STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELP AT HOME SKILLED CARE	**833 W LINCOLN HIGHWAY SUITE 330 E , SCHERERVILLE, Indiana, 46375**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Facility ID: 004456 Survey dates: 7/19/2021, 7/20/2022, 8/1/2022-8/9/2022, and 8/11/2022-8/15/2022. At this Emergency Preparedness survey, Help At Home Skilled Care was found to not be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E0000		
E0001	Establishment of the Emergency Program (EP) CFR(s): 484.102 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that	E0001		

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

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E0001	Continued from page 1 provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed: to develop and maintain an emergency preparedness plan which included a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation (see tag E0009); to develop and implement individualized emergency preparedness plans for the patients which provided appropriate instructions, in the event of an emergency, to communicate with the agency (see tag E0017); to develop and implement emergency preparedness policies and procedures which included procedures to follow-up with on-duty staff and patients to determine services that are needed in the event there in an interruption in services during or due to an emergency and must inform State and local emergency preparedness officials about any on-duty staff or patients they are unable to contact (see tag E0021); to ensure a policy included a system for medical documentation that preserves patient information, protects patient confidentiality, and secures and maintains availability of records in the event of an emergency (see tag E0023); to ensure a policy included the use of volunteers or other emergency staffing in the event of an emergency (see tag E0024); to develop and maintain an emergency	E0001		

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E0001	Continued from page 2 preparedness communication plan which included names and contact information for staff, patients' physicians, volunteers and other agencies (E0030); to develop and maintain an emergency preparedness communication plan which included a method for sharing information and medical documentation for patients under the agency's care, as necessary, with other health providers to maintain the continuity of care and a means for providing information about the general condition and location of patients under the agency's care as permitted (see tag E0033); and to conduct exercises to test the emergency plan annually (see tag E0039). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment and resulted in the agency being found out of compliance with the condition 42 CFR 484.102 Emergency preparedness.	E0001		
E0006	Plan Based on All Hazards Risk Assessment CFR(s): 484.102(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency	E0006		

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E0006	Continued from page 3 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the emergency preparedness plan was developed by utilization of a facility-based and community-based risk assessment utilizing an all-hazards approach.	E0006		

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E0006	Continued from page 4 The findings include: Review of the agency's emergency preparedness plan on 7/20/2022 evidenced an agency document titled "Hazard Vulnerability Assessment" dated 5/19/2022 for the Schererville office. The document was evidenced to be blank. Review failed to evidence a facility-based and community-based risk assessment for the Valparaiso, South Bend, Laporte, and Logansport locations. During an interview on 7/20/2022, at 10:00 AM, Administrator #1 indicated the risk assessment should have been completed.	E0006		
E0009	Local, State, Tribal Collaboration Process CFR(s): 484.102(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency.	E0009		

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E0009	Continued from page 5 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure an emergency preparedness plan was developed and maintained to include a process for cooperation and collaboration with local, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency. The findings include: Review of an agency policy revised 1/4/2022, titled “Emergency Management Plan” stated, “… The emergency plan will identify the links to local community organizations that may be needed to assist the office in responding to client needs or who may need to utilize staff members and resources to respond to community needs….” Review of the agency’s emergency preparedness plan on 7/20/2022 failed to evidence the plan included a process for cooperation and collaboration with local, regional, State, and Federal emergency preparedness officials’ efforts to maintain an integrated response during a disaster or emergency. During an interview on 7/20/2022, at 10:00 AM, Administrator #1 indicated the agency has been trying to get settled with the branch manager positions and then each location would attend the district emergency preparedness meetings. Administrator #1 indicated the agency tried to contact the local fire department but did not receive a return phone call and indicated there was not any documentation of the attempt to contact the local fire department.	E0009		
E0017	HHA Comprehensive Assessment in Disaster CFR(s): 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	E0017		

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E0017	Continued from page 6 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. This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to develop and implement individualized emergency preparedness plans for the patients which provided appropriate instructions, in the event of an emergency in 2 of 4 home visits. (#1, 3) The findings include: 1. Review of an agency policy revised 1/4/2022, titled “Emergency Management Plan” stated, “… Clients and family/caregivers will receive information on an emergency management plan during the initial visit. … To provide guidelines for specific instruction and information for clients and family/caregivers in relation to emergency preparedness and actions to take in the event of a natural disaster and/or emergency. … emergency preparedness/natural disaster plan that will include … day-to-day necessities, oxygen, and medical supplies….” 2. During an observation of care on 8/2/2022 at 10:12 AM, at the home of patient #1, start of care 11/26/2019, the skilled nurse was observed pouring a liquid into a tube inserted into the patient’s abdomen. An emergency plan to include the medical supplies required for the patient was not observed in the patient’s home. Review of an agency documents observed in the agency folder titled “Emergency Plan” indicated a blank for the physician’s name and phone number, a blank for the name and phone number of a close relative, and a blank for the hospital. Clinical record review on 8/3/2022 evidenced the patient had a gastrostomy (a surgically inserted tube into the stomach through the abdomen to	E0017		

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E0017	Continued from page 7 deliver nutrition, hydration, and/or medications) and was NPO (nothing by mouth). Review indicated the patient received tube feeding and water flushes through the gastrostomy. Review failed to evidence an emergency preparedness plan which included the gastrostomy supplies required by the patient. 3. During an observation of care on 8/4/2022, at 10:19 AM, at the home of Patient #3, start of care 5/5/2021, the patient was observed to have a plastic tube inserted into the throat and a tube inserted into the upper left quadrant of the abdomen. Clinical record review on 8/3/2022 evidenced the patient had a tracheostomy (a surgically inserted tube into the windpipe through the neck to assist with breathing) and a gastrostomy. Review indicated the patient received tube feeding and water flushes through the gastrostomy. Review failed to evidence an emergency preparedness plan which included the tracheostomy and gastrostomy supplies required by the patient. 4. During an interview on 8/5/2022, at 4:28 PM, Administrator #1 indicated the emergency preparedness forms should be completed specific to the patient.	E0017		
E0021	HHA- Procedures for Follow up Staff/Pts. CFR(s): 484.102(b)(3) §484.102(b)(3) Condition of Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to	E0021		

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E0021	Continued from page 8 contact. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure a policy included the agency must inform state and local officials of on-duty staff and patients that are unable to be reached in the event of an emergency. The findings include: Review of an agency's policy revised 1/4/2022 titled "Emergency Management Plan" failed to evidence the policy included the process for how the agency would inform State and local officials of on-duty staff and patients that are unable to be reached. During an interview on 7/20/2022, at 10:00 AM, Administrator #1 indicated she could not locate where in a policy included the process for informing State and local officials of on-duty staff and patients that were not able to be reached.	E0021		
E0023	Policies/Procedures for Medical Documentation CFR(s): 484.102(b)(4) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4), §485.68(b)(3), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical	E0023		

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E0023	Continued from page 9 documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure a policy included a system for medical documentation that preserves patient information, protects patient confidentiality, and secures and maintains availability of records in the event of an emergency. The findings include: Review of an agency's policy revised 1/4/2022, titled "Emergency Management Plan" failed to evidence the policy included a system for medical documentation that preserves patient information, protects patient confidentiality, and secures and maintains availability of records in the event of an emergency. During an interview on 7/20/2022, at 10:00 AM, Administrator #1 indicated the patients' medical information is electronic and was not sure how the agency would maintain the patients' records if a disaster and/or emergency did not allow for electronic documentation. Administrator indicated the policy did not include a process for medical documentation in the event there was not	E0023		

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E0023	Continued from page 10 electricity.	E0023		
E0024	Policies/Procedures-Volunteers and Staffing CFR(s): 484.102(b)(5) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure a policy included the use of volunteers or other emergency staffing in the event of an emergency.	E0024		

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E0024	Continued from page 11 The findings include: Review of an agency's policy revised 1/4/2022, titled "Emergency Management Plan" stated, "… In the event of damage to the office, limitations or cessation of operations, arrangements will be made by the Administrator/designee or Nursing/Clinical Manager with another Home Care provider to receive our clients to maintain continuity of services…." Review failed to evidence the policy included which agency was to receive the agency's patients. During an interview on 7/20/2022, at 10:00 AM, Administrator #1 indicated she did not know what the agency's emergency staffing plan was.	E0024		
E0030	Names and Contact Information CFR(s): 484.102(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.	E0030		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELP AT HOME SKILLED CARE	**833 W LINCOLN HIGHWAY SUITE 330 E , SCHERERVILLE, Indiana, 46375**

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E0030	Continued from page 12 *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (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.	E0030		

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E0030	Continued from page 13 *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the communication plan included	E0030		

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E0030	Continued from page 14 names and contact information for patients' physicians in the event of an emergency. The findings include: Review of the agency's emergency preparedness and communication plan on 7/20/2022 failed to evidence the communication plan include the contact information for the patients' physicians. During an interview on 7/20/2022, at 10:00 AM, Administrator #1 indicated the plan did not include contact information for the patients' physicians.	E0030		
E0031	Emergency Officials Contact Information CFR(s): 484.102(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency.	E0031		

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E0031	Continued from page 15 (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to develop and maintain an emergency preparedness communication plan which included contact information for Federal and State emergency preparedness officials. The findings include: Review of an agency policy revised 1/4/2022, titled “Emergency Management Plan” stated, “… Staff members will receive a copy of numbers and websites of … state, local, federal agencies that will assist with emergencies or disasters. A copy of all the numbers and websites will be kept in the Emergency Preparedness binder….” Review of the agency’s emergency preparedness plan on 7/20/2022 evidenced an undated agency document titled “Emergency Action Plan”. Review failed to evidence the contact information for federal and state emergency preparedness officials. During an interview on 7/20/2022, at 10:00 AM, Administrator #1 indicated she could not locate the contact information for federal and state emergency preparedness officials.	E0031		
E0033	Methods for Sharing Information CFR(s): 484.102(c)(4)-(5)	E0033		

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E0033	Continued from page 16 §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This STANDARD is NOT MET as evidenced by:	E0033		

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E0033	Continued from page 17 Based on record review and interview, the agency failed to ensure the communication plan included a method for sharing information and medical documentation for patients under the agency's care with other health care providers to maintain continuity of care, and in the event of an evacuation, a means of releasing patient information and providing general information about the general condition and location of patients under the agency's care. The findings include: Review on 2/16/2022 of the emergency preparedness binder evidenced an undated agency document titled "Emergency Preparedness Plan". This document stated, "… If the patient is unharmed but the home is damaged or unsafe and the telephone system is working, contact family or friends that the patient may request and make arrangements for the patient's transportation…." Review of a document titled "Patients" dated 12/27/2021, failed to evidence the names and patient information for patient #3, start of care 1/8/2022, patient #4, start of care 2/2/2022, and patient #5, start of care 2/2/2022. During an interview on 2/16/2022, at 1:48 PM, the administrator indicated the patient roster is outdated and should be updated as patients come and go.	E0033		
E0034	Information on Occupancy/Needs CFR(s): 484.102(c)(6) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(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:	E0034		

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E0034	Continued from page 18 (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to develop and maintain an emergency preparedness communication plan which included a means of providing information about the agency's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. The findings include: Review of an agency policy revised 1/4/2022, titled “Emergency Management Plan” stated, “… If assistance is requested by the County Defense Director, the Emergency Supervisors who are at the assigned alternate location will coordinate staff member assignments for this….” Review failed to evidence a process for providing information about the agency’s occupancy, needs, and its ability to provide assistance to the authority having jurisdiction. During an interview on 7/20/2022, at 10:00 AM, Administrator #1 indicated she was not sure who the County Defense Director was and indicated she could not locate a process for providing information about the agency’s occupancy and needs to the authority having jurisdiction.	E0034		

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E0034 E0036	EP Training and Testing CFR(s): 484.102(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).	E0034 E0036		

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E0036	Continued from page 20 *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan, risk assessment, policies and procedures and the communication plan. The findings include: Review of an agency policy revised 1/4/2022, titled “Emergency Management Plan” stated, “… Staff members will be oriented at time of hire and annually to the emergency preparedness plan and their associated responsibilities. … Clients and staff should use local radio station to listen for disasters/emergencies updates, closures, etc. … In the event of damage to the office, the Administrator/designee will make arrangements for an alternate location to conduct business activities….” Review of the agency’s emergency preparedness training titled “Disaster Planning” evidenced training on hurricanes. Review failed to evidence hurricanes were identified as a disaster risk. Review failed to evidence which local radio stations staff and patients were to listen to in the event of a disaster/emergency. Review failed to evidence where the alternate location was located in the event of a disaster/emergency damaged the office. Review failed to evidence the training was specific to the agency’s emergency preparedness plan.	E0036		

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E0036	Continued from page 21 During an interview on 7/20/2022, at 10:00 AM, Administrator #1 indicated she was not aware of the where was the alternate location in the event of a disaster/emergency for the parent or branch locations. During an interview on 8/3/2022, at 5:02 PM, Administrator #1 indicated the Disaster Planning module was the emergency preparedness training provided to staff at time of hire and annually. Administrator #1 indicated hurricanes were not a disaster risk for the location of the agency and indicated the training was not specific to the agency's emergency preparedness plan.	E0036		
E0037	EP Training Program CFR(s): 484.102(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.	E0037		

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E0037	Continued from page 22 *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and	E0037		

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E0037	Continued from page 23 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	E0037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELP AT HOME SKILLED CARE	833 W LINCOLN HIGHWAY SUITE 330 E , SCHERERVILLE, Indiana, 46375

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E0037	Continued from page 24 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	E0037		

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E0037	Continued from page 25 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to provide and maintain documentation of emergency preparedness training at time of hire and every 2 years for agency personnel. The findings include: Review of an agency policy revised 1/4/2022, titled “Emergency Management Plan” stated, “… Staff members will be oriented at time of hire and annually to the emergency preparedness plan and their associated responsibilities….” During an interview on 8/3/2022, at 5:02 PM, Administrator #1 indicated the Disaster Planning module was the emergency preparedness training provided to staff at time of hire and annually. Review of training records on 8/8/2022 failed to evidence emergency preparedness training with the completion of the disaster planning module for home health aide (HHA) #4, HHA #5, HHA #6, HHA #7, the alternate clinical manager, registered nurse (RN) #8, and RN #11. Review failed to evidence RN #10 received emergency preparedness training with the completion of the disaster planning module since 8/5/2019. Review failed to evidence HHA #8 received emergency preparedness training with the completion of the disaster planning module since 6/16/2018. Review failed to evidence HHA #3 received emergency preparedness training with the completion of the disaster planning module since 6/27/2018. Review failed to evidence licensed practical nurse (LPN) #3 received emergency preparedness training with the completion of the disaster planning module since 6/28/2018. Review failed to evidence LPN #4 received emergency preparedness training with the completion of the disaster planning module since 6/20/2019. Review failed to evidence LPN #5 received emergency preparedness training with the completion of the disaster planning module since 6/13/2019. Review	E0037		

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E0037	Continued from page 26 failed to evidence RN #11 received emergency preparedness training with the completion of the disaster planning module since 5/4/2020.	E0037		
E0039	EP Testing Requirements CFR(s): 484.102(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by	E0039		

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E0039	Continued from page 27 a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E0039		

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E0039	Continued from page 28 (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual,	E0039		

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E0039	Continued from page 29 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.	E0039		

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E0039	Continued from page 30 (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	E0039		

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E0039	Continued from page 31 (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.	E0039		

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E0039	Continued from page 32 (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360]	E0039		

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E0039	Continued from page 33 (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to conduct exercises to test the emergency plan annually. The findings include: Review of an agency policy revised 1/4/2022, titled “Emergency Management Plan” stated, “…	E0039		

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E0039	Continued from page 34 Drills, tabletop exercises … will be held annually…." Review of the agency's emergency preparedness plan on 7/20/2022 failed to evidence any testing of the emergency preparedness plan. During an interview on 7/20/2022, at 10:00 AM, Administrator #1 indicated there are not any exercises and tabletops yet in the emergency preparedness plan. Administrator #1 indicated the agency tried contacting the fire department but had not received a return phone call.	E0039		
G0000	INITIAL COMMENTS This visit was for a Re-certification and State Re-Licensure survey for a home health agency. Survey Dates: 7/19/2021, 7/20/2022, 8/1/2022-8/9/2022, and 8/11/2022-8/15/2022. A revisit for the Immediate Jeopardy removal was conducted at the agency on 8/22/2022 and 9/1/2022. Facility ID: 004456 Active Patient Census: 415 The first Immediate Jeopardy related to §484.70 Infection Prevention and Control was identified and announced on 8/8/2022 at 2:40 PM. Immediate Jeopardy began on 8/4/2022 when the licensed practical nurse (LPN) #1 was observed providing care at the home of patient #3, start of care 5/5/2021 while wearing a surgical mask. The administrator, alternate administrator, registered nurse (RN) #1, RN #2, RN #3, Other personnel #1, Other personnel #2, Other personnel #3, and Other personnel #4 were observed not wearing a mask in the office. Review of the agency's Covid-19 vaccination status report indicated LPN #1, administrator, alternate administrator, RN #1, #2, #3, Other personnel #1, #2, #3, and #4 had religious exemptions. Review of an agency policy indicated staff who received a religious exemption would wear a KN95 mask while at work. The agency	G0000		

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G0000	Continued from page 35 failed to include in its policy a process for tracking and securely documenting the COVID-19 vaccination status of all staff, a process for tracking and documenting the vaccination status of any staff who have obtained any booster doses as recommended by the CDC (Centers for Disease Control and Prevention), and a process for tracking and documenting the vaccination status for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations. Review of the agency's COVID-19 vaccination status report failed to evidence vaccination status for 72 agency personnel. Review of the agency's COVID-19 infection log indicated 48 patient COVID-19 infections since 1/1/2022, and the administrator indicated patient #3 tested positive for COVID-19 on 8/5/2022. Due to the actions taken by the agency, the Immediate Jeopardy was removed prior to the conclusion of the survey on 8/15/2022, at 12:13 PM. A second Immediate Jeopardy related to §484.60 Care Planning, Coordination of Services, and Quality of Care was identified and announced on 8/11/2022 at 2:45 PM. The Immediate Jeopardy began on 8/1/2022 when the record review evidenced the agency failed to provide home health aide services as ordered by the physician for patients #5 and #7 who had little to no mobility and lived alone. Review indicated Patient #5 has a diagnosis of quadriplegia, and the registered nurse (RN) assessed the patient to be dependent on personal care, transfers, toileting, and ambulation. The RN assessed the patient on 5/9/22 to have 11 wounds. Review of the plan of care indicated the agency was to provide home health aide services 3 hours a visit, 2 visits a day, 7 days a week. Review indicated the agency did not provide home health aide services on 6/5/2022, 6/12/2022, 6/14/2022-6/26/2022, 6/28/2022-7/1/2022, 7/3/2022, 7/5/2022-7/10/2022, 7/12/2022-7/17/2022, 7/20/2022-7/24/2022, and 7/31/2022. Review of documents from the wound clinic dated 7/28/2022 indicated the patient had 15 wounds. Review indicated the patient had another agency providing skilled nursing services for wound care. Review failed to evidence the agency coordinated care with the agency providing skilled nursing services. Record review indicated Patient #7 has a diagnosis of paraplegia, and the RN assessed the patient to be personal care, transfers, toileting, and ambulation. The RN assessed the patient on	G0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELP AT HOME SKILLED CARE	833 W LINCOLN HIGHWAY SUITE 330 E , SCHERERVILLE, Indiana, 46375

