and/or the therapist who establish the plan based upon the current assessment of the client & The agency will provide care/services consistent with the plan of treatment & Physician s orders on the plan of treatment shall relate to the diagnosis and must be considered reasonable and necessary treatment for that diagnosis &. 2. Observation of a home visit for patient #1 was conducted on 7/14/2022, at 10:00 AM, to observe a routine physical therapy visit. During the visit, the therapist performed with the patient: bike pedal exercises, leg stretching, sitting foot pumps, sitting leg kicks, sitting side leg kicks, ambulation with walker, resistance arm pull downs to the side and back. Clinical record review for patient #1 was completed on 7/19/2022. Record review evidenced a plan of care for certification period 6/29/2022 8/27/2022, which indicated patient was to receive physical therapy 1 time per week for 1 week and 2 times per week for 3 weeks. This document failed to be individualized to include any specific interventions or orders physical therapy would perform. Record review evidenced a physical therapy evaluation dated 7/1/2022, which failed to include any individualized orders or interventions for treatment. During an interview on 7/18/2022, at 11:24 AM, when queried what was considered the therapy plan of care, administrator/clinical manager #1 indicated the physical therapy evaluation was considered the therapy plan of care. When queried if this plan of care was individualized to include interventions, administrator/clinical manager #1 indicated it only included short-term and long-term goals and did not include any interventions to perform. 3. Observation of a home visit for patient #2		records, and MD visit notes to accurately describe and date presence of any ostomies, catheter insertions, stages of lesions, nutritional status and the like and provide to clinicians concerned c. will provide 2 sizes of BP cuffs to all clinicians: a regular size cuff and for a large adult for a better accuracy of BP readings and a handheld mirror to view posteriorly located wounds in bedridden patients. d. updated Missed Visit Note to include line that states that missed visits cannot be re-scheduled and the reason for it. **(See attachment: Sample of Computerized PT assessment, Missed visit report)** **To prevent the deficiency from recurring QA** will check all clinician submitted notes and compare with hospital records/MD visit notes for	

observe a routine skilled nurse visit. The patient was observed to be bedbound and non-responsive. The patient was on tube feedings, had a stage 4 wound to her sacrum, and a foley catheter (a tube inserted into the urethra to drain urine). During the visit, the nurse indicated the patient had just been diagnosed with a urinary tract infection and was waiting on culture results for antibiotic orders.

Clinical record review for patient #2 was completed on 7/19/2022, for certification period 5/20/2022 7/18/2022. Record review evidenced a history and physical dated 5/23/2022, which indicated the patient was emaciated, very thin, malnourished, and on tube feedings due to dysphagia (inability to swallow). This document indicated the patient had a complicated urinary tract infection in mid-April 2022. Record review evidenced a plan of care for certification period 5/20/2022 7/18/2022, which failed to be individualized to include interventions/goals/education regarding poor nutritional status or malnutrition. This document indicated the skilled nurse was to change the foley catheter monthly and as needed. Record review evidenced the catheter was changed by the skilled nurse on 6/29/2022 and 7/6/2022. Record review failed to evidence the foley catheter was changed in the month of May, as per the plan of care.

During an interview on 7/18/2022, at 11:56 AM, when queried how a plan of care should have been individualized for a patient who was malnourished, administrator/clinical manager #1 indicated the plan of care should have included orders for weights, and nutritional education. When queried why the catheter was not changed in the month of May as ordered on the plan of care, administrator/clinical manager #1 indicated they did not know when the catheter was last changed, so they used the date of discharge to base catheter changes off of. Administrator/clinical manager #1 indicated the agency should have documented the last foley change date and changed catheter monthly.

accuracy and query clinicians. **DON shall review and monitor** all assessment entries before documents are sent to MD for signing.

The **DON and QA** shall be responsible for ensuring that this deficient practice does not recur.

DON and QA had reviewed 70 % of active charts since 08-09-22 and queried clinicians on the accuracies of their entries and will be attaining 100% mid-September 2022. Therapy will start using the computerized assessments starting September 15, 2022 because the agency will still have to purchase computers and will inform the software company to integrate PT assessments.

4. Clinical record review for patient #3 was completed on 7/19/2022. Record review evidenced a start of care assessment dated 6/22/2022, which indicated patient had 3 wounds to right popliteal fossa (space behind the knee). Record review evidenced a plan of care for certification period 6/22/2022 8/20/2022, which indicated patient was to receive home health aide visits 2 times per week for 8 weeks. Record review evidenced patient only received 1 home health aide visit the week of 6/26/2022 and 7/10/2022. The plan of care indicated wound care for 1 wound to right popliteal fossa. This document failed to be individualized to include wound care orders for 2 additional wounds. This document indicated the wounds were to be measured the first visit of every week. The plan of care indicated the clinician was to notify the physician for diastolic (bottom number of blood pressure) blood pressure lower than 60 millimeters mercury.

