STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	200081930A	A. BUILDING B. WING	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCROGGINS NURSING AND HOME SERVICES INC	8525 SW JENNINGS ST, COMMISKEY, IN, 47227

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health Agency. Survey Dates: 9/26/2022-10-03/2022 Facility ID: IN010088 Active census: 23	N0000		2022-11-23
G0000	INITIAL COMMENTS This visit was for a Federal and State Re-licensure Survey of a Home Health Agency. Survey Dates: 9/26/2022-10/03/2022	G0000	The agency has read the responses and have implemented the corrections. This tag is the initial responses for the survey and doesn't have anything we need to correct listed.	2022-11-23

	Facility ID: IN010088 Active census: 23 The Survey was Partially Extended on 9/29/2022 at 3:00 p.m. These deficiencies reflect State Findings cited in accordance with 410 IAC 17. Refer to state form for additional state findings. QR Completed 10/19/2022 A4			
G0372	Encoding and transmitting OASIS 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. Based on record review and interview, the agency failed to	G0372	The agency will ensure that all client's with skilled nursing services and over the age of 18 have an electronic oasis completed every 60 days. The agency will also ensure that the paper copy is placed with the plan of care in the client's chart. These records will also be kept in a binder so that the submission record of each oasis submission can be viewed upon request. This will be done by keeping a binder with a calendar that includes dates of when each submission is due.	2022-10-31

	encode and transmit completed OASIS (Outcome and Assessment Information Set) assessment data on 4 of 4 skilled patient records reviewed (Patient #1, #2, #3, & #5), which had the potential to affect all patients. Findings include: A policy titled "Comprehensive Assessment of Client Discharge" was provided by the Director of Nursing on 09/26/2022 at 11:30 a.m. The policy indicated but was not limited to; "Discharge OASIS Data will be collected at the time of discharge...the collected data will be encoded/locked within 7 calendar days from the date of the collection...collected data will be transferred to the state monthly...validation reports to verify transmission will be maintained in the client's record." During an interview on 9/26/2022 at 1:30 p.m. the Director of Nursing (DON) was asked for a copy of their validation reports showing the agency was submitting OASIS		The DON is responsible for maintaining Oasis submission and ensuring that they are completed in a timely manner.	

	the age of 18 utilizing Medicaid or Medicare. On 9/29/2022 at 10:30 a.m. the Director of Nursing stated they went to pull their validation reports and were unsuccessful. They contacted the help desk and were working with the state to fix the issue. The DON believes they are using an outdated program to submit the data which is why it was unsuccessful but are now working with the state to get it updated and corrected.			
N0434	Renewal of home health licensure 410 IAC 17-11-3 Rule 11 Sec. 3 An application for renewal of license shall be filed with the department at least sixty (60) days prior, but not sooner than ninety (90) days before, the expiration date of the current license. Based on record review and interview the agency failed to file a license renewal application with the Department of Health prior to 60 days but not sooner than 90 days of the expiration of the current license for 3 of 3	N0434	The agency was out of compliance with this regulation because we failed to ensure that all of our home health aides and nurses renewed their licenses in the 60 day window prior to their expiration date. The agency has since sent out a memo notifying all home health aides and nurses of this requirement. Our office manager has a list of all employees this pertains to along with the date of expiration of their licenses, she will send out reminder notices 15 days prior to the 60 day window and follow up to ensure this requirement is met. If an employee fails to meet this requirement they will not be able to provide patient care until the issue is resolved. This will be continuously monitored by documenting this information in a spreadsheet and keeping track of who renews and when they renew their license via spreadsheet. This process also includes sending reminders 15 days prior to the 60 day window. The office manager and the DON are responsible for this process.	2022-11-01

	years reviewed (2020, 2021, & 2022). Findings include: The agency's 2022 license expired on 07/31/2022. The license renewal application was received on 07/27/2022. The agency's 2021 license expired on 07/31/2021. The license renewal application was received on 08/03/2021. The agency's 2020 license expired on 07/31/2020. The license renewal application was received on 07/22/2020 During an interview on 10/03/2022 at 11:30 a.m., the Director of Nursing stated they did not realize the application should be submitted in the 60-90 day window prior to the expiration of their current license and they would make sure to stay on top of that.			
G0452	Transfer and discharge 484.50(d)	G0452	The agency will ensure that all admission packets include a copy of our discharge policy so that each client is aware of their discharge rights. The agency will also ensure that within five (5) days of a transfer/discharge that a discharge assessment is completed and filed not only in the client's chart but also send to their primary physician. During this process we	2022-10-31

