STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	201190850A	A. BUILDING B. WING	09/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
1ST OPTION ADULT DAY SERVICES & HOME HEALTH INC	6111 HARRISON STREET SUITE 225, MERRILLVILLE, IN, 46411

(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 relicensure survey. Survey Dates: 9/13/2022, 9/14/2022, 9/15/2022, 9/16/2022, 9/19/2022, and 9/20/2022. Facility ID: 012812 Census: 13	N0000		2022-11-30
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey. Facility ID: 012812 Survey Dates: 9/13/2022, 9/14/2022, 9/15/2022, 9/16/2022, 9/19/2022, and 9/20/2022.	G0000		2022-11-30

	Census: 13 1st Option Adult Day Services and Home Health INC., is precluded from providing its own home health aide training and competency evaluation for a period of two years from 9/20/2022 – 09/19/2024, due to being found out of compliance with Conditions of Participation: 42 CFR 484.102 Emergency preparedness, 42 CFR 484.55 Comprehensive assessment of patients, 42 CFR 484.60 Care Planning, Coordination of Care and Quality of Care, 42 CFR 484.65 Quality Assessment and Performance Improvement, 42 CFR 484.80 Home health aide services, and 42 CFR 484.105 Organization and administration of services. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Quality Review Completed 10/05/2022			
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 9/13/2022, 9/14/2022, 9/15/2022, 9/16/2022, 9/19/2022, and 9/20/2022. Facility ID: 012812	E0000		2022-11-30
E0001	Establishment of the Emergency Program (EP) 403.748,482.15,485.625	E0001	Effectiveimmediately, 1st Option Adult Day Services & Home Health hasrevised its policy on emergency preparedness to include all hazards, likely tooccur in the region. Developed procedures on how to contact emergencyorganizations in the region.	2022-11-30

	§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 provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on observation, record		The agency has initiated training ofall employees on emergency preparedness via phone tree monthly. The agency will collaborate andcooperate with federal, state, and regional level officials to maintain aneffective and integrated response system during emergency events. Agency willattend meetings and workshops organized by these organizations to be abreast ofevents happening in the region. The agency will develop and maintain theseagencies' contact information, e.g., phone numbers, e-mails, etc. Theadministrator is responsible for the implementation of this corrective action toensure 100% compliance. The administrator will monitor this corrective actionto ensure that this deficiency is corrected and will not recur.	

	review, and interview, the home health agency failed to: ensure the emergency preparedness plan included an all-hazards, community-based risk assessment, and/or strategies for addressing emergency events identified by the risk assessment (see tag E0006); ensure the emergency preparedness plan included a process for cooperation and collaboration with regional, state, and/or federal emergency preparedness officials' efforts to maintain an integrated response during an emergency (see tag E0009); ensure patients had individual emergency preparedness plans as a part of the comprehensive assessment (see tag E0017); ensure the emergency preparedness policies and procedures included procedures to inform state and/or local officials of on duty staff or patients they were unable to contact (see tag E0021); ensure the emergency preparedness communication plan was updated at least every 2 years (see tag E0029); ensure the emergency preparedness communication plan included names and contact information for staff and patients' physicians (see tag E0030); ensure the			

	emergency preparedness communication plan which included contact information for federal, state, regional and local emergency preparedness staff (see tag E0031); ensure the emergency preparedness communication plan included a primary and alternate means of communicating with federal, state, regional, and local emergency management agencies and facility staff (see tag E0032); provide and maintain documentation of emergency preparedness training at least every 2 years (see tag E0037); and conduct any 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.			
E0006	Plan Based on All Hazards Risk Assessment 403.748(a)(1)-(2),482.15(a)(1)-(2),485.625(a)(1)-	E0006	The agency has updated its policy onemergency policy on how to handle /address	2022-11-30

	(§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 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		emergency events identified in therisk assessment of likely emergency events to occur in the region. The emergenciesare but not limited to fire, power outages, hazardous materials, accidents, anddisease outbreaks. Agency has reached out to the federal,state, and regional emergency agencies in the region and has obtained thecontact information for constant communication. When necessary, attend meetings,training seminars, and workshops to be aware of current events or happenings inthe region. Agency has developed procedures, and willcontact federal, state, and regional emergency organizations knowledgeable ofthe events; collaborating and cooperating with them in all events likely toimpact our patients. The Administrator is responsible forthe implementation of this corrective action to ensure 100% compliance. Theadministrator will monitor this corrective action to ensure that thisdeficiency is corrected	

	that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the home health agency failed to ensure the emergency preparedness plan included an all-hazards, community-based risk assessment, and/or strategies for addressing emergency events identified by the risk assessment. The findings include: Review of the agency's emergency preparedness plan on 9/16/2022, evidenced an		and will not recur.	

	undated document obtained 9/15/2022, titled "The Home Health Agency Emergency Preparedness Plan" which stated, "... The home health agency preparedness plan is detailed, all hazard, plan designed to guide for agencies when developing their emergency preparedness policies and procedures ... This plan uses the term 'all hazard' to address all types of incidents ... Examples of incidents include: ... Fire ... Weather related emergencies ... Hazardous materials accidents ... Power outages ... Transit and worker strikes ... Natural disasters ... Terrorist/WMD events ... Incidents of naturally occurring disease outbreak ... Planned Public Events ...."			

	Review of the agency's emergency preparedness plan on 9/16/2022, evidenced an agency document updated 9/3/2020, titled "Staffing Strategy/Use of Volunteers Emergency Planning Policy" which stated, "... This policy includes disasters such as ... hurricane ... earthquake, wildfire, erosion ...." Review of the emergency preparedness plan on 9/16/2022, failed to include strategies to address the events identified in the risk assessment such as fire, hazardous materials accidents, power outages, transit and worker strikes, terrorist events, disease outbreak, and planned public events. During an interview on 9/16/2022, at 11:04 AM, administrator #1 indicated the biggest risks based on the community the agency served would be COVID-19 and monkey pox. Clinical manager #2 indicated the agency usually saw storms and blizzards. Administrator #1 indicated			

	hurricanes were included in the plan because a hurricane could happen, even if a hurricane hasn't happened in the past. Administrator #1 indicated the emergency plan included all the possibilities.			
E0009	Local, State, Tribal Collaboration Process 403.748(a)(4),482.15(a)(4),485.625(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	E0009	The agency has updated its policy onemergency policy to include how to collaborate and cooperate with federal,state, and regional emergency organizations in event of emergencies in theregion. Agency initiated the training of allemployees on proper procedures, and how to collaborate and cooperate withfederal, state, and regional emergency organizations in times of emergencies. Agency will ensure that this policy isupdated or revised every two years. Agency will attend themeeting, seminars, or workshops organized by emergency organizations, when necessary,to acquire new information and skills on how to handle a particular emergency.The contact information of these organizations will be always maintained. Theadministrator is responsible for the implementation of this corrective action toensure 100% compliance. The administrator will monitor this corrective actionto ensure	2022-11-30

	emergency. Based on record review and interview, the home health agency failed to ensure the emergency preparedness plan included a process for cooperation and collaboration with regional, state, and/or federal emergency preparedness officials' efforts to maintain an integrated response during an emergency. The findings include: Review on 9/16/2022, of the emergency preparedness plan evidenced a document revised 9/3/2020, titled "Staffing Strategy/Use of Volunteers Emergency Planning Policy" which stated, "... 1st Option Adult Day Services will partner/contact with local or state emergency management agencies to find out what is happening, request for specific help or rescue, and keep updated as the situation unfolds ... Local emergency management agencies to collaborate with includes EMS [emergency medical services], Fire, police, local and state		that this deficiency is corrected and will not recur.	

	and other home health agencies ….” The emergency preparedness plan failed to include the process for collaboration with regional and federal emergency preparedness officials. During an interview on 9/16/2022, at 11:07 AM, administrator #1 stated, “… We deal with local emergency management agencies, not directly with federal or state ….”			
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the	E0017	Effective immediately, the agency hasreviewed and updated its emergency preparedness policy to include evacuationlocations and updated patients’ contact person information. The Administrator has directed theclinical nurse supervisor to ensure that patients #1 and #2 clinical records werereviewed/updated to ensure that their emergency preparedness plan includesevocation location and current contact person. Agency will annually review	2022-11-30

	provisions at §484.55. Based on observation, record review, and interview, the home health agency failed to ensure patients had individual emergency preparedness plans as a part of the comprehensive assessment in 2 of 3 home visits conducted. (#1, 2) The findings include: 1. Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, a home folder was reviewed, which contained an individual emergency preparedness plan. This plan failed to include an evacuation location or emergency classification level. Patient #1's emergency contact was person #4, who was deceased according to patient #1. During an interview on 9/16/2022, at 11:09 AM, clinical manager #2 indicated the individual emergency preparedness plans do not		ensure that their emergency preparedness plan hasan evacuation location and current contact person. This will ensure that thedeficiency is corrected and will not recur. Theadministrator is responsible for the implementation of this corrective action toensure 100% compliance. The Administrator will monitor this corrective actionto ensure that this deficiency is corrected and will not recur.	

	Administrator #1 indicated the agency instructed patients to go anywhere safe in case of emergency but did not designate specific areas. Clinical manager #2 indicated patient #1's emergency contact had not been updated with a new emergency contact yet. 2. Observation of a home visit for patient #2 was conducted on 9/14/2022, at 12:30 PM, to observe a routine home health aide visit. During the visit, a home folder was reviewed, which contained an individual emergency preparedness plan. This plan failed to include an evacuation location. During an interview on 9/16/2022, at 11:12 AM, clinical manager #2 indicated evacuation locations were not discussed with the patients as part of their emergency plans. Administrator #1 indicated the patients should just go outside or somewhere safe and then call for help.			

E0021	HHA- Procedures for Follow up Staff/Pts. 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 contact. Based on record review and interview the agency failed to ensure the emergency preparedness policies and procedures included procedures to inform state and/or local officials of on duty staff or patients they were unable to contact. The findings include: Record review evidenced an undated agency policy obtained	E0021	Effectiveimmediately, 1st Option Adult Day Services & Home Health hasupdated its policy on emergency preparedness to include a procedure on how to notifystate and local emergency officials on how, and where to reach and connect withagency employees and patients during emergencies. The Director of Nursing in-serviced all fieldemployees about the appropriate procedure to follow when contacted by state andlocal emergency officials during emergency events. Agency will obtain, record, andmaintain contact information for state and local emergency organizations. Thiswill enable the agency to report emergencies, and communicate with theseagencies during emergencies. The administrator is responsible forthe implementation of this corrective action to ensure 100% compliance. Theadministrator will monitor this corrective action to ensure that this deficiencyis corrected and will not recur.	2022-11-30

	Preparedness Policy" which stated, "... The Red Cross and local authorities will be notified by the Director of high-risk clients ... Upon arrival, every 5 minutes, secretary will try those employees not found with the first call attempt and notify the disaster supervisors of any other employees available to be on standby ...." The emergency preparedness policies and procedures failed to include notification of local and state officials of staff who they are unable to contact, and failed to include notification of state officials for patients who they are unable to contact. During an interview on 9/16/2022, at 11:07 AM, administrator #1 stated, "... We deal with local emergency management agencies, not directly with federal or state ...." At 11:16 AM, clinical manager #2 stated, "... if I can't get the employees, I will call the emergency contact, and if I still can't get ahold of them, I would go to their house, and check and if I'm not able to reach them, I would call the police ...."			

E0029	Development of Communication Plan 403.748(c),482.15(c),485.625(c) §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the agency failed to ensure the emergency preparedness communication plan was updated at least every 2 years. The findings include: Review on 9/16/2022, of the emergency preparedness communication plan evidenced an undated patient call list and an undated employee call list, which included 7 employees who were no longer employed by the agency and failed to include 6 home health aides who were currently employed.	E0029	The Administrator has directed the Directorof Nursing to ensure that the agency's emergency preparedness communicationplan; patients' call list and employees' call list are updated annually. The Administrator in-serviced officestaff to constantly review patients' medical records to ensure the emergencypreparedness communication plan contains the current patients' list and currentemployees' list. The Director of Nursing will reviewquarterly all client's clinical records to ensure that their emergencypreparedness communication plan is up to date. This will ensure the deficiencyis effectively corrected to prevent its reoccurrence. The Director of Nursing is responsiblefor the implementation of this corrective action to ensure 100% compliance. TheAdministrator will monitor this corrective action to ensure that thisdeficiency is corrected and will not recur.	2022-11-30

	include 10 of 13 active patients on the communication call list. During an interview on 9/16/2022, at 11:25 AM, administrator #1 indicated the communication plan had not been updated since the beginning of 2020.			
E0030	Names and Contact Information 403.748(c)(1),482.15(c)(1),485.625(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].	E0030	Effective immediately, the Administratorhas directed the Director of Nursing to update the emergency preparednesscommunication plan to include all contact information of federal, state, tribal,regional, and local emergency preparedness staff. And include the staff,patient's physicians, an agency providing services under arrangement, next ofkin, guardian, or custodian. The Administrator in-serviced theDirector of Nursing to quarterly review the agency's policy on emergencypreparedness communication plan to ensure that it contains all the necessarycontact information of emergency agencies.	2022-11-30

	(v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (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.		The agency will maintain records andcontact information of these emergency response organizations. Agency willattend meetings, seminars, or workshops organized by emergency organizationswhen necessary to obtain useful information in case of emergency. TheAdministrator is responsible for the implementation of this corrective action toensure 100% compliance. The Administrator will monitor this corrective actionto ensure that this deficiency is corrected and will not recur.	