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G0000	Continued from page 36 5/25/2022 to have an abrasion to the labia. Review of the plan of care indicated the agency was to provide home health aide services 6 hours a day, 7 days a week. Review failed to evidence the agency provided 6 hours a day of home health aide services on 6/5/2022-6/20/2022, 6/23/2022-7/15/2022, and 7/17/2022-7/30/2022. Review failed to evidence the agency provided a home health aide at all on 6/17/2022, 6/22/2022, and 7/16/2022. Review indicated the RN assessed the patient on 7/21/2022 to have macerated labia and a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage III (an open pressure ulcer with full thickness loss of skin) to the left heel. Review indicated the patient had another agency providing skilled nursing services for wound care. Review failed to evidence the agency coordinated care with the agency that was providing skilled nursing services for wound care. The Immediate Jeopardy related to §484.60 Care Planning, Coordination of Services, and Quality of Care were not removed prior to exit on 8/15/2022 at 12:13 PM. An IJ removal visit was conducted and remained unabated upon exit on 8/22/2022. The administrator was notified on 8/22/2022 at 4:20 PM. The IJ remained unremoved due to the agency's ongoing failure to ensure all plans of care contained wound care orders and failure to coordinate care with other entities to ensure the patient's needs were met. The agency, by their own admission, indicated on an IJ removal plan submitted 8/18/2022, a comprehensive assessment would be completed for Patients #5 and #7 to include wound locations and status of care provided by outside entities. Registered Nurse (RN) #8 indicated she did not assess the wounds of Patient #7. Review of wound documentation from the wound clinic and podiatrist evidenced wounds to the left thigh, left buttock, right foot, and left foot the agency did not have included in the comprehensive assessment. Review of documents from the podiatrist indicated wound care was being provided by a home health agency 3 times a week. An interview with the wound clinic indicated the wound clinic was providing wound care weekly and home health was to provide wound care in between the care provided by the wound clinic. The alternate administrator indicated the agency that was providing skilled nursing for wound care had discharged the patient and Help at Home was unsure	G0000		

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G0000	Continued from page 37 who was now providing the wound care. A second IJ removal visit was conducted and remained unabated upon exit on 9/1/2022. The administrator was notified on 9/1/2022 at 1:45 PM. The IJ remained unremoved due to the agency's ongoing failure to ensure the services were provided as directed in the plans of care to meet the needs of the patient as assessed. Patient #5 had unassigned shifts on 8/26/2022, 8/28/2022, 8/31/2022, and 9/1/2022. The home health aide failed to arrive at the patient's home as scheduled on 8/20/2022, 8/29/2022, and 8/30/2022. The agency indicated on an IJ removal plan submitted on 8/30/2022, audits of plans of care compared to the schedule would be completed, and the agency indicated the physician would be notified if the patient's needs were not met. The agency indicated other agencies involved in the patient's care would be coordinated with to ensure the patient's needs were met. Review failed to evidence the agency coordinated care with the agency providing skilled nursing care regarding the provision of home health aide services to meet the needs of the patient. Review failed to evidence the physician was notified of the agency's inability to meet the needs of the patient as ordered. During an interview with the patient, Patient #5 indicated he called the agency and left messages when his home health aide did not arrive as scheduled and his calls to the agency were not returned. Patient #5 indicated he sits up in his wheelchair until after midnight when his brother gets off work to come to his home and assist him to bed. The Immediate Jeopardy began on 8/1/2022 when the record review evidenced the agency failed to provide home health aide services as ordered by the physician for patients #5 and #7 who had little to no mobility and lived alone. Review indicated Patient #5 has a diagnosis of quadriplegia, and the registered nurse (RN) assessed the patient to be dependent on personal care, transfers, toileting, and ambulation. The RN assessed the patient on 5/9/22 to have 11 wounds. Review of the plan of care indicated the agency was to provide home health aide services 3 hours a visit, 2 visits a day, 7 days a week. Review indicated the agency did not provide home health aide services on 6/5/2022, 6/12/2022, 6/14/2022-6/26/2022, 6/28/2022-7/1/2022, 7/3/2022, 7/5/2022-7/10/2022, 7/12/2022-7/17/2022,	G0000		

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G0000	Continued from page 38 7/20/2022-7/24/2022, and 7/31/2022. Review of documents from the wound clinic dated 7/28/2022 indicated the patient had 15 wounds. Review indicated the patient had another agency providing skilled nursing services for wound care. Review failed to evidence the agency coordinated care with the agency providing skilled nursing services. Record review indicated Patient #7 has a diagnosis of paraplegia, and the RN assessed the patient to be personal care, transfers, toileting, and ambulation. The RN assessed the patient on 5/25/2022 to have an abrasion to the labia. Review of the plan of care indicated the agency was to provide home health aide services 6 hours a day, 7 days a week. Review failed to evidence the agency provided 6 hours a day of home health aide services on 6/5/2022-6/20/2022, 6/23/2022-7/15/2022, and 7/17/2022-7/30/2022. Review failed to evidence the agency provided a home health aide at all on 6/17/2022, 6/22/2022, and 7/16/2022. Review indicated the RN assessed the patient on 7/21/2022 to have macerated labia and a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage III (an open pressure ulcer with full thickness loss of skin) to the left heel. Review indicated the patient had another agency providing skilled nursing services for wound care. Review failed to evidence the agency coordinated care with the agency that was providing skilled nursing services for wound care. Help At Home Skilled Care is precluded from providing its own home health aide training and competency evaluation for a period of two years from 08/15/2022 – 08/15/2024, due to being found out of compliance with Conditions of Participation 484.60 Care Planning, Coordination of Care and Quality of Care, 484.65 Quality Assessment and Performance Improvement, 484.70 Infection Prevention and Control, 484.102 Emergency Preparedness, and 484.105 Organization and Administration of Services. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Quality Review Completed 09/08/2022	G0000		
G0372	Encoding and transmitting OASIS	G0372		

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G0372	Continued from page 39 CFR(s): 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to encode and electronically transmit a completed OASIS (Outcome and Assessment Information Set, a comprehensive assessment data collection tool) assessment to the CMS (Centers for Medicare and Medicaid Services) system in 1 of 2 active clinical records reviewed with skilled nursing services. (#3) The findings include: Review of an agency policy revised 1/4/2022, titled “OASIS and Reporting of OASIS” stated, “… The agency must collect, encode, and transmit OASIS data for: Non-maternity Medicare and Medicaid patients that are ages 18 and over, and receiving skilled nursing services….” Clinical record review on 8/3/2022, for Patient #3, start of care 8/3/2022, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 6/30/2022-8/28/2022. Review indicated the patient was non-maternity, over the age of 18 years old, and receiving Medicaid respite skilled nursing services. Review failed to evidence OASIS assessments. During an interview on 8/5/2022, at 4:53 PM, the administrator indicated there were not any OASIS submissions for the patient because she was told the agency did not need to submit OASIS assessments if the patient was just respite.	G0372		
G0374	Accuracy of encoded OASIS data CFR(s): 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment.	G0374		

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G0374	Continued from page 40 This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the OASIS (Outcome and Assessment Information Set, a comprehensive assessment data collection tool) accurately reflected the patient's status in 1 of 1 active clinical records reviewed with OASIS submissions. (#1) The findings include: Review of an agency policy revised 1/4/2022, titled "OASIS and Reporting of OASIS" stated, "Agency staff will ensure that the accuracy of OASIS data will reflect client status at the time of assessment…." Clinical record review on 8/3/2022, for Patient #1, start of care 11/26/2019, evidenced an agency document titled "Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information" dated 7/12/2022, which indicated the patient's diagnoses included, but were not limited to, pressure ulcer sacral (lower back above the buttocks) region. Review failed to evidence an assessment of a pressure ulcer to the sacral region. During an interview on 8/5/2022, at 4:05 PM, the administrator indicated the patient did not have a wound and the diagnosis was not accurate. The administrator indicated they were instructed in the past diagnoses could not be removed.	G0374		
G0412	Written notice of patient's rights CFR(s): 484.50(a)(1)(i) (i) Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the patient was provided a written copy of the patient rights in 3 of 6 active clinical records reviewed with home health aide services. (#2, 7, 8)	G0412		

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G0412	Continued from page 41 The findings include: 1. Review of an agency document revised 11/2019 titled “Patient’s Bill of Rights/Responsibilities and Transfer/Discharge Criteria” stated, “… Home care patients have a right to be notified in writing of their rights during the initial evaluation visit before initiation of care and to exercise those rights….” 2. Clinical record review on 8/2/2022, for Patient #2, start of care 4/12/2022, failed to evidence a written copy of the patient rights were provided to the patient. 3. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, failed to evidence a written copy of the patient rights were provided to the patient. 4. Clinical record review on 8/2/2022, for Patient #8, start of care 2/17/2021, failed to evidence a written copy of the patient rights were provided to the patient. 5. During an interview on 8/4/2022, at 2:51 PM, the administrator indicated the agency had the patient’s review and sign a copy of the patient’s rights at time of admission and the signed copy was kept in the patient’s clinical record. The administrator indicated she could not locate the patient’s signed copy of the patient rights. The administrator indicated she would contact the off-site clinical record storage facility and indicated the patient’s signed copy of the written patient rights should be in the clinical record. The administrator indicated when the agency switched to an electronic medical record, the paper documents should have been scanned into the record before being stored at the off-site storage location. No additional documents were provided. 17-12-3(a) 1 (A)	G0412		
G0414	HHA administrator contact information CFR(s): 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. This ELEMENT is NOT MET as evidenced by:	G0414		

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G0414	Continued from page 42 Based on observation, record review, and interview, the agency failed to ensure the patients were provided the name of the administrator to receive complaints in 1 of 2 home visits conducted with the home health aide. (#2) The findings include: Review of an agency document revised 11/2019, titled “Patient’s Bill of Rights/Responsibilities and Transfer/Discharge Criteria” stated, “… Patients have the right: … The following information during the initial evaluation visit, in advance of furnishing care to the patient; … Contact information for the Agency Administrator, including the Administrator’s name, business address and business phone number in order to receive complaints….” During an observation of care on 8/3/2022, at 7:59 AM, at the home of Patient #2, start of care 4/12/2022, an agency folder was observed. The name and contact information for the administrator was observed to be blank. During an interview on 8/5/2022, at 10:24 AM, Administrator #1 indicated the patients are to be informed of who was the administrator by filling out the name and contact information in the agency folder provided to the patient.	G0414		
G0458	Outcomes/goals have been achieved CFR(s): 484.50(d)(3) The transfer or discharge is appropriate because the physician or allowed practitioner, who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with §484.60(a)(2)(xiv) have been achieved, and the HHA and the physician or allowed practitioner, who is responsible for the home health plan of care agree that the patient no longer needs the HHA’s services; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure patients were discharged once goals were met in 1 of 1 closed clinical record reviewed with a discharge reason of goals met. (#11)	G0458		

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G0458	Continued from page 43 The findings include: Review of an agency policy revised 11/2019, titled "Patient's Bill of Rights/Responsibilities and Transfers/Discharge Criteria" stated, "… Patients will be discharged from Agency based on Agency Discharge Criteria Policy: … This discharge is appropriate because the physician who is responsible for the home health plan of care and the Agency agree that measurable outcomes and goals set forth in the plan of care have been achieved …." Clinical record review on 8/7/2022, for Patient #11, start of care 2/12/2019, evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 3/28/2022-5/26/2022, which indicated the agency was to provide a skilled nurse for 1 hour a day, 1 day every other week for medication planner fill and education on medication compliance. Review evidenced the goals included the patient would be compliant with taking medications as scheduled. Review of an agency document titled "Activity Individual" dated 4/25/2022, indicated the patient was discharged on 4/25/2022 and the patient was receiving monthly pill packs from a pharmacy. Review indicated the patient had not been sent digoxin (a medication used to treat heart failure) and metoprolol (a medication used to treat high blood pressure) in the pill pack yet. Review indicated a nurse from Entity M was to fill until all medications were in the pill pack. Review failed to evidence the patient's goals were met before discharge due to the patient did not have all the medications in the pre-filled pill pack sent by the pharmacy. During an interview on 8/8/2022, at 11:44 AM, Administrator #1 indicated she was not sure why the agency did not continue services until the pharmacy sent the digoxin and metoprolol in the pre-filled medication pack since the patient still required someone to set-up his meds to include digoxin and metoprolol until the pharmacy included them in the monthly pill set-up.	G0458		
G0484	Document complaint and resolution CFR(s): 484.50(e)(1)(ii)	G0484		

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G0484	Continued from page 44 (ii) Document both the existence of the complaint and the resolution of the complaint; and This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure complaints made by the patient were documented in 3 of 8 clinical records reviewed with home health aide services. (#5, 7, 9) The findings include: 1. Review of an agency document revised 11/2019, titled “Patient’s Bill of Rights/Responsibilities and Transfer/Discharge Criteria” stated, “… Patients have the right: … Document both the existence of the complaint and the resolution of the complaint….” 2. During an interview on 8/9/2022, at 10:31 AM, Patient #5, start of care 11/11/2021, indicated he has made complaints about his lack of home health aide staffing to the agency and has not received any solutions from the agency. 3. During an interview on 8/9/2022, at 10:04 AM, Patient #7, start of care 4/2/2021, indicated she has made complaints about the lack of home health aide staffing to the agency and has not received any answers on why she does not receive all her home health aide hours. 4. During an interview on 8/9/2022, at 10:15 AM, the caregiver for Patient #9, start of care 12/27/2021, indicated he contacted the agency about his complaints regarding the lack of home health aide staffing and the home health aide bringing her baby to the patient’s home during work hours. The patient’s caregiver indicated he did not receive a return phone call from the agency about his complaints. 5. Review of an agency document on 8/8/2022, titled “Grievance Log” failed to evidence a complaint was documented for Patient #5, Patient #7, and Patient #9. 6. During an interview on 8/8/2022, at 2:22 PM, Administrator #1 indicated the complaint process was a new process for the agency and indicated there was some misunderstanding on what a grievance was. Administrator #1 indicated there was no additional documentation of complaints. At	G0484		

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G0484	Continued from page 45 4:19 PM, Administrator #1 indicated complaints should be entered into the complaint log. 7. During an interview on 8/9/2022, at 11:43 AM, Administrative Staff #6 indicated Patient #5 had made concerns about the lack of staffing known and indicated the patient's concerns should have been entered into the clinical record. Administrative Staff #6 indicated the agency was aware the caregiver for Patient #7 was not happy with the lack of staffing and had complaints and indicated the agency was having difficulty getting home health aides competencies completed because the agency was short-staffed on registered nurses to complete the home health aide competencies. 17-12-3(c)(2)	G0484		
G0536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the patient's medication was reviewed to identify any potential adverse effects and drug reactions in 2 of 4 home visits conducted. (#1, 2) The findings include: 1. Review of an agency policy revised 1/4/2022, titled "Medication Management" stated, "… The nurse will reconcile all medications taken by the client upon admission, with every home visit …The medication Profile shall document: … Identified potential drug or food interactions … If the physician changes the medication orders, the RN [registered nurse] must add newly ordered drugs or medication changes to the Medication Profile. … The Medication Profile shall be reviewed by a Registered Nurse on each home visit, every sixty (60) days and updated whenever there is a change or discontinuation in medication…." 2. During an observation of care on 8/2/2022, at	G0536		

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HELP AT HOME SKILLED CARE	833 W LINCOLN HIGHWAY SUITE 330 E , SCHERERVILLE, Indiana, 46375

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G0536	Continued from page 46 10:33 AM, at the home of Patient #1, start of care 8/3/2022, a bottle labeled Lactulose (medication used to treat constipation) was observed with the patient's medication. During an interview on 8/2/2022, at 10:33 AM, the patient's caregiver indicated the patient was treated at the urgent care on 7/20/2022 for constipation and lactulose was ordered by the urgent care physician to use as needed for constipation. Clinical record review on 8/3/2022 evidenced an agency document titled "Medication Report" signed by the RN and dated 7/12/2022. Review failed to evidence lactulose was on the medication profile to include a review of potential adverse effects and drug reactions. 3. Clinical record review on 8/2/2022, Patient #2, start of care date 4/12/2022, evidenced an agency document titled "Medication Report" signed by the RN and dated 6/6/2022. Review evidenced the document stated, "… Drug Interaction Review: Potential adverse effects, duplicate ineffective drug therapy, and contradictions identified?" Review failed to evidence the nurse answered the question and reviewed the medications for potential adverse effects and drug reactions. During an interview on 8/5/2022, at 4:37 PM, the administrator indicated the questions on the medication report should be completed. During an observation of care at the patient's home on 8/3/2022, at 8:20 PM, the patient's medications were observed and reviewed with the patient. The patient indicated oxycodone (pain medication) was discontinued about 2 months ago and she was started on hydrocodone 7.5 milligrams (mg) instead. The patient indicated she takes Emgality (an injectable medication for the treatment of migraines) which she injects herself every 3 months. 4. During an interview at the entrance conference on 7/19/2022 at 12:15 PM, the administrator indicated the drug review was completed automatically by the electronic health record program when the medications were entered onto the medication profile. The administrator indicated new medications found in the home should be added to the medication profile.	G0536		

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G0536	Continued from page 47 17-14-1(a)(1)(B)	G0536		
G0544	Update of the comprehensive assessment CFR(s): 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the comprehensive assessment was updated and revised to include new wounds in 1 of 3 active clinical records reviewed with wounds. (#8) The findings include: Review of an agency policy revised 1/4/2022, titled “Nursing Documentation of Client Assessments” stated, “… The Comprehensive Assessment will be updated and revised by the Registered Nurse [RN] as often as the client’s condition warrants, such as the following situations: … When significant changes occur in their condition ….” Clinical record review on 8/2/2022, for Patient #8, start of care 2/17/2021, evidenced an untitled agency document the administrator identified as the comprehensive assessment, dated 6/10/2022, which indicated the patient had no skin breakdown. During an interview on 8/2/2022, at 11:20 AM, Administrator #1 indicated the patient had a debridement to a wound on the foot and a wound drain was placed in the foot. Review of an agency document titled “Activity Individual” dated 8/2/2022 indicated the home health aide reported the patient has a bandage with a woundvac (a medical device used to remove fluid/drainage from an area using vacuum pressure). Review on 8/5/2022 failed to evidence the comprehensive assessment was updated to include an assessment of the wound.	G0544		