	Standard: Transfer and discharge. The patient and representative (if any), have a right to be informed of the HHA's policies for transfer and discharge. The HHA may only transfer or discharge the patient from the HHA if: Based on record review, and interview the agency failed to provide all patients with a written policy informing them of their discharge rights prior to discharge for 7 of 7 clinical records reviewed. (Patient #1, #2, #3, #4, #5, #6, & #7). Findings include: 1. An undated policy was provided by the Director of Nursing (DON) on 9/26/2022 at 11:36 a.m. The policy indicated but was not limited to; "Clients or their legal representative will be notified of their discharge from the agency (5) calendar days before services are stopped." 2. The agency's admission packet was provided by the DON on 9/26/2022 at 11:36 a.m. and failed to evidence of a copy of the agency's transfer or discharge policy. 3. The complete clinical record		will also ensure that the client being discharged/transferred understands and has read our discharge/transfer policy and will be given a second copy of the policy. The agency will also update their policy to ensure it contains the exact process of a discharge/transfer and our employees that handle discharges or transfers will be educated on the process as well. This process will be implemented by reviewing the current policy to ensure that it includes all pertinent information. The agency will also have employees locate the admission packet in each of their client's homes so that they know where it is and can place a copy of the this policy in each client's admission packet. The office manager, human resources director, and the DON will oversee that these actions are completed and meet state standards.	

	9/26/2022 and failed to evidence documentation that patient #1 received a copy of the agency's discharge/transfer policy. 4. The complete clinical record for patient #2 was reviewed on 9/26/2022 and failed to evidence documentation that patient #2 received a copy of the agency's discharge/transfer policy. 5. The complete clinical record for patient #6 was reviewed on 9/29/2022 and failed to evidence documentation that patient #6 received a copy of the agency's discharge/transfer policy. 6. The complete clinical record for patient #7 was reviewed on 9/29/2022 and failed to evidence documentation that patient #7 received a copy of the agency's discharge/transfer policy. 8. During a home visit on 9/27/2022 for patient #5, patient #5 did not have an agency admission packet or documentation for review. 9. During a home visit on 9/28/2022 for patient #4 at 9:00			

	a.m., patient #4 stated they did not have an admission packet or documents to review. 10. During a home visit on 9/28/2022 for patient #3 at 11:40 a.m., patient #3 did not have a written discharge/transfer policy in the home. 11. During an interview on 9/27/2022 at 3:50 p.m. the Director of Nursing stated, "We do need to update our policies. I actually like the survey process because it helps us recognize what we may in have missed in regulation changes."			
N0462	Home health agency administration/management 410 IAC 17-12-1(h) Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on record review and	N0462	The agency was out of compliance with this regulation because our physical form that employees must have completed before their first day of patient contact did not include an area for the NP or physician to state that they are free from all infectious and communicable diseases. The agency has corrected this by adding a section to the bottom of the physical form for the doctor to check if the employee is free from infectious or communicable diseases. This form will be completed by any and all new employees prior to their first patient contact. This has been corrected by adding a section to our already existing physical form that can be found in our employee packet. The office manager was responsible for correcting the form and the DON and human resource director will be responsible for making sure each employee has a form on file	2022-10-19

	interview the agency failed to ensure all personnel records included a physical that indicated the employee was from infectious or communicable diseases or sufficient to ensure employees would not spread infectious or communicable diseases for 8 of 8 personnel records reviewed. (Employee B, D, E, H, F, I, C, & O). Findings include: 1. The complete personnel record for employee B was reviewed on 9/29/2022 and the health physical failed to indicate employee B was free from infectious or communicable diseases. 2. The complete personnel record for employee D was reviewed on 9/29/2022 and the health physical failed to indicate employee D was free from infectious or communicable diseases		in their medical file prior to their first patient contact.	