	*[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on record review and interview, the home health agency failed to ensure the			

	emergency preparedness communication plan included names and contact information for staff and patients' physicians. The findings include: Review on 9/16/2022, of the agency's emergency preparedness communication plan evidenced an undated employee call list, which included 7 employees who were no longer employed by the agency and failed to include 6 home health aides who were currently employed. The communication plan failed to include names and contact information for patients' physicians.			

	During an interview on 9/16/2022, at 11:25 AM, administrator #1 indicated the call list did not include all active employees because it had not been updated since the beginning of 2020. Administrator #1 indicated the call list did not include physician's names or contact information.			
E0031	Emergency Officials Contact Information 403.748(c)(2),482.15(c)(2),485.625(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.	E0031	Effective immediately, 1st option Adult Day Services & Home health agency has revised its policy onemergency preparedness to include the contact information for federal, state,regional, and local emergency preparedness staff. The agency has initiated training of staff onemergency preparedness via phone tree weekly. Agency will collaborate and cooperate withfederal, state, and regional level officials to maintain an integrated responsesystem during an emergency event. The agency obtained the contact informationof these organizations; phone numbers, emails, etc., and attain meetings	2022-11-30

	*[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. (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. Based on record review and interview, the agency failed to ensure the emergency preparedness communication plan which included contact information for federal, state, regional and local emergency preparedness staff. The findings include:		whennecessary. The Administrator is responsible forimplementation to ensure 100% compliance. The administrator will monitor thiscorrective action to ensure that this deficiency is corrected and will notrecur.	

	Review on 9/16/2022 of the emergency preparedness communication plan failed to evidence any contact information for local, federal, state, or regional emergency preparedness staff. During an interview on 9/16/2022, at 11:20 AM, clinical manager #2 stated, "... I would call 911 ... I don't have other numbers ... I would call 911 and they would direct us ...."			
E0032	Primary/Alternate Means for Communication 403.748(c)(3),482.15(c)(3),485.625(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following:	E0032	Effective immediately, 1st option Adult Day Services & Home health agency has revised its policy onemergency preparedness to include the contact information for federal, state,regional, and local emergency preparedness staff. The agency obtained the contactinformation of local, federal, state, or regional emergency preparedness staff;other healthcare institutions, and state protection and advocacy agencies inthe region. Agency will annually review allpatients' clinical records to	2022-11-30

	(i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the home health agency failed to ensure the emergency preparedness communication plan included a primary and alternate means of communicating with federal, state, regional, and local emergency management agencies and facility staff. The findings include: Review on 9/16/2022 of the emergency preparedness communication plan failed to evidence any contact information for local, federal, state, or regional emergency preparedness staff. Review of the agency's emergency preparedness communication plan evidenced an undated employee call list, which failed to include 6 home health aides who were currently employed and any primary or alternate means of communication with		ensure that their emergency preparednesscommunication plan is current and up to date. This will ensure that thedeficiency is corrected and will not recur. TheAdministrator is responsible for the implementation of this corrective action toensure 100% compliance. The Administrator will monitor this corrective actionto ensure that this deficiency is corrected and will not recur.	

	them. During an interview on 9/16/2022, at 11:20 AM, clinical manager #2 stated, "... I would call 911 ... I don't have other numbers ... I would call 911 and they would direct us ...." Administrator #1 indicated the communication plan had not been updated, so it didn't include 6 of the home health aides.			
E0037	EP Training Program 403.748(d)(1),482.15(d)(1),485.625(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (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	E0037	The Administrator has directed the Directorof Nursing to review and update the appropriate documentation procedure forevery emergency preparedness training conducted. The agency ensured all new employeesare oriented and trained within two weeks after employment, and continuingemergency preparedness training (in-service) of all employees is to beconducted annually. The Director of Nursing will annuallyreview employees' files to ensure that emergency	2022-11-30

	at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:		newand all employees were conducted, and properly documented. This will ensurethat the deficiency does not recur. TheDirector is responsible for the implementation of this corrective action toensure 100% compliance. The administrator will monitor this corrective actionto ensure that this deficiency is corrected and will not recur.	

	(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:			

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

	prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the agency failed to provide and maintain documentation of emergency preparedness training at least every 2 years. The findings include: Record review evidenced an undated agency policy obtained 9/15/2022, titled “Emergency			

	stated, "... All staff members will be oriented to the emergency preparedness plan and their associated responsibilities ... Reviews will be held at least annually ...." Record review on 9/15/2022, evidenced an employee in-service dated 11/23/2021, but failed to evidence documentation that emergency preparedness training was completed at this in-service. Review failed to evidence any additional employee emergency preparedness training. During an interview on 9/15/2022, at 3:07 PM, administrator #1 indicated emergency preparedness training was completed at every in-service, at least yearly. Administrator #1 indicated this would be documented on the in-service sheet.			
E0039	EP Testing Requirements 403.748(d)(2),482.15(d)(2),485.625(d)(2)	E0039	The Administrator has directed thehuman resource manager to liaise with emergency preparedness agencies and otherhealthcare institutions in	2022-11-30

	§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 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		the region to participate in any full-scale community-baseddrill organized by these agencies. The human resource manager liaised with otheremergency preparedness agencies to schedule 1st Option Adult DayServices & Home Health to participate in any full-scale community-based emergencydrills organized by these agencies. The agency will ensure accurate andproper documentation annually, of all community-based emergency preparednessdrills it participated in. The Director of Nursing is responsiblefor the implementation of this corrective action to ensure 100% compliance. Theadministrator will monitor this corrective action to ensure that thisdeficiency is corrected and will not recur.	

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.

(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, 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			

following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.

*[For PACE at §460.84(d):]

(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following:

(A) A second full-scale exercise that is

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

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

*[For HHAs at §484.102]

(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at

least annually. The HHA must do the following:

(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires 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]

(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. Based on record review and interview, the agency failed to conduct any exercises to test the emergency plan annually. The findings include: Record review evidenced an undated agency policy obtained			

	Preparedness Policy" which stated, "... Agency staff members will participate in an annual desktop drill to determine the effectiveness and efficiency of the current plan and any forms developed for use in disaster ...." Record review on 9/16/2022, of the agency's emergency preparedness plan, failed to evidence any testing exercises were completed. During an interview on 9/16/2022, at 3:45 PM, administrator #1 indicated the only drills or testing of an emergency preparedness plan the agency participated in, was for the office building they resided in. Administrator #1 indicated no testing was documented or completed for the agency specific emergency preparedness plan. Administrator #1 indicated the agency could not participate in a drill for emergencies which had not yet happened.			

G0414	HHA administrator contact information 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. Based on observation, record review and interview, the home health agency failed to provide patients with contact information for the administrator, including name, address, and/or phone number in 3 of 3 home visits conducted. (#1, 2, 3) The findings include: 1. Record review on 9/13/2022, evidenced a home folder which contained an undated document titled "Client Bill of Rights and Responsibilities" which stated, "... Clients of 1st Option Home Health have the right to: ... Receive complete written information on the plan of care, including the name of the home aide and supervisor responsible for the services and the agency phone number ....."	G0414	The agency reviewed the admissionpackets and added the administrator's name, phone number, and business address,and encouraged clients to report any complaints they may have. The agency called all active patientsand updated the agency folders in every active patient's home with theadministrator's name, address, and business phone number for any complaintsthey may have. For patient #1, the patient's folderwas updated with the administrator's name and contact information. For patient #2, the patient's folderwas updated with the administrator's name and contact information. For patient #3, the patient's folderwas updated with the administrator's name and contact information. The agency will go through everyclient's folder during recertification to ensure that the administrator's name,business phone number, and address are included in the clients' home	2022-11-30

	2. Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, a home health folder was reviewed, which failed to include the administrator's name. During an interview on 9/19/2022, at 1:41 PM, clinical manager #2 indicated patients should have the administrator's name and phone number in their home folder. 3. Observation of a home visit for patient #2 was conducted on 9/14/2022, at 12:30 PM, to observe a routine home health aide visit. During the visit, a home health folder was reviewed, which failed to include the administrator's name. 4. Observation of a home visit for patient #3 was conducted on 9/19/2022, at 9:00 AM, to observe a routine skilled nurse		admissionfolder. The Director of Nursing will monitorand inspect every client's folder during recertification to ensure that allclients have the administrator's name, business phone number, and address. Thiswill prevent this deficiency from recurring and ensure 100% compliance.	

	health folder was reviewed, which failed to include the administrator's name.			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the home health agency failed to ensure patients were informed about the completion of all assessment and the care to be furnished in 1 of 3 home visits conducted. (#2)	G0434	The agency reviewed the client'srecords and documented the reason for the delay with the start of Home HealthAide services. A copy of the written document was put in the client's homefolder. As per Medicaid policy, the agency cannot render services to the patientuntil the prior authorization is approved by Indiana Medicaid priorauthorization. This was communicated to the patient and the primary care physician. All clients' charts were reviewed andupdated with communication notes regarding any form of delay in service andcommunicated to clients as well. All forms of delay with the start ofservices will be closely monitored by The Director of Nursing and communicatedto the affected patient promptly. This will ensure this deficiency does not recur. The Director of Nursing will	2022-11-30

	The findings include: Record review evidenced an undated agency policy obtained 9/20/2022, titled "Service Agreement" which stated, "... The client has the right to be informed, in advance, about the care to be furnished and of anticipated changes in the care to be furnished ...." Clinical record review for patient #2 was completed on 9/19/2022. Record review evidenced a plan of care for certification period 8/15/2022 – 10/13/2022, which indicated the patient was to receive home health aide services 6 hours per day/5 days per week. Record review evidenced a comprehensive assessment dated 8/15/2022, which indicated the start of care date was 8/15/2022. Record review indicated the patient failed to receive any home health aide services until 9/6/2022 (21 days after start of care). Record review failed to evidence any patient or physician communication regarding delay in services.		beresponsible for monitoring and communicating with affected clients whenever a situationlike this occurs. This will ensure 100% compliance and prevent the deficiencyfrom recurring.	

	During an interview on 9/14/2022, at 12:35 PM, patient #1 indicated the home health aide services had just started recently. He did not know why he hadn't received home health aide services beginning 8/15/2022. He indicated he thought it was because the home health agency was waiting on the physician for something. During an interview on 9/19/2022, at 2:33 PM, clinical manager #2 indicated patient #2 did not receive any home health aide visits for 3 weeks following the start of care because the agency was waiting for insurance approval. 410 IAC 17-12-3(b)(2)(D)(ii)(BB)			

N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home health agency failed to ensure personnel records were kept current, and failed to include: documentation of orientation to the job for 4 of 7 home health aides records reviewed (#3, 6, 7, 8); receipt of job description for 3 of 7 home health aides records reviewed (#6, 7, 8); and annual performance evaluations for 4 of 4 home health aides who were employed greater	N0458	For Home Health Aides #3, #6, #7, and#8 the Administrator reviewed their employee personnel records and immediately includeddocumentation of job orientation. For Home Health Aides #6, #7, and #8, theAdministrator reviewed employee personnel records and immediately documented employees'signed job descriptions. For Home Health Aide #3 the Administratorreviewed employee personnel records and included the performance evaluationsfor the years 2020 and 2021, and immediately scheduled the performance evaluationfor the year 2022. For Home Health Aide #5 the Administratorreviewed employee personnel records and included the performance evaluationsfor the years 2020, and 2021, and immediately scheduled the performance evaluationfor the year 2022. For Home Health Aide #9 the Administratorreviewed employee personnel records and included the performance evaluationsfor the years 2020,	2022-11-30

	than 1 year. (#3, 5, 9, 10) The findings include: Record review evidenced an undated agency policy obtained 9/20/2022, titled "Personnel Records" which stated, "... The personnel record for an employee will include, but not be limited to: ... Signed job description ... Criminal history record ... Competence assessment ...." Personnel record review was completed on 9/15/2022. 7 home health aides personnel records were reviewed. Review failed to evidence documentation of orientation to the job for 4 home health aides (#3, 6, 7, 8). Personnel record review failed to evidence documentation of receipt of job description for home health aides #6, #7,and #8. Review of home health aide		and 2021, and immediately scheduled the performance evaluationfor the year 2022. For Home Health Aide #10 the Administratorreviewed employee personnel records and included the performance evaluationsfor the years 2020, and 2021, and immediately scheduled the performance evaluationfor the year 2022. The Administrator has immediatelyreviewed all active employee personnel records to identify those likely to beaffected by this deficiency to ensure all employees had their performanceevaluation updated. The Administrator instructed the AdministrativeAssistant to audit all personnel records quarterly to ensure 100%% compliance withthis regulatory requirement. The Administrator will be responsiblefor monitoring this corrective action to ensure 100% compliance.	