Record review evidenced a skilled nurse visit dated 6/30/2022, which failed to include measurements for 2 out of 3 right popliteal fossa wounds as ordered on the plan of care. The skilled nurse visit note dated 6/30/2022, indicated the patient s blood pressure was 104/49. Record review failed to evidence the physician was notified of blood pressure outside of parameters as indicated on the plan of care.

During an interview on 7/19/2022, at 12:20 PM, administrator/clinical manager #1 indicated there should have been missed visit notes for the missed home health aide visits, and patient should have received 2 visits per week. At 12:25 PM, administrator/clinical manager #1 indicated the plan of care should be individualized to include wound care orders for all wounds. At 12:45 PM, when queried why all wounds were not measured on 6/30/2022 skilled nurse visit, administrator/clinical manager #1 indicated maybe the nurse could not assess the wounds because of their location. Administrator/clinical manager #1

	orders as indicated on the plan of care. When queried if the physician was notified of low blood pressure on 6/30/2022 nurse visit, alternate clinical manager #2 indicated they were not. 5. Clinical record review for patient #4 was completed on 7/19/2022. Record review evidenced a plan of care for certification period 6/8/2022 8/6/2022, which indicated the patient was to receive physical therapy visits 2 times per week for 3 weeks and 1 time per week for 1 week. This document failed to be individualized to include any specific interventions, exercises, education or orders for physical therapy to provide patient #4. Record review evidenced a physical therapy evaluation, which administrator/clinical manager #1 indicated was the therapy care plan, dated 6/13/2022. This document also failed to include any patient-specific, individualized interventions, exercises, or orders for treatment regarding physical therapy services. During an interview on 7/19/2022, at 1:06 PM, administrator/clinical manager #1 indicated the therapy care plans should include specific interventions, orders, and exercises for therapists to perform. 6. Clinical record review for patient #5 was completed on 7/19/2022. Record review evidenced a plan of care for certification period 6/1/2022 7/30/2022, which indicated the patient was to receive physical therapy visits 1 time per week for 1 week and 2 times per week for 3 weeks, skilled nursing visits 2 times per week for 1 week and 3 times per week for 8 weeks, and home health aide visits 2 times per week for 8 weeks. The plan of care failed to include any interventions, orders, exercises, or patient-specific education regarding physical therapy. Review of a physical therapy evaluation (identified by administrator/clinical manager #1 as the therapy plan of care), dated 6/20/2022, which also failed to be individualized to include any orders, treatments to be provided, exercises to			

	be performed, or patient-specific education to be administered. Record review evidenced the patient only received 1 home health aide visit the week of 6/5/2022 and only 2 skilled nurse visits the week of 7/4/2022. During an interview on 7/19/2022, at 1:19 PM, when queried why the patient had a missed home health aide visit the week of 6/5/2022, administrator/clinical manager #1 indicated the patient cancelled, but she was not sure why, because it wasn t documented. Administrator/clinical manager #1 indicated the doctor should have been notified, but they couldn t reschedule due to it being the end of the week. When queried why the patient only received 2 skilled nurse visits the week of 7/4/2022, administrator/clinical manager #1 indicated she did not know because there was no missed visit note. She indicated she did not know the patient did not receive services as ordered this week. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations;	G0574	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: theinclusion of the following in the plan of care: all pertinent diagnoses; Thepatient's mental, psychosocial, and cognitive status; The types of services, supplies,and equipment required; The frequency and duration of visits to be made; Prognosis;Rehabilitation potential; Functional limitations; Activities permitted; Nutritionalrequirements; All	2022-08-15

	(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 home health agency failed to ensure the individualized plan of care included all pertinent diagnoses, type of supplies/equipment required, activities permitted, nutritional requirements, all medications and treatments, safety measures, and information related to advanced directives, in 6 of 7 clinical records reviewed. (#1, 2, 3, 4, 5, 6) The findings include: 1. Record review evidenced an undated agency policy obtained 7/19/2022, titled Physician s Plan of Treatment which stated, & The physician s plan of treatment is an individualized plan of care & The plan of treatment shall include but not limited to: & diagnosis primary and secondary ... safety precautions ... medications ... Diet ... Medical supplies and equipment ... activity permitted and restricted ... orders for treatment &." 2. Observation of a home visit for patient #1 was conducted on 7/14/2022, at 10:00 AM, to observe a routine physical therapy visit. During the visit, the patient was observed to have		medications and treatments; Safety measures to protect againstinjury; A description of the patient's risk for emergency department visits andhospital re-admission, and all necessary interventions to address the underlyingrisk factors; Patient and caregiver education and training to facilitate timelydischarge; Patient-specific interventions and education; measurable outcomesand goals identified by the HHA and the patient; Information related to any advanced directives;Any additional items the HHA or physician or allowed practitioner may choose toinclude. To correct these deficiencies theDON instructed: All clinicians to a. perform system review before synchronizing assessment data to the office to ensure that all pertinent elements are included in the assessment. b. use abbreviated assessment in the absence of laptop	