	3. The complete personnel record for employee E was reviewed on 9/29/2022 and the health physical failed to indicate employee E was free from infectious or communicable diseases 4. The complete personnel record for employee H was reviewed on 9/29/2022 and the health physical failed to indicate employee H was free from infectious or communicable diseases 5. The complete personnel record for employee F was reviewed on 9/29/2022 and the health physical failed to indicate employee F was free from infectious or communicable diseases 6. The complete personnel record for employee I was reviewed on 9/29/2022 and the health physical failed to indicate employee I was free from infectious or communicable diseases 7. The complete personnel record for employee C was reviewed on 9/29/2022 and the health physical failed to indicate employee C was free from infectious or communicable			

	diseases 8. The complete personnel record for employee O was reviewed on 9/29/2022 and the health physical failed to indicate employee O was free from infectious or communicable diseases 9. During an interview at 10:45 a.m. the Director of Nursing stated all employees do have health physicals but did not realize they needed to indicate the employee was free of or free from spreading infectious and/or communicable diseases.			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances:	N0488	The agency failed to meet this requirement because our discharge policy gave a 5 day notice instead of the required 15 days. The discharge policy will be updated to state that the client will be notified 15 days prior to discharge in writing with the reason as to why they are being discharged. Whether that is because the client wants to be discharge, they no longer need services, the agency can no longer provide appropriate services, or the agency can no longer receive payment for the client's services. All future client's will be informed of and receive a copy of this policy in their admission folder. Current clients will receive the updated policy and will be asked to place it in their already existing admission folder. The DON is responsible for updating the policy and then the human resource director and office manager will help to ensure that all current clients receive a copy of the updated policy. The DON will ensure that all future	2022-11-23

	(1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview the agency failed to create and implement a policy requiring the agency to provide patients a 15-day notice prior to discharge for 1 of 1 agency reviewed. Findings include:		admitted and fully understand the policy. The updated policy will then also be added to our policy and procedure manual.	

	1. An undated policy was provided by the Director of Nursing (DON) on 9/26/2022 at 11:36 a.m. The policy indicated, but was not limited to; "Clients or their legal representative will be notified of their discharge from the agency (5) calendar days before services are stopped." 2. The agency's admission packet was provided by the DON on 9/26/2022 at 11:36 a.m. and failed to evidence a copy of the agency's transfer or discharge policy. 3. During an interview on 9/27/2022 at 3:50 p.m. the Director of Nursing stated, "We do need to update our policies. I actually like the survey process because it helps us recognize what we may in have missed in regulation changes."			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses;	G0574	This deficiency will be corrected by doing the following: 1. each chart will be audited to ensure that each plan of care now includes patient specific goals/outcomes and that they are related to each client's specific diagnosis and health status. Every 60 days this will be evaluated again and changes will be made as necessary. 2. Each plan of care will be updated to include each client's risk for an ER visit or hospitalization and will also be reviewed every	2022-11-15

	(ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview the agency failed to include the patients' risk for hospitalization and failed to include patient-specific education, outcomes, and measurable goals identified by the patient and the agency for 7 of 7 clinical records reviewed. (Patient #1, #2, #3, #4, #5, #6, & #7).		necessary. This will be achieved by conducting an audit of all current client charts. The DON will be responsible for completing the audit and updating the plan of care for each client to include these changes.	

	1. An undated policy titled "Certification and Plan of Treatment" was provided by the Director of Nursing (DON) on 9/26/2022 at 11:30 a.m. The document indicated, but was not limited to; "The goals should be measurable ..." 2. The complete clinical record for the certification period of 01/20/2022-3/20/2022 for patient #1 was reviewed on 9/26/2022 and included the following: A document titled Certification and Plan of Treatment dated 2/08/2022 for patient #1 indicated but was not limited to; "Goals ... client will be clean and free from odor (ongoing)." The plan of care failed to include patient #1's risk for an emergency room visit or rehospitalization. 3. The complete clinical record for the certification period of 6/20/2022-8/18/2022 for patient #2 was reviewed on 9/26/2022 and included the following: A document titled Certification and Plan of Treatment dated			

	indicated but was not limited to; "Goals ... client will be clean and free from odor (ongoing)." The plan of care failed to include patient #2's risk for an emergency room visit or rehospitalization. 4. The complete clinical record for the certification period of 08/01/2022-09/29/2022 for patient #3 was reviewed on 9/27/2022 and included the following: A document titled Certification and Plan of Treatment dated 8/11/2022 for patient #3 indicated, but was not limited to; "Goals ... client will have necessary care while the primary caregiver is absent from the home (ongoing)." The plan of care failed to include patient #3's risk for an emergency room visit or rehospitalization. 5. The complete clinical record for the certification period of 06/10/2022-08/08/2022 for patient #4 was reviewed on 9/27/2022 and included the following: A document titled Certification			

	and Plan of Treatment dated 6/10/2022 for patient #4 indicated, but was not limited to; "Goals ... client will maintain adequate nutrition, and skin integrity." The plan of care failed to include patient #4's risk for an emergency room visit or rehospitalization. 6. The complete clinical record for the certification period of 08/31/2022-10/29/2022 for patient #5 was reviewed on 9/27/2022 and included the following: A document titled Certification and Plan of Treatment dated 6/10/2022 for patient #5 indicated, but was not limited to; "Goals ...client will be able to meet/perform all aspects of care." The plan of care failed to include patient #5's risk for an emergency room visit or rehospitalization.			