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G0544	Continued from page 48 During an interview on 8/5/2022, at 3:37 PM, Administrator #1 indicated the comprehensive assessment had not been updated. Administrator #1 indicated a new wound was considered a change in condition and an update in the comprehensive assessment should be completed. 17-14-1(a)(1)(B)	G0544		
G0564	Discharge or Transfer Summary Content CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the discharge/transfer summary included all necessary information pertaining to services received, post-discharge goals of care, and current medications and failed to ensure the summary was sent to the receiving healthcare practitioner in 3 of 3 closed clinical records reviewed. (#9, 10, 11) The findings include: 1. Review of an agency policy revised 1/4/2022, titled “Client Transfer” stated, “… A Transfer Summary/Form shall be completed by the Case Manager, communicated/faxed to the receiving agency/facility, and be added to the client’s electronic chart. This summary … shall include documentation of services received … current medications ….” 2. Clinical record review on 8/3/2022, for Patient #9, start of care 12/27/2021, evidenced an agency document titled “Discharge Summary” dated 4/5/2022. Review failed to evidence the summary included the current medications and services received. Review indicated the goals were ongoing at time of discharge and failed to evidence which goals were ongoing. Review failed to evidence the summary was sent to the receiving healthcare practitioner.	G0564		

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G0564	Continued from page 49 During an interview on 8/8/2022, at 11:32 AM, Administrator #1 indicated she could not locate a fax confirmation page and could not say the discharge summary was sent to the physician. 3. Clinical record review on 8/7/2022, for Patient #10, start of care 11/15/2021, evidenced an agency document titled “Discharge Summary” dated 4/4/2022, indicated the patient transferred to a different home care agency. Review failed to evidence the summary included the current medications and services received. Review indicated the goals were ongoing at time of discharge and failed to evidence which goals were ongoing. Review failed to evidence the summary was sent to the receiving home care agency. During an interview on 8/8/2022, at 11:49 AM, Administrator #1 indicated the discharge summary was not sent to the receiving home care agency. 4. Clinical record review on 8/8/2022, for Patient #11, start of care 2/12/2019, evidenced an agency document titled “Discharge Summary” dated 4/25/2022, which failed to evidence the summary included the current medications and services received. Review indicated the goals were ongoing at time of discharge and failed to evidence which goals were ongoing. Review indicated the patient would continue receiving skilled nursing services through Agency M. Review failed to evidence the summary was sent to the receiving healthcare practitioner and Agency M. During an interview on 8/8/2022, at 11:43 AM, Administrator #1 indicated there was no documentation the discharge summary was sent to the physician and Agency M. 5. During an interview on 8/8/2022, at 11:32 AM, Administrator #1 indicated the agency faxes the discharge summaries to the physician responsible for the plan of care and should keep a fax confirmation to show the fax was sent. Administrator #1 indicated the summaries did not include the medications the patient was taking at time of discharge and the services provided by the agency and indicated it should be included.	G0564		
G0570	Care planning, coordination, quality of care CFR(s): 484.60	G0570		

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G0570	Continued from page 50 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. This CONDITION is NOT MET as evidenced by: An Immediate Jeopardy related to §484.60 Care Planning, Coordination of Services, and Quality of Care was identified and announced on 8/11/2022 at 2:45 PM and remained unabated upon survey exit on 8/15/2022. The IJ remained unabated upon exit of the re-visit conducted on 8/22/2022. The administrator was notified on 8/22/2022 at 4:20 PM. The IJ remained unremoved due to the agency's ongoing failure to ensure all plans of care contained wound care orders and failure to coordinate care with other entities to ensure the patients' needs were met. The agency, by their own admission, indicated on an IJ removal plan submitted 8/18/2022, a comprehensive assessment would be completed for Patients #5 and #7 to include wound locations and status of care provided by outside entities. Registered Nurse (RN) #8 indicated she did not assess the wounds for Patient #7. Review of wound documentation from the wound clinic and podiatrist evidenced wounds to the left thigh, left buttock, right foot and left foot the agency did not have included in the comprehensive assessment. Review of documents from the podiatrist indicated wound care was being provided by a home health agency 3 times a week. An interview with the wound clinic indicated the wound clinic was providing wound care weekly and home health was to provide wound care in between the care provided by the wound clinic. The alternate administrator indicated the agency providing skilled nursing for wound care had	G0570		

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G0570	Continued from page 51 discharged the patient and was unsure who was providing wound care. The IJ remained unabated upon exit of the re-visit conducted on 9/1/2022. The administrator was notified on 9/1/2022 at 1:45 PM. The IJ remained unremoved due to the agency's ongoing failure to ensure the services were provided as directed in the plans of care to meet the needs of the patient as assessed. Patient #5 had unassigned shifts on 8/26/2022, 8/28/2022, 8/31/2022 and 9/1/2022. The home health aide failed to arrive to the patient's home as scheduled on 8/20/2022, 8/29/2022, and 8/30/2022. The agency indicated on an IJ removal plan submitted 8/30/2022, audits of plans of care compared to the schedule would be completed, and the agency indicated the physician would be notified of patient's needs not met. The agency indicated other agencies involved in the patient's care would be coordinated with to ensure the patient's needs were met. Review failed to evidence the agency coordinated care with the agency providing skilled nursing care regarding the provision of home health aide services to meet the needs of the patient. Review failed to evidence the physician was notified of the agency's inability to meet the needs of the patient as ordered. During an interview with the patient, Patient #5 indicated he called the agency and left messages when his home health aide did not arrive as scheduled and his calls to the agency were not returned. Patient #5 indicated he sits up in his wheelchair until after midnight when his brother gets off work to come to his home and assist him to bed. The Immediate Jeopardy began on 8/1/2022 when record review evidenced the agency failed to provide home health aide services as ordered by the physician for patients #5 and #7 who had little to no mobility and lived alone. Review indicated Patient #5 has a diagnosis of quadriplegia, and the registered nurse (RN) assessed the patient to be dependent for personal care, transfers, toileting, and ambulation. The RN assessed the patient on 5/9/22 to have 11 wounds. Review of the plan of care indicated the agency was to provide home health aide services 3 hours a visit, 2 visits a day, 7 days a week. Review indicated the agency did not provide home health aide services on 6/5/2022, 6/12/2022, 6/14/2022-6/26/2022, 6/28/2022-7/1/2022, 7/3/2022, 7/5/2022-7/10/2022, 7/12/2022-7/17/2022, 7/20/2022-7/24/2022, and 7/31/2022. Review of	G0570		

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G0570	Continued from page 52 documents from the wound clinic dated 7/28/2022 indicated the patient had 15 wounds. Review indicated the patient had another agency providing skilled nursing services for wound care. Review failed to evidence the agency coordinated care with the agency providing skilled nursing services. Record review indicated Patient #7 has a diagnosis of paraplegia, and the RN assessed the patient to be personal care, transfers, toileting, and ambulation. The RN assessed the patient on 5/25/2022 to have an abrasion to the labia. Review of the plan of care indicated the agency was to provide home health aide services 6 hours a day, 7 days a week. Review failed to evidence the agency provided 6 hours a day of home health aide services on 6/5/2022-6/20/2022, 6/23/2022-7/15/2022, and 7/17/2022-7/30/2022. Review failed to evidence the agency provided a home health aide at all on 6/17/2022, 6/22/2022, and 7/16/2022. Review indicated the RN assessed the patient on 7/21/2022 to have a macerated labia and a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage III (an open pressure ulcer with full thickness loss of skin) to the left heel. Review indicated the patient had another agency providing skilled nursing services for wound care. Review failed to evidence the agency coordinated care with the agency providing skilled nursing services for wound care. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for the Condition of Participation 42 CFR 484.60 Care planning, coordination, and quality of care. Other unrelated conditions of participation and findings will be cited. Based on record review and interview, the home health agency failed to ensure the patient needs were met in regard to the provision of home health aide services and failed to ensure coordination of care with other agencies providing care to the patients in 2 of 2 clinical records reviewed with limited to no mobility and living at home alone without a live-in caregiver (#5, #7). This practice has the potential to affect all patients with limited mobility, patients at risk for skin impairment, and patients without a live-in caregiver. The findings include:	G0570		

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G0570	Continued from page 53 1. Review of an agency policy revised 1/4/2022, titled “Plan of Care” stated, “… Clients shall be accepted for care based on a reasonable expectation that the client’s health needs can be adequately met by the home health agency in the client’s place of residence. … Medical care shall follow a written medical plan of care established and periodically reviewed by the physician….” 2. Review of an agency policy revised 1/4/2022, titled “Coordination of Care” stated, “… Care conferences will be documented in communications of the EMR [electronic medical record] or in the plan of care. … Client care will be coordinated with other agencies in the home, dialysis facilities, physicians, caregivers in the home ….” 3. Clinical record review on 8/1/2022, for patient #5, start of care 11/11/2021, evidenced an untitled agency document dated 5/9/2022 and identified by the administrator as the comprehensive assessment completed by the RN. Review indicated the patient’s primary diagnosis was quadriplegia (paralysis from the neck down, including the trunk, legs, and arms) and lived at home alone with no willing or able caregiver. Review indicated the patient was dependent for transfers, personal care, bathing, toileting, and ambulation. Review indicated the patient had 11 wounds: left ankle, right ankle, left buttocks, left heel, right heel, right hip, left hip, right knee, left knee, right lower leg, and upper back. Review indicated the patient had a suprapubic catheter (a plastic tube surgically inserted into the bladder through the abdomen to drain urine from the body). Review indicated the patient received skilled nursing services 3 times a week from Agency A for wound and catheter care. Review evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 7/9/2022 – 9/6/2022. Review indicated the agency was to provide home health aide services 3 hours a visit, 2 visits a day, 7 days a week for personal care and assistance with ADLs (activities of daily living). Review indicated the agency did not provide home health aide services on 6/5/2022, 6/12/2022, 6/14/2022-6/26/2022, 6/28/2022-7/1/2022, 7/3/2022, 7/5/2022-7/10/2022, 7/12/2022-7/17/2022, 7/20/2022-7/24/2022, and	G0570		

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G0570	Continued from page 54 7/31/2022. Review indicated the agency failed to provide home health aide services for 2 visits on 6/8/2022, 6/13/2022, 6/27/2022, 7/2/2022, 7/4/2022, 7/11/2022, 7/18/2022, 7/19/2022, 7/26/2022, 7/27/2022, 7/29/2022, 8/2/2022, 8/5/2022, and 8/6/2022. Review of documents from the wound clinic at Hospital B dated 7/28/2022 indicated the patient had 15 wounds: left hip, right hip, left ankle, right ankle, right heel, left heel, right superior lower leg, right inferior lower leg, back, buttock, left lower leg, left superior lower leg, right foot, left foot, and left great toe. Review failed to evidence care coordination with Agency A and the wound clinic at Hospital B. During an interview on 8/3/2022, at 4:30 PM, the administrator indicated there was no attempts to coordinate care with Agency A since 5/10/2022. The administrator indicated she was unsure if another agency had been contacted to provide the patient with home health aide services to meet the patient's needs. During an interview on 8/4/2022, at 9:34 AM, the director of Agency A indicated there were no successful attempts to coordinate care with the agency. During an interview on 8/4/2022 at 1:58 PM, RN #3 indicated she was the case manager for the patient. RN #3 indicated Agency A sent a wound note in May 2022 but had not coordinated care with Agency A and stated, "I forgot about it." RN #3 indicated a home health aide for the patient had health issues and was taken off the schedule and indicated the patient is not getting the care he needs. RN #3 indicated there is not much the agency can do if they can not provide the staff for the patient. RN #3 indicated she has not called any other agencies to check if they could provide the services the patient requires, has not talked to the patient's brother regarding the lack of staffing, and has not talked with the physician about the agency's inability to provide the care as ordered. RN #3 indicated she does not have time because she has 40 plus clients. RN #3 indicated she was not aware the patient received care at the wound clinic at Agency A.	G0570		

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G0570	Continued from page 55 During an interview on 8/9/2022, at 10:31 AM, the patient indicated he was not satisfied with the care received from the agency and indicated he does not receive the services the agency told him he would receive. The patient indicated there are unfilled shifts and sometimes the aides never show up and when he calls the office, he does not get an answer on when a home health aide will arrive. The patient indicated he frequently has to call his brother to put him to bed when the home health aide does not show up, and indicated his brother is a surgeon and sometimes cannot come to help him until midnight. The patient indicated he does not like to call his brother because his brother is busy, and he does not like to burden him. The patient indicated he sometimes chooses to pay someone he knows $40 to help get him up or put him to bed when agency staffing does not come. The patient indicated he wishes to stay in his home and can do so if he had the assistance from the home health aide as he was told he would. 4. Clinical record review on 8/1/2022, for patient #7, start of care 4/2/2021, evidenced an untitled agency document the administrator identified as a comprehensive assessment dated 5/25/2022 and completed by the RN. Review indicated the patient's primary diagnosis was paraplegia (paralysis of the legs and lower body) and lived at home alone. Review indicated the patient was dependent for transfers, personal care, bathing, toileting, and ambulation. Review indicated the patient had an abrasion on her labia, had a suprapubic catheter, and had a colostomy (a surgically created hole in the abdomen to allow stool to collect outside of the body into a drainage bag). Review indicated Agency C provided skilled nursing services 3 times a week for wound care, suprapubic catheter care, and colostomy care. Review evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 7/26/2022 – 9/23/2022, which indicated the agency was to provide home health aide services 6 hours a day, 7 days a week for personal care and ADLs. Review failed to evidence the agency provided 6 hours a day of home health aide services on 5/30/2022, 6/2/2022, 6/3/2022, 6/5/2022-6/20/2022,	G0570		

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G0570	Continued from page 56 6/23/2022-7/15/2022, and 7/17/2022-7/30/2022. Review failed to evidence the agency provided a home health aide at all on 5/31/2022, 6/1/2022, 6/4/2022, 6/17/2022, 6/22/2022, and 7/16/2022. Review of an untitled agency document identified by the administrator as a comprehensive assessment completed by a RN and dated 7/21/2022, indicated the patient's labia was macerated and the patient had a pressure ulcer Stage III to the left heel. Review failed to evidence the agency coordinated care with Agency C. During an interview on 8/4/2022, at 3:00 PM, Administrator #1 indicated there was no coordination of care documented with Agency C regarding the skilled nursing plan of care. Administrator #1 indicated the patient can be difficult to staff due to her behavior towards staff. Administrator #1 indicated there was not any communication to the physician regarding the difficulty staffing the patient and the patient's behaviors. Administrator #1 indicated the agency had not reached out to any other agencies to inquire about finding the patient home health aide services to meet the patient's needs. During an interview on 8/4/2022 at 3:33 PM, RN #8 indicated she was the case manager for the patient. RN #8 indicated the patient was seen weekly by Physician D for wound care and indicated she has not called Physician D to coordinate care because she does not do anything with the patient's wound. RN #8 indicated the patient's wound to the labia has worsened from the comprehensive assessment in May to the comprehensive assessment in July. RN #8 indicated the labia was last assessed to be macerated with white fluid around the open areas and is more reddened. RN #8 indicated the patient is in a wheelchair most of the time and can not perform her own perineal (genital area) care. During an interview on 8/4/2022, at 3:56 PM, the director of Agency C indicated there was not any care coordination documented with the agency. Review on 8/22/2022 of documents from the wound clinic dated 8/12/2022 evidenced the patient had a	G0570		

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G0570	Continued from page 57 pressure ulcer stage II to the right labia/perineum, a pressure ulcer stage II left buttocks, and a second degree burn to the left thigh. Review indicated wound care to the right labia/perineum was to cleanse wound with chlorhexidine (a wound cleanser), loosely pack with alginate ribbon (an absorbent wound treatment) and cover with a foam dressing 2 times a week and as needed to keep clean and dry. Review indicated wound care to the left buttock and left thigh was to apply a duoderm (an absorbent, waterproof wound treatment) weekly and as needed. Review of documents from the podiatrist dated 8/8/2022 indicated the patient has wounds to the left foot 5th MPJ (metatarsophalangeal joint, the links between the toes and the main part of the foot), right foot 4th MPJ, and right foot 1st MPJ. Review indicated the patient receives home health services 3 times a week for wound care to the right and left feet. Review indicated the wounds to the right and left feet were to be cleansed with hibiclens (a wound cleanser), apply sulfadiazine (antibiotic), and wrap with kerlix. Review indicated the patient was to wear heel protectors, continue with wound care, and monitor feet daily for changes. Review of a comprehensive assessment completed by RN #8 on 8/12/2022, indicated the patient had a pressure ulcer stage III to the left heel which was bandaged, and patient reported the bandage was not to be removed. Review indicated maceration to the perineum was observed. Review failed to evidence assessments to the wounds to the left thigh and left buttock. Review indicated the agency who had been providing skilled nursing services for wound care and suprapubic catheter care had discharged the patient. Review indicated the patient was receiving wound care to the left heel from the podiatrist weekly and was receiving wound care for the perineum at the wound clinic. Review indicated the patient was going to go to the emergency room the following week for the suprapubic catheter change. Review indicated the patient's daughter does not assist with personal care and is available for emergencies only. Review failed to evidence the plan of care included wound care orders for the wounds to the left thigh, left buttock, right labia/perineum, and left heel and failed to evidence the patient was to wear heel protectors. During an interview on 8/22/2022, at 12:55 AM, the	G0570		

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G0570	Continued from page 58 alternate administrator indicated the skilled nursing agency providing wound care discharged the patient and was unsure who was providing wound care to the patient. The alternate administrator indicated the patient had temporarily moved in with her daughter who was not willing to provide wound care. During an interview on 8/22/2022, at 2:40 PM, when queried why the agency could not provide skilled nursing for wound care and suprapubic catheter care, Administrator #9 indicated the nurse case managers are case managers and not field staff. Administrator #9 indicated she was unsure who is caring for the suprapubic catheter. At 4:20 PM, Administrator #9 indicated the plan of care should include wound care orders and the nurse should assess all wounds and re-apply wound dressings unless there was an order to not remove a wound dressing. Administrator #9 indicated she was unsure why the RN documented there was a wound to the left heel when the podiatrist's notes indicated 2 wounds to the right foot MPJ area and 1 wound to the left foot MPJ area. Administrator #9 indicated she was unsure if the podiatrist was informed the skilled nursing agency previously providing wound care discharged the patient. During an interview on 8/22/2022, at 3:00 PM, RN #8 indicated she did not complete a wound assessment for the left thigh burn on 8/12/2022 because the patient did not tell her about the burn. RN #8 indicated she did not assess wound to the perineum and left buttock at the comprehensive assessment on 8/12/2022 due to the patient did not want to get into the bed so the nurse could assess the wounds. RN #8 indicated she did not complete an assessment to the wound to the left heel because the foot was wrapped, and the patient told her not to remove the dressing. RN #8 indicated the wound clinic was to care for the suprapubic catheter and the wound to the perineum and left buttock and the podiatrist was to care for the wound to the left heel. During an interview on 8/23/2022, at 10:51 AM, the provider at the wound clinic indicated the wound clinic is not caring for the suprapubic catheter and is providing wound care 1 time a week. The provider at the wound clinic indicated their impression was there was a home health agency providing wound care in between wound clinic visits.	G0570		