	right foot drop, and utilized bilateral braces which stabilized her feet, ankles, and lower legs while ambulating with a walker. A medication list was reviewed in the patient s home folder, which included Synthroid (a medication to treat hypothyroidism). The medication list included the following medications which were not included in patient s plan of care: Acidophilus (probiotic), albuterol (to open the airways), diltiazem (to lower blood pressure), and Lasix (a diuretic, to pull water off the body). The medication list included Eliquis (blood thinner) 5 milligrams twice per day orally. Clinical record review for patient #1 was completed on 7/19/2022, for certification period 6/29/2022 8/27/2022. Record review evidenced a referral order and history and physical dated 6/27/2022, which included, but was not limited to, the following diagnoses which failed to be included on the patient s plan of care: hypothyroidism (dysfunction of thyroid gland causing slower metabolism) and right foot drop (difficulty lifting the front part of the foot). During an interview on 7/18/2022, at 11:12 AM, administrator/clinical manager #1 indicated the patient s plan of care should have included foot drop. Administrator/clinical manager #1 indicated the priority diagnoses should be included on the plan of care, including diagnoses which are being treated. When queried which medications should be included on the plan of care, administrator/clinical manager #1 indicated all the medications the patient was taking, including over the counter medications. 3. Observation of a home visit for patient #2 was conducted on 7/15/2022, at 10:00 AM, to observe a routine skilled nurse visit. During the visit, the patient was observed to be bedbound, and a tube feeding pump was in use. Clinical record review for patient #2 was		when recording examination findings. 1. The agency to procure patient's hospital records/MD visit note to assist in recording patient's history 2. Office Coder to include all pertinent diagnoses especially those ailments that the patient is taking for ex.: Sleep Apnea, hypothyroidism, DVT, Atrial fibrillation, etc. **QA** to review and monitor aboveelements by using the QA form and query clinician for verification. The **QA** shall beresponsible for ensuring that this deficient practice does not recur. QA monitored and reviewed clinician notes withattention to deficiencies identified during this survey which started week of08-15-22 and will continue as clinician submit visit notes.	

completed on 7/19/2022, for certification period 5/20/2022 7/18/2022. Record review evidenced a referral document dated 5/23/2022, which indicated the patient had an acute DVT (deep vein thrombosis/blood clot in vein) and would be restarted on Eliquis (blood thinner) twice per day. Record review evidenced a discharge summary dated 5/11/2022, which indicated the patient was a do not resuscitate. Record review evidenced a plan of care for certification period 5/20/2022 7/18/2022, which failed to include diagnosis of DVT, and failed to include Eliquis on medication list. This document included a section titled Activities Permitted which was blank. This document failed to include the tube feeding pump in durable medical equipment section. This document failed to include any information regarding advanced directives.

During an interview on 7/18/2022, at 11:34 AM, administrator/clinical manager #1 indicated all pertinent diagnosis should be included on the plan of care. Administrator/clinical manager #1 indicated all medications the patient was taking should have been included on the plan of care. Administrator/clinical manager #1 indicated the diagnosis of DVT and medication Eliquis should have been included in patient #2 s plan of care. At 12:06 PM, when queried what should have been included in activities permitted section of plan of care, administrator/clinical manager #1 indicated the plan of care should have said patient was bedbound. At 12:22 AM, administrator/clinical manager #1 indicated a tube feeding pump should have been included in patient #2 s plan of care. At 12:32 PM, when queried where in the plan of care the advanced directives were documented, administrator/clinical manager #1 indicated the software the agency used for the plan of care didn t allow them to document advanced directive information on the plan of care. Administrator/clinical manager #1 indicated the plan of care failed to include patient #2 s code status.