	7. The complete clinical record for the certification period of 08/31/2022-10/29/2022 for patient #6 was reviewed on 9/27/2022 and included the following: A document titled Certification and Plan of Treatment dated 8/23/2022 for patient #6 indicated, but was not limited to; "Goals ...client will be clean and free from odor (ongoing)." The plan of care failed to include patient #6's risk for an emergency room visit or rehospitalization. 8. The complete clinical record for the certification period of 07/21/2022-09/18/2022 for patient #7 was reviewed on 9/29/2022 and included the following: A document titled Certification and Plan of Treatment dated 7/24/2022 for patient #7 indicated, but was not limited to; "Goals ...client will be clean and free of odor." The plan of care failed to include patient #5's risk for an emergency room visit or rehospitalization.			

	9. During an interview on 10/03/2022 the Director of Nursing stated she agreed the patient's goals were not measurable, did not include the patient's personal goals, and did not include interventions for achieving those goals. The DON was unable to identify the patient's risk for an emergency room visit or hospitalization risk on the plans of care. 410 IAC 17-13-1(a)(1)(D)(xiii)			
G0644	Program data 484.65(b)(1),(2),(3) Standard: Program data. (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. Based on record review, and interview, the agency failed to	G0644	This deficiency will be corrected during our governing body meetings. Going forward at each meeting we will look at the Oasis data that has been collected on our clients so that we can track issues that may be present, such as falls or wounds. This will help us identify the client's at risk for these issues and implement measures to decrease that risk. The Oasis data will be put into spreadsheet form so that it is easy to look at and review. At each meeting this data will be presented and discussed by the members on the governing body. Prior to each meeting the DON will ensure that this information is updated so the the governing body has the most current data. A copy of the spreadsheet will be included in the board meeting minutes binder. This will be completed by having the DON insert the Oasis data of each client into a spreadsheet and update that spreadsheet every 60 days in order to ensure that the governing body is always reviewing current data.	2022-11-15

	OASIS (Outcome and Assessment Information Set) data being incorporated into the quality assurance improvement program for 1 of 1 agency reviewed. Findings Include: 1. Review of patient #? lacked evidence of OASIS submission. 2. Review of patient #? lacked evidence of OASIS submission. 3. Review of patient #? lacked evidence of OASIS submission. Findings include: On 10/03/2022 the agency's Quality Assurance Program was reviewed and failed to incorporate OASIS data into the improvement program. During an interview with the Director of Nursing on 10/03/2022 at 10:42 a.m., they stated they do not incorporate OASIS data but will address this at the next Governing Body Meeting. They stated they do complete an OASIS for each patient when required so they have the data it is just not in the binder.		The DON will be responsible for presenting this data as well as collecting the data for each governing body meeting.	

G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview the agency failed to track adverse patient events in their quality assurance and improvement program for 1 of 1 agency reviewed. Findings include: A Quality Assurance Program policy was provided by the Director of Nursing (DON) on 9/29/2022. The document indicated the Quality Assurance program is designed to systematically and objectively monitor the quality of patient care. On 10/03/2022 the agency's Quality Assurance Program was reviewed and failed to evidence the tracking of patient adverse events. During an interview on	G0654	This deficiency will be corrected by initiating a program that tracks any adverse events that any of our client's experience. Every time we have a fall, infection, or any other adverse event that data will be put into a spreadsheet so that we have a record of any and all adverse events. The agency will then review this data every time we do quality assurance audits of the chart. This will help us identify which patients are at a higher risk for these events. We have already started implementing this in the chart audits that we have done since the survey. Documentation of these events will be kept in our quality assurance binder so that it can be easily viewed. Any and all adverse events will be promptly reported to the DON so that she can update the spreadsheet and notify the appropriate individuals. Every quarter these reports will be discussed at the governing body meeting so that we can implement changes that may decrease the occurrence of these events. The DON is responsible for keeping track of these events as well as presenting the information during the governing body meeting.	2022-10-31