	#3's employee file evidenced a start date of 11/20/2019, and failed to include a performance evaluation for 2020, 2021, and 2022. Review of home health aide #5's employee file evidenced a start date of 12/18/2015, and failed to include a performance evaluation for 2020, 2021, and 2022. Review of home health aide #9's employee file evidenced a start date of 10/18/2018, and failed to include a performance evaluation for 2020, 2021, and 2022. Review of home health aide #10's employee file evidenced a start date of 7/22/2016, and failed to include a performance evaluation for 2020, 2021, and 2022. During an interview on 9/16/2022, at 12:00 PM, clinical manager #2 indicated			

	include receipt of job description, annual performance evaluations, and documentation of orientation. Administrator #1 indicated performance evaluations should be completed yearly and would be located in the employee's personnel record.			
N0460	Home health agency administration/management 410 IAC 17-12-1(g) Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) Limited criminal history pursuant to IC 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment.	N0460	The Agency Administrator immediatelyreviewed the Director of Nursing personnel record and identified deficiencies thatneeded to be corrected such as performance evaluation, current licensure, anddocumentation of job orientation. A copy of the Director of Nursing'scurrent licensure was made and put in her personnel record. The Administrator furtherscheduled annual performance evaluations and documented the job orientation ofthe director of nursing. TheAdministrator has instructed the Administrative Assistant to review allemployee personnel records quarterly to ensure employees likely to be affected bythis deficiency are corrected in a timely manner. The Administrator is responsible formonitoring this corrective action to ensure 100%	2022-11-30

	Based on record review and interview, the home health agency failed to ensure the supervising nurse's personnel record was kept current and included a copy of the current nursing license, annual performance evaluation, and documentation of orientation to the job. The findings include: Record review evidenced an undated agency policy obtained 9/20/2022, titled "Performance Evaluations" which stated, "... A competency-based performance evaluation will be conducted for all employees after one year of employment and at least annually thereafter ... The original completed performance evaluation will be retained in the employee's personnel record, and a photocopy will be provided to the employee ...." Record review evidenced an undated agency policy obtained 9/20/2022, titled "Personnel Records" which stated, "... The personnel record for an		compliance with the regulatoryrequirements.	

	employee will include, but not be limited to: ... License and certifications ... Orientation checklist ...." Review of personnel records was completed on 9/15/2022. Review evidenced a personnel record for clinical manager/registered nurse #2 which indicated clinical manager #2 started employment as the clinical manager on 8/18/2011. This personnel record included a nursing license which expired on 10/31/2021. This personnel record included an annual performance evaluation dated 12/4/2019. Review failed to evidence a current copy of a nursing license or an annual performance evaluation for 2020, 2021, or 2022. Review failed to evidence documentation of orientation to the job. During an interview on 9/16/2022, at 12:02 PM, administrator #1 indicated performance evaluations were performed yearly and should be			

	Administrator #1 indicated documentation of orientation should be documented in personnel records. Administrator #1 indicated the copies of current licenses should be located in personnel records.			
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 interview, the home health agency failed to ensure each employee who has direct patient contact had a physical examination no more than 180 days prior to patient contact in 1 of 7 home health aide personnel record reviewed. (#8)	N0462	The agency reviewed the home healthAide #8 personnel record affected by this deficiency immediately. The agencyfurther reviewed other home health Aide personnel records to ensure thoselikely to be affected are identified. Employee home health Aide #8 physicalexamination/health screening was retrieved from her doctor's office and placedin her personnel record. Agency has ensured all employee physicalexaminations/health screenings are updated. The Administrator has instructed the AdministrativeAssistant to review all employee personnel records quarterly to ensureemployees likely to be affected by this deficiency are corrected in a timelymanner.	2022-11-30

	The findings include: Record review evidenced an undated agency policy obtained 9/20/2022, titled "Health Screening" which stated, "... Each employee having direct contact with clients must have documentation of baseline health screening prior to providing care to clients ...." Personnel record review on on 9/15/2022, indicated home health aide #8's start date was 5/18/2022, and failed to include a physical examination or health screening. During an interview on 9/16/2022, 12:02 PM, clinical manager #2 indicated the physicals prior to patient care should have all been in the personnel files.		The Administrator is responsible formonitoring this corrective action to ensure 100% compliance with the regulatoryrequirements.	
N0464	Home health agency administration/management	N0464	The Administrator reviewed Home Health Aides #10, #5, and #2personnel records and	2022-11-30

	410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or		included a copy of each employee's current tuberculosistests in their respective records. The Administrator instructed the Administrative Assistant toreview all active employee's records to ensure they all have a copy of their currenttuberculosis test to ensure 100% compliance. TheAdministrator in-serviced the Administrative Assistant that a tuberculosis testshould be done according to the state regulation before every Home HealthAide's first contact with a patient. This was included in the onboardingprocess for every new field employee. The Administrator will review allactive employee's personnel records quarterly to ensure that they all have acopy of the current tuberculosis test. The Administrator will be responsiblefor monitoring this corrective action to ensure 100% compliance.	

(B) provide direct patient contact;

unless approved by a physician to work.

(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:

(A) working for the home health agency; or

(B) having direct patient contact;

has had a negative finding on a tuberculosis examination within the previous twelve (12) months.

Based on record review and interview, the home health agency failed to maintain documentation showing that any employees with direct patient contact had annual tuberculosis screenings/exams which demonstrated a negative finding within the last 12 months for 2 of 7 home health aide personnel records reviewed (#5, 10).

The findings include:

1. Record review evidenced an undated agency policy obtained 9/14/2022, titled "Mycobacterium Tuberculosis and Other Infection (COVID-19) Exposure Control Program" which stated, "... Follow-up risk

	based on the data of the most recent risk assessment ... In Low risk areas, at least annually: Repeat PPD testing ... Repeat skin assessment ... The intervals for repeat PPD testing of Health Care Workers is determined by the risk assessment ... Results of the PPD test will be recorded in the Health Care Workers' employee health record ...." 2. Personnel record review on 9/15/2022, evidenced home health aide #10 started on 7/22/2016, and had first patient contact on 8/7/2016. Review indicated the last tuberculosis screening was on 1/13/2021. 3. Personnel record review on 9/15/2022, evidenced home health aide #5 started on 12/18/2015, and had first patient contact on 12/22/2015. Record review failed to evidence a tuberculosis screening for 2020 or 2021. 4. During an interview on 9/16/2022, at 12:01 PM, clinical manager #2 indicated			

	employees with direct patient contact should have been tested for tuberculosis every 6 months.			
G0484	Document complaint and resolution 484.50(e)(1)(ii) (ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview, the home health agency failed to document complaints and the resolution of complaints. The findings include: Record review evidenced an undated agency policy obtained 9/20/2022, titled "Home Care Bill of Rights/Grievance Procedure" which stated, "... If a complaint regarding services provided is received by an agency staff professional providing care, the complaint will be documented and communicated to the Director/Clinical Supervisor. The Director of Nursing/Designee	G0484	The Administrator immediatelyinstructed the Director of Nursing to log **EVERY** complaint to thecomplaint log book either resolved or not. This will let the agency keep trackof every complaint. All clients' records were reviewedensuring that there was no complaint not logged in the complaints log book. The Administrator in-serviced alloffice staff on the importance of documenting **EVERY** complaint receivedfrom the clients and making sure they are resolved promptly. This will ensurethat this deficiency does not recur. The Director of Nursing will audit allclients' records quarterly to ensure 100% compliance and monitoring of any complaintsreceived.	2022-11-30

	and/or interested parties, and attempt to reconcile the situation ... The complaint shall be documented on the Client Grievance/Complaint Form ...." Review of a complaint log on 9/14/2022, failed to evidence documentation of any complaints. Personnel record review on 9/15/2022, evidenced a personnel file for home health aide #3. This personnel file contained an incident report dated 8/17/2022, which stated, "... home health aide #3 took it upon herself to wash her underwear while at work, and dry them with the box fan that was in [patient #8's] household ... [person #1/patient #8's power of attorney] felt it was inappropriate to do so inside of their home. So, she requested for [home health aide #3] to leave and not return to their home ...." This complaint failed to be documented in the complaint log.			

	During an interview on 9/13/2022, at 11:58 AM, clinical manager #2 stated, "... since COVID, we haven't had any severe complaints which need to be documented ... person #4 [patient care coordinator/non-clinical] handles complaints with scheduling like the aide running late ... we just fix it ...." During an interview on 9/20/2022, at 11:45 PM, clinical manager #2 indicated the complaint log was blank, because the agency had not received any complaints. Clinical manager #2 indicated most of the issues were patients who called the agency if the home health aide was running late, or not at the visit at the expected time. Clinical manager #2 indicated these patient calls were not documented in the complaint log because they were resolved with the patient during the call. Clinical manager #2 indicated these were not considered complaints. Clinical manager #2 indicated they considered it a complaint if the home health aide did not show up for a visit, or the patient did			

	not want an aide to come back to their home. Clinical manager #2 indicated the incident involving patient #8 and home health aide #3 was not documented in the complaint log because an incident report was completed instead. 410 IAC 17-2-3(c)(2)			
N0488	Q A and performance improvement 410 IAC 17-12-2(i) and (j) Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the 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	N0488	The Administrator immediately instructed the Director ofNursing that all patients about to be discharged should be notified by calls,emails if necessary, and by mail at least fifteen (15) days before thedischarge date. This was communicated to the Director of Nursing on 10/27/2022. On 10/27/2022, the Director of Nursing reviewed all activepatients' charts to know if there are any patient(s) about to be discharged inorder to notify them at least fifteen (15) days before their discharge date.This will be checked periodically to ensure 100% compliance with the stateregulation. The Director of Nursing will	2022-11-30

	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 home health agency failed to develop and implement a policy requiring a notice of discharge of service to the patient or legal representative at least 15 calendar days prior to discontinuing services. The findings include: Record review evidenced an undated agency policy obtained 9/20/2022, titled “Client Discharge Process” which		bi-monthly to check for discharge dates to notify any upcomingdischarges within the stipulated time. This will ensure compliance. The Director of Nursing will be responsible for monitoringthis corrective action to prevent it from recurring.	

	initiated for every home care client at the time of the client's admission for home care ... The agency will notify the client 5 DAYS before the discharged day ...." During an interview on 9/20/2022, at 10:30 AM, clinical manager #2 indicated the agency gave patients 5 days notice prior to discharging and stopping services.			
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on observation, record review and interview, the home health agency failed to: ensure the initial assessment visit was held within 48 hours of referral, the patient's return home, or on the physician ordered start of care date (see tag G514); ensure	G0510	Theaffected clients' records were reviewed, and identified chart deficiencies werecorrected to meet the regulatory requirement for the admission of clients within48 hours of referral. TheDirector of Nursing immediately reviewed all active patients' charts ensuring thestart of care date, comprehensive assessment accuratelyreflects the patient's current status, and admission is completed within 48hours of referral. The Director of Nursing will review allpatients' chart quarterly to ensure 100% compliance with the admissionstandards.	2022-11-30

	the comprehensive assessment accurately reflected the patient's status (see tag G526); ensure the comprehensive assessments included the patient's current health, psychosocial, functional, and/or cognitive status (see tag G528); and complete a review of all medications the patient was currently using in order to identify potential drug interactions, duplicative drug therapy, and/or noncompliance with drug therapy (see tag G536). 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 of participation: 42 CFR 484.55 Comprehensive assessment of patients. A standard citation was also evidenced at this level as follows: Based on record review and interview, the home health agency failed to ensure comprehensive assessments		The Director of Nursing will be responsibleand will be monitoring all referrals to follow the admission timeline. Thiswill ensure this deficiency will not recur. **For patient #1**, theAdministrator instructed the Director of Nursing to complete an in-home patientcomprehensive assessment per OASIS which includes respiratory, sensory,medications, nutritional and functional, reassessments of the patient's status,obtain the patient's signature, and document it in the patient chart. **For patient #4,** theAdministrator instructed the Director of Nursing to complete an in-home patientcomprehensive assessment per OASIS which includes respiratory, sensory,medications, nutritional and functional, reassessments of the patient's status,obtain the patient's signature, and document it in the patient chart. **For patient #5,** theAdministrator instructed the Director of Nursing to complete	

	were updated, and assessment visits were made to the patient's home to assess the patient in 5 of 7 clinical records reviewed. (1, 4, 5, 6, 7) The findings include: 1.Record review evidenced an undated agency policy obtained 9/20/2022, titled "Comprehensive Client Assessment" which stated, "... In addition to general health status/system assessment, the agency comprehensive assessment assessment tool with OASIS will include: ... respiratory status ... sensory status ... integumentary status ... medications ... nutritional status ... functional status ... Assessment and doucmentation are made regarding whether the home environment is suitable for providing home care ...." 2. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Client		patientcomprehensive assessment per OASIS which includes respiratory, sensory,medications, nutritional and functional, reassessments of the patient's status,and conduct a wound assessment, obtain the patient's signature, and document itin the patient chart. **For patient #6,** theAdministrator instructed the Director of Nursing to complete an in-home patientcomprehensive assessment per OASIS which includes respiratory, sensory,medications, nutritional and functional, reassessments of the patient's status,and conduct a wound assessment, obtain the patient's signature, and document itin the patient chart. **For patient #7,** theAdministrator instructed the Director of Nursing to complete an in-home patientcomprehensive assessment per OASIS which includes respiratory, sensory,medications, nutritional and functional, reassessments of the patient's status,obtain the patient's signature, and	