4. Observation of a home visit for patient #3

	observe a routine home health aide visit. During the visit, the patient indicated he wore oxygen 3 liters per nasal cannula as needed during the day, and 2 liters with Bi-Pap at night for sleep apnea. Clinical record review for patient #3 was completed on 7/19/2022. Record review evidenced a plan of care for certification period 6/22/2022 8/20/2022, which failed to evidence diagnosis of sleep apnea, or oxygen use. The plan of care failed to include oxygen in equipment or medication sections. During an interview on 7/19/2022, at 12:26 PM, when queried if the plan of care should have included diagnosis of sleep apnea, and if oxygen should have been included on the plan of care, administrator/clinical manager #1 indicated oxygen should have been included as a medication, and sleep apnea should have been included as a diagnosis. 5. Clinical record review for patient #4 was completed on 7/19/2022. Record review evidenced a plan of care for certification period 6/8/2022 8/6/2022, which indicated the patient was taking Eliquis (blood thinner), but failed to include safety measures such as bleeding precautions. During an interview on 7/19/2022, at 1:02 PM, when queried what kind of safety measures should be included on a plan of care for a patient taking blood thinners, administrator/clinical manager #1 indicated bleeding precautions. 6. Clinical record review for patient #5 was completed on 7/19/2022, for certification period 6/1/2022 7/30/2022. Record review evidenced history and physical dated 6/24/2022, which the patient had a diagnosis of atrial fibrillation (irregular heartbeat) and was being treated with Coumadin (blood thinner). Record review evidenced a plan of			

	care for certification period 6/1/2022 7/30/2022, which failed to include the diagnosis of atrial fibrillation. This document indicated the patient was receiving Glytrol tube feedings, but failed to include all the nutritional requirements such as rate, duration, free water flush amount, frequency, or volume of tube feeding to be administered. During an interview on 7/19/2022, at 1:10 PM, administrator/clinical manager #1 did not know why the atrial fibrillation diagnosis was not included on the plan of care, but indicated the plan of care should include all pertinent diagnoses. At 1:25 PM, when queried what should be included on the plan of care regarding tube feedings, administrator/clinical manager #1 indicated it should specify the type of tube feeding, rate, volume, duration, and any free water flushes. Administrator/clinical manager #1 indicated she did not know why the plan of care did not include the necessary nutritional information. 7. Clinical record review for patient #6 was completed on 7/19/2022, for certification period 3/25/2022 5/23/2022. Record review evidenced a referral document dated 3/24/2022, which indicated the patient was taking Nepro (a nutritional supplement) one time per day. This document indicated the patient was taking the following medications which were not included on the plan of care: Lidocaine-Prilocaine Cream (numbing cream), and MiraLax (laxative). Review evidenced a plan of care for certification period 3/25/2022 5/23/2022, which failed to include Nepro order. During an interview on 7/19/2022, at 1:30 PM, administrator/clinical manager #1 indicated the Nepro should have been included in the plan of care. At 1:31 PM, when queried if the MiraLax and Lidocaine-Prilocaine cream should have been included on the plan of care, administrator/clinical manager #1 indicated they should have.			

	410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(ii, vii, viii, ix, x)			
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the home health agency failed to ensure all patient care orders were recorded in the plan of care for 2 of 7 clinical records reviewed. (#1, 6) The findings include: 1. Record review evidenced an undated agency policy obtained 7/19/2022, titled Physician s Plan of Treatment which stated, & The physician s Plan of Treatment is an individualized Plan of Care and treatment prepared by the client s physician & The plan of treatment shall include but not limited to: & Orders for treatment & The Agency will accept faxed copies of signed physician orders &. 2. Clinical record review for patient #1 was completed on 7/19/2022, for certification period 6/29/2022 8/27/2022. Record review evidenced a referral order signed by physician #1 on 6/27/2022, which indicated the patient was to receive physical therapy, occupational therapy, skilled nursing, and home health aide services. Record review evidenced a plan of care for certification period 6/29/2022 8/27/2022, which failed to evidence orders for occupational therapy services as ordered on referral. During an interview on 7/19/2022, at 11:06	G0576	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: recordingall patient care orders in the plan of care. **To correct this deficiency:** Intakewill ensure that all ordered disciplines shall be noted in the intake form. **To prevent a recurrence ofthis deficiency,** the QA will re-check intake/referral forms and check accuracyof verbal and written MD orders. The DON and **QA** shall beresponsible for ensuring that this deficient practice does not recur. DON and QA had reviewed 100 % of active charts since 08-09-22 and had ensured all written orders are followed and carried out.	2022-08-09

	AM, when queried why occupational therapy was ordered, but not included on the plan of care, administrator/clinical manager #1 indicated the patient had indicated they did not need occupational therapy because it was only her legs which were weak. Administrator/clinical manager #1 indicated the reason patient did not receive therapy should have been documented, but could not find any evidence of this documentation. 3. Clinical record review for patient #6 was completed on 7/19/2022, for certification period 3/25/2022 5/23/2022. Record review evidenced a referral order signed by physician #5 on 3/17/2022, which included an order for occupational therapy services. Record review evidenced a plan of care for certification period 3/25/2022 5/23/2022, which failed to evidence any orders for occupational therapy as ordered on referral. During an interview on 7/19/2022, at 1:32 PM, when queried why orders were not included on his plan of care for occupational therapy, administrator/clinical manager #1 indicated the patient probably refused occupational therapy. Administrator/clinical manager #1 could not find documentation of this refusal.			
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on record review and interview, the home health agency failed to coordinate care delivery and involve the patient in coordination of care activities in 1 of 1 clinical records for patients who received dialysis. (#6)	G0608	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: onCoordination of services. **To correct this deficiency:** 1. the agency updated its **Policy on Coordination of Services** to reflect the inclusion of dialysis and wound clinics in areas of coordination. 2. The DON instructed the clinicians to coordinate	2022-08-16