	DON stated they do not currently track adverse events such as falls or infections in their Quality Assurance program but they do audit charts quarterly. The DON stated they are a small agency so they usually are aware of any falls or infections but it is not tracked in the program. 410 IAC 17-12-2(a)			
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview the agency failed to develop, improve, or complete a performance improvement project for 1 of 1 agency	G0658	This deficiency will be addressed at our next governing body meeting. AT this meeting we will decide based on the information that is being and has been collected by our DON what our current project will be. This project will help us improve the quality of care that we are providing for our patients and will reflect what we see as the greatest current need of the majority of our clients. Once the highest need is identified we will have certain steps that we ask our employees to take to ensure that we are addressing this need and will have them report the progress in the homes that they are responsible for. The data collected from the caregivers will then be placed into a spreadsheet so that we can see how the issue is improving and will help us identify in the future if we need to address the topic again. THe employees in the field will be responsible for implementing certain steps in client's homes to ensure better care as well as responsible for reporting information back to the DON. The DON will be responsible for overseeing the entire project and keeping track of the data and information collected.	2022-11-15

reviewed.

Findings Include:

1. Quarterly medical record reviews completed for 10% of census or minimum of 5 records did not include the incorporation of OASIS data to identify and mitigate risk factors.
2. Quality indicators based on patient satisfaction surveys reviewed with monthly governing body meetings where satisfaction was equivalent to high quality care by skilled staff, rather than use of OASIS report data identifying significant events or trends.
3. Interview with Director of Nursing (DON) on 10/03/2022 at 10:40am revealed current Quality Assurance Performance Improvement (QAPI) Program was lacking necessary details for improvement plans discussed in governing body meetings. DON

and plans to incorporate this detail in future meetings.

4. Policy revised date of 01/04/2017 labeled Quality Assurance Program states SNHS (Scroggins Nursing and Homecare Services) will have an ongoing Quality Assurance Program ... designed to objectively and systematically monitor ...

Findings include:

A Quality Assurance Program policy was provided by the DON on 9/29/2022. The policy indicated, but was not limited to: the program is designed to systematically monitor and evaluate the quality and appropriateness of patient care, resolve unidentified problems, and improve the quality of care.

On 10/03/2022 the agency's Quality Assurance Program was reviewed and failed to evidence a current or past performance improvement project in place.

During an interview on 10/03/2022 at 10:40 a.m., the Director of Nursing stated they do not currently have any performance improvement

	projects but plan to incorporate this detail in the future.			
G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly	G0687	This deficiency has been corrected by the agency receiving either religious exemptions or vaccination cards from the remaining employees that were not in the binder at the time of the state survey. Going forward the agency will ensure that either a vaccination card or a religious or medical exemption form is collected from any and all new hires. The records will continue to be kept in the COVID vaccination binder as well as a copy in the employees medical file. The 3 individuals responsible for ensuring this process continues are the human resource director, the office manage, and the DON. The employee will not be allowed to have patient contact until these things are received by the office staff.	2022-10-31

	provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;			

	(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and			

(B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and

(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Based on record review and interview the agency failed to maintain a 100% compliance rate for the federal COVID-19 vaccination requirement for 5 of 29 personnel records reviewed. (Employee J, K, L, M & N)

Findings include:

A document titled "COVID-19 Vaccination Policy" was provided by the Director of Nursing on 10/03/2022 at 9:35 a.m. The document indicated, but was not limited to;
"Purpose: The policy is to ensure that all staff is either fully vaccinated for COVID-19 or

	has an exemption on file ... Employees will be required to have their vaccination card on file no more than five (5) days after their vaccination series complete ... Tracking employees who receive a medical/religious exemption ... This must be filed to the agency by the employee no more than five (5) days after completion." The agency COVID-19 Vaccination binder was provided by the Director of Nursing on 10/03/2022 at 9:35 a.m. The binder failed to evidence a vaccination card, medical exemption, or religious exemption for employees J, K, L, M, and N. During an interview on 10/03/2022 at 9:37 a.m. the Director of Nursing stated they had reached out to employees J, K, L, M, and N to provide copies of their vaccination cards for the employees' files.			
G1012	Required items in clinical record 484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments	G1012	This deficiency will be corrected by educating all employees on how to better document care provided, especially our nurses. They will recieve a copy of the client's plan of care so that they are completely aware of the goals that have been set for that client. All nurses will ensure that when charting they are addressing those goals and whether or not the client has met them and what is being done to	2022-10-28