	Comprehensive Assessment" which stated, "... Clients are reassessed to determine their response to care ... Each professional discipline will be responsible for reassessing care/services at lease every 56-60 days ... the initial and ongoing assessments inclcue consideration of the following: ... Description of any appliclable strength the client has including physican, psychosocial, and or spiritual ... Condition of the home and surrounding environment ...." 3. Clinical record review for patient #1 was completed on 9/19/2022, for certification period 8/13/2022 - 10/11/2022. Record review evidenced a comprehensive recertification assessment dated 8/8/2022, which failed to be signed by patient #1. Record review failed to evidence the recertification visit was completed in person. During an interview on 9/14/2022, at 8:00 AM, patient #1 indicated the home health nurse came to do an assessment visit about every 4		document it in the patient chart. All client charts have been reviewed and60-day recertification to include a comprehensive assessment has been outlinedfor each patient likely to be affected. The Administrator has in-serviced the Directorof Nursing to include all comprehensive assessments of patients duringrecertification, the start of care, and the resumption of care effective10/17/2022. All client records will be auditedquarterly to ensure 100% compliance. The Director of Nursing is responsible formonitoring this corrective action to ensure that this deficiency will notreoccur.	

	months. During an interview on 9/19/2022, at 2:03 PM, clinical manager #2 indicated the home health agency verified visits were made by obtaining the patient's signature every visit. Clinical manager #2 indicated sometimes patients wouldn't let her in to do comprehensive assessments, so she would complete the comprehensive assessment over the phone. Clinical manager #2 indicated re-assessment visits should have been made every 60 days in the patient's home. 4. Clinical record review for patient #4 was completed on 9/19/2022, for certification period 9/11/2022 - 11/9/2022. Record review evidenced a recertification comprehensive assessment dated 9/6/2022, which failed to include the patient's signature. Record review failed to evidence the assessment visit was conducted in the patient's home.			

	5. Clinical record review for patient #5 was completed on 9/19/2022, for certification period 7/28/2022 - 9/25/2022. Record review evidenced a recertification comprehensive assessment dated 7/25/2022, which failed to include vital signs, documentation of a wound assessment for patient's pressure ulcer, or a patient signature. Record review failed to evidence the assessment visit was conducted in person in the patient's home. During an interview on 9/19/2022, at 3:53 PM, clinical manager #2 indicated she was unsure of the location of the wound because she did not assess it during the visit. Clinical manager #2 indicated no vital signs were completed during the comprehensive assessment due to patient shaking. 6. Clinical record review for patient #6 was completed on 9/20/2022, for certification period 2/15/2022 - 4/15/2022. Record review evidenced a recertification comprehensive assessment dated 2/10/2022,			

	which failed to include a wound assessment for patient's wound, vitals, or a patient signature. Record review failed to evidence this comprehensive assessment visit was conducted in person at the patient's home. During an interview on 9/20/2022, at 10:50 AM, clinical manager #2 indicated the wound was not assessed during the assessment. Clinical manager #2 indicated vital signs were not completed during the assessment visit maybe because the patient refused. 7. Clinical record review for patient #7 was completed on 9/20/2022, for certification period 7/6/2022 - 9/3/2022. Record review evidenced a recertification comprehensive assessment dated 7/1/2022, which failed to include the patient's signature. During an interview on 9/20/2022, at 11:00 AM, clinical manager #2 indicated the			

	assessment for patient #7 was completed over the phone since the patient was not home when she arrived for the visit.			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the home health agency failed to ensure the initial assessment visit was held within 48 hours of referral, upon the patient's return home, or on the physician ordered start of care date in 1 of 3 home visits conducted. (#2) The findings include: Record review evidenced an undated agency policy obtained 9/20/2022, titled "Client	G0514	For clinical record review patient #2,the agency immediately educated supporting staff on the importance of admittingthe client within 48 hours of referral to ensure this deficiency will not occuragain. 100% of clients' charts likely to beaffected were reviewed immediately and supporting staff was in-servicedensuring referrals of patient admission is done within 48 hours of the client'sacceptance by the Director of Nursing. 50% of all client's charts will beaudited quarterly to ensure this deficiency will not reoccur again. Clients tobe admitted will be educated on the regulatory requirements of admission within48 hours to prevent this deficiency from reoccurring again. The Director of Nursing is responsiblefor monitoring this	2022-11-30

	stated, "... Upon referral, each client shall be evaluated by a Registered Nurse/Therapist to determine the immediate care and support needs of the client; ... The initial assessment visit will be completed within 48 hours of referral or within 48 hours of the client's return home, or on the physician ordered start of care date ...." Clinical record review for patient #2 was completed on 9/19/2022, for certification period 8/15/2022 – 10/13/2022. Record review evidenced a referral order dated 8/10/2022 which indicated the patient required home health aide services. Record review evidenced an initial assessment visit was conducted on 8/15/2022 (5 days after referral). Record review failed to evidence the physician had ordered a start of care date of 8/15/2022. During an interview on 9/14/2022, at 12:40 PM, patient #2 indicated he didn't receive home health services immediately because the		corrective action and ensuring 100% compliance withregulatory requirements.	

	agency indicated they were waiting for the doctor. During an interview on 9/19/2022, at 2:30 PM, clinical manager #2 indicated the agency based the initial assessment visit timeline on patients' requests. Clinical manager #2 indicated the agency completed the initial assessment visit after speaking with the patient to see when the visit could be made. 410 IAC 17-14-1(a)(1)(A)			
G0526	Content of the comprehensive assessment 484.55(c) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment accurately reflected the patient's status in 4 of 5 active	G0526	For patients #1 & 3, the agencyimmediately reviewed their charts and documentation to reflect their use ofoxygen, route, and how many liters as ordered by their physicians. Non-complacencewith oxygen use has been documented and the physician's office notified. Thiscorrective action was implanted on 10/19/22. Agency will audit patients' chartslikely to be affected quarterly, call patients from time to time, and during	2022-11-30

	clinical records reviewed. (#1, 3, 4, 5) The findings include: 1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Comprehensive Client Assessment" which stated, "... Purpose: ... To accurately reflect the current health status of the client and need for home care services ...." 2. Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, the patient was observed to be alert and oriented, and was not wearing any oxygen. Patient #1 indicated he hadn't worn oxygen since he got out of the hospital for colitis (inflammation of the bowels). Clinical record review for patient #1 was completed on 9/19/2022, for certification period 8/13/2022 – 10/11/2022.		regularvisits to encourage the use of oxygen as ordered by their physician. This willprevent this deficiency from reoccurring again. The Director of Nursing is responsiblefor monitoring this corrective action and ensuring 100% compliance. Forpatient #4, the Administrator instructed the Director of Nursingto perform and document wound assessments of clients and their location on the client'sbody during the visit. The Administrator further instructed the director ofnursing to document the exact tube inserted into the bladder to drain urineeither foley or suprapubic catheter, and to document the size and the last timeit was changed. All client charts likely to beaffected by this deficiency were reviewed, and a visit was scheduled to assessand document the client's wound locations and the exact tube inserted into theurethra to drain urine. This corrective action will be implemented on11/21/2022. The administrator has in-serviced thedirector of nursing on the importance of assessing and documenting the patient'swounds and tubes inserted into the urethra ensuring this deficiency does notreoccur again. A 50% audit of patients will be donequarterly to adhere to 100% compliance. The director of nursing is responsiblefor monitoring this corrective action. For patient #5, the Administrator immediatelyinstructed the Director of Nursing to perform and document wound assessments ofclients and their location on the client's body	

	Record review evidenced a recertification assessment dated 8/8/2022, which indicated the patient wore oxygen at 3 liters per minute through a nasal cannula continuously. During an interview on 9/19/2022, at 11:45 AM, clinical manager #2 indicated they did not know the patient was not wearing oxygen and they only knew what the patient told them during the assessment. 3. Observation of a home visit for patient #3 was conducted on 9/20/2022, at 9:00 AM, to observe a routine skilled nurse visit. During the visit, the patient was observed not wearing oxygen. The patient indicated she wore 2 liters of oxygen via a nasal cannula, as needed. Clinical record review for patient #3 was completed on 9/20/2022, for certification period 8/18/2022 – 10/16/2022. Record review evidenced a comprehensive assessment		during the visit. The Administratorfurther instructed the director of nursing to document the exact tube insertedinto the small intestine for nutrition (jejunostomy) and to document the functionalityof the tube. All client charts likely to beaffected by this deficiency were reviewed, and a visit was scheduled to assessand document the client wound's locations the and exact tube inserted into thesmall intestine for nutrition. This corrective action will be implemented on11/22/2022. The Administrator has in-serviced the Directorof Nursing on the importance of assessing and documenting patients' wounds andtubes inserted into the small intestine ensuring this deficiency does notreoccur again. A 50% audit of patients will be donequarterly to adhere to 100% compliance. The director of nursing is responsiblefor monitoring this corrective action.	

	indicated the patient did not wear oxygen. During an interview on 9/20/2022, at 2:55 PM, clinical manager #2 indicated the patient had been non-compliant with oxygen use, and only wore it sometimes. Clinical manager #2 indicated the assessment should have included oxygen use. 4. Clinical record review for patient #4 was completed on 9/20/2022, for certification period 9/11/2022 – 11/9/2022. Record review evidenced a comprehensive assessment dated 9/6/2022, which indicated the patient had 2 pressure wounds, the patient had no pressure wounds, and the patient had a healing wound to the left lower extremity, being treated by home health agency #7. This document indicated the patient had a foley catheter (tube inserted into the urethra to drain urine from the bladder). This document failed to include any wound assessment, or frequency of dressing changes. This document failed to include			

a site assessment of foley catheter, or care instructions, including date changed.

Clinical record review evidenced a plan of care from home health agency #7, for certification period 8/29/2022 – 10/27/2022, which was faxed to surveyor on 9/20/2022. This document indicated the patient had the following 3 wounds: right top of foot (diabetic wound), right great toe (pressure wound), and sacral wound (pressure wound). This document indicated home health agency #7 was providing wound care 3 times per week to these wounds. The plan of care from home health agency #7 indicated the patient had a suprapubic catheter (tube inserted through the skin into the bladder to drain urine), which was changed monthly by the skilled nurse.

During an interview on 9/19/2022, at 3:38 PM, clinical manager #2 indicated patient #4 previously had wounds, but they were all healed, but she left them on the comprehensive assessment in case they opened

	again. Clinical manager #2 did not know when patient #4's catheter was last changed. Clinical manager #2 did not know any wound care was being performed by home health agency #7. Clinical manager #2 indicated the comprehensive assessment should include an accurate wound assessment, and assessment of catheter site. Clinical manager #2 did not know why the comprehensive assessment indicated foley catheter if the patient had a suprapubic catheter.			