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G0570	Continued from page 59 5. Review of agency documents on 7/19/2022 titled "Client Admission Listing" and "Discharged Admissions" evidenced the agency admitted 38 patients since 4/1/2022. During an interview on 8/4/2022, at 3:20 PM, the clinical manager indicated the governing body was pushing patient admissions despite the lack of adequate staffing to ensure the services were provided as directed in the plan of care. During an interview on 8/4/2022, at 4:45 PM, Administrative Staff #4, governing body member, indicated the lack of staff was a known issue and indicated the agency was still going to grow the business by accepting new patient referrals if they had staff available to work with the new patient while recruiting additional staff to increase staffing levels. 410 IAC 17-13-1(a)	G0570		
G0572	Plan of care CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure home health aide services were provided to the patient as directed in the plan of care in 4 of 6 active clinical records reviewed with home health aide services. (#4, 5, 6, 7) The findings include: 1. Review of an agency policy revised 1/4/2022, titled "Plan of Care" stated, "… Medical care should follow a written medical plan of care established and periodically reviewed by the	G0572		

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G0572	Continued from page 60 physician…." 2. Clinical record review on 8/1/2022, for patient #5, start of care 11/11/2021, evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 7/9/2022 – 9/6/2022. Review indicated the agency was to provide home health aide services 3 hours a visit, 2 visits a day, 7 days a week for personal care and assistance with ADLs (activities of daily living). Review indicated the agency did not provide home health aide services as ordered on 6/5/2022, 6/12/2022, 6/14/2022-6/26/2022, 6/28/2022-7/1/2022, 7/3/2022, 7/5/2022-7/10/2022, 7/12/2022-7/17/2022, 7/20/2022-7/24/2022, and 7/31/2022. Review indicated the agency failed to provide home health aide services for 2 visits on 6/8/2022, 6/13/2022, 6/27/2022, 7/2/2022, 7/4/2022, 7/11/2022, 7/18/2022, 7/19/2022, 7/26/2022, 7/27/2022, 7/29/2022, 8/2/2022, 8/5/2022, and 8/6/2022. During an interview on 8/4/2022 at 1:58 PM, RN #3 indicated she was the case manager for the patient. RN #3 indicated a home health aide for the patient had health issues and was taken off the schedule and indicated the patient was not getting the care he needed. RN #3 indicated there was not much the agency can do if they cannot provide the staff for the patient. 3. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 5/27/2022-7/25/2022, which indicated the agency was to provide home health aide services 6 hours a day, 7 days a week. Review failed to evidence the agency provided 6 hours a day of home health aide services on 6/5/2022-6/20/2022, 6/23/2022-7/15/2022, and 7/17/2022-7/30/2022. Review failed to evidence the agency provided a home health aide at all on 6/17/2022, 6/22/2022, and 7/16/2022. During an interview on 8/4/2022, at 3:00 PM, the administrator indicated the patient was difficult to staff due to the patient's treatment of staff. The administrator indicated the agency keeps trying to find new staff to provide home health aide services to the patient. 4. Clinical record review on 8/3/2022, for Patient	G0572		

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G0572	Continued from page 61 #4, start of care 6/3/2020, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 5/24/2022-7/22/2022 which indicated the agency was to provide home health aide services 2 hours a day, 3 days a week. Review indicated the agency failed to provide the home health aide 3 days a week as directed in the plan of care during the weeks of 6/26/2022 and 7/3/2022. During an interview on 8/8/2022, Administrator #1 indicated the home health aide was sick and there were no alternate days offered to the patient in order to meet the patient’s ordered frequency. 5. Clinical record review on 8/1/2022, for Patient #6, start of care 5/25/2021, evidenced agency documents titled “Home Health Certification/Recertification Plan of Care Order” for certification periods 5/3/2022-7/1/2022 and 7/2/2022-8/30/2022, which indicated the agency was to provide home health aide services 6 hours a day, 4 days a week. Review indicated the agency did not provide home health aide services 4 days a week per the plan of care during the weeks of 6/5/2022, 6/26/2022, and 7/24/2022. Review failed to evidence the agency provided 6 hours a day of home health aide services per the plan of care on 7/2/2022, 7/5/2022, and 7/23/2022. During an interview on 8/4/2022, at 2:22 PM, Administrator #1 indicated during the week of 6/5/2022 and 6/27/2022, the home health aide called off. Administrator #1 indicated there were no documented attempts to reschedule the visits. 17-13-1(a)	G0572		
G0574	Plan of care must include the following CFR(s): 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;	G0574		

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G0574	Continued from page 62 (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to ensure the plan of care was individualized to include medications, frequency of visits, caregiver information, treatments and services, and safety measures in 8 of 8 active clinical records reviewed. (#1, 2, 3, 4, 5, 6, 7, 8) The findings include: 1. Review of an agency policy revised 1/4/2022, titled “Plan of Care” stated, “… The plan of care/treatment shall cover pertinent diagnoses … types of services and equipment required, frequency of visits … medications and treatments … Any additional items the agency or physician may choose to include ….”	G0574		

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G0574	Continued from page 63 2. Review of an agency policy revised 1/4/2022, titled “Physician Orders” stated, “… Orders for PRN [as needed] as needed medications must include … reason for use … Range orders are not acceptable for medications….” 3. During an observation of care on 8/2/2022, at 10:06 AM, at the home of Patient #1, start of care 11/26/2019, the patient was observed wearing heel protectors to both feet. At 10:33 AM, a bottle labeled Lactulose (medication used to treat constipation) was observed with the patient’s medication. During an interview on 8/2/2022, at 10:33 AM, the patient’s caregiver indicated the patient was treated at the urgent care on 7/20/2022 for constipation and lactulose was ordered by the urgent care physician to use as needed for constipation. Clinical record review on 8/3/2022 evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 7/13/2022-9/10/2022, which indicated the patient had a gastrostomy (a surgically inserted tube into the stomach through the abdomen to provide fluid, nutrition, and/or medication) and was NPO (not able to eat or drink by mouth). The document indicated the nurse was to encourage the patient to remain in an upright position when eating/drinking, to eat slowly, and chew small bites thoroughly. Review failed to evidence the plan of care included individualized safety precautions related to the patient’s NPO status. Review failed to evidence the plan of care included heel protectors. Review indicated the patient’s medications included, but were not limited to, albuterol ipratropium as needed for lung disease. Review failed to indicate for what symptoms of lung disease the patient was to take albuterol ipratropium. Review failed to evidence the plan of care included lactulose in the patient’s medication. During an interview on 8/5/2022, at 4:01 PM, Administrator #1 indicated the direction for the nurse to encourage upright position while eating, eating small bites slowly and thoroughly should not have been included in the plan of care. Administrator #1 indicated it might have been a standard order for a patient with a gastrostomy but it should have been changed. Administrator #1	G0574		

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G0574	Continued from page 64 indicated she was unsure how long the patient was to wear the heel protectors and did not see it included in the plan of care. Administrator #1 indicated she was unsure what the direction was for when the patient was to take albuterol ipratropium and indicated the plan of care should be individualized to include patient-specific symptoms. Administrator #1 indicated the lactulose should have been added to the plan of care. 4. Clinical record review on 8/1/2022, for Patient #5, start of care 11/11/2021, evidenced an untitled agency document dated 7/6/2022 and was identified by the administrator as the comprehensive assessment completed by the registered nurse (RN). Review indicated the patient's primary diagnosis was quadriplegia (paralysis from the neck down, including the trunk, legs, and arms) and they lived at home alone. Review indicated the patient was dependent for transfers, personal care, bathing, toileting, and ambulation. Review indicated the patient's brother helped with care but worked full time and was on-call as a surgeon. Review indicated there was no other willing or able caregiver. Review indicated the patient had a suprapubic catheter (a plastic tube surgically inserted into the bladder through the abdomen to drain urine from the body). Review indicated Agency A was providing skilled nursing care 3 times a week for catheter care. Review evidenced an agency document titled "Plan of Care Service Plan" dated 7/5/2022, and identified by the administrator as the home health aide care plan. Review indicated the home health aide was assigned to empty the catheter bag. Review evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 7/9/2022 – 9/6/2022. Review failed to evidence the plan of care included the patient's suprapubic catheter. Review indicated the patient/family was to assume care in the absence of agency staff. During an interview on 8/3/2022, at 4:48 PM, Administrator #1 indicated the plan of care should include the suprapubic catheter to include the type and size of the catheter, the frequency of the catheter changes and who was providing catheter care. Administrator #1 indicated the patient cannot provide self care and was unsure who provided care in the absence of the agency staff. Administrator #1 indicated case managers	G0574		

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G0574	Continued from page 65 are instructed to include the patient/family that was to assume care in the absence of the agency's staff in the plan of care. 5. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced the agency provided home health aide services 2 visits per day on 6/6/2022, 6/7/2022, 6/8/2022, 6/14/2022, and 6/21/2022. Review of an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 5/27/2022-7/25/2022 failed to evidence the agency was to provide home health aide services for multiple visits a day. Review evidenced the patient's medications included, but were not limited to, dextromethorphan/guaifenesin/phenylephrine (medication used to treat cough and congestion) every 4-6 hours and buspirone (medication used to treat anxiety) every 8-12 hours. Review failed to evidence the directions for when the patient should take dextromethorphan/guaifenesin/phenylephrine and buspirone during the range of time. During an interview on 8/4/2022, at 2:35 PM, Administrator #1 indicated the plan of care indicated the home health aide was to get 1 visit per day and stated, "We were told not to write the number of visits a day." Administrator #1 indicated the plan of care was not individualized per the patient need. At 2:47 PM, Administrator #1 indicated the nurse should have called the physician to clarify the frequency of the medication. 6. Clinical record review on 8/2/2022, for Patient #2, start of care 4/12/2022, evidenced an untitled agency document identified by the administrator as the comprehensive assessment completed by the RN on 6/6/2022, which indicated the patient was independent for medication administration. Review evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 6/11/2022-8/9/2022, which indicated the home health aide was to assist with nail care and give medication reminders. Review failed to evidence the plan of care was specific to the needs of the patient. Review of an agency document titled "Plan of Care	G0574		

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G0574	Continued from page 66 Service Plan", signed and dated by the RN on 6/6/2022 and identified by the administrator as the home health aide care plan, failed to indicate nail care and medication reminders were included in the home health aide care plan. During an interview on 8/5/2022, at 4:40 PM, Administrator #1 indicated nail care and medication reminders should not be included on the plan of care and should be patient specific. 7. Clinical record review on 8/3/2022, for Patient #3, start of care 5/5/2021, evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 6/30/2022-8/28/2022 which evidenced the patient's inner tracheostomy (a surgically created hole in the neck to assist the patient's breathing) tube was to be changed twice daily as needed. Review failed to evidence for what indications the tracheostomy should be changed. During an interview on 8/5/2022, at 4:47 PM, Administrator #1 indicated she did not know for what reasons the inner tracheostomy should be changed and indicated the plan of care should include the patient specific reasons for the change as needed. 8. Clinical record review on 8/3/2022, for Patient #4, start of care 6/3/2020, evidenced an untitled agency document identified by the administrator as the comprehensive assessment completed by the RN on 7/22/2022, which indicated the patient was independent for toileting and medication management. Review indicated the patient used a CPAP machine (a medical device used to assist with breathing) while sleeping. Review evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 7/23/2022-9/20/2022 which indicated the home health aide was to assist with incontinent care and give medication reminders. Review failed to evidence the plan of care included a CPAP machine for the patient's required medical equipment. During an interview on 8/8/2022, at 11:10 AM, Administrator #1 indicated the home health aide order on the plan of care was standardized and not individualized to reflect the patient's needs. Administrator #1 indicated the CPAP machine should	G0574		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELP AT HOME SKILLED CARE	**833 W LINCOLN HIGHWAY SUITE 330 E , SCHERERVILLE, Indiana, 46375**

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G0574	Continued from page 67 have been included in the plan of care. 9. Clinical record review on 8/1/2022, for Patient #6, start of care 5/25/2021, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 7/2/2022-8/30/2022, which indicated the agency was to provide home health aide services. Review failed to evidence what services the home health aide was to provide. During an interview on 8/4/2022, at 2:21 PM, Administrator #1 indicated the plan of care typically indicated the home health aide was for personal care and activities of daily living (ADLs). 10. Clinical record review on 8/2/2022, for Patient #8, start of care 2/17/2021, evidenced an untitled agency document identified by the administrator as the comprehensive assessment completed by the RN on 6/10/2022, which indicated the patient was able to administer medications per self from a pre-filled mediplanner. Review of an agency document titled “Plan of Care Service Plan”, signed and dated by the RN on 6/20/2022 and identified by the administrator as the home health aide care plan, failed to indicate medication reminders were included in the home health aide care plan. Review evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 6/12/2022-8/10/2022 which indicated the home health aide was to give medication reminders. Review failed to evidence the plan of care was individualized to include the needs of the patient. During an interview on 8/5/2022, at 3:23 PM, Administrator #1 indicated the nurse should remove whatever was not specific to the patient from the plan of care. 17-13-1(a)(1)(D)(ii, iii, ix, x, xiii	G0574		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed	G0580		

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G0580	Continued from page 68 practitioner. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to provide services as only ordered by a physician in 3 of 8 active clinical records reviewed. (#1, 4, 7) The findings include: 1. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced an agency document titled “Physician Order” dated 7/22/2022. Review evidenced the agency’s registered nurse (RN) spoke to a RN at the physician’s office for an order for continuation of care for home care services for the next 60 days. Review failed to evidence the order was received by an authorized healthcare personnel authorized to order services. Review evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 7/26/2022-9/23/2022, which was not signed by the physician. Review evidenced home health aide services were provided 7/26/2022-8/6/2022 for personal care and assistance with activities of daily living (ADL). Review failed to evidence a physician order for services after the certification period expired on 7/25/2022. During an interview on 8/4/2022, at 2:44 PM, Administrator #1 indicated there were no orders for care from a physician since the plan of care expired on 7/25/2022. 2. During an observation of care on 8/2/2022, at 10:12 AM, at the home of Patient #1, start of care 11/26/2019, licensed practical nurse (LPN) #1 was observed administering a liquid the LPN identified as a multivitamin into a tube inserted into the patient’s abdomen. Clinical record review on 8/3/2022 evidenced agency documents titled “Private Duty Nursing Flow Sheet” completed by the skilled nurse and dated 7/19/2022, 7/21/2022, 7/26/2022 and 7/28/2022, which indicated the nurse administered scheduled medications. Review failed to evidence an order for the administration of medications.	G0580		

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G0580	Continued from page 69 During an interview on 8/5/2022, at 4:20 PM, Administrator #1 indicated there was not an order for the skilled nurse to administer medications. 3. Clinical record review on 8/3/2022, for Patient #4, start of care 6/3/2020, evidenced a “Physician Order” dated 7/25/2022. Review indicated the agency’s RN spoke to a RN at the physician’s office for an order for continuation of care for home care services for the next 60 days. Review failed to evidence the order was given by an authorized healthcare personnel, authorized to order services. Review evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 7/23/2022-9/20/2022, which was not signed by the physician. Review evidenced home health aide services were provided 7/25/2022, 7/27/2022, and 7/29/2022 for personal care and assistance with ADLs. Review failed to evidence a physician order for services after the certification period expired on 7/22/2022. During an interview on 8/8/2022, at 11:04 AM, Administrator #1 indicated the agency did not have any orders from the physician since the expiration of the plan of care on 7/22/2022 until the plan of care beginning 7/23/2022 was signed by the physician on 8/4/2022. 4. During an interview on 8/4/2022, at 2:44 PM, Administrator #1 indicated verbal orders should be taken from a physician or a nurse practitioner. 17-13-1(a)	G0580		
G0584	Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner	G0584		

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G0584	Continued from page 70 responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure verbal orders were documented and authenticated in 1 of 3 active clinical records reviewed with wounds. (#7) The findings include: Review of an agency policy revised 1/4/2022, titled "Physician Orders" stated, "… Verbal orders must be authenticated and dated by the physician in accordance with applicable state law and regulations …." Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced an untitled agency document identified by the administrator as a comprehensive assessment dated 7/21/2022, which indicated the patient had maceration to the labia. During an interview on 8/4/2022, at 3:33 PM, RN #8 indicated the maceration to the patient's labia was worsening and when she contacted the physician to get a treatment order, the physician responsible for the plan of care ordered the patient to the emergency room for treatment. RN #8 indicated she did not write the verbal order for the patient to go to the emergency room because the order was not a treatment. RN #8 indicated she should have written the order to cover herself.	G0584		
G0588	Reviewed, revised by physician every 60 days CFR(s): 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date.	G0588		

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G0588	Continued from page 71 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the plan of care was reviewed by the physician responsible for the plan of care no less than every 60 days in 4 of 8 active clinical records reviewed. (#1, 3, 4, 8) The findings include: 1. Review of an agency policy revised 1/4/2022, titled “Plan of Care” stated, “… The total medical plan of care shall be reviewed by the physician and home health agency personnel as often as the severity of the client’s condition requires, but at least once every sixty (60) days….” 2. Clinical record review on 8/3/2022, for Patient #1, start of care 11/26/2019, evidenced agency documents titled “Home Health Certification/Recertification Plan of Care Order”. Review of the document for certification period 5/14/2022-7/12/2022 evidenced it was signed by the physician on 5/13/2022. Review of the document for certification period 7/13/2022-9/10/2022 evidenced it was signed by the physician on 7/28/2022. Review failed to evidence the plan of care was reviewed by the physician at least every 60 days. During an interview on 8/5/2022, at 4:21 PM, Administrator #1 indicated the nurse was late to send the physician the plan of care to review on 7/27/2022. 3. Clinical record review on 8/3/2022, for Patient #3, start of care 5/5/2021, evidenced agency documents titled “Home Health Certification/Recertification Plan of Care Order”. Review of the document for certification period 3/2/2022-4/30/2022 was signed by the physician on 3/8/2022. Review of the document for certification period 5/1/2022-6/29/2022 was signed by the physician on 6/22/2022. Review failed to evidence the plan of care was reviewed by the physician at least every 60 days. 4. Clinical record review on 8/3/2022, for Patient #4, start of care 6/3/2020, evidenced agency documents titled “Home Health Certification/Recertification Plan of Care Order”. Review evidenced the document for certification period 3/25/2022-5/23/2022 was signed by the physician on 3/25/2022. Review evidenced the document for certification period	G0588		

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G0588	Continued from page 72 5/24/2022-7/22/2022 was signed by the physician on 6/14/2022. Review failed to evidence the plan of care was reviewed by the physician at least every 60 days. 5. Clinical record review on 8/2/2022, for Patient #8, start of care 2/17/2021, evidenced agency documents titled “Home Health Certification/Recertification Plan of Care Order”. Review evidenced the document for certification period 2/12/2022-4/12/2022 was signed by the physician on 2/15/2022. Review evidenced the document for certification period 4/13/2022-6/11/2022 was signed by the physician on 5/3/2022. Review failed to evidence the plan of care was reviewed by the physician at least every 60 days. 6. During an interview on 8/8/2022, at 11:09 AM, Administrator #1 indicated the agency should resend the plan of care every week to the physician until it returns signed. The administrator indicated the branch manager should be involved in making sure the plans of care are signed no later than every 60 days by the physician. 17-13-1(a)(2)	G0588		
G0590	Promptly alert relevant physician of changes CFR(s): 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to notify the physician of changes in the patient’s status in 4 of 8 active clinical records reviewed. (#1, 5, 7, 8) The findings include: 1. Review of an agency policy revised 1/4/2022, titled “Plan of Care” stated, “… The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the client’s care to any changes that suggest a need to alter the medical	G0590		