	from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders; Based on record review and interview the agency failed to ensure the clinical record contained clinical notes recording clinical progress, interventions and response to those interventions, and goals including progress towards those goals for 2 of 4 skilled nursing clinical records reviewed. (Patient #1, & #3) Findings include: 1. A policy titled "Certification and Plan of Treatment" was provided by the Director of Nursing (DON) on 9/26/2022 at 11:30 a.m. The document indicated, but was not limited to; "Remember that what you the discipline should be doing, will be monitored on the care note of that discipline ... if items are not documented as ordered, it then appears the discipline is not following physician orders."		help ensure that they do meet those goals. Also nurses will be educated on providing documentation that always includes any and all treatments and interventions and the times that those were completed during their shift. The agency will also ensure that all nurses are documenting at least every 2 hours during a visit. when documenting the nurse will also document how the patient tolerated an intervention. THe agency will also ensure that all documents are backed up in several different ways to ensure that any and all documentation can be accessed. This will be done by utilizing flash drives. The DON will be responsible for ensuring the all employees especially nurses are well educated on the proper way they should be documenting care and will check notes as they come in to ensure the employees are implementing these changes.	

	2. The complete clinical record for patient #3 for the certification period of 8/01/2022 through 9/29/2022 was reviewed on 9/26/2022. The record included the following: A document titled "Certification and Plan of Treatment" that indicated, but was not limited to; " Principal Diagnosis: Cerebral Palsy ... Other Pertinent Diagnosis: Seizure Activity ... Orders for Discipline and Treatments ... 9-11 hours x [time] 5 days per week ... Assess for s/s [signs/symptoms] of disease process exacerbation ... physical assessment ... 60 Day Summary ... CP [Cerebral Palsy]/Seizure Activity, cannot stay alone ... has only had focal seizures." Clinical Notes dated from 8/01/2022 through 9/23/2022 were reviewed on 9/26/2022 and failed to evidence documentation of seizure status, failed to evidence documentation of focal seizures, exacerbation, and/or remission of seizure activity. Clinical notes indicate "6A Received [sic] care, 8A Breakfast,			

	The clinical documents failed properly to describe the patient's clinical status, the necessity for skilled nursing care, clinical progress, and improvement/decline in clinical status. 3. During an interview on 9/26/2022 employee H, a Licensed Practical Nurse, stated that patient #3 experienced a seizure the night before the visit that did not require medication. 4. The complete clinical record for patient #1 was reviewed on 9/26/2022 and included the following: Patient #1 had a start-of-care date of 9-10-2021 and an end-of-care date of 7/21/2022. Only 1 comprehensive assessment, the discharge comprehensive assessment, was included in the clinical record out of the required 6 comprehensive assessments for the period of care received. The record failed to include 5 of 6 plans of care, and 3 of 5 60-day summaries. 5. During an interview on 9/27/2022 at 1:00 p.m. the Director of Nursing stated she			

	missing documents and the backup copies of the files were located on a disk that is now corrupted and unable to be read. 410 IAC 17-15-1(a)(1)-(7)			
G1026	Retention of records 484.110(c)(1)(2) Standard: Retention of records. (1) Clinical records must be retained for 5 years after the discharge of the patient, unless state law stipulates a longer period of time. (2) The HHA's policies must provide for retention of clinical records even if it discontinues operation. When an HHA discontinues operation, it must inform the state agency where clinical records will be maintained. Based on record review and interview the agency failed to ensure all items in the clinical record were retained for a period of 5 years for 1 of 2 closed records reviewed. (Patient #1). Findings include: The complete clinical record for patient #1 was reviewed on 9/26/2022 for the period of	G1026	The agency will ensure that all files are safely backed up by utilizing several flash drives in case one becomes damaged. Also the agency will ensure that paper copies of all clinincal files are kept for at least 5 years. These paper documents will be maintained in a locked back room in files boxes. The agency is in the process of ensuring all paper documents are properly filed and labeled so that they can be easily found. WE are also conducting an audit of all thinned documents of current and past clients and properly disposing of documents that are older than 7 years to ensure that there is sufficient room in the locked room for us to keep documents for up to 5 years. Every time a client is discharged or a file is thinned the office staff will ensure that all documentation is included in the thinned or discharge file to ensure that if these files are requested in the future they will contain all required documentation. The individuals responsible for ensuring this process is maintained are the office manager, and the human resource director.	2022-10-20