	5. Clinical record review for patient #5 was completed on 9/19/2022, for certification period 7/28/2022 – 9/25/2022. Record review evidenced a comprehensive assessment dated 7/25/2022, which indicated the patient had no wounds, and indicated the patient had a pressure wound, but failed to specify any additional information. This document indicated the patient was NPO (nothing by mouth) and also indicated the patient was on a cardiac, renal, diabetic diet. During an interview on 9/19/2022, at 3:53 PM, clinical manager #2 indicated the patient had a wound, but was unsure of it's location since it was not assessed on the comprehensive assessment. Clinical manager #2 indicated the patient had a jejunostomy (tube inserted through the skin into the small intestine to provide nutrition) tube, and was receiving tube feedings previously. Clinical manager #2 indicated she thought the caregiver had been educated on			

	feedings, and maybe the patient was also eating regular food now. Clinical manager #2 was unsure of what diet the patient was on. Clinical manager #2 did not know why the comprehensive assessment indicated the patient had a wound and also did not have any wounds. 410 IAC 17-15-1(a)			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessments included the patient's current health, psychosocial, functional, and/or cognitive status in 5 of 5 active clinical records reviewed. (#1, 2, 3, 4, 5) The findings include: 1. Record review evidenced an	G0528	**For patient #1,** the Administrator immediately reviewed the clientchart affected with this deficiency, and instructed the director of nursing toensure pain assessment, patient history of pacemaker insertion and colitis, andCPAP machine use at night are included in the comprehensive assessment, Effective immediately, all clients'charts have been reviewed to identify others likely to be affected with thisdeficiency ensuring that this deficiency does not reoccur, and 60-dayrecertification to include pain assessment, patienthistory of pacemaker insertion and colitis, and CPAP machine use at night havebeen	2022-11-30

	undated agency policy obtained 9/20/2022, titled "Comprehensive Client Assessment" which stated, "... In addition to a general health status/system assessment, the agency comprehensive assessment tool with OASIS will include: ... Demographics and client history ... Sensory status ... Respiratory status ... Equipment management ...." 2. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Pain Assessment/Management" which stated, "... All clients admitted to the Agency will receive a comprehensive assessment that includes identification of pain and its impact on function as well as the treatment and efficacy of treatment ... The assessment includes a measure of pain intensity and quality [character, frequency, location, and duration] .... The nurse/therapist will use a standardized agency accepted pain assessment tool that evaluates the location, duration, severity [rating scale], alleviating factors, exacerbating factors, current treatment and		outlined. 50% of clients' charts will be auditedquarterly to ensure 100% adherence to the regulatory requirements. The Director of Nursing will beresponsible for monitoring this corrective action to ensure that thisdeficiency does not reoccur. **For patients #2 &3,** the agency Administrator instructedthe Director of Nursing to include pain assessment of all patients including location,severity, quality, and frequency in their comprehensive assessment on admissionand per regulatory standards. Allclient charts likely to be affected by this deficiency have been reviewed, anda -day recertification to include pain assessment in their comprehensiveassessment has been outlined for each patient likely to be affected. 50% of patients' charts will be auditedquarterly to ensure 100% compliance and to prevent this deficiency fromreoccurring again. The director of nursing is responsible formonitoring this corrective action scheduled to be implemented on 11/19/2022.	

	response to treatment ….” 3. Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, the patient was observed to be alert and oriented. Patient #1 indicated he wore a CPAP machine (machine which provides air through a mask, while sleeping) nightly. Patient #1 indicated he was hospitalized for colitis (inflammation of colon) a while ago but could not remember exactly when. Patient #1 also indicated he had a pacemaker placed due to a very low heart rate. Patient #1 indicated he used pain medication for pain in his back. Clinical record review for patient #1 was completed on 9/19/2022, for certification period 8/13/2022 – 10/11/2022. Record review evidenced a recertification assessment dated 8/8/2022, which failed to include information regarding the patient wearing a CPAP machine nightly, history of		**For patients #4& 5,** the Administrator instructed the Directorof Nursing to perform and document wound assessments of clients and theirlocation, measurement, drainage, and characteristics during visits. The Administratorfurther instructed the Director of Nursing to document the exact tube insertedinto the bladder to drain urine either foley or suprapubic catheter, and todocument size, site, duration, intensity, and last time it was changed, andassess and document jejunostomy site, fistula site for dialysis, and todocument vital signs accordingly. All client’s charts likely to beaffected by this deficiency were reviewed, and a visit was scheduled to assessand document the client wound’s locations and the exact tube inserted into theurethra to drain urine, and jejunostomy site, Fistula site for dialysis and todocument vital signs. This corrective action will be implemented on 11/30/2022. The administrator has in-serviced thedirector of	

	colitis, or pacemaker. This document indicated the patient was taking pain medication 2 – 3 times per day, and experienced pain on a daily basis, but failed to include a full pain assessment, including location, severity rating, or descriptors of pain. During an interview on 9/19/2022, at 2:23 PM, clinical manager #2 indicated a complete pain assessment should have included location, rating, and quality of pain. Clinical manager #2 indicated the CPAP should have been included in the assessment. Clinical manager #2 indicated they had no way of knowing any other medical history unless the patient told them about it. 4. Clinical record review for patient #2 was completed on 9/19/2022, for certification period 8/15/2022 – 10/13/2022. Record review evidenced a comprehensive assessment dated 8/15/2022, which indicated patient used breakthrough pain medication 2 – 3 times per day but failed to		nursing on the importance of assessing and documenting patients'wounds and tubes inserted into the urethra, jejunostomy, and fistula fordialysis ensuring this deficiency does not reoccur again. A 50% audit of patients will be donequarterly to adhere to 100% compliance. The director of nursing is responsiblefor monitoring this corrective action.	

include an assessment of pain including rating, location, or quality.

5. Clinical record review for patient #3 was completed on 9/20/2022, for certification period 8/18/2022 – 10/16/2022. Record review evidenced a comprehensive assessment dated 8/15/2022, which indicated the patient utilized pain medication, but failed to include an assessment of pain including rating, location, frequency, and quality. The assessment indicated the patient had edema (swelling), but failed to include location of swelling or any other assessment.

During an interview on 9/20/2022, at 2:55 PM, clinical manager #2 indicated the comprehensive assessment should have included the location of edema and how much edema the patient had.

6. Clinical record review for

	9/20/2022, for certification period 9/11/2022 – 11/9/2022. Record review evidenced a comprehensive assessment dated 9/6/2022, which indicated the patient had 2 wounds, but failed to include a wound assessment, including location, measurements, drainage, or other characteristics. This document indicated the patient had a foley catheter (tube inserted into the urethra to drain urine from the bladder) but failed to include an assessment of the catheter site. This document indicated the patient had pain but failed to include any assessment of pain including location, duration, intensity, or quality. Clinical record review evidenced a plan of care for certification period 8/29/2022 – 10/27/2022, from home health agency #7, which was faxed to surveyor on 9/20/2022. This document included the following diagnoses and medical history, which were not included in the comprehensive assessment: diabetes (problem regulating blood sugar) with foot ulcer (wound to foot), and the			

following diagnoses, non-pressure ulcer of right foot, pressure ulcer of sacral region, pressure ulcer of other site, urethral stricture (narrowing of urethra), hypertensive heart disease (high blood pressure causing heart disease), heart failure, chronic kidney disease, and chronic obstructive pulmonary disease (lung disease which makes it increasingly difficult to breathe).

During an interview on 9/19/2022, at 3:59 PM, clinical manager #2 indicated the comprehensive assessment wound assessment should include location, measurements, site assessment, and drainage. Clinical manager #2 indicated the comprehensive catheter assessment should have included if there was any redness or signs of infection. Clinical manager #2 indicated the only diagnoses included in the comprehensive assessment, are the diagnoses the patient tells her about.

7. Clinical record review for

	9/19/2022. Record review evidenced a plan of care for certification period 7/28/2022 – 9/25/2022, which indicated the patient was a dialysis (artificial kidney filtration) patient, and had a fistula. Record review evidenced a comprehensive assessment dated 7/25/2022, which indicated the patient had pain, but failed to include a complete assessment of pain including rating, location, severity, frequency, or quality. This document indicated the patient had a stage 2 (pressure wound rating characterized by loss of the surface of skin) pressure wound, but failed to include a full assessment including, location, measurements, appearance, drainage, or odor. This document failed to include the patient's jejunostomy (tube inserted through the skin into the small intestine for nutrition) assessment or tube feeding status. This document failed to include vital signs. This document failed to include an assessment of patient's arteriovenous fistula (a connection made between a vein and an artery, to allow blood to be pulled out and pushed back into patient's body			

during dialysis.

Record review evidenced a plan of care for certification period 8/14/2022 – 10/12/2022, from home health agency #8, which was faxed to the surveyor on 9/21/2022. This document indicated the patient was receiving tube feedings through a jejunostomy tube.

During an interview on 9/19/2022, at 3:53 PM, clinical manager #2 indicated she was unsure of the location of the wound because she did not assess it during the visit. Clinical manager #2 indicated the comprehensive assessment should include pain rating, location, and quality, and wound measurements and assessment. Clinical manager #2 indicated the patient had a jejunostomy tube, and the comprehensive assessment should have included a site assessment. Clinical manager #2 indicated maybe the patient was eating regular food now, but was unsure. Clinical manager #2 indicated no vital signs were completed during

	the comprehensive assessment due to patient shaking. Clinical manager #2 indicated the comprehensive assessment should have included an assessment of the patient's fistula, its appearance, and blood flow. 410 IAC 17-14-1(a)(1)(B)			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the home health agency failed to complete a review of all medications the patient was currently using in order to identify potential drug interactions, duplicative drug therapy, and/or noncompliance with drug therapy in 4 of 5 active clinical records reviewed. (#1, 3, 4, 5)	G0536	**For patient #1,** the Director of Nursingimmediately reviewed the client's chart and identified the client affected bythis deficiency. The Director of Nursing further reviewed the client's reconciledpatient medications list. The Director of Nursing identified all the medicationspatients are no longer taking and reported to the physician to be discontinued. All clients' charts likely to be affected bythis deficiency have been reviewed, and 60-day recertification to include allclients' current medications reconciliation has been outlined for each patientlikely to be affected. Quarterly audits of 50% of patients' chartswill be audited to ensure 100% compliance. Web-based drug interactions will besourced and patients will be re-educated regarding drug	2022-11-30

	The findings include: 1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Comprehensive Client Assessment" which stated, "... The comprehensive assessment will include a review of all medications the client is using. This assessment will identify potential adverse effects and drug reactions, including ineffective therapy, significant side effects, significant drug interactions, duplicative drug therapy, and non-compliance with therapy ...." 2. Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, the patient's medication bottles were reviewed. The following medication were observed which were not included in the patient's home health medication list: mesalamine (anti-inflammatory to treat colitis), omeprazole (for stomach acid), duloxetine (anti-depressant), metoprolol		lists. This will ensure that this deficiency does not recur again. The Director of Nursing is responsible formonitoring this corrective action scheduled to be implemented on 11/30/2022. **For patient #3,** the Director of Nursingimmediately reviewed the client's chart and identified the client affected bythis deficiency. The Director of Nursing further reviewed the client's reconciledpatient medications list. The Director of Nursing identified all the medicationspatients are no longer taking and reported to the physician to be discontinued. All clients' charts likely to be affected withthis deficiency have been reviewed, and 60-day recertification to include allclients' current medications in their medication list during comprehensive assessmenthas been outlined for each patient likely to be affected. Quarterly audits of 50% of patients' chartswill be audited to ensure 100% compliance. Web-based drug interactions will besourced and patients will be re-educated regarding drug interactions in theirmedication lists. This will ensure that this deficiency does not reoccur again. The director of nursing is	