	The findings include: Record review evidenced an undated agency policy obtained 7/19/2022, titled Coordination of Services which stated, & The following are essential components of professional coordination and supervision of services to assigned patients for the ongoing evaluation of the patient s needs: & Maintaining efficient communications with patient, family, physician and all care providers to ensure prompt transmission of significant information which may require immediate action or decision making & Coordinating with patient, family and caregivers and all involved services to unify and maximize their contributions to ensure patient safety comfort and benefits of service &. Clinical record review for patient #6 was completed on 7/19/2022, for certification period 3/25/2022 5/23/2022. Record review evidenced a history and physical dated 3/24/2022, which indicated the patient received dialysis (artificial kidney filtration) 3 times per week at a dialysis clinic. Clinical record review evidenced a plan of care for certification period 3/25/2022 5/23/2022, clinical notes, and a comprehensive assessment dated 3/25/2022, which all failed to evidence any documentation from the dialysis clinic, communication with the dialysis clinic, the name and address of the dialysis clinic, or what patient #6 s schedule was for the dialysis clinic. During an interview on 7/19/2022, at 1:35 PM, when queried how the agency coordinates patient care for patients who receive dialysis, administrator/clinical manager #1 indicated they call the clinic and request records. Administrator/clinical manager #1 indicated they had never received any documentation for patient #6 from the dialysis clinic, and they were unsure which clinic he went to or at what time. 410 IAC 17-12-2(g)		care with dialysis personnel or wound clinic to be shown in the clinical note **at least monthly** or when a significant event occurs during treatment. The newly established At-risk patient Evaluation form in the patient folder reflects information on the name of dialysis center, schedules, and telephone numbers. **(See attachment: Updated Policyon Care Coordination)** To prevent a recurrence of thisdeficiency, the QA will check for presence of care coordination notes in clinicianssubmitted notes and DON will assist in coordinating with other agencies providingcare to patient. The **DON and QA** shall be responsiblefor ensuring that this deficient practice does not recur. DON and QA had reviewed 100 % of active charts since 08-09-22and had noted that care coordinations with the wound clinic and dialysis centers had been documented by the clinicians.	

	410 IAC 17-14-1(a)(1)(F)			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview, the agency failed to ensure patients received written medication schedule/instructions including: medication name, dosage and frequency in 2 of 3 home visits conducted. (#1, 2) The findings include: 1. Record review evidenced an undated agency policy obtained on 7/19/2022, titled Drug Regimen Review which stated, & The clinician updates medication list on patient s book as needed or provided them with printed copy &. 2. Observation of a home visit for patient #1 was conducted on 7/14/2022, at 10:00 AM, to observe a routine physical therapy visit. During the visit, a home folder containing a medication list was reviewed. This list failed to include the following medications from the patient s plan of care: Iodine (disinfectant), Nystatin (antifungal powder), Namenda (to help memory), Magnesium (vitamin), Famotidine (to decrease stomach acid), Colace (stool softener), Calcium/Vitamin D3 (vitamin), Aricept (for memory) and Ammonium lactate (cream to improve dry skin). A bottle of Ammonium lactate was observed in the patient s home. During an interview on 7/18/2022, at 11:13	G0616	The DON conducted a meeting on 08-09-22 with all the staff to discuss corrections on the deficiencies particularly: to ensure patients received written medication schedule/instructions including medication name, dosage, and frequency. **To correct this deficiency:** Clinicians were instructed by DON to copy names of medication which patients are using (from hospital record if available, discharge instructions or from medication bottles found at home) into the patient's folder/binder, clearly marking the strength, dose, route (where to apply for topical medications), and its' purpose. Include medications which are used for dialysis patients prior to dialysis as well as over-the-counter medications. To prevent a recurrence of	2022-08-16