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G0590	Continued from page 73 plan of care. … Home health agency personnel shall promptly notify a client's physician or other appropriate licensed professional staff and legal representative, if any, of any significant physical or mental changes observed or reported by the client…." 2. During an interview on 8/2/2022, at 10:33 AM, the caregiver for patient #1, start of care 11/26/2019, indicated the patient was treated at the urgent care on 7/20/2022 for constipation and lactulose (a medication used to treat constipation) was ordered by the urgent care physician to use as needed for constipation. Clinical record review on 8/3/2022 failed to evidence an order for lactulose. Review failed to evidence the physician responsible for the plan of care was notified of the patient's urgent care visit and treatment of constipation to include the new medication, lactulose. During an interview on 8/5/2022, at 4:09 PM, Administrator #1 indicated she could not find any documented communication with the physician regarding the patient's constipation and urgent care visit and indicated there was not a physician's order for lactulose. 3. Clinical record review on 8/1/2022, for patient #5, start of care 11/11/2021, evidenced an untitled agency document dated 7/6/2022 and identified by the administrator as the comprehensive assessment completed by the registered nurse (RN). Review indicated the patient had 11 wounds: left ankle, right ankle, left buttocks, left heel, right heel, right hip, left hip, right knee, left knee, right lower leg, and upper back. Review of documents from the wound clinic at Hospital B dated 7/28/2022 indicated the patient had 15 wounds: left hip, right hip, left ankle, right ankle, right heel, left heel, right superior lower leg, right inferior lower leg, back, buttock, left lower leg, left superior lower leg, right foot, left foot, and left great toe. Review failed to evidence the physician was notified of the new wounds to the right foot, left foot, left great toe, and the second wound to the right lower leg. During an interview on 8/4/2022, at 1:56 AM, Administrator #1 indicated the RN should contact	G0590		

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G0590	Continued from page 74 the physician with any new wounds and indicated she did not see any documentation the physician was notified of the 4 additional wounds. Review was conducted of an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 7/9/2022 – 9/6/2022. Review indicated the agency was to provide home health aide services 3 hours a visit, 2 visits a day, 7 days a week for personal care and assistance with ADLs (activities of daily living). Review indicated the agency did not provide home health aide services as ordered on 6/5/2022, 6/12/2022, 6/14/2022-6/26/2022, 6/28/2022-7/1/2022, 7/3/2022, 7/5/2022-7/10/2022, 7/12/2022-7/17/2022, 7/20/2022-7/24/2022, and 7/31/2022. Review indicated the agency failed to provide home health aide services for 2 visits on 6/8/2022, 6/13/2022, 6/27/2022, 7/2/2022, 7/4/2022, 7/11/2022, 7/18/2022, 7/19/2022, 7/26/2022, 7/27/2022, 7/29/2022, 8/2/2022, 8/5/2022, and 8/6/2022. Review failed to evidence the physician was notified the agency did not provide home health aide services as ordered during the week of 7/3/2022 and 7/24/2022. During an interview on 8/3/2022, at 4:20 PM, Administrator #1 indicated the agency faxed to the physician missed visit notifications. The administrator indicated she was unsure if the physician received or reviewed the faxed missed visit notifications and indicated there was no documentation agency personnel discussed the agency's inability to provide home health aide services as ordered with the physician. During an interview on 8/4/2022, at 1:58 PM, RN #3 indicated she was the case manager for the patient. RN #3 indicated a home health aide for the patient had health issues and was taken off the schedule and indicated the patient was not getting the care he needs. RN #3 indicated she has not talked with the physician about the agency's inability to provide the care as ordered. RN #3 indicated she does not have time because she has 40 plus clients. 4. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 5/27/2022-7/25/2022, which indicated the agency was to provide home health aide services 6 hours a day, 7 days a week.	G0590		

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G0590	Continued from page 75 Review failed to evidence the agency provided 6 hours a day of home health aide services on 6/5/2022-6/20/2022, 6/23/2022-7/15/2022, and 7/17/2022-7/30/2022. Review failed to evidence the agency provided a home health aide at all on 6/17/2022, 6/22/2022, and 7/16/2022. During an interview on 8/4/2022, at 3:00 PM, Administrator #1 indicated the patient was difficult to staff due to the patient's treatment of staff. The administrator indicated there was no documentation in the clinical record with the patient's physician of the patient's difficult behavior was affecting the agency's ability to staff. Review evidenced an untitled agency document identified by the administrator as a comprehensive assessment dated 7/21/2022, which indicated the patient had a new pressure ulcer pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage III (an open pressure ulcer with full thickness loss of skin) to the left heel. Review indicated the patient is seen weekly by the podiatrist for wound care. Review failed to evidence the agency notified the physician of the new wound to the left heel and the services provided by the podiatrist weekly. Review indicated the patient had maceration to the labia. During an interview on 8/4/2022, at 3:33 PM, RN #8 indicated she had not communicated with the physician regarding the weekly wound care provided by the podiatrist. RN #8 indicated she did not notify the physician responsible for the plan of care regarding the wound to the patient's left heel because Agency C managed the patient's wounds. RN #8 indicated the maceration to the patient's labia was worsening and when she contacted the physician to get a treatment order, the physician responsible for the plan of care ordered the patient to the emergency room for treatment. RN #8 indicated the patient refused to go to the emergency room and she did not inform the physician of the patient's refusal to go to the emergency room. During an interview on 8/4/2022, at 4:02 PM, Administrator #1 indicated the RN should have informed the physician of the patient's refusal to go to the emergency room as ordered. 5. Clinical record review on 8/2/2022, for Patient	G0590		

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G0590	Continued from page 76 #8, start of care 2/17/2021, evidenced an untitled agency document the administrator identified as the comprehensive assessment, dated 6/10/2022, which indicated the patient had no skin breakdown. During an interview on 8/2/2022, at 11:20 AM, Administrator #1 indicated the patient had a debridement to a wound on the foot and a wound drain was placed in the foot. Review of an agency document titled “Activity Individual” dated 8/5/2022 indicated the podiatrist debrided a wound to an unidentified location and placed a wound vac (a medical device used to drain fluid/drainage from an area using vacuum pressure). Review failed to evidence the primary care physician responsible for the plan of care was notified of the new wound and treatment provided by the podiatrist. During an interview on 8/5/2022, at 3:52 PM, Administrator #1 indicated there was no documentation of communication with the physician responsible for the plan of care regarding the new wound and treatment provided by the podiatrist. 17-13-1(a)(2)	G0590		
G0606	Integrate all services CFR(s): 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to coordinate care with other agencies providing services to the patient in 3 of 3 clinical records reviewed receiving services from another home care agency. (#1, 5, 7) The findings include: 1. Review of an agency policy revised 1/4/2022, titled “Coordination of Care” stated, “… Care conferences will be documented in communications of the EMR [electronic medical record] or in the plan of care. … Client care will be coordinated	G0606		

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HELP AT HOME SKILLED CARE	833 W LINCOLN HIGHWAY SUITE 330 E , SCHERERVILLE, Indiana, 46375

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G0606	Continued from page 77 with other agencies in the home, dialysis facilities, physicians, caregivers in the home … The plan of care will be provided to the others involved in the client's care and we will also request a copy of their plan of care. This will be documented in the client records." 2. Review of an agency policy revised 1/4/2022, titled "Plan of Care" stated, "… Care will be coordinated initially and ongoing among staff and other agencies providing care. Care planning for each client will be individualized to include: Problems and needs … Goals based on problems, needs conditions, wishes, and ability to respond to care or services … Specific care or services to be provided including frequency, type, and duration … Implementation of actions and interventions …." 3. Clinical record review on 8/3/2022, for Patient #1, start of care 11/26/2019, evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 7/13/2022-9/10/2022, which indicated Agency H provided skilled nursing services for 8 hours a day, 5 days a week. During an interview on 8/2/2022, at 10:33 AM, the patient's caregiver indicated the patient was treated at the urgent care on 7/20/2022 for constipation and lactulose (a medication used to treat constipation) was ordered by the urgent care physician to use as needed for constipation. Review failed to evidence coordination of care with Agency H regarding the patient's urgent care visit and treatment of constipation to include a new medication, lactulose. During an interview on 8/5/2022, at 4:09 PM, Administrator #1 indicated there was not any care coordination in the clinical record with Agency H regarding the patient's urgent care visit and new medication. The administrator indicated there were no attempts to request the plan of care from Agency H. 4. Clinical record review on 8/1/2022, for Patient #5, start of care 11/11/2021, evidenced an untitled agency document dated 5/9/2022 and identified by the administrator as the comprehensive assessment completed by the registered nurse (RN). Review indicated the patient received skilled nursing services 3 times	G0606		

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G0606	Continued from page 78 a week from Agency A for wound and catheter care. Review failed to evidence care coordination with Agency A and the wound clinic at Hospital B to include requests for a copy of their plans of care per agency policy. Review of documents from the wound clinic at Hospital B dated 7/28/2022 indicated the patient had 15 wounds: left hip, right hip, left ankle, right ankle, right heel, left heel, right superior lower leg, right inferior lower leg, back, buttock, left lower leg, left superior lower leg, right foot, left foot, and left great toe. Review failed to evidence care coordination with Agency A and the wound clinic at Hospital B. During an interview at the entrance conference on 7/19/2022, at 12:15 PM, Administrator #1 indicated care coordination was completed every 60 days with the recertification and should be done over the phone with the other entities providing care. During an interview on 8/3/2022, at 4:30 PM, Administrator #1 indicated the agency should send the other agencies involved in the patient's care a copy of the patient's plan of care and request a copy of the patient's plan of care with the other agency. The administrator indicated there were no attempts to coordinate care with Agency A since 5/10/2022. During an interview on 8/4/2022, at 9:34 AM, the director of Agency A indicated there were no successful attempts to coordinate care with the agency. During an interview on 8/4/2022 at 1:58 PM, RN #3 indicated she was the case manager for the patient. RN #3 indicated Agency A sent a wound note in May 2022 but had not coordinated care with Agency A and stated, "I forgot about it." RN #3 indicated she was not aware the patient received care at the wound clinic at Agency A. 4. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced untitled agency documents identified by the administrator as comprehensive assessments dated 5/25/2022 and 7/21/2022, signed by the RN. Review indicated the patient received skilled nursing services from Agency C 3 times a week for wound care, colostomy (a surgically-created opening in the abdomen to allow stool to drain from the body) care, and catheter changes. Document dated 7/21/2022	G0606		

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G0606	Continued from page 79 indicated the patient was seen weekly by physician D for wound care. Review failed to evidence care coordination with Agency C and Physician D to include requests for a copy of the plan of care per agency policies. During an interview on 8/4/2022, at 3:00 PM, Administrator #1 indicated there was no documented care coordination with Agency C and Physician D in the clinical record to include requests for the plans of care. During an interview on 8/4/2022, at 3:33 PM, RN #8 indicated she was the case manager for the patient. RN #8 indicated she had not coordinated care with Physician D. RN #8 indicated she had not requested a copy of the plan of care from Agency #8. 17-12-2(h)	G0606		
G0614	Visit schedule CFR(s): 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to provide the patient and caregiver in writing with a copy of the visit schedule in 1of 4 home visits conducted. (#1) The findings include: Review of an agency document revised 11/2019 titled “Patient’s Bill of Rights/Responsibilities and Transfer/Discharge Criteria” stated, “… Patients have the right: … To be informed of: Visit schedule and frequency.…” During an observation of care on 8/2/2022 at 10:20 AM, at the home of patient #1, start of care 11/26/2019, an agency folder was observed. A written copy of the visit schedule was observed in the patient’s home dated 9/1/2021-10/31/2021. No current visit schedule was observed in the patient’s home. During an interview on 8/2/2022, at 10:20 AM, the patient’s caregiver indicated she use to get a	G0614		

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G0614	Continued from page 80 copy of the visit schedule from the agency but has not received one in awhile. During an interview on 8/5/2022, at 10:24 AM, Administrator #1 indicated the agency should provide a written calendar of the scheduled visits or the agency staff should complete a blank calendar left in the patient's home with the date and time the staff is to visit next.	G0614		
G0618	Treatments and therapy services CFR(s): 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to provide the patient and caregiver in writing with the treatments to be administered by agency personnel in 2 of 2 home visits conducted with a skilled nurse. (#1, 3) The findings include: 1. Review of an agency document revised 11/2019 titled "Patient's Bill of Rights/Responsibilities and Transfer/Discharge Criteria" stated, "… Patients have the right: … To be informed of: ... Treatments to be administered by Agency staff.…" 2. During an observation of care on 8/2/2022 at 10:20 AM, at the home of patient #1, start of care 11/26/2019, an agency folder was observed. A plan of care for the certification period 5/14/2022-7/12/2022 was observed in the folder. A current plan of care with services and treatments provided by the agency was not observed. 3. During an observation of care on 8/4/2022, at 10:19 AM, at the home of Patient #3, start of care 5/5/2021, an agency folder was observed. A plan of care for the certification period 5/6/2021-7/4/2021 was observed in the home. A current plan of care with the services and treatments provided by the agency was not observed. 4. During an interview on 8/5/2022, at 10:27 AM, Administrator #1 indicated the agency should provide the patient with a copy of the current	G0618		

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G0618	Continued from page 81 plan of care to inform the patient in writing of the services and treatments to be provided by the agency.	G0618		
G0622	Name/contact information of clinical manager CFR(s): 484.60(e)(5) Name and contact information of the HHA clinical manager. This ELEMENT is NOT MET as evidenced by: Based on observation, record review and interview, the agency failed to provide the patient and caregiver in writing with the name and contact information of the clinical manager in 3 of 4 home visits conducted. (#1, 2, 3) The findings include: 1. During an observation of care on 8/2/2022 at 10:20 AM, at the home of Patient #1, start of care 11/26/2019, an agency folder was observed. The name and contact information for the clinical manager was not observed. Clinical record review on 8/3/2022 evidenced an agency document titled “Patient’s Bill of Rights/Responsibilities and Transfer/Discharge Criteria” signed and dated by the patient’s caregiver on 7/20/2020, which indicated Person I was the agency administrator and Person J was the clinical manager. 2. During an observation of care on 8/3/2022, at 7:59 AM, at the home of Patient #2, start of care 4/12/2022, an agency folder was observed. The name and contact information for the clinical manager was not observed. 3. During an observation of care on 8/4/2022, at 10:19 AM, at the home of Patient #3, start of care 5/5/2021, an agency folder was observed. The name of the clinical manager listed in the agency folder was for Person J. 4. During an interview on 8/5/2022, at 10:24 AM, Administrator #1 indicated the name and contact information for the clinical manager should be provided to the patient in writing in the agency folder provided to the patient in the home. Administrator #1 indicated Person J was a previous clinical manager for the agency.	G0622		

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G0622 G0640	Quality assessment/performance improvement CFR(s): 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the quality assurance and performance improvement (QAPI) program failed to measure, analyze and track quality indicators and other aspects of performance that enable the agency to assess processes of care, agency services and operations (see tag G642); to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement (see G644); to focus on high risk areas (see tag G648); to lead to an immediate correction of any identified problem that directly or potentially threatens the health and safety of patients (see G652); and to conduct performance improvement projects (see G658). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 484.65 Quality Assessment / Performance Improvement.	G0622 G0640		
G0642	Program scope CFR(s): 484.65(a)(1),(2)	G0642		

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G0642	Continued from page 83 Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to measure, analyze and track quality indicators and other aspects of performance that enable the agency to assess processes of care, agency services and operations for all of its locations The findings include: Review of an agency policy revised 1/4/2022, titled “Quality Assurance Performance Improvement [QAPI] Plan and Program” stated, “… The agency must measure, analyze and track quality indicators … that enable the agency to assess processes of care, services and operations….” Review of the agency’s QAPI program on 8/11/2022 failed to evidence the collection of data for Quarter 4 of 2021 for the Logansport location and for Quarters 3 and 4 of 2021 for the Laporte, South Bend, Valparaiso, and Schererville locations. During an interview on 8/11/2022, at 10:40 AM, Administrator #1 indicated there was missing data for all of the locations and indicated she did not have much data for Quarter 4 of 2021 because the agency was going through a transition at this time. 17-12-2(a)	G0642		
G0644	Program data CFR(s): 484.65(b)(1),(2),(3) Standard: Program data.	G0644		

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G0644	Continued from page 84 (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the Quality Assessment and Performance Improvement (QAPI) Program utilized quality indicator data to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement and failed to ensure the frequency and detail of the data collection was approved by the Governing Body. The findings include: Review of an agency policy revised 1/4/2022, titled “Quality Assurance Performance Improvement Plan and Program” stated, “… The agency will use the data collected to: Monitor the effectiveness and safety of services and quality of care … Identify opportunities for improvement … The frequency and detail of the data collection must be approved by the Governing Body….” Review of an untitled, undated agency document provided on 8/5/2022 and identified by the administrator as the COVID-19 Infection Log indicated 48 COVID-19 infections with patients serviced by the agency since 1/1/2022. Review failed to evidence the Governing Body approved the frequency and detail of the data collection. During an interview on 8/11/2022, at 10:40 AM, Administrator #1 indicated infections were tracked as part of the agency's QAPI program and indicated	G0644		

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G0644	Continued from page 85 the agency had not developed an action plan to address the number of patients with COVID-19 infections. Administrator #1 indicated the Governing Body did not approve the frequency and detail of the data collection. 17-12-2(a)	G0644		
G0648	High risk, high volume, or problem-prone area CFR(s): 484.65(c)(1)(i) (i) Focus on high risk, high volume, or problem-prone areas; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the performance improvement activities focused on high risk, high volume, or problem-prone areas. The findings include: Review of an agency policy revised 1/4/2022, titled “Quality Assurance Performance Improvement [QAPI] Plan and Program” stated, “… The agency’s performance improvement activities will: Focus on high risk and problem-prone areas ….” Review of the agency’s QAPI plan on 8/11/2022 evidenced an agency document titled “Schererville license QAPI meeting [Quarter] 1, 2022” dated 5/4/2022, which indicated the agency had 11 reported hospitalizations. Review failed to evidence performance improvement activities related to the hospitalizations. During an interview on 8/11/2022, at 10:40 AM, Administrator #1 indicated the agency had not yet developed performance improvement activities related to the hospitalizations.	G0648		
G0652	Activities lead to an immediate correction CFR(s): 484.65(c)(1)(iii) (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.	G0652		