	(to control heart rate and blood pressure), buspirone (anti-anxiety), topiramate (anti-seizure), oxybutynin (for overactive bladder), atorvastatin (to lower cholesterol), and multivitamin. Sertraline (anti-depressant) and aspirin (to prevent blood clots and heart attack) were also observed. The home health aide indicated the patient was also taking klonopin (anti-anxiety) and Norco (pain medication), which was not on the patient's medication list. Review on 9/20/2022, of the following web-based source, https://www.drugs.com/interactions-check.php, included 6 major drug interactions between the following medications observed in the patient's home: sertraline and duloxetine – can cause seizures, dizziness, confusion, changes in blood pressure and heart rate; buspirone and duloxetine – can cause seizures, dizziness, confusion, changes in blood pressure and heart rate; buspirone and sertraline – can cause seizures, dizziness, confusion, changes in blood		responsible formonitoring this corrective action scheduled to be implemented on 11/30/2022. **For patient #4**, the Director of Nursing immediately reviewed theclient chart and identified the client affected by this deficiency. The Directorof Nursing further reviewed the client's drug regimen to identify drug-druginteractions or duplicate drug therapy to ensure this deficiency does nothappen again. All clients' charts likely to be affected withthis deficiency have been reviewed, and 60-day recertification to include allclients' current medications in their medication list during comprehensiveassessment and to identify drug-drug interactions have been outlined for eachpatient likely to be affected. Quarterly audits of 50% of patients' chartswill be audited to ensure 100% compliance. Web-based drug interactions will besourced and patients will be re-educated regarding drug interactions in theirmedication lists. This will ensure that this deficiency does not reoccur	

	oxybutynin and topiramate – can cause decreased sweating and increased body temperature; buspirone and Norco – can cause respiratory depression, coma, or death; and klonopin and Norco – can cause respiratory depression, coma, or death. This source also included the following 4 duplicative drug therapies: central nervous system medications – sertraline, Klonopin, duloxetine, buspirone and topiramate - the recommended maximum number of drugs in this category was 3; psychotropics – sertraline, Klonopin, duloxetine, and buspirone – recommended maximum number of drugs in this category was 3; antidepressants – sertraline and duloxetine – recommended maximum number of drugs in this category was 1; and tranquilizers – Klonopin and buspirone – recommended maximum number of drugs in this category was 1. Clinical record review for patient #1 was completed on 9/19/2022, for certification period 8/13/2022 – 10/11/2022. Review evidenced a		again. The director of nursing is responsible formonitoring this corrective action scheduled to be implemented on 11/30/2022. **For patient #5,** the Director of Nursing immediately reviewed theclient chart and identified the client affected by this deficiency. The Directorof Nursing further reviewed the client's drug regimen to identify drug-druginteractions or duplicate drug therapy to ensure this deficiency does nothappen again. All clients' charts likely to beaffected with this deficiency have been reviewed, and 60-day recertification toinclude all clients' current medications in their medication list duringcomprehensive assessment and to identify drug-drug interactions, report anymedications clients are no longer taking to the physician have been outlinedfor each patient likely to be affected. Quarterly audits of 50% of patients'charts will be audited to ensure 100% compliance. Web-based drug	

	comprehensive assessment dated 8/8/2022, which failed to evidence a medication review had been completed and drug interactions or duplicative drug therapy had been identified. Record review evidenced a medication profile dated 8/8/2022, which included the following medications the patient was not taking: acetaminophen-codeine (pain medication), isosorbide mononitrate (to prevent chest pain), cyclobenzaprine (muscle relaxant), Butalb-Acetaminophen-Caff-Codeine (to treat migraines), Flexeril (muscle relaxer), megestrol acetate (to increase appetite), nortriptyline (anti-depressant), prednisone (steroid), and questran light (to lower cholesterol). During an interview on 9/20/2022, at 2:12 PM, clinical manager #2 indicated the agency only knew what medications the patient was taking by what patients told them. Clinical manager #2 indicated the agency did not do anything with the patients' medications unless the patient		patients will be re-educated regarding drug interactions intheir medication lists. This will ensure that this deficiency does not reoccuragain. The director of nursing is responsiblefor monitoring this corrective action scheduled to be implemented on 11/30/2022.	

	was receiving skilled nursing services. Clinical manager #2 indicated they did not review the patients' medication bottles. Clinical manager #2 indicated the agency did not perform a medication review for drug interactions or duplicative drug therapy for patients receiving only home health aide services. 3. Observation of a home visit for patient #3 was conducted on 9/20/2022, at 9:00 AM, to observe a routine skilled nurse visit. During the visit the patient's medications were reviewed. The observed medications included: baclofen (muscle relaxer), potassium chloride (supplement), gabapentin (for nerve pain), Reglan (for upset stomach or constipation), folic acid (supplement), oxycarbazapine (anti-seizure), magnesium (supplement), Keppra (anti-seizure), furosemide (to pull water off body), omeprazole (to decrease stomach acid), lacosamide (anti-seizure), iron (supplement), vitamin B12, aspirin (to prevent stroke or heart attack), Singulair (to help			

	with breathing), Plavix (to prevent blood clots), clonazepam (anti-anxiety), Lipitor (to lower cholesterol), and ergocalciferol (vitamin D).			

	Clinical record review for patient #3 was completed on 9/20/2022, for certification period 8/18/2022 – 10/16/2022. Record review evidenced a comprehensive assessment dated 8/15/2022, which failed to evidence a medication regimen review was completed. Record review evidenced a medication profile dated 8/15/2022, which included the following medications the patient was not taking: methenamine Hippurate (antibiotic), acetaminophen (for pain), mycophenolate mofetil (immunosuppressive), oxycodone (for pain), phenytoin (anti-seizure), Vimpat (anti-seizure), lactulose (for constipation), bumetanide (to pull water off the body), and sodium chloride (supplement). The medication profile failed to include the following medications the patient was taking: magnesium, iron, aspirin, and ergocalciferol. Review on 9/20/2022, of the following web-based source, https://www.drugs.com/interactions-check.php, included the following 3 categories of			

	duplicative drug therapy: central nervous system drugs – Keppra, gabapentin, lacosamide, oxycarbazapine, and clonazepam – usually only 3 drugs in this category are prescribed; nutritionals – magnesium, potassium, folic acid, iron, vitamin B12, and ergocalciferol – usually only 3 drugs in this category are prescribed; and anticonvulsants – oxycarbazapine, Keppra, lacosamide, clonazepam, and gabapentin – usually only 3 drugs in this category are prescribed. During an interview on 9/20/2022, at 3:18 PM, clinical manager #2 indicated the medication list was not updated with all the patient's medications. Clinical manager #2 indicated if drug duplication was identified, it would have been documented in the notes, and physician would have been notified. Clinical manager #2 indicated there was no duplicative drug therapy identified. 4. Clinical record review for			

	patient #4 was completed on 9/20/2022, for certification period 9/11/2022 – 11/9/2022. Record review evidenced a comprehensive assessment dated 9/6/2022, which failed to evidence a drug regimen review had been completed. Record review failed to evidence the home health agency identified any drug-drug interactions or duplicative drug therapy. Review on 9/20/2022, of the following web-based source, https://www.drugs.com/interactions-check.php, included 2 major drug-drug interactions: aspirin (to prevent stroke and heart attack) and Xarelto (blood thinner), and Plavix (anti-platelet, to prevent blood clots) and Xarelto – both interactions increased risk for bleeding and potentially fatal hemorrhage. This source also included duplicative drug therapy between Plavix, aspirin, and Xarelto – increasing risk for bleeding. Record review evidenced a plan of care from home health			

	surveyor on 9/20/2022, for certification period 8/29/2022 – 10/27/2022. This document indicated home health agency #7 was providing skilled nursing to fill patient's medication planner weekly. This document included the following 11 medication orders, which were not included in the home health agency's medication list: Lexapro (anti-depressant), Floranex (probiotic), glipizide (to lower blood sugar), Lantus (insulin/to lower blood sugar) 40 units nightly, Rexulti (antipsychotic), trazodone (antipsychotic), calcium alginate (wound dressing), Nuedexta (to treat uncontrollable laughing or crying), Ramipril (to lower blood pressure), Tylenol (for pain or fever), and Gabapentin (for nerve pain) 300 milligrams three times daily. During an interview on 9/19/2022, at 2:12 PM, clinical manager #2 indicated no drug regimen review had been completed, because the agency was only providing home health aide services for patient #4.			

	5. Clinical record review for patient #5 was completed on 9/19/2022, for certification period 7/28/2022 – 9/25/2022. Record review evidenced a comprehensive assessment dated 7/25/2022, which failed to evidence a review of all medications the patient was taking was completed. Record review failed to evidence any drug-drug interactions or duplicative drug therapy was identified. Record review evidenced a medication list for certification period 7/28/2022 – 9/25/2022, which included duplications of the following medications: Allegra (allergy medicine), atorvastatin (to lower cholesterol), glyburide (to lower blood sugar), aspirin (to prevent stroke and heart attack), pantoprazole (to reduce stomach acid), clonidine (to lower blood pressure), acetaminophen (for pain or fever), metoprolol (to lower blood pressure), and quetiapine (antipsychotic). Review on 9/20/2022, of the following web-based source, https://www.drugs.com/interacti			

following 3 major drug-drug interactions between medication on patient #5's medication list: clonidine (to lower blood pressure) and metoprolol (to lower blood pressure and heart rate) – can cause slow heart beat, headaches, or dizziness; aspirin (to prevent stroke and heart attack) and Eliquis (blood thinner) – can cause bleeding or hemorrhage; and quetiapine (antipsychotic) and escitalopram (anti-anxiety) – can cause irregular heart beat which can be life threatening.

Record review evidenced a plan of care from home health agency #8, for certification period 8/14/2022 – 10/12/2022, which was faxed to surveyor on 9/21/2022. This document included the following medications which were not include in the home health agency's plan of care: clonazepam (anti-anxiety), and ferrous sulfate (iron supplement). This document indicated the following medications were discontinued, which were on patient #5's

	midodrine. During an interview on 9/19/2022, at 3:50 PM, clinical manager #2 indicated a medication review was not completed for patient #5 because she was only receiving home health aide services. 410 IAC 17-14-1(a)(1)(B)			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the home health agency failed to send transfer/discharge summaries containing all necessary medical information pertaining the the current course of illness and treatment, post-discharge goals of care, and treatment	G0564	**For patient #5,** the Administrator immediately reviewed agencypolicy and identified the patients affected with deficiency. The Administrator furtherinstructed the Director of Nursing effective immediately to sendtransfer/discharge summaries containing necessary medical information about thecurrent course of illness and treatment to the receiving facility or healthcare practitioner to ensure this deficiency does not reoccur. 100% of agency client charts werereviewed to identify clients' charts likely to be affected. The director ofnursing further	2022-11-30

	preferences to the receiving facility or health care practitioner in 2 of 2 transfer records reviewed (#5, 6) and 1 of 2 discharged clinical records reviewed. (#7) The findings include: 1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Client Transfer" which stated, "... A transfer summary shall be completed by the registered nurse/therapist. This summary will be based on data collected on the last visit and shall include documentation of services received, reason for transfer, the client's physical and psychosocial status, current medications, continuing symptom management needs, instruction and referrals provided to the client, summary of care, any existing advance directives, and any relevant changes in caregiver support or lab results ... The original transfer summary form shall be sent to the new provider or facility, and a copy shall be retained for the client's chart ...."		in-serviced supporting staff to immediately send transfers/dischargesto the receiving facility or the health care provider. The Administrator has in-serviced thedirector of nursing and all supporting staff on the importance of sendingtransfer/discharge to the health care provider or the receiving facility. 25% of all clients will be completedon 11/20 2022 and will be subsequently audited quarterly to ensure 100%compliance. The director of nursing is responsible for monitoring thiscorrective action to ensure that this deficiency will not reoccur. **For patients #6 &7,** the agency is unable to correct thisdeficiency because clients expired and were discharged and are no longer beingserviced. The Director of Nursing audited allpatient's charts to ensure patients' transfers/discharges were faxed, signed,and kept in the respective affected client's chart.	

	2. Clinical record review for patient #5 was completed on 9/20/2022, for certification period 5/29/2022 – 7/27/2022, and 7/28/2022 – 9/25/2022. Record review indicated the patient was hospitalized and returned from the hospital on 6/15/2022. Record review failed to evidence a transfer summary was completed or sent to the hospital upon patient transfer. During an interview on 9/19/2022, at 3:52 PM, clinical manager #2 indicated the agency does not send transfer summaries, they instead call the doctor's office and let them know the patient was in the hospital.		The Director of Nursing will audit thepatient's chart every 60 days to ensure this deficiency does not reoccur. TheDirector of Nursing further in-serviced all supporting staff on the importanceof faxing all discharges/transfers to the health care provider/receivingfacility. The Director of Nursing completedauditing 50% of patients' charts on 10/21/2022 and will audit every client'schart quarterly to ensure 100% compliance. The Director of Nursing will beresponsible for monitoring this corrective action to ensure this deficiencydoes not reoccur.	

	3. Clinical record review for patient #6 was completed on 9/20/2022, for certification period 2/15/2022 – 4/15/2022. Record review indicated the patient was transferred to the hospital on 3/7/2022. Review failed to evidence a transfer summary had been sent to the hospital. During an interview on 9/20/2022, at 10:35 AM, clinical manager #2 indicated she did not send transfer summaries, because she called the patient's physician. Clinical manager #2 indicated the agency didn't send transfer summaries to the hospital if the patient was admitted. 4. Clinical record review for patient #7 was completed on 9/20/2022, for certification period 7/6/2022 – 9/3/2022. Record review evidenced the patient was discharged on 8/29/2022, but failed to evidence a discharge summary was completed or sent to the patient's physician.			