	AM, administrator/clinical manager #1 indicated all the medications from the patient s plan of care should have been included on their written medication list. Administrator/clinical manager #1 indicated the clinician should have updated the patient s medication list every visit. 3. Observation of a home visit for patient #2 was conducted on 7/15/2022, at 10:00 AM, to observe a skilled nurse visit and recertification assessment. During the visit, a home folder containing a medication list was reviewed. The list failed to include metoprolol (to lower blood pressure and control heartrate), which was included in the patient s plan of care medication list. During an interview on 7/18/2022, at 11:37 AM, administrator/clinical manager #1 indicated they did not know why metoprolol was not included on patient s home medication list.		conducted home visits to check the accuracy and timeliness of entries in the patients' home folder. The **DON and/or alternate clinical manager** shall be responsible for ensuring that this deficient practice does not recur. The correction of the deficiencies had been implemented on 08-09-22 by informing all clinicians of the document changes. 70% of all active patient' home folders had been reviewed for this deficient practice. Targeted completion date for reviewing patient's home folders will be mid Sept 2022	
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation and interview, the agency failed to provide patients with written instructions outlining treatments to be administered by home health personnel in 3 of 3 home visits conducted. (#1, 2, 3) The findings include: 1. Observation of a home visit for patient #1	G0618	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: on theabsence of a plan of care in patient's folder. **To correct this deficiency:** TheDON had provided all clinicians a copy of the plan of care to be placedin patients' home folders. To prevent a recurrence of this deficiency; the agencywill ensure that all active patients be provided with	2022-08-16

	observe a routine physical therapy visit. During the visit, a home folder was reviewed, which included a document which outlined the types of disciplines and frequency of visits to be performed, but failed to include a plan of care, or other written instructions describing which treatments the home health personnel would be administering during the visits. During an interview on 7/18/2022, at 11:30 AM, when queried what written information the agency provided to patients regarding interventions/treatments to be administered, alternate clinical manager #2 indicated they didn t provide patients with a written plan of care including interventions to be performed. 2. Observation of a home visit for patient #2 was conducted on 7/15/2022, at 10:00 AM, to observe a skilled nurse visit and recertification assessment. During the visit, a home folder was reviewed, which failed to include a plan of care, or other written instructions describing which treatments the home health personnel would be performing during visits. 3. Observation of a home visit for patient #3 was conducted on 7/15/2022, at 1:30 PM, to observe a routine home health aide visit. During the visit, a home folder was reviewed, which failed to include a plan of care, or other written instructions describing which treatments the home health personnel would be performing during visits.		the plan of care and thePT evaluation notes, aside from the Statement of financial liabilities which outlinesthe frequencies of the nurse, therapists, and home health aide. The **DON** shall be responsible for ensuring that thisdeficient practice does not recur. ***70% of active patient's home folders were reviewed byDON and will be attaining 100% mid-September 2022.***	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes;	G0716	The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: on accuracyof entries in the patient assessment.	2022-08-16

	Based on observation, record review, and interview, the agency failed to ensure clinicians accurately prepared clinical notes in 3 of 7 clinical records reviewed. (#1, 2, 6) The findings include: 1. Record review evidenced an undated agency policy obtained 7/19/2022, titled Clinical records which stated, & All entries recorded electronically by the clinician & [SN {skilled nurse}] & must be accurate &. 2. Clinical record review for patient #1 was completed on 7/19/2022, for certification period 6/29/2022 8/27/2022. Record review evidenced a plan of care for certification period 6/29/2022 8/27/2022, signed by a registered nurse on 6/29/2022, which included an order for Eliquis (blood thinner) 5 milligrams every 2 hours orally. During an interview on 7/18/2022, at 11:14 AM, when queried why the plan of care included an order for Eliquis every 2 hours, administrator/clinical manager #1 indicated it was an error in documentation and should have been twice per day. 3. Observation of a home visit for patient #2 was conducted on 7/15/2022, at 10:00 AM, to observe a routine skilled nurse visit. During the visit, patient was observed to have a gastrostomy tube (tube in stomach for feeding) and was incontinent of stool. Clinical record review for patient #2 was completed on 7/19/2022, for certification period 5/20/2022 7/18/2022. Record review evidenced a start of care comprehensive assessment dated and signed by a registered nurse on 5/20/2022, which indicated the patient had an ileostomy (opening created on surface of skin, connecting directly to part of intestines, which allows stool to collect in a bag attached to skin).		**To correct this deficiency,** TheDON has instructed the clinicians to review their assessmentfindings before synchronizing all collected patient data to the office payingparticular attention to medication, presence of any stoma (gastrostomy,ileostomy, urostomy, gastrostomy) and any IV access/infusion sites and notingits location, presence or absence of any bruit or thrill. **To prevent a recurrence ofthis deficiency**: QA will review patient's charts and query clinicians to ensureaccuracy of assessment findings. QA will check patient's history and systemsreview and validate entries with clinician by using the QA form. The agency updated an At-risk evaluation form whichspecifically indicates presence of any stoma (gastrostomy, ileostomy, urostomy,gastrostomy) IV access/infusion sites to assist in capturing a completeassessment of the patient. The **QA** shall be responsiblefor ensuring that this deficient practice does not recur.	