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G0652	Continued from page 86 This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the performance improvement activities lead to an immediate correction of any identified problems that directly or potentially threatens the health and safety of patients. The findings include: Review of an agency policy revised 1/4/2022, titled “Quality Assurance Performance Improvement [QAPI] Plan and Program” stated, “… The agency’s performance improvement activities will: … Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of clients ….” Review of the agency’s QAPI plan on 8/11/2022 evidenced an agency document titled “Schererville license QAPI meeting [Quarter] 1, 2022” dated 5/4/2022, which indicated the agency had 7 reported patient falls. Review indicated the agency was going to continue to educate patients and caregivers on the importance of falls prevention and encourage use of appropriate assistive devices. Review of agency documents titled “Falls Incident Log” for Quarter 2 of 2022 evidenced the agency reported 19 patient falls. Review failed to evidence the performance improvement activities led to a correction of the patient falls. During an interview on 8/11/2022, at 10:40 AM, Administrator #1 indicated the agency had not changed the performance improvement activities regarding patient falls. Administrator #1 indicated QAPI was ongoing and interventions should be taken as needed. 17-12-2(a)	G0652		
G0658	Performance improvement projects CFR(s): 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects.	G0658		

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G0658	Continued from page 87 (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to conduct a performance improvement project that reflected the scope, severity and past performance of the agency's services and operations and failed to document the quality improvement project which was conducted, the reasons for conducting the project and the measurable progress achieved on the project. The findings include: Review of an agency policy revised 1/4/2022, titled “Quality Assurance Performance Improvement [QAPI] Plan and Program” stated, “… The agency will conduct performance improvement projects … The agency will document the quality improvement projects undertaken, the reasons for conducting these projects and the measurable progress achieved on these projects….” Review of the agency’s QAPI program on 8/11/2022 failed to evidence a performance improvement project. During an interview on 8/11/2022, at 10:40 AM, Administrator #1 stated, “I’ve heard them talk about that but I’m not sure,” when queried what was the agency’s performance improvement project.	G0658		
G0680	Infection prevention and control CFR(s): 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and	G0680		

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G0680	Continued from page 88 communicable diseases. This CONDITION is NOT MET as evidenced by: An Immediate Jeopardy related to §484.70 Infection Prevention and Control was identified and announced on 8/8/2022 at 2:40 PM. The Immediate Jeopardy began on 8/4/2022 when licensed practical nurse (LPN) #1 was observed providing care at the home of patient #3, start of care 5/5/2021, while wearing a surgical mask. The administrator, alternate administrator, registered nurse (RN) #1, RN #2, RN #3, Other personnel #1, Other personnel #2, Other personnel #3, and Other personnel #4 were observed not wearing a mask in the office. Review of the agency's Covid-19 vaccination status report indicated LPN #1, administrator, alternate administrator, RN #1, #2, #3, Other personnel #1, #2, #3, and #4 had religious exemptions. Review of an agency policy indicated staff who received a religious exemption would wear a KN95 mask while at work. The agency failed to include in its policy a process for tracking and securely documenting the COVID-19 vaccination status of all staff, a process for tracking and documenting the vaccination status of any staff who have obtained any booster doses as recommended by the CDC (Centers for Disease Control and Prevention), and a process for tracking and documenting the vaccination status for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations. Review of the agency's COVID-19 vaccination status report failed to evidence vaccination status for 72 agency personnel. Review of the agency's COVID-19 infection log indicated 48 patient COVID-19 infections since 1/1/2022, and the administrator indicated patient #3 tested positive for COVID-19 on 8/5/2022. Due to the actions taken by the agency, the Immediate Jeopardy was removed prior to the conclusion of the survey on 8/15/2022, at 12:13 PM. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for the Condition of Participation 42 CFR 484.70 Infection Prevention and Control. Other unrelated conditions of participation and findings will be	G0680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELP AT HOME SKILLED CARE	833 W LINCOLN HIGHWAY SUITE 330 E , SCHERERVILLE, Indiana, 46375

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G0680	Continued from page 89 cited. Based on observation, record review and interview, the home health agency failed to create, maintain, and implement written policies and procedures which are compliant with requirements for CMS (Centers for Medicare and Medicaid Services) vaccine mandate issued on 1/14/2022 in 1 of 1 home visits conducted with a LPN. (#3) This practice has the potential to affect all patients serviced by the agency. The findings include: On 8/04/2022, the agency's Logansport branch was visited from 9:59 AM - 10:40 AM. Registered Nurse (RN) #2 was not wearing a mask, indicated she was not vaccinated, and she provided direct patient care; Other personnel #1 was not wearing a mask, and indicated she was not vaccinated; Other personnel #2 was not wearing a mask, and indicated she was not vaccinated; Other personnel #3 was not wearing a mask, and indicated she was not vaccinated; and Admin #5 (Logansport Branch Manager) indicated an additional employee, RN #5 not present during the visit, was also unvaccinated. At 10:10 AM, when queried if the branch office kept a record of all employees' vaccination status readily available, Other Personnel #1 indicated that information was in each individual human resource chart in Matrix (electronic record), and would have to be accessed individually. At 10:25 AM, when queried if the branch office maintained a COVID-19 binder with all required information, Admin #5 indicated they didn't. On 8/04/2022, the agency's South Bend branch was visited from 12:22 PM - 1:30 PM. RN #2 was not wearing a mask, indicated she was not vaccinated, and she provided direct patient care; Other personnel #4 was not wearing a mask, and indicated she was not vaccinated. Admin #6 (South Bend Branch manager) indicated she had a mask on simply because she just came off of COVID-19 exposure precautions. Observed a paper sign posted on the wall which stated "It is now REQUIRED for you to wear a face mask in our office ... You may remove your mask at your desk if social distancing requirements are met ...." 1. Review of an agency policy dated 3/16/2022, titled “COVID-19 Guidelines for Unvaccinated	G0680		

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G0680	Continued from page 90 Associates" stated, "… Individuals with Approved Exemptions in accordance with the COVID-19 Vaccine Administration Policy are required to wear KN95 masks when on the job …." 2. Review of an agency policy dated 3/23/2022, titled "COVID-19 Vaccination Administration Policy" stated, "… Help At Home collects data related to associate vaccination status … Help At Home intends to comply with local/state/federal mandates …." Review failed to evidence the policy included: a process for tracking and securely documenting the COVID-19 vaccination status of all staff, a process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC, and a process for ensuring the tracking and secure documentation of the vaccination status of staff for who COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations. 3. Review of an untitled, undated agency document provided on 7/20/2022 and identified by the administrator as the COVID-19 vaccination status report indicated Administrator #1, alternate administrator, LPN #1, RN #1, RN #2, RN #3, Other personnel #1, Other personnel #2, Other personnel #3, and Other personnel #4 had a religious exemption. Review evidenced failed to evidence COVID-19 vaccination status for 71 of 387 agency employees. 4. Administrator #1 was observed not wearing a mask at the parent location on 7/19/2022, at 12:15 PM; 7/20/2022, at 9:45 AM; 8/3/2022, at 2:13 PM; and 8/5/2022, at 11:53 AM. The administrator was observed at the parent location wearing a surgical mask and not a KN95 mask per agency policy on 8/2/2022, at 10:30 AM; 8/4/2022, at 1:15 PM; 8/5/2022, at 5:18 PM; 8/8/2022, at 10:59 AM; 8/8/2022, at 12:45 PM; and 8/8/2022, at 4:43 PM. 5. The alternate administrator was observed not wearing a mask at the parent location on 8/5/2022, at 11:53 AM. The alternate administrator was observed at the parent location wearing a surgical mask and not a KN95 mask per agency policy on 8/1/2022, at 12:45 PM; 8/5/2022, at 5:18 PM; and	G0680		

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G0680	Continued from page 91 8/8/2022, at 12:45 PM. 6. During an observation at the parent location on 8/5/2022, at 9:45 AM, RN #1 was observed wearing a surgical mask and not a KN95 mask per agency policy. During an observation at the parent location on 8/5/2022, at 12:18 PM, RN #1 was observed not wearing a mask. 7. During an observation on 8/4/2022, at 10:19 AM, at the home of patient #3, start of care 5/5/2021, LPN #1 was observed wearing a surgical mask while providing care to the patient. LPN #1 was not observed wearing a KN95 mask per agency policy. 8. Review of an untitled, undated agency document provided on 8/5/2022 and identified by the administrator as the COVID-19 Infection Log indicated 48 COVID-19 infections with patients serviced by the agency since 1/1/2022. 9. During an interview on 8/5/2022, at 10:40 AM, Administrator #1 indicated human resources tracks and documents COVID-19 vaccination status. Administrator #1 indicated the recruiter collected the employee's vaccination status at time of hire, entered the proof of vaccination into the electronic employee record, and informed human resources of the employee's vaccination status. Administrator #1 indicated human resources then entered the employee's vaccination status onto the COVID-19 vaccination spreadsheet. Administrator #1 indicated she was unsure how the agency collected and tracked COVID-19 booster vaccinations and indicated the agency's policy did not include a process for tracking and documenting booster vaccination status. Administrator #1 indicated the agency's policy did not include a process for tracking and documenting the vaccination status for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations. At 10:49 AM, Administrator #1 indicated the agency personnel with an approved vaccination exemption should wear a KN95 mask when caring for patients and indicated she was not sure what precautions should be taken when staff with an approved exemption were in the office. When the administrator reviewed the agency policy and found agency personnel with an approved exemption were	G0680		

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G0680	Continued from page 92 to wear a KN95 mask, Administrator #1 stated, “Oh, that’s not what I was told then.” 10. During an interview on 8/5/2022, at 2:48 PM, Administrator #1 indicated she was just notified that patient #3 tested positive for COVID-19. 11. During an interview on 8/9/2022, at 10:31 AM, patient #5, start of care 11/11/2021, indicated he tested positive for COVID-19 at the end of July. Review failed to evidence the COVID-19 infection log included the patient’s COVID-19 infection.	G0680		
G0682	Infection Prevention CFR(s): 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure all employees practiced standard/universal precautions to prevent the transmission of infections and failed to follow agency infection control policies and procedures in 2 of 4 home visits. (#2, 3) The findings include: 1. Review of an agency policy revised 1/4/2022, titled “Hand Hygiene” stated, “… The Center for Disease Control (CDC) recommends routinely washing hands in the following situations: … Before moving from a soiled body site to a clean body site on the same patient … Scrub your hands for at least 20 seconds. Hum the “Happy Birthday” song from beginning to end twice … Dry your hands using a clean paper towel ….” 2. During an observation of care at the home of Patient #2, start of care 4/12/2022, on 8/3/2022, at 8:15 AM, home health aide (HHA) #2 was observed removing her gloves after assisting the patient with a shower and washing her hands at the sink in	G0682		

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G0682	Continued from page 93 the bathroom. HHA #2 was observed washing her hands with soap for 3 seconds before rinsing her hands. HHA #2 was observed drying her hands with a cloth hand towel lying on the patient's bathroom counter. At 8:20 AM, HHA #2 was observed washing her hands at the kitchen sink after taking trash outside and washed her hands with soap for 3 seconds before rinsing her hands. HHA #2 was observed drying her hands with a cloth hand towel lying on the kitchen counter. HHA #2 was not observed washing her hands with soap for 20 seconds and drying her hands with a paper towel per agency policy. During an interview on 8/5/2022, at 4:45 PM, Administrator #1 indicated staff should wash their hands until they are done singing and should dry their hands with a paper towel. 3. During an observation of care at the home of Patient #3, start of care 5/5/2021, on 8/4/2022, at 10:35 AM, LPN #1 was observed wearing gloves and listening to the patient's abdomen with a stethoscope. The patient was observed to have a plastic tube inserted into the upper left quadrant of the abdomen. LPN #1 attached a syringe to the tube and poured in liquid from a container labeled "Fibersource [tube feeding formula]". LPN #1 was observed pouring in water into the tube through the large syringe. At 10:43 AM, the patient was observed coughing and a plastic tube was observed inserted into the patient's neck. LPN #1 was observed suctioning the tube in the patient's neck with a small tube while wearing gloves. LPN #1 was observed wiping clear drainage from the end of the plastic tube in the patient's neck while wearing gloves. LPN #1 was not observed changing gloves and providing hand hygiene after administering the liquid through the patient's tube in the abdomen and before suctioning the tube in the patient's neck. During an interview on 8/5/2022, 4:53 PM, Administrator #1 indicated the nurse should have changed his gloves and washed his hands after administering the tube feeding and before suctioning the tracheostomy (a plastic tube inserted into the airway through the neck to assist with breathing). 17-12-1(m)	G0682		

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G0682 G0684	Infection control CFR(s): 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. The findings include: Review of an agency policy revised 1/4/2022, titled “Infection Prevention and Control Plan” stated, “… The Infection Control Plan establishes and implements policies and procedures … These policies/procedures include: … Establishes a surveillance program for infection acquired in home health care….” During an interview on 8/9/2022, at 10:31 AM, patient #5, start of care 11/11/2021, indicated he tested positive for COVID-19 at the end of July. Review of an undated, untitled agency document, identified by the administrator as the COVID-19 Infection Log, on 8/9/2022 failed to evidence the patient’s COVID-19 infection. During an interview on 8/9/2022, at 11:43 AM, Administrative Staff #6 indicated the agency was aware the patient tested positive for COVID-19 and indicated the home health aide did not inform the	G0682 G0684		

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G0684	Continued from page 95 nurse and the infection was not entered in the COVID-19 infection log. During an interview on 8/15/2022, at 11:02 AM, Administrator #1 indicated all patient infections should be entered in the infection log so the agency can investigate the infection and track them for QAPI (Quality Assurance Performance Improvement).	G0684		
G0686	Infection control education CFR(s): 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure staff was educated per agency policy on infection control in 12 of 17 personnel records reviewed. (HHA #3, HHA #5, HHA #8, RN #8, RN #10, RN #11, RN #12, LPN #2, LPN #3, LPN #4, LPN #5, and alternate clinical manager The findings include: Review of an agency policy revised 1/4/2022, titled “Infection Prevention and Control Plan” stated, “… The agency provides a training program to each of its employees at the time of initial employment as part of employee orientation and annually thereafter….” Review of training records on 8/8/2022 failed to evidence infection control training for registered nurse (RN) #10, date of hire 9/8/2008, since 8/5/2019; home health aide (HHA) #8, date of hire 12/9/2014, since 12/15/2018; licensed practical nurse (LPN) #2, date of hire 3/25/2014, since 4/19/2021; LPN #3, date of hire 1/12/2017, since 6/16/2017; LPN #4, date of hire 5/1/2017, since 6/20/2019; LPN #5, date of hire 5/19/2017, since 6/29/2018; RN 11, date of hire 10/5/2015, since 6/13/2019; and RN #12, date of hire 5/4/2020, since 5/4/2020. Review failed to evidence any infection control training for HHA #5, date of hire 4/21/2022; HHA #3, date of hire 7/1/2020; alternate clinical manager, date of hire 4/19/2021; and RN #8, date of hire 8/6/2018.	G0686		

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G0686	Continued from page 96 During an interview on 8/5/2022, at 10:49 AM, Administrator #1 indicated agency personnel should receive infection control education annually.	G0686		
G0710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the skilled nurse failed to provide services as ordered in the plan of care in 4 of 8 active clinical records reviewed. (#1, 2, 3, 7) The findings include: 1. Review of an agency policy revised 1/4/2022 titled “Scope of Nursing Services” stated, “… Skilled professionals must assume responsibility for, but not be restricted to the following: … Providing services that are ordered by the physician as indicated in the plan of care ….” 2. Clinical record review on 8/3/2022, for Patient #1, start of care 11/26/2019, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 5/14/2022 – 7/12/2022, which indicated the nurse was to monitor temperature, pulse, respiration, blood pressure, and oxygen saturation at every visit. Review indicated the skilled nurse was to notify the physician if the pulse was greater than 100 beats per minute and if the respiration rate was more than 20 breaths per minute. Review evidenced an agency document titled “Recertification/Follow-Up Assessment Including OASIS Elements with Plan of Care Information” dated 7/12/2022 and completed by the registered nurse (RN). Review failed to evidence the RN obtained the oxygen saturation as ordered. Review evidenced agency documents titled “Private Duty Nursing Flow Sheet” completed by the licensed practical nurse (LPN) which indicated the patient’s respiration rate was 22 on 6/7/2022, 6/9/2022, 6/14/2022, and 24 on 6/23/2022, 7/5/2022 and 7/7/2022. Review indicated the patient’s pulse	G0710		

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G0710	Continued from page 97 was 101 on 6/23/2022 and 120 on 6/30/2022. Record review failed to evidence the LPN obtained temperature, pulse, respiration, blood pressure, and oxygen saturation were on 6/21/2022 as directed in the plan of care. Review failed to evidence the nurse notified the physician of the pulse and respiratory rate outside of parameters as directed in the plan of care. During an interview on 8/5/2022, at 4:07 PM, Administrator #1 indicated the nurse probably did not obtain the oxygen saturation because the agency probably did not issue the nurse a pulse oximeter (a medical device to monitor oxygen saturation). At 4:30 PM, the administrator indicated the nurse should have called the physician regarding the pulse and respirations outside of normal parameters. 3. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 3/28/2022 – 5/26/2022. Review indicated the nurse was to monitor oxygen saturation at every visit. Review of an untitled agency document identified by the administrator as the comprehensive assessment dated 5/25/2022 and signed by the RN, failed to evidence the nurse assessed the patient’s oxygen saturation. During an interview on 8/4/2022, at 2:54 PM, Administrator #1 indicated the agency never used to have to obtain oxygen saturation and the agency might not have supplied her with a pulse oximeter. 4. Clinical record review on 8/2/2022, for Patient #2, start of care 4/12/2022, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 4/12/2022-6/10/2022 which indicated the skilled nurse was to notify the physician for a pulse greater than 100 beats per minute. Review indicated the nurse was to monitor oxygen saturation at every visit. Review of an untitled agency document identified by the administrator as the comprehensive assessment completed by the RN and dated 6/6/2022, failed to evidence the nurse obtained the oxygen saturation. Review indicated the patient’s pulse was 104 beats per minute and failed to evidence	G0710		

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G0710	Continued from page 98 the nurse informed the physician of the pulse outside of normal parameters as ordered in the plan of care. During an interview on 8/5/2022, at 4:40 PM, Administrator #1 indicated the nurse probably did not have a pulse oximeter to obtain the oxygen saturation. 5. Clinical record review on 8/3/2022, for Patient #3, start of care 5/5/2021, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 6/30/2022-8/28/2022. Review indicated the nurse was to administer tube feedings in the morning, mid-day, evening, and at bedtime and flush the gastrostomy tube (a tube surgically inserted into the stomach through the abdomen to administer nutrition, fluid, and medication) with 500 milliliters (ml) of water after meals. Review evidenced agency documents titled “Private Duty Nursing Flow Sheet” completed by the nurse. Document dated 7/26/2022 evidenced the nurse flushed the gastrostomy tube with 400 ml of water at 9:00 AM, 10:30 AM, and 2:30 PM. Document dated 7/27/2022 evidenced the nurse flushed the gastrostomy tube with 400 ml of water at 9:00 AM and 10:30 AM and with 850 ml at 2:30 PM. Documents dated 7/28/2022, 7/29/2022, and 8/2/2022 evidenced the nurse flushed the gastrostomy tube with 400 ml of water at 9:00 AM and 10:30 AM and with 800 ml of water at 2:30 PM. Review failed to evidence the nurse flushed the gastrostomy tube as ordered in the plan of care. During an interview on 8/4/2022, at 10:41 AM, licensed practical nurse (LPN) #1 indicated if the patient’s urine looks a little darker, he gives the patient a little more water and indicated the patient does not have any fluid restrictions. During an interview on 8/5/2022, at 4:51 PM, Administrator #1 indicated the nurse should follow the plan of care. 17-14-1(a)(1)(H) 17-14-1(a)(2)(F)	G0710		
G0716	Preparing clinical notes CFR(s): 484.75(b)(6)	G0716		