	During an interview on 9/20/2022, at 10:55 AM, clinical manager #2 indicated she did not send a discharge summary for patient #7 because she called his physician.			
G0570	Care planning, coordination, quality of care 484.60 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. Based on observation, record review, and interview, the home health agency failed to: ensure patients received the home health services which were written in an individualized plan	G0570	The Administratorimmediately directed the Director of Nursing to revise all active patients'current plans of care, and all missing information, diagnoses, and medicationswere included and faxed to the patient's physician for signature. The Directorof Nursing was also instructed to individualize all active patients' plans ofcare to meet their respective needs. This will ensure a patient-centered planof care for all active patients and as well improve the delivery of qualityhealthcare services to all patients. On 10/18/2022, the Director of Nursingaudited all patients' chart to ensure there was written documentation of carecoordination in every patient's chart for clients who	2022-11-30

	the plan of care included, all pertinent diagnoses, types of supplies and equipment required, nutritional requirements, all medications and treatments, patient and caregiver education and training, and/or measurable outcomes and goals (see tag G574); ensure services were provided, only as ordered by the physician (see tag G580); review and revise the plan of care (see tag G586); ensure the physician was promptly notified of any changes in patients' condition which suggested goals were not being achieved (see tag G590); provide patients with written visit schedules (see tag G614); ensure patients received written medication schedule/instructions including medication name, dose and frequency of medications to be taken (see tag G616); provide patients with written instructions outlining treatments to be administered by home health personnel or personnel acting on behalf of the home health agency (see tag G618); and ensure patients received written name and contact information for the clinical manager (see tag G622).		have services or hasreceived services from other healthcare providers. The Director of Nursing will audit everypatient's chart bimonthly to ensure all care is properly coordinated with otheragencies providing services for the same client. The Director of Nursingin-serviced all office staff on the importance of care coordination with otheragencies providing services for every client. The Director of Nursing completedauditing every patient's chart on 10/18/2022 and will audit every client'schart bimonthly to ensure proper documentation of care coordination with otheragencies providing services for the same client The Director of Nursing will beresponsible for monitoring corrective action to ensure this deficiency does notrecur.	

	The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review and interview, the home health agency failed to ensure patients received the home health services which were written in an individualized plan of care in 5 of 5 active clinical records reviewed. (#1, 2, 3, 4, 5) The findings include:	G0572	**For patient #1**, the agency immediately reviewed its standardof practice on missed visits and implemented procedures for properdocumentation of missed visits to ensure the patient is provided with servicesunder the plan of care signed by the physician. The Director of Nursinghas in-serviced all home health aides to report missed visits to the schedulingcoordinator of care for proper action and documentation. The agency hasassigned the scheduling coordinator of care to complete, track, notifyclients/family members and fax missed visits to physicians. All clientmedical charts will be reviewed monthly to ensure that other patients likely tobe affected by this deficiency are corrected timely. Affected	2022-11-30

	1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Plan of Treatment" which stated, "… The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members … An individualized Plan of Care/485 signed by a physician shall be required for each client receiving home health and personal care services …." 2. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Client Admission Process" which stated, "… Services will be initiated within 24 hours after the assessment, unless documentation supports alternate plan based on client needs and wishes and caregiver availability …." 3. Clinical record review for patient #1 was completed on 9/19/2022. Record review evidenced a plan of care for certification period 8/13/2022 – 10/11/2022, which indicated the patient was to receive home		clients' chartsare audited, corrected, and properly documented. 50% of clientmedical records will be audited to ensure 100% compliance. The Director of Nursingis responsible for this corrective action to ensure that this deficientpractice does not reoccur. **For patient #2**, the Administrator immediatelyreviewed likely clients affected with this deficiency and instructed thedirector of nursing to ensure upon admission that communication between patientand physician regarding any delay in initiation of care within 24 hours ofcompletion of admission assessment is identified, handled appropriately, anddocumented. All patient'splans of care likely to be impacted by this deficiency were revised, tailored,and logged into their medical records. The affected clients were called and explanationsfor the delay in their home health aide services were made aware of them. Upon completion of the	

	health aide visits 3 days per week. Record review evidenced the patient only received 1 home health aide visit the week of 8/28/2022, and 2 home health aide visits the week of 9/4/2022. Review failed to evidence a missed visit note or documentation of why the visits were not completed. The plan of care included the following goals: able to understand medication regime and care related to diagnosis, medical condition stabilizes, when maximum functional potential reached, discharge at the end of the episode if the patient was hospitalized. During an interview on 9/19/2022, at 1:46 PM, clinical manager #2 indicated she did not know why patient #1 did not receive 3 home health aide visits the weeks of 8/28/2022 and 9/4/2022. Clinical manager #2 indicated the patient would have to call the agency and request a missed visit be rescheduled if a visit was missed. Clinical manager #2 did not know why the reason the visit was missed was not documented. At 2:39 PM,		initialassessment and evaluation, the clinical manager will notify the client and discusswith the physician of client's needs, if the physician agreed, services will beprovided to the patient within 24 hours, if there is a delay in the start ofcare at no fault of the agency, written communication will be documented withclient and physician aware. If the physician disagrees, the agency will take nofurther action, The Agency's50% of the client's medical records will be audited quarterly to ensure100% compliance. The Director ofNursing is responsible for monitoring this corrective action to ensure thatthis deficiency will not recur. **For patient #3,** the agency reviewed its Plan of Care policy and identified likelyaffected patients with this deficiency. Agency individualized the affected client'splan of care/485 to include specific interventions to prevent skin breakdown,regarding diagnoses, respiratory assessment with pulse oximetry monitoring, keepingthe head of the bed elevated, safety	

	clinical manager #2 indicated the goals were the exact same on every patients' plan of care because it was a generic template used when completing the plan of care. 4. Clinical record review for patient #2 was completed on 9/19/2022. Record review evidenced a plan of care for certification period 8/15/2022 – 10/13/2022, which indicated the patient was to receive home health aide services 6 hours per day/5 days per week. Record review evidenced a comprehensive assessment dated 8/15/2022, which indicated the start of care date was 8/15/2022. Record review indicated the patient failed to receive any home health aide services until 9/6/2022 (21 days after start of care). Record review failed to evidence any patient or physician communication regarding delay in services. The plan of care included the following goals: able to understand medication regime		teachings, and measurable outcomes/goals and sent to thephysician for signature. Agency audited All clients'charts likely to be affected by this deficiency, and 60-day recertification hasbeen outlined to address their individualized needs and interventions in theirplan of care/485 and to ensure that this deficiency does not reoccur. The Director ofNursing in-serviced supporting staff to ensure that plan of care is individualized,up-to-date, and faxed to the physician for signature. 50% ofall clients' charts will be audited quarterly by the Director of Nursing, andfindings reported to the Administrator. The Administrator will be responsiblefor monitoring this corrective action to ensure 100% compliance and avoid itsreoccurrence. **For patient #4,** the agency reviewed its "Plan of Care"policy, and identified likely affected patients with this deficiency. Agencyindividualized the affected patient plan of care/485 to include the patientmedical condition, functional limitations, and measurable goals and outcomesand faxed it to the physician for signature.	

	medical condition stabilizes, when maximum functional potential reached, discharge at the end of the episode if the patient is hospitalized. During an interview on 9/19/2022, at 2:33 PM, clinical manager #2 indicated patient #2 did not receive any home health aide visits for 3 weeks following the start of care because the agency was waiting for insurance approval. Clinical manager #2 indicated the physician should have been aware of the delay in services because they signed the plan of care. 5. Observation of a home visit for patient #3 was conducted on 9/19/2022, at 9:00 AM, to observe a routine skilled nurse visit. The patient was observed to be alert and oriented, sitting in a recliner. The patient indicated she could not walk, and was only able to stand with a walker, while the aides bathe her or clean up her bottom. The patient indicated she was incontinent of urine, and previously had an open wound		Agency audited All clients'charts likely to be affected by this deficiency, and a -day recertification hasbeen outlined to address their individualized needs and interventions in theirplan of care/485 and to ensure that this deficiency does not recur. The Director ofNursing serviced supporting staff to ensure that plan of care is individualized,up-to-date, and faxed to the physician for signature. 50% of allclients' charts will be audited quarterly by the director of nursing, andfindings reported to the administrator that is responsible for monitoring thiscorrective action to ensure 100% compliance and avoid its reoccurrence. **For patient #5,** the agencyreviewed its "Plan of Care" policy, and identified likely affected patientswith this deficiency. Agency individualized the affected patient plan ofcare/485 to include the patient medical condition, functional limitations,	

	to her bottom from the moisture. The patient indicated she used a cream on her bottom to prevent any more open areas. The nurse failed to complete a skin assessment during the visit or complete any education. Clinical record review for patient #3 was completed on 9/20/2022. Record review evidenced a plan of care for certification period 8/18/2022 – 10/16/2022, which indicated the primary diagnosis was chronic obstructive pulmonary disease (a chronic disease which blocks airflow and makes it hard to breathe). The plan of care indicated the patient had an oxygen concentrator. This document also included but was not limited to the following diagnoses: diabetes (problem regulating blood sugar), muscle weakness, hemiplegia affecting right side (weakness or paralysis of one side of body), sarcoidosis (inflammatory disease), and seizures. The plan of care included the following skilled nursing interventions: teach disease process, signs and		outcomes and faxed it to the physician for signature. Agency audited Allclients' charts and 60-day recertification have been outlined to addressaffected patients' individualized needs and interventions in their plan ofcare/485 and to ensure that this deficiency does not recur. All client charts will be subsequently auditedbimonthly. The Director of Nursing in-serviced supporting staff to ensure thatplan of care is individualized, specific, accurate, up-to-date, and signed by thephysician. 50% of allclients' charts will be audited quarterly by the director of nursing, andfindings reported to the administrator that is responsible for monitoring thiscorrective action to ensure 100% compliance and avoid its reoccurrence.	

	prevention. The plan of care failed to be individualized to include any specific interventions or education regarding relevant diagnoses, such as respiratory assessment, monitoring pulse oximetry, keeping head of bed elevated, instructions on oxygen use and safety, educating on assistive devices, education on energy conservation, medication education, or dietary compliance education. The plan of care failed to be individualized to include any interventions for preventing skin breakdown or maintaining skin integrity such as head-to-toe skin assessment, repositioning, or preventative creams. The plan of care included the following goals: able to understand medication regime and care related to diagnosis, medical condition stabilizes, when maximum functional potential reached, discharge at the end of the episode if the patient was hospitalized. The plan of care indicated the skilled nurse was to administer insulin, but insulin was not ordered. This document failed to be individualized to reflect that the patient did not take insulin.			

G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to ensure the plan of care included, all	G0574	**For patient # 1,** the Administratorhas directed the Director of Nursing to revise the patient's plan of care toinclude the patient's identified history and equipment uses; such as cane andCPAP. This was documented and sent to the patient's physician for signature. Theagency audited all client's medical records to ensure that clients likely to beimpacted by this deficiency are corrected. The plans of care will be documentedand logged in the client's medical charts. Theadministrator has in-serviced the Director of Nursing on 10/17/2022 and supportstaff to ensure that plan of care is individualized, accurate, complete, up todate, and signed by the physician. 50% of theclient's records will be audited quarterly by the Director of Nursing, andfindings reported to the administrator that is responsible for monitoring thiscorrective action to ensure 100% compliance and avoid its reoccurrence **For patient #2,** the Administratorhas instructed the Director of Nursing that during	2022-11-30

	pertinent diagnoses, types of supplies and equipment required, nutritional requirements, all medications and treatments, patient and caregiver education and training, and/or measurable outcomes and goals in 5 of 5 active clinical records reviewed. (#1, 2, 3, 4, 5) The findings include: 1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Plan of Treatment" which stated, "... An individualized Plan of Care/485 signed by a physician shall be required for each client receiving home health and personal care services ... The Plan of Care shall be completed in full to include: ... All pertinent diagnoses ... Surgical procedures ... Specific dietary or nutritional requirements or restrictions ... Medications, treatments, and procedures ... Medical supplies and equipment required ... Any safety measures to protect against injury ... Instructions to client/caregiver ... Treatment goals ... Name and address of		admission, recertification,or re-evaluation of clients, all client's diagnoses, durable medical equipment,teachings, and medications are documented to ensure that patients identifiedneeds are met. Theagency immediately audited all client's medical records to ensure that clientslikely to be impacted by this deficiency are corrected. The plan of care willbe documented and logged in the client's medical charts. The Administratorhas in-serviced the Director of Nursing and support staff on 10/17/2022 to ensure that plan of care isindividualized, accurate, complete, up to date, and signed by the physician. 50% of theclient's records will be audited quarterly by the director of nursing, andfindings reported to the administrator that is responsible for monitoring thiscorrective action to ensure 100% compliance and avoid its reoccurrence	