	through 5/20/2022 (End of Care) and included: A plan of care for the certification period 1/20/2022 through 3/20/2022 indicating patient #1 received a home health aide 1-2 hours/day 1-3 days/week and attendant care services 1-4 hours/day 1-5 days/week. Aide Daily Visit Notes for the month of July 2022. A completed OASIS discharge assessment. The clinical record failed to include 5 of 6 required comprehensive assessments, 4 of 5 plans of care, 4 of 5 aide plans of care, and all home health aide visit notes for 2021 and January through June of 2022. During an interview on 9/27/2022 at 1:00 p.m. the Director of Nursing stated she was unsuccessful in locating the missing documents and the backup copies of the files were located on a disk that is now corrupted and unable to be read.			

	IAC 410 17-15-1(b)			
N9999	Final Observations Pursuant to Senate Enrolled Act No. 350, Indiana will no longer recognize the use of a "limited criminal history." Therefore, effective July 01, 2016 home health agencies and personal services agencies must obtain one of the following lifetime searches: An "(E)xpanded criminal history check" as defined at IC 20-26-2-1.5; or B) A "(N)ational criminal history background check" as defined at IC 10-13-3-12; Employees; criminal history Sec.4. (a) A person who operates a home health agency under IC 16-27-1 or a personal services agency under IC 16-27-4 shall apply, not more than three (3) business days after the date that an employee	N9999	The agency was not in compliance with running a national criminal background check on all employees. We were doing it on new hires but did not understand that we needed to go back and do it on employees that were hired before 2016. The agency is in the process of correcting this. We will be sending any employee that does not already have a national criminal history on record to obtain one. Each month we will send 3-5 employees who do not already have one to get their fingerprints taken in order to receive one. WE will continue to do this until all of our current employees have a national criminal background check on file. We have chosen to do it this way in order to ensure that it remains cost effective to our small agency. Once we receive the results of the background check it will be placed in their personell file. We will continue to send all new hires to get a national background check prior to their first patient contact. This will be done by sending 3-5 employees each month until every current employee has a national background check. The office manager and human resource director will be responsible for helping get the appointments set up and ensuring that the employees have these background checks completed. Once every employee has had a national background check the owner and DON will be notified that this process is completed.	2022-10-26

begins to provide services in a patient's temporary or permanent residence, for a copy of the employee's criminal history check.
(d) A home health agency or personal services agency may not employ a person to provide services in a patient's or client's temporary or permanent residence for more than three (3) business days without applying for a national criminal history background check or an expanded criminal history check.
As added by P.L.2-1993, SEC.10. Amended by P.L.178-1993, SEC.6; P.L.146-1996, SEC 4; P.L.148-1997, SEC.1; P.L.2-2003, SEC.48; P.L.212-2005, SEC.14; P.L.197-2007, SEC.9; P.L.177-2009, SEC.5.; P.L.84-2010, SEC.4. Amended 2016 session.

Based on record review and interview the agency failed to ensure all employees have a national or expanded criminal history check on file for 7 of 8 personnel records reviewed. (Employee B, D, H, F, I, C, & O)

Findings include:

1. The complete personnel

record for employee B was reviewed on 9/29/2022 and failed to include a national or expanded criminal history check.

2. The complete personnel record for employee D was reviewed on 929/2022 and failed to include a national or expanded criminal history check.

3. The complete personnel record for employee O was reviewed on 9/29/2022 and failed to include a national or expanded criminal history check.

4. The complete personnel record for employee H was reviewed on 9/29/2022 and failed to include a national or expanded criminal history check.

5. The complete personnel record for employee F was reviewed on 9/29/2022 and failed to include a national or expanded criminal history check.

6. The complete personnel record for employee I was reviewed on 9/29/2022 and

	expanded criminal history check. 7. The complete personnel record for employee C was reviewed on 9/29/2022 and failed to include a national or expanded criminal history check. 8. During an interview on 10/03/2022 at 10:45 a.m. the Director of Nursing stated they did not realize the limited criminal history check requirement had been changed to expanded or national background history check and that it applied to all employees including those that were hired prior to 2016.			

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
Richanda Hahn	DON	11/14/2022 11:59:30 AM