	During an interview on 7/18/2022, at 11:57 AM, when queried why the assessment indicated patient #2 had an ileostomy, administrator/clinical manager #1 indicated it was an error. 4. Clinical record review for patient #6 was completed on 7/19/2022, for certification period 3/25/2022 5/23/2022. Record review evidenced a start of care comprehensive assessment dated and signed by a registered nurse on 3/25/2022, which indicated the patient had a right arm fistula (connection of a vein and an artery for dialysis access). The same document indicated the patient had a left arm dialysis access. Record review evidenced a history and physical dated 3/24/2022, which indicated the patient had a left arm fistula. During an interview on 7/19/2022, at 1:40 PM, administrator/clinical manager #1 indicated it must have been an error in documentation and patient had a left arm fistula. 410 IAC 17-14-1(a)(1)(E)		QA had reviewed 100 % of active charts since 08-09-22 and had clinicians correct their entries in 100% of the charts.	
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, the agency failed to ensure communication with all physicians involved in the plan of care related to the current plan of care in 2 of 5 active clinical records reviewed. (#1, 3)	G0718	G0718 The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly: toensure communication with all physicians involved in the plan of careespecially on drug interactions. **To correct this deficiency:** TheDON instructed all clinicians	2022-08-16

	The findings include: 1. Record review evidenced an undated agency policy obtained 7/19/2022, titled Drug Regimen Review which stated, & Any major interactions will be brought to the attention of the physician &. 2. Clinical record review for patient #1 was completed on 7/19/2022, for certification period 6/29/2022 8/27/2022. Record review evidenced a start of care comprehensive assessment dated 6/29/2022, which indicated 2 major drug-drug interactions were found between aspirin (to prevent heart attack) and Eliquis (blood thinner), and metoprolol (to regulate heartbeat and lower blood pressure) and Cardizem (to lower blood pressure). Record review failed to evidence the physician was notified of major drug interactions as per agency policy. Record review on 7/19/2022, of a web-based source at https://www.drugs.com/interactions-check.php , indicated the following major drug-drug interactions from patient's medication list: Eliquis and metoprolol - use of both medications may cause fainting, irregular heart beat, increased or decreased heart rate, shortness of breath, or chest pain; and aspirin and Eliquis - use of both medications may cause an increase in bleeding, and possible hemorrhage. During an interview on 7/18/2022, at 11:28 AM, when queried what action is taken once major drug interactions are identified, alternate clinical manager #2 indicated the clinician would inform the family and the patient of any probable reaction. Alternate clinical manager #2 indicated the physician was not notified of drug interactions found on drug regimen review. 3. Clinical record review for patient #3 was completed on 7/19/2022, for certification		that at the start of care, resumption of care,recertification of care or when there is a new medication, the Drug Regimenreview shall be performed. This can be done through Netsmart or any website thatprovides information on medication interaction for example: drugs.com. Shouldthere be any adverse interaction noted; clinicians shall inform physiciansaccordingly and document in the skilled note. **To prevent the deficiency fromrecurring, the DON and QA** will check each patient's chart as soon asassessment data is synchronized to the office portal. The DON will provide the drug interaction to MD if present. The DON and QA shall beresponsible for ensuring that this deficient practice does not recur. DON and QA had reviewed 100 % of active charts since 08-09-22 and found that drug regimen review has been done on all the charts with drug interactions noted.	

	evidenced a medication list dated 6/22/2022, which included an order for Colace (stool softener) 100 milligrams as needed orally. This medication list failed to include an indication. Record review evidenced a comprehensive assessment dated 6/22/2022, which identified 1 major drug interaction between aspirin (to prevent stroke/heart attack) and Xarelto (blood thinner). Review on 7/19/2022, of a web-based source at https://www.drugs.com/interactions-check.php , indicated the following major drug-drug interactions between medications on patient s medication list: potassium chloride (electrolyte) and losartan (to lower blood pressure) - losartan may increase levels of potassium in blood, causing high potassium levels, which can result in kidney failure, irregular heart beat, or death; ciprofloxacin (antibiotic) and hydrocodone (pain medication) - ciprofloxacin may increase blood levels of hydrocodone, causing dizziness, drowsiness, low blood pressure, or respiratory distress; ciprofloxacin and Lexapro (antidepressant) - increased risk for an irregular possibly fatal heart rhythm; and hydrocodone and gabapentin (for nerve pain) - may cause respiratory depression, coma, and/or death. Clinical record review on 7/19/2022, failed to evidence physician notification of identified drug-drug interactions as per agency policy. During an interview on 7/19/2022, at 12:40 PM, administrator/clinical manager #1 indicated the physician was not notified of drug-drug interactions. 410 IAC 17-14-1(a)(1)(G)			
G0808	Onsite supervisory visit every 14 days	G0808	G0808	2022-08-16