	client's physician ...." 2. Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, the patient was observed to be alert and oriented, and using a cane. He indicated he had a history of colitis (inflammation of the colon), liver cancer, and a pacemaker. He indicated he used a CPAP (machine which provides air through a mask, while sleeping) nightly. Clinical record review for patient #1 was completed on 9/19/2022. Record review evidenced a plan of care for certification period 8/13/2022 – 10/11/2022, which failed to include diagnoses of colitis, liver cancer, and pacemaker. This document failed to include a cane or CPAP. This plan of care failed to include any education or training. Record review evidenced a plan of care from home health		**For patient #3**, the agency reviewed its policy on the planof care, discussed it with the client/ caregiver, and revised the client's planof care to specifically include a walker, commode, wheelchair under durablemedical equipment, and appropriate medication prescribed and sent to thephysician for signature and documented in the client chart. Agency auditedall client's medical records. The plan of care is revised and tailored to theclient's needs, and sent to the physician for signature, ensuring that the clientlikely to be impacted by this deficiency is corrected and logged in the client'smedical charts. The Director ofNursing in-serviced all clinical staff on 10/17/2022 regarding the importanceof an individualized, accurate, and up-to-date plan of care tailoring only whatis appropriate to the client's needs during assessments/ recertification andadmission and signed by the physician. The Agency's 25%of the client's medical records will be audited quarterly to ensure 100%compliance. The Director of Nursing will be monitoring this process ensuringthat this deficiency will not recur. **For patient #4,** the agency reviewed its policy on the plan ofcare, discussed it with the client/ caregiver, and revised the client's plan ofcare to specifically include a walker,	

	agency #3, which was faxed to surveyor on 9/14/2022. This document included a primary diagnosis of hypertensive chronic kidney disease, which was not included in the 1st Option Adult Day Services plan of care. This document also included the following diagnoses which were not included in the 1st Option Adult Day Services's plan of care: peripheral vascular disease (circulation problem to legs), chronic pain syndrome, gastro-esophageal reflux disease with esophagitis (inflammation of the esophagus due to stomach acid reflux), and repeated falls. During an interview on 9/19/2022, at 1:55 PM, clinical manager #2 indicated the agency only included diagnoses on the plan of care which were verbalized to them by the patient. Clinical manager #2 indicated all durable medical equipment in use should be included in the plan of care. Clinical manager #2 indicated education was not included on plans of care for home health aide only patients because the		under durablemedical equipment, and appropriate medication prescribed and sent to thephysician for signature and documented in the client chart. Agencyaudited all client's medical records. The plan of care is revised and tailoredto the client's individualized needs, and sent to the physician for signature,ensuring that clients likely to be impacted by this deficiency are correctedand logged in the client's medical charts. The Directorof Nursing in-serviced all clinical staff on 10/17/2022 regarding theimportance of an individualized, accurate, and up-to-date plan of caretailoring only what is appropriate to the client's needs during assessments/recertification and admission and signed by the physician. The Agency's50% of the client's medical records will be audited quarterly to ensure 100%compliance. The Director of Nursing will be monitoring this process ensuringthat this deficiency will not recur.	

	home health aides do not educate patients. At 2:41 PM, clinical manager #2 indicated the patients should receive education at every recertification assessment. 3. Observation of a home visit for patient #2 was conducted on 9/14/2022, at 12:30 PM, to observe a routine home health aide visit. The patient was observed sitting in a recliner. The patient's right side was weak from a stroke in 2013. During the visit an electric wheelchair, cane, and hemi walker were observed. Patient #2 indicated he used the wheelchair, cane, and walker depending on the activity. Clinical record review for patient #2 was completed on 9/19/2022. Record review evidenced a plan of care for certification period 8/15/2022 – 10/13/2022, which failed to include any durable medical equipment. The plan of care failed to include any education or training.		**For patient #5,** the agency reviewed the client's plan of careimmediately and revised the plan of care to include the patient's tube feedingstatus at this time. The plan of care is sent to the physician for signatureand documented in the client's chart. Agencyaudited all client's medical records. The plan of care is revised and tailoredto the client's individualized needs, and sent to the physician for signature,ensuring that client likely to be affected by this deficiency is corrected andlogged in the client's medical charts. TheDirector of Nursing in-serviced all clinical staff on 10/17/2022 regarding theimportance of an individualized, accurate, and up-to-date care plan tailoringonly to what is appropriate to the client's needs during assessments/recertification and admission and signed by the physician. The Agency's50% of the client's medical records will be audited quarterly to ensure	

	Clinical record review evidenced a comprehensive assessment dated 8/15/2022, which indicated the patient was taking a CBD (cannabidiol, medication used for pain, anxiety, and inflammation) prescription, which was not included on the plan of care. During an interview on 9/19/2022, at 2:41 PM, clinical manager #2 indicated home health aide only patients do not receive any education or training. During an interview on 9/19/2022, at 2:45 PM, clinical manager #2 indicated the CBD medication should have been included in the plan of care. 4. Observation of a home visit for patient #3 was conducted on 9/20/2022, to observe a routine skilled nurse visit. During the visit, the following durable medical equipment was observed: walker, commode, and wheelchair. Patient #3 indicated she had broken her right ankle, and as a result, was unable to walk. Patient #3		100%compliance. The Director of Nursing will be monitoring this process ensuringthat this deficiency will not recur.	

	indicated she was applying a cream to her bottom to prevent skin breakdown. Clinical record review for patient #3 was completed on 9/20/2022. Record review evidenced a plan of care for certification period 8/18/2022 – 10/16/2022, which only included an oxygen concentrator for durable medical equipment. This document failed to include a walker, commode, or wheelchair under durable medical equipment. This document failed to include diagnosis of broken right ankle. This document failed to include the medication Triamcinolone, which had been prescribed. During an interview on 9/20/2022, at 3:22 PM, clinical manager #2 indicated the physician had prescribed Triamcinolone for patient #3. Clinical manager #2 indicated all medications should be included on the plan of care.			

	5. Clinical record review for patient #4 was completed on 9/20/2022, for certification period 9/11/2022 – 11/9/2022. Record review evidenced a comprehensive assessment dated 9/6/2022, which indicated the patient used a wheelchair and walker. Record review evidenced a plan of care for certification period 9/11/2022 – 11/9/2022, which failed to include a wheelchair and walker under durable medical equipment. This document failed to include any education or training for patient. Clinical record review evidenced a plan of care from home health agency #7, for certification period 8/29/2022 – 10/27/2022, faxed to surveyor on 9/20/2022, which included the following diagnoses, which were not included in patient #4's plan of care: diabetes (problem regulating blood sugar) with foot ulcer (wound to foot), non-pressure ulcer of right foot, pressure ulcer of sacral region, pressure ulcer of other site, urethral stricture (narrowing of urethra), hypertensive heart			

	causing heart disease), heart failure, chronic kidney disease, and chronic obstructive pulmonary disease (lung disease which makes it increasingly difficult to breathe). 6. Clinical record review for patient #5 was completed on 9/20/2022, for certification period 7/28/2022 - 9/25/2022. Record review evidenced a plan of care from home health agency #8, for certification period 8/14/2022 – 10/12/2022, which indicated the patient received tube feedings. Record review evidenced a plan of care for certification period 7/28/2022 – 9/25/2022, which failed to include tube feedings. During an interview on 9/19/2022, at 3:50 PM, clinical manager #2 indicated the plan of care should have been updated to include tube feedings.			

	410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C) 410 IAC 17-13-1(a)(1)(D)(ii, iii, viii, ix, xi)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to ensure services were provided, only as ordered by the physician in 1 of 5 active clinical records reviewed. (#5) The findings include: Record review evidenced an undated agency policy obtained 9/20/2022, titled "Home Health Aide Assignment" which stated, "... Any changes in the assignment will be communicated to the home health aide and will be documented on a new care plan. Changes must reflect physician orders and be	G0580	Agencyreviewed the plan of care of the client affected with this deficiency,discussed it with the client/ caregiver, and revised the client's plan of careto specifically include appropriate wording "home health aide to assist patientin transferring to dialysis and to go with the patient to dialysis" and sent tothe physician for signature and documented in the client chart. Agencyaudited all client's medical records. The plan of care is revised and tailoredto the client's individualized needs, and sent to the physician for signature,ensuring that clients likely to be impacted by this deficiency are correctedand logged in the client's medical charts. The Directorof Nursing in-serviced all clinical and supporting staff on 10/17/2022regarding the importance of an individualized	2022-11-30

	and in the client's chart (signed physician orders) ...." Clinical record review for patient #5 was completed on 9/20/2022. Record review evidenced a plan of care for certification period 7/27/2022 – 9/25/2022, which indicated the patient went to dialysis (artificial kidney filtration) on Monday, Wednesday, and Friday. This document failed to include any orders for home health aides to assist patient in transferring to dialysis, or to go with the patient to dialysis. During an interview on 9/19/2022, at 3:46 PM, clinical manager #2 indicated the home health aides accompanied patient #5 to dialysis on Mondays, Wednesdays, and Fridays, and stay for the duration of the treatment. Clinical manager #2 indicated the home health aides know which services to provide by the plan of care. Clinical manager #2 indicated the orders for treatment should all be on the plan of care.		and up-to-date plan of caretailoring only what is appropriate to the client's needs during assessments/recertification and admission and signed by the physician. The Agency's50% of the client's medical records will be audited quarterly to ensure 100%compliance. The Director of Nursing will be monitoring this process ensuringthat this deficiency will not recur.	

	410 IAC 17-13-1(a)			
N0586	Scope of Services 410 IAC 17-14-1(h) Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas: (1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff. (2) Observing, reporting, and documenting patient status and the care or service furnished. (3) Reading and recording temperature, pulse, and respiration. (4) Basic infection control procedures and universal precautions. (5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (6) Maintaining a clean, safe, and healthy environment. (7) Recognizing emergencies and knowledge of emergency procedures. (8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property. (9) Appropriate and safe techniques in	N0586	The Administrator immediately drafted a schedule forcontinuous training covering the major topics in accordance with the scope ofservice which includes but is not limited to communication skills, observing,reporting, and documenting the patient's status, reading, and recording vitalsigns, infection control and maintaining a clean and safe environment. Thesetopics have been added to the already designed curriculum of the annual HomeHealth Aides in-service. This continuous training is scheduled to cover atleast twelve (12 hours). All Home Health Aides were immediately notified about thecontinuous training and that the schedule will be sent to them in order to beprepared. This continuous training will be conducted by the Director of Nursing. The Administrative Assistant will constantly remind the HomeHealth Aides about their	2022-11-30

	the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Any other task that the home health agency may choose to have the home health aide perform. Based on record review and interview, the home health agency failed to ensure the home health aides received 12 hours of continuing education. The findings include: Record review evidenced an undated agency policy obtained 9/20/2022, titled "Competency Evaluation of Home Care Staff" which stated, "... A home health aide will not be permitted to provide home health aide services until evidence of		training schedule. This will ensure 100% compliance. The Director of Nursing will be responsible for monitoringthis corrective action to ensure that this deficiency does not recur.	

competency has been determined by the designated professional in the agency ... Documentation of individual Home Health Aide training and/or competency shall be maintained in the Home health aide's personnel file ...."

Employee record review on 9/15/2022, evidenced an in-service meeting dated 11/23/2021, which included the following topics: patient's financial belongings, patient's medication, passwords, and clocking in and out, infection control, patient care/responsibilities, patient's approved hours, professionalism, proper handwashing, and protected health information compliance. This document failed to evidence the home health aides had received 12 hours of in-services in the last 12 months.

During an interview on 9/16/2022, at 11:52 AM, clinical manager #2 indicated home health aides completed 2 hours

	which included infection control, hand washing, not touching patient's personal belongings, clocking in and out, confidentiality, emergency training, and fall issues.			
G0586	Review and revision of the plan of care 484.60(c) Standard: Review and revision of the plan of care. Based on record review and interview, the home health agency failed to review and revise the plan of care in 5 of 5 active clinical records reviewed. (#1, 2, 3, 4, 5) The findings include:	G0586	For patient #1, the plan of care wascorrected, and the hours were adjusted to reflect the current insuranceauthorization and sent to the patient's primary care physician for signature. For patient #2, the plan of care wascorrected, and the hours were adjusted to reflect the current insuranceauthorization and sent to the patient's primary care physician for signature. For patient #3, the plan of care wascorrected, and the hours were adjusted to reflect the current insuranceauthorization and sent to the patient's primary care physician for signature. For patient #4, the plan of care wascorrected, and the hours were adjusted to reflect the current insuranceauthorization and sent to the patient's	2022-11-30

	1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Plan of Treatment" which stated, "... the Plan of Care shall be completed in full to include: ... Type, frequency, and duration of all visits/services ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ...." 2. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Coordination of Client Services" which stated, "... The primary care Nurse or Therapist will assume responsibility for updating/changing the Care Plan and communicating changes to caregivers within 24 hours following the conference or changes. The physician will be contacted when