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(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
G0716	Continued from page 99 Preparing clinical notes; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the skilled nurse failed to accurately prepare clinical notes in 4 of 8 active clinical records reviewed with wounds. (#1, 3, 5, 7) The findings include: 1. Review of an agency policy revised 1/4/2022 titled “Scope of Nursing Services” stated, “… Skilled professionals must assume responsibility for, but not be restricted to the following: … Preparing clinical notes ….” 2. Clinical record review on 8/1/2022, for Patient #5, start of care 11/11/2021, evidenced an untitled agency document identified by the administrator as a comprehensive assessment dated 7/6/2022, and completed by the registered nurse (RN). Review indicated the patient's pulse was 89105 [sic]. During an interview on 8/3/2022, at 4:17 PM, Administrator #1 indicated the pulse documented by the RN was an error. 3. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced untitled agency documents identified by the administrator as a comprehensive assessment dated 5/25/2022 and 7/21/2022, completed by the RN. Review indicated the patient’s wound to the right toe was healed and indicated wound measurements of 3 centimeters (cm) in length and 2 cm in width. During an interview on 8/4/2022, at 2:49 PM, Administrator #1 indicated the wound measurements to the right toe were carried over by mistake from the previous assessment. 4. During an observation of care on 8/2/2022, at 10:12 AM, at the home of Patient #1, start of care 11/26/2019, licensed practical nurse (LPN) #1 was observed administering a liquid the LPN identified as a multivitamin into a tube inserted into the patient’s abdomen. Clinical record review on 8/3/2022 evidenced agency documents titled “Private Duty Nursing Flow Sheet” completed by the skilled nurse and dated	G0716		

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G0716	Continued from page 100 7/19/2022, 7/21/2022, 7/26/2022 and 7/28/2022, which indicated the nurse administered scheduled medications. Review failed to evidence the nurse prepared clinical notes to include which medications were administered at what date and time, what dose and via which route. 5. Clinical record review on 8/3/2022, for patient #3, start of care 5/5/2021, evidenced agency documents titled “Private Duty Nursing Flow Sheet” completed by the nurse and dated 7/26/2022, 7/27/2022, 7/28/2022, 7/29/2022, and 8/2/2022 which indicated the nurse administered medications via the patient’s gastrostomy (a tube surgically inserted into the stomach through the abdomen to deliver nutrition, fluid, and/or medications). Review failed to evidence the nurse prepared clinical notes to indicate which medications, what dose, and at what time the medications were administered. 6. During an interview on 8/5/2022, at 4:20 PM, Administrator #1 indicated the medication administration should be documented by the nurse on an agency form titled “Weekly Medication Record”. The administrator indicated she could not locate documentation of the medications administered by the nurses. 17-14-1(a)(1)(E) 17-14-1(a)(2)(B)	G0716		
G0726	Nursing services supervised by RN CFR(s): 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the registered nurse (RN) failed to provide supervision of nursing services provided in 1 of 2 active clinical records reviewed with skilled nursing services. (#1) The findings include: Review of an agency policy revised 1/4/2022, titled “Supervision of Staff” stated, “… All staff providing home care services will be supervised as	G0726		

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G0726	Continued from page 101 outlined by federal and state regulations and accepted standards of practice. … To ensure staff are demonstrating competence with communication, identifying and responding to client needs ….” Clinical record review on 8/3/2022, for Patient #1, start of care 11/26/2019, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 5/14/2022 – 7/12/2022, which indicated the nurse was to monitor temperature, pulse, respiration, blood pressure, and oxygen saturation at every visit. Review indicated the skilled nurse was to notify the physician if the pulse was greater than 100 beats per minute and if the respiration rate was more than 20 breaths per minute. Review evidenced agency documents titled “Private Duty Nursing Flow Sheet” completed the licensed practical nurse (LPN) which indicated the patient’s respiration rate was 22 on 6/7/2022, 6/9/2022, 6/14/2022, and 24 on 6/23/2022, 7/5/2022 and 7/7/2022. Review indicated the patient’s pulse was 101 on 6/23/2022 and 120 on 6/30/2022. Review failed to evidence the LPN obtained temperature, pulse, respiration, blood pressure, and oxygen saturation were obtained on 6/21/2022 as directed in the plan of care. Review failed to evidence the nurse notified the physician of the pulse and respiratory rate outside of parameters as directed in the plan of care. Review of an agency document titled “Supervisory Visits of Home Health Care Staff” signed by the RN and dated 7/12/2022, indicated the LPN followed the care plan. Review failed to evidence the RN supervised the LPN to ensure the care plan was followed. During an interview on 8/5/2022, at 4:30 PM, Administrator #1 indicated the RN reviews the LPN’s visit notes and should not have marked the care plan was being followed. 17-14-1(a)(1)(J)	G0726		
G0798	Home health aide assignments and duties CFR(s): 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific	G0798		

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G0798	Continued from page 102 patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). This STANDARD is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the home health aides had complete, patient-specific written patient care instructions to be performed by the home health aides in 3 of 6 active clinical records reviewed with home health aide services. (#2, 5, 8) The findings include: 1. Review of an agency policy revised 1/4/2022, titled “Home Health Aide Care Service Plan” stated, “… A complete and appropriate Care Service Plan … shall be developed by a Registered Nurse [RN]. … Purpose: … To provide documentation that the client’s care is individualized to his/her specific needs….” 2. Clinical record review on 8/1/2022, for patient #5, start of care 11/11/2021, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 7/9/2022 – 9/6/2022. Review indicated the agency was to provide home health aide services 3 hours a visit, 2 visits a day, 7 days a week for personal care and assistance with ADLs (activities of daily living). Review evidenced an agency document titled “Plan of Care Service Plan” dated 7/5/2022 and identified by the administrator as the home health aide care plan. Review failed to evidence the care plan included the frequency of home health aide visits. Review failed to evidence the care plan gave specific directions for what tasks were to be completed at the first and second visit of the day. Review indicated the home health aide was to bathe the patient 7 times a week. Review failed to evidence the care plan was individualized to include if the patient was to be bathed during the first or second visit of the day. During an interview on 8/3/2022, at 4:42 PM,	G0798		

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G0798	Continued from page 103 Administrator #1 indicated the home health aide care plan should be more specific since the patient receives multiple visits per day. 3. During an observation of care at the home of Patient #2, start of care 4/12/2022, on 8/3/2022, at 7:59 AM, the patient was observed ambulating with no assistance to the bathroom. Clinical record review on 8/2/2022 evidenced an agency document titled “Plan of Care Service Plan” signed and dated by the RN on 6/6/2022 and identified by the administrator identified as the home health aide care plan, which indicated the home health aide was assist the patient with ambulation using a wheelchair and walker. During an interview on 8/5/2022, at 4:43 PM, Administrator #1 indicated the home health aide care plan should probably be marked as stand by assist. 4. Clinical record review on 8/2/2022, for Patient #8, start of care 2/17/2021, evidenced an agency document titled “Plan of Care Service Plan”, signed and dated by the RN on 6/20/2022 and identified by the administrator as the home health aide care plan, which indicated the home health aide was to assist the patient with a shower 3 times a week. During an interview on 8/2/2022, at 11:20 AM, Administrator #1 indicated the patient had a debridement to a wound on the foot, a wound drain was placed in the foot, and the patient could not shower while the drain was in place. Review failed to evidence the home health aide care plan was revised to reflect the change in patient’s inability to shower. During an interview on 8/5/2022, at 3:23 PM, Administrator #1 indicated the home health aide care plan should have been updated to reflect the patient could not shower. 17-14-1(m)	G0798		
G0800	Services provided by HH aide CFR(s): 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed	G0800		

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G0800	Continued from page 104 practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health aide failed to provide services that were ordered by the physician, included in the plan of care, and consistent with the aide care plan in 5 of 6 active clinical records reviewed with home health aide services. (#4, 5, 6, 7, 8) The findings include: 1. Review of an agency policy revised 1/4/2022, titled “Home Health Aide Care Service Plan” stated, “… All home health aide staff will follow the identified plan….” 2. Clinical record review on 8/1/2022, for Patient #5, start of care 11/11/2021, evidenced an agency document titled “Plan of Care Service Plan” dated 7/5/2022 and identified by the administrator as the home health aide care plan. Review indicated the home health aide was to apply non-medicated lotions/creams/powders to the client’s skin after showering. Review of agency documents titled “Daily Visit Sheet”, identified by the administrator as home health aide visit notes, indicated the home health aide did not apply lotions/creams/powders as directed in the care plan on 7/11/2022 and 7/28/2022. Review of an agency document titled “Tasks Report by Client” and identified as a home health aide visit note dated 7/19/2022, failed to evidence the home health aide applied lotions/creams/powders as directed in the care plan. During an interview on 8/3/2022, at 4:30 PM, Administrator #1 indicated the home health aide should have applied lotions and creams as directed in the plan of care of should have marked the patient refused if that was why the lotions and creams were not applied.	G0800		

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G0800	Continued from page 105 3. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced agency documents titled “Plan of Care Service Plan” dated 5/23/2022 and 7/11/2022, identified by the administrator as the home health aide care plan. Review indicated the home health aide was to shampoo the patient’s hair and assist the patient in the shower 7 days a week. Review indicated the home health aide was to assist with a bed bath when the patient refused to take a shower. Review of agency documents titled “Daily Visit Sheet”, identified by the administrator as home health aide visit notes, indicated the home health aide did not shampoo the patient’s hair on 6/3/2022, 7/17/2022, and 7/24/2022. Record review indicated the home health aide documented they showered and provided a bed bath on 6/30/2022, 7/3/2022, and 7/5/2022. During an interview on 8/4/2022, at 3:07 PM, Administrator #1 indicated the home health aide should not have provided both a shower and a bed bath and only 1 should have been checked. The administrator indicated the home health aide should document why the shampoo was not completed or why it was not needed. 4. Clinical record review on 8/3/2022, for Patient #4, start of care 6/3/2020, evidenced an agency document titled “Plan of Care Service Plan” dated 6/1/2022, and identified by the administrator as the home health aide care plan. Review indicated the home health aide was to apply lotion and assist with nail care 1 time weekly. Review of agency documents titled “Daily Visit Sheet”, identified by the administrator as home health aide visit notes, indicated the home health aide applied lotion 3 times a week during the weeks of 7/3/2022, 7/10/2022, and 7/17/2022. Review indicated the home health aide did not provide nail care during the weeks of 7/3/2022, 7/10/2022, and 7/17/2022 as directed in the care plan. 5. Clinical record review on 8/1/2022, for Patient #6, start of care 5/25/2021, evidenced an agency document titled “Plan of Care Service Plan” dated 6/29/2022. Review indicated the home health aide was to shampoo the patient’s hair and assist with nail care 1 time a week.	G0800		

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G0800	Continued from page 106 Review of agency documents titled “Daily Visit Sheet” indicated the home health aide shampooed the patient’s hair and provided nail care 4 times a week during the weeks of 7/3/2022, 7/10/2022, and 7/17/2022. Review failed to evidence the home health aide provided services as directed by the care plan. 6. Clinical record review on 8/2/2022, for Patient #8, start of care 2/17/2021, evidenced an agency document titled “Plan of Care Service Plan” dated 6/20/2022. Review indicated the home health aide was to provide nail care 1 time weekly. Review of agency documents titled “Daily Visit Sheet” indicated the home health aide provided nail care 2 times a week during the week of 6/19/2022 and 3 times a week during the weeks of 6/26/2022 and 7/3/2022. Review failed to evidence the home health aide provided services as directed by the care plan. 7. During an interview on 8/8/2022, at 11:13 AM, Administrator #1 indicated the home health aide should follow the aide care plan.	G0800		
G0804	Aides are members of interdisciplinary team CFR(s): 484.80(g)(4) Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the home health aide failed to report changes in the patient’s condition to a registered nurse or other appropriate skilled professional in 2 of 3 active clinical records reviewed with wounds. (#5, 7) The findings include: 1. Review of an agency policy revised 1/4/2022, titled “Home Health Aide Care Service Plan” stated, “… The HHA [home health aide] is responsible for reporting any changes in the patient’s condition to the supervising Registered Nurse….”	G0804		

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G0804	Continued from page 107 2. Clinical record review on 8/1/2022, for patient #5, start of care 11/11/2021, evidenced an untitled agency document dated 5/9/2022 and identified by the administrator as the comprehensive assessment completed by the registered nurse (RN). Review indicated the patient had 11 wounds: left ankle, right ankle, left buttocks, left heel, right heel, right hip, left hip, right knee, left knee, right lower leg, and upper back. Review evidenced an agency document titled “Plan of Care Service Plan” dated 7/5/2022 and identified by the administrator as the home health aide care plan. Review indicated the home health aide was to assist with skin inspection and notify the RN of any new or worsening skin issues. Review of documents from the wound clinic at Hospital B dated 7/28/2022 indicated the patient had 15 wounds: left hip, right hip, left ankle, right ankle, right heel, left heel, right superior lower leg, right inferior lower leg, back, buttock, left lower leg, left superior lower leg, right foot, left foot, and left great toe. Review indicated the home health aide provided services 7/28/2022, 7/29/2022, 7/30/2022, 8/1/2022, 8/2/2022, 8/3/2022 and failed to evidence the home health aide reported any changes in skin condition to the RN. During an interview on 8/4/2022, at 1:58 PM, RN #3 indicated the HHA had not reported any changes in the patient’s skin condition. 3. Clinical record review on 8/1/2022, for patient #7, start of care 4/2/2021, evidenced an untitled agency document the administrator identified as a comprehensive assessment dated 5/25/2022 and completed by the RN. Review indicated the patient had an abrasion on her labia. Review evidenced an agency document titled “Plan of Care Service Plan” dated 5/23/2022 and 7/11/2022, identified by the administrator as the home health aide care plan. Review indicated the home health aide was to assist with skin inspection and notify the RN of any new or worsening skin issues. Review of an untitled agency document identified by the administrator as a comprehensive assessment completed by a RN and dated 7/21/2022, indicated the patient’s labia was macerated and the patient	G0804		

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G0804	Continued from page 108 had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage III (an open pressure ulcer with full thickness loss of skin) to the left heel. Review evidenced the HHA provided services on 7/17/2022, 7/18/2022, 7/19/2022, 7/20/2022, and 7/21/2022. Review failed to evidence the home health aide reported any changes in skin condition to the RN. During an interview on 8/4/2022 at 3:33 PM, RN #8 indicated the HHA did not report any changes in the patient's skin condition. 4. During an interview on 8/3/2022, at 4:45 PM, Administrator #1 indicated the HHA should report to the RN any changes in the skin condition and indicated there was no documentation of the new wounds reported by the HHA to the RN.	G0804		
G0818	HH aide supervision elements CFR(s): 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the home health aide (HHA) was supervised to ensure the aides furnished care that	G0818		

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G0818	Continued from page 109 followed the patient's plan of care in 4 of 6 active clinical records reviewed with home health aide services. (#4, 6, 7, 8) The findings include: 1. Review of an agency policy revised 1/4/2022, titled "Supervision of Staff" stated, "… The aide visit record is reviewed by the supervising Registered Nurse [RN] to assure services are being provided according to the care plan…." 2. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced agency documents titled "Plan of Care Service Plan" dated 5/23/2022 and 7/11/2022, identified by the administrator as the home health aide care plan. Review indicated the home health aide was to shampoo the patient's hair and assist the patient in the shower 7 days a week. Review indicated the home health aide was to assist with a bed bath when the patient refused to take a shower. Review of agency documents titled "Daily Visit Sheet", identified by the administrator as home health aide visit notes, indicated the home health aide did not shampoo the patient's hair on 6/3/2022, 7/17/2022, and 7/24/2022. Review indicated the home health aide documented the home health aide showered and provided a bed bath on 6/30/2022, 7/3/2022, and 7/5/2022. Review of agency documents titled "Supervisory Visits of Home Health Care Staff" dated 6/16/2022, 6/30/2022, and 7/21/2022 and signed by the RN, indicated the home health aide followed the care plan. Review failed to evidence the registered nurse provided home health aide supervision to ensure the home health aides followed the aide care plan as directed. 3. Clinical record review on 8/3/2022, for Patient #4, start of care 6/3/2020, evidenced an agency document titled "Plan of Care Service Plan" dated 6/1/2022, and identified by the administrator as the home health aide care plan. Review indicated the home health aide was to apply lotion and assist with nail care 1 time weekly. Review of agency documents titled "Daily Visit Sheet", identified by the administrator as home health aide visit notes, indicated the home health aide applied lotion 3 times a week during the weeks of 7/3/2022, 7/10/2022, and 7/17/2022.	G0818		

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G0818	Continued from page 110 Review indicated the home health aide did not provide nail care during the weeks of 7/3/2022, 7/10/2022, and 7/17/2022 as directed in the care plan. Review of an agency document titled “Supervisory Visits of Home Health Care Staff” dated 7/22/2022 and signed by the RN, indicated the home health aide followed the care plan. Review failed to evidence the registered nurse provided home health aide supervision to ensure the home health aide followed the aide care plan as directed. 4. Clinical record review on 8/1/2022, for Patient #6, start of care 5/25/2021, evidenced an agency document titled “Plan of Care Service Plan” dated 6/29/2022, and identified by the administrator as the home health aide care plan. Review indicated the home health aide was to shampoo the patient’s hair and assist with nail care 1 time a week. Review of agency documents titled “Daily Visit Sheet”, identified by the administrator as home health aide visit notes, indicated the home health aide shampooed the patient’s hair and provided nail care 4 times a week during the weeks of 7/3/2022, 7/10/2022, and 7/17/2022. Review failed to evidence the home health aide provided services as directed by the care plan. Review of an agency document titled “Supervisory Visit Form” dated 7/27/2022 and signed by the RN, indicated the home health aide followed the care plan. Review failed to evidence the registered nurse provided home health aide supervision to ensure the home health aide followed the aide care plan as directed. 5. Clinical record review on 8/2/2022, for Patient #8, start of care 2/17/2021, evidenced an agency document titled “Plan of Care Service Plan” dated 6/20/2022. Review indicated the home health aide was to provide nail care 1 time weekly. Review of agency documents titled “Daily Visit Sheet” indicated the home health aide provided nail care 2 times a week during the week of 6/19/2022 and 3 times a week during the weeks of 6/26/2022 and 7/3/2022. Review failed to evidence the home health aide provided services as directed by the care plan. Review of an agency document titled “Supervisory Visit Form” dated 7/28/2022 and signed by the RN,	G0818		