	484.80(h)(1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit. Based on record review and interview, the agency failed to ensure supervisory home health aide visits were conducted no less than every 14 days in 1 of 6 clinical records reviewed with skilled patients who received home health aide services. (#4) The findings include: Record review evidenced an undated agency policy obtained 7/19/2022, titled Home Health Aide Supervision which stated, & The registered nurse makes a home health aide supervisory visit to the patient at least every 2 weeks, either when the aide is present, or when the aide is absent, to assess the relationship and determine whether goals are being met &. Clinical record review for patient #4 was completed on 7/19/2022. Record review evidenced a plan of care for certification period 6/8/2022 8/6/2022, which indicated the patient was to receive home health aide supervisory visits at least every 14 days. Record review evidenced supervisory visits on 6/20/2022, and the next supervisory visit was 7/8/2022 (18-day interval). During an interview on 7/19/2022, at 1:05 PM, alternate clinical manager #2 indicated home health aide supervisory visits should be		The DON conducted a meeting on 08-09-22with all the staff to discuss corrections on the deficiencies particularly on homehealth aide supervision every 14 days. **To correct this deficiency theDON**: 1. Provided concerned clinicians (nurses and therapists) a copy on the policy on home health aide supervision. 2. Instructed concerned clinicians to complete the entries on supervision of home health aides found in Netsmart every 14 days. 3. When clinician is unable to perform scheduled supervisory visit, the DON will do the scheduled supervisory visit.	

	usually complete them every visit. Alternate clinical manager #2 indicated the patient should have received a home health aide supervisory visit before 18 days.		**To prevent the recurrence of thisdeficiency** the DON instructed all clinicians to review assessment data priorto synchronization. QA will monitor and ensure the presence of HHAidesupervision by marking the frequency scheduler as a visual reminder. The **QA** shall beresponsible for ensuring that this deficient practice does not recur. QA had reviewed 100 % of active charts since 08-09-22 and had noted that home health aide supervisions were done as per plan of care on all the charts that had home health aides.	
N9999	Final Observations Review of Indiana Code 16-27-2.5 stated in "... Section 2.(a) A home health agency must: (1) have a written drug testing policy that is distributed to all employees; and (2) require each employee to acknowledge receipt of the policy. (b) A home health agency shall randomly test: (1) at least fifty percent (50 %) of the home health agency's employees who: (A) have direct contact with patients; and (B) are not licensed by a board or commission	N9999	The DON conducted a meeting on 8-9-22_withall the staff to discuss corrections on the deficiencies particularly: failure of the agency to randomlydrug test at least 50% of the unlicensed employees with direct patient contactand failed to have a written drug testing policy that included random testing procedures.	2022-08-09

	under IC 25; at least annually; or (2) when the home health agency has reasonable suspicion that an employee is engaged in the illegal use of a controlled substance...." Based on record review and interview, the home health agency failed to randomly drug tested at least 50% of the unlicensed employees with direct patient contact and failed to have a written drug testing policy that included random testing procedures. The findings include: Record review evidenced an undated agency policy obtained 7/19/2022, titled "Policy on Drug Testing" which stated, "... A home health agency must: ... have a written drug testing policy that is distributed to all employees; and ... Require each employee to acknowledge receipt of the policy ... A home health agency shall randomly test ... At least 50% of the home health agency's employees who: ... Have direct contact with patients; and ... Are not licensed by a board or commission under IC 25 ...." Record review on 7/13/2022, evidenced an employee list which indicated the agency employed 4 home health aides, who were unlicensed and had direct patient contact. 3 of 4 home health aides were employed with the agency for more than 1 year. Record review evidenced pre-employment drug screens for all home health aides, but failed to evidence any random drug screens were completed. During an interview on 7/14/2022, at 3:00 PM, when queried how frequently the agency performed drug screens on home health aides, administrator/clinical manager #1 indicated they were performed upon hire. Administrator/clinical manager #1 was not aware of 50% of unlicensed staff with patient contact were supposed to be randomly drug tested.		**To correct this deficiency theagency** shall implement the Policy on Drug testing. **To prevent the deficiency fromrecurring** the DON shall implement Policy on Drug testing and schedule drugtesting of employee concerned. **(see policy on drug testing,drug test result of HHA)** The **DON** shall be responsible for ensuring that thisdeficient practice does not recur. The correction of this deficiency had been implementedon 08-09-22.	

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