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G0818	Continued from page 111 indicated the home health aide followed the care plan. Review failed to evidence the registered nurse provided home health aide supervision to ensure the home health aide followed the aide care plan as directed. 6. During an interview on 8/4/2022, at 3:07 PM, Administrator #1 indicated the RN should review the home health aide visit notes and should follow-up with the home health aide if the plan of care was not followed. Administrator #1 indicated the RN should not have indicated the home health aide was providing services as directed in the plan of care. 17-14-1(n)	G0818		
G0940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to ensure the organization and management of the home health agency as follows: the administrator failed to maintain the day-to-day operations of the agency (see tag G0948); the administrator failed to ensure the agency employed qualified personnel (see tag G0952); and the clinical manager failed to ensure the implementation of the plan of care (see tag G0968). The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a	G0940		

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G0940	Continued from page 112 safe environment for the condition of participation 42CFR 484.105 Organization and Administration of Services. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the agency failed to ensure administrative function of maintaining the personnel files, random drug testing selection, and COVID-19 vaccination tracking were not delegated to another agency or organization, failed to ensure the Indiana Department of Health was notified of administrative staff changes, and failed to establish the lines of authority. The findings include: 1. Review of an undated agency job description on 8/15/2022, titled “Administrator” stated, “… The Administrator … Maintains compliance with applicable federal, state, accrediting bodies and local rules and regulations….” 2. Review of pre-survey information on 7/19/2022, from the Indiana Department of Health, indicated Person J was the alternate clinical manager. Review of an untitled, undated agency document on 7/19/2022, identified by Administrator #1 as the organizational chart, indicated the alternate administrator reported to the administrator. During an interview at the entrance conference on 7/19/2022, at 12:15 PM, Administrator #1 indicated registered nurse (RN) #13, date of hire 4/19/2021, was the alternate clinical manager. At 2:05 PM, Administrator #1 indicated Person J was the previous alternate clinical manager and indicated the Indiana Department of Health had not yet been notified of the change in the alternate clinical manager. During an interview on 8/1/2022, at 10:00 AM, Administrator #1 indicated RN #13 started as the alternate clinical manager in April 2022. During an interview on 8/1/2022, at 4:57 PM, Administrator #1 indicated the alternate administrator reported to Administrative Staff #7, governing body member. During an interview on 8/2/2022, at 12:45 PM, the alternate administrator indicated he reported to Administrative Staff #7, governing body member.	G0940		

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G0940	Continued from page 113 During an interview on 8/2/2022, at 10:33 AM, licensed practical nurse (LPN) #6 indicated Administrative Staff #10 was the agency administrator and indicated she was unsure who was the clinical manager. During an interview on 8/3/2022, at 8:20 AM, home health aide (HHA) #2 indicated Administrative Staff #12 was the agency administrator and was unsure who was the clinical manager. During an interview on 8/2/2022, at 9:10 AM, Administrative Staff #11 indicated she was aware of the alternate clinical manager's name but was unsure of her role and title. 3. During an interview on 7/20/2022, at 11:40 AM, Administrator #1 indicated the personnel files were not maintained at this agency but by the corporate office and unsure if the corporate office was in Chicago or Indianapolis. Administrator #1 indicated she was unsure how the agency personnel for random drug tests was selected. During an interview at the end-of-day conference at 1:54 PM, Administrator #1 indicated the agency did not have a written agreement with the corporate office. During an interview on 7/20/2022, at 11:40 AM, Administrative staff #10 indicated the corporate office chooses the names of the personnel selected for the random drug tests. A request was made for the personnel file for Administrative Staff #10 on 8/1/2022, at 12:05 PM. During an interview on 8/2/2022, at 12:12 PM, Administrator #1 indicated she knew the corporate office was still working on getting the personnel record for Administrative Staff #10. During an interview on 8/3/2022, at 3:39 PM, Administrator #1 indicated there was no word from the corporate office on where the personnel record was for Administrative Staff #10. At 5:02 PM, Administrator #1 indicated no one at the agency has access to the personnel record for Staff #10 and corporate was still trying to locate the personnel record. Administrator #1 indicated any personnel record that was not scanned into the electronic personnel record, no one from the agency has access to the paper personnel record. No other documentation for the personnel record	G0940		

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G0940	Continued from page 114 for Administrative Staff #10 was provided. During an interview on 8/5/2022, at 10:08 AM, Administrator #1 indicated the corporate human resources office reviewed and approved the requests for COVID-19 vaccine exemption and tracked the COVID-19 vaccination status for agency personnel. 17-12-1(a)(1) 17-12-1(a)(2)	G0940		
G0948	Responsible for all day-to-day operations CFR(s): 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the administrator failed to be responsible for the day-to-day operations of the agency. The findings include: Review of an undated agency job description on 8/15/2022, titled “Administrator” stated, “… The Administrator … responsible for all day-to-day operations of the Agency. … Employs qualified personnel and ensures adequate staff education and evaluations. … Uniformly enforces policies and procedures. … Evaluates effectiveness and efficiency of the Agency. … Uses statistical data to determine quality and quantity of services. Maintains compliance with applicable federal, state, accrediting bodies and local rules and regulations. … Plans and directes operations to ensure the provision of adequate and appropriate care and services. … Recruits employees and retains qualified personnel to maintain appropriate staffing levels by employing qualified staff. … Ensures staff development including orientation, inservice education and continuing education. Coordinates with other program areas and management as appropriate. … Directs and monitors organizational Quality Assessment and Performance Improvement activities….” The administrator failed to ensure the day-to-day operations of the home health agency as evidenced	G0948		

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G0948	Continued from page 115 by: The administrator failed to ensure there was a complete Emergency Preparedness Program in place for the home health agency. Please see tags associated with federal regulation 42CFR 484.102. The administrator failed to ensure OASIS (Outcome and Assessment Information Set, a comprehensive assessment data collection tool) assessments were transmitted to the CMS system. Please see tag G0372. The administrator failed to ensure the patients were provided the name of the administrator to receive complaints. Please see tag G0414. The administrator failed to ensure the patient was discharged because the physician responsible for the plan of care and the agency agreed the measurable goals and outcomes set forth in the plan of care had been achieved. Please see tag G0458. The administrator failed to ensure the comprehensive assessment included a review of all the patient's medications for potential interactions. Please see tag G0536. The administrator failed to ensure the comprehensive assessment was updated and revised to include new wounds. Please see tag G0544. The administrator failed to ensure the discharge/transfer summary included all necessary information pertaining to services received, post-discharge goals of care, and current medications and failed to ensure the summary was sent to the receiving healthcare practitioner. Please see tag G0564. The administrator failed to ensure the home health agency was meeting all the needs of agency patients. Please see tag G0570.	G0948		

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G0948	Continued from page 116 The administrator failed to ensure the services were provided to the patient as directed in the plan of care. Please see tag G0572. The administrator failed to ensure the plan of care contained all required elements. Please see tag G0574. The administrator failed to ensure all drugs, treatments, and services were only provided as ordered by a physician or other appropriate healthcare professional. Please see tag G0580. The administrator failed to ensure the clinician received orders from a qualified healthcare professional and documented verbal orders in the patient's clinical record. Please see tag G0584. The administrator failed to ensure the plan of care was reviewed and revised by the primary care physician every 60 days. Please see tag G0588. The administrator failed to ensure the primary care physician was promptly alerted to changes in the patient’s condition. Please see tag G0590. The administrator failed to ensure there was coordination of care amongst all agency disciplines and with outside healthcare entities who serviced agency patients. Please see tag G0606. The administrator failed to ensure there was a written visit schedule in all patients’ homes. Please see tag G0614. The administrator failed to ensure there was a written, current medication schedule in all patients’ homes. Please see tag G0616. The administrator failed to provide the patient and caregiver in writing with the treatments to be administered by agency personnel. Please see tag G0618.	G0948		

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G0948	Continued from page 117 The administrator failed to provide the patient and caregiver in writing with the name and contact information of the clinical manager. Please see tag G0622. The administrator failed to ensure there was a Quality Assessment and Performance Improvement (QAPI) program maintained at the home health agency. Please see tag G0640. The administrator failed to ensure the agency created and implemented written policies and procedures which are compliant with requirements for CMS (Centers for Medicare and Medicaid Services) vaccine mandate. Please see tag G0680. The administrator failed to ensure all employees practiced standard/universal precautions to prevent the transmission of infections and failed to follow agency infection control policies and procedures. Please see tag G0682. The administrator failed to ensure all home health agency skilled professionals provided services as indicated on the plan of care. Please see tag G0710. The administrator failed to ensure skilled professionals created clinical notes and/or accurate complete notes for all services provided to patients. Please see tag G0716. The administrator failed to ensure the skilled professional provided supervision of the licensed practical nurse (LPN). Please see tag G0726. The administrator failed to ensure all tasks for the home health aide were assigned specific to the needs of the patient. Please see tag G0798. The administrator failed to ensure all services provided by the home health aide followed the care plan. Please see tag G0800.	G0948		

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G0948	Continued from page 118 The administrator failed to ensure the home health aide failed to report changes in the patient's condition to a registered nurse. Please see tag G0804. The administrator failed to ensure the supervising nurse ensured the home health aide followed the aide care plan. Please see tag G0818. The administrator failed to employ qualified personnel. Please see tag G0952. The administrator failed to ensure the clinical manager implemented the plans of care. Please see tag G0968. The administrator failed to ensure all clinical records contained all required documentation of services rendered by agency staff. Please see tag G1012. The administrator failed to ensure all clinical notes were accurate and appropriately authenticated. Please see tag G1024. During an interview on 8/2/2022, at 3:50 PM, Administrator #1 indicated she was unsure how the staff education was tracked to ensure it was completed. During an interview on 8/11/2022, at 10:40 AM, Administrator #1 indicated she was unsure what quality indicator data was collected to monitor the effectiveness of services and the quality of care. 17-12-1(c)(1)	G0948		
G0968	Assure implementation of plan of care CFR(s): 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the clinical	G0968		

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G0968	Continued from page 119 manager failed to ensure the plans of care were implemented in 4 of 6 active clinical records reviewed with home health aide services. (#4, 5, 6, 7) The findings include: 1. Review of an undated agency job description on 8/15/2022, titled “Area Clinical Leader” stated, “… Responsible in planning, directing, and evaluating the clinical operations … Directs, coordinates, and evaluates the delivery of home care services ….” 2. Clinical record review on 8/1/2022, for patient #5, start of care 11/11/2021, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 7/9/2022 – 9/6/2022. Review indicated the agency was to provide home health aide services 3 hours a visit, 2 visits a day, 7 days a week for personal care and assistance with ADLs (activities of daily living). Review indicated the agency did not provide home health aide services as ordered on 6/5/2022, 6/12/2022, 6/14/2022-6/26/2022, 6/28/2022-7/1/2022, 7/3/2022, 7/5/2022-7/10/2022, 7/12/2022-7/17/2022, 7/20/2022-7/24/2022, and 7/31/2022. Review indicated the agency failed to provide home health aide services for 2 visits on 6/8/2022, 6/13/2022, 6/27/2022, 7/2/2022, 7/4/2022, 7/11/2022, 7/18/2022, 7/19/2022, 7/26/2022, 7/27/2022, 7/29/2022, 8/2/2022, 8/5/2022, and 8/6/2022. During an interview on 8/3/2022, at 4:20 PM, the clinical manager indicated she was unaware of any staffing issues for the patient and would reach out to the South Bend branch. The administrator indicated the branch manager at each location was to notify her if there were patients whose frequencies were not being met as ordered. 3. Clinical record review on 8/1/2022, for Patient #7, start of care 4/2/2021, evidenced an agency document titled “Home Health Certification/Recertification Plan of Care Order” for certification period 5/27/2022-7/25/2022, which indicated the agency was to provide home health aide services 6 hours a day, 7 days a week. Review failed to evidence the agency provided 6 hours a day of home health aide services on 6/5/2022-6/20/2022, 6/23/2022-7/15/2022, and 7/17/2022-7/30/2022. Review failed to evidence the	G0968		

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G0968	Continued from page 120 agency provided a home health aide at all on 6/17/2022, 6/22/2022, and 7/16/2022. During an interview on 8/4/2022, at 3:00 PM, the clinical manager indicated the patient was difficult to staff due to the patient's treatment of staff. The administrator indicated the agency keeps trying to find new staff to provide home health aide services to the patient. 4. Clinical record review on 8/3/2022, for Patient #4, start of care 6/3/2020, evidenced an agency document titled "Home Health Certification/Recertification Plan of Care Order" for certification period 5/24/2022-7/22/2022 which indicated the agency was to provide home health aide services 2 hours a day, 3 days a week. Review indicated the agency failed to provide the home health aide 3 days a week as directed in the plan of care during the weeks of 6/26/2022 and 7/3/2022. During an interview on 8/8/2022, the clinical manager indicated the home health aide was sick and there were no alternate days offered to the patient to meet the patient's ordered frequency. 5. Clinical record review on 8/1/2022, for Patient #6, start of care 5/25/2021, evidenced agency documents titled "Home Health Certification/Recertification Plan of Care Order" for certification periods 5/3/2022-7/1/2022 and 7/2/2022-8/30/2022, which indicated the agency was to provide home health aide services 6 hours a day, 4 days a week. Review indicated the agency did not provide home health aide services 4 days a week per the plan of care during the weeks of 6/5/2022, 6/26/2022, and 7/24/2022. Review failed to evidence the agency provided 6 hours a day of home health aide services per the plan of care on 7/2/2022, 7/5/2022, and 7/23/2022. During an interview on 8/4/2022, at 2:22 PM, the clinical manager indicated during the week of 6/5/2022 and 6/27/2022, the home health aide called off. Administrator #1 indicated there were no documented attempts to reschedule the visits. 6. During an interview at entrance conference on 7/19/2022, at 12:15 PM, the administrator indicated she was the clinical manager and the Area Clinical Leader. 7. During an interview on 8/4/2022, at 3:20 PM,	G0968		

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G0968	Continued from page 121 the clinical manager indicated the governing body was pushing patient admissions despite the lack of adequate staffing to ensure the services were provided as directed in the plan of care. 17-14-1(a)(1)	G0968		
G1012	Required items in clinical record CFR(s): 484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to include clinical notes in the clinical record in 3 of 8 active clinical records reviewed. (#1, 3, 8) The findings include: 1. Review of an agency policy, revised 1/4/2022, titled “Medical Record Content” stated, “… Clinical notes are incorporated into the clinical record within fourteen (14) days…. 2. Clinical record review on 8/3/2022, for Patient #1, start of care 11/26/2019, evidenced skilled nurse visits were completed on 6/21/2022, 6/23/2022, 6/30/2022, 7/5/2022, 7/7/2022, 7/19/2022, 7/21/2022, 7/26/2022, and 7/28/2022. Review failed to evidence skilled nurse visit notes were incorporated into the clinical record since 6/14/2022. 3. Clinical record review on 8/3/2022, for Patient #3, start of care 5/5/2021, evidenced skilled nurse visits were completed on 6/30/2022, 7/5/2022, 7/6/2022, 7/7/2022, and 7/8/2022. Review failed to evidence the skilled nurse visit notes were incorporated into the clinical record. 4. Clinical record review on 8/2/2022, for Patient #8, start of care 2/17/2021, evidenced home health aide visits were completed on 6/14/2022, 6/16/2022, 6/17/2022, and 6/21/2022. Review failed to evidence the skilled nurse visit notes were incorporated into the clinical record.	G1012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2022

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HELP AT HOME SKILLED CARE	833 W LINCOLN HIGHWAY SUITE 330 E , SCHERERVILLE, Indiana, 46375

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G1012	Continued from page 122 5. During an interview on 8/3/2022, at 12:55 PM, Administrator #1 indicated the skilled nurse visit notes are completed on paper. The administrator indicated the case manager reviews the skilled nurse visit notes before the visit notes are scanned into the clinical record and indicated the cases manager must not have completed the review yet. During an interview on 8/5/2022, at 3:35 PM, Administrator #1indicated if the plan of care is not published when the new plan of care begins, the home health aide visit notes for the visits completed do not show up in the electronic clinical record. 17-15-1(a)(4)	G1012		
G1024	Authentication CFR(s): 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the clinical record was accurate and complete to include the signature, title, and date in 2 of 6 clinical records reviewed with home health aide services. (#1, 5) The findings include: 1. Review of an agency document revised 1/4/2022, titled “Medical Record Entries and Authentication” stated, “… By authenticating entries in the client’s record, staff is validating the correctness of the information. … authentication includes a signature and title ….” 2. Clinical record review on 8/3/2022, for patient #1, start of care 11/26/2019, evidenced an agency document titled “Plan of Care Service Plan” identified by the administrator as the home health aide care plan dated 7/8/2022. Review evidenced personal care and assistance with activities of daily living (ADL) to be completed. Review of the clinical record failed to evidence home health	G1024		

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HELP AT HOME SKILLED CARE	**833 W LINCOLN HIGHWAY SUITE 330 E , SCHERERVILLE, Indiana, 46375**

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G1024	Continued from page 123 aide services were provided to the patient. During an interview on 8/5/2022, at 3:59 PM, Administrator #1 indicated she was unsure why the clinical record contained a home health aide care plan because the agency did not provide home health aide services. The administrator indicated the home health aide care plan was completed in error. 3. Clinical record review on 8/1/2022, for patient #5, start of care 11/11/2021, failed to evidence home health aide visit notes for 7/19/2022 and 7/28/2022 (shift 5:00-8:00 PM). A request for the visit notes was made to the administrator. Review of the printed agency documents titled “Tasks Report by Client” dated 7/19/2022 and 7/28/2022 and identified by the administrator as home health aide visit notes, failed to evidence a signature, date, and title from the home health aide who completed the visit. During an interview on 8/3/2022, at 4:55 PM, Administrator #1 indicated she was unsure why the visit notes printed without the electronic signature, date, and title of the staff who completed the visit. 17-15-1(a)(7)	G1024		
G1028	Protection of records CFR(s): 484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview, the home health agency failed to ensure the patient's protected health information (PHI) was safeguarded against loss or unauthorized use for 1 of 1 random record revealed during the Logansport branch visit tour (#12).	G1028		

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G1028	Continued from page 124 Findings include: During an interview on 8/8/2022, at 11:00 AM, the administrator indicated staff should lock computer screens and flip papers over when walking away from patient information. 17-15-1(c) On 8/04/2022, the agency's South Bend branch was visited from 12:22 PM - 1:30 PM. At 1:10 PM, observed a patient document titled "Physician Order" for certification period 5/13/2022 - 7/11/2022. The document clearly revealed Patient #12's last name, first name, date of birth, gender, address, phone number, health insurance claim number, and medical record number. The document was lying on the top of a piece of office equipment, and was easily observed from a public reception area in the entrance of the building.	G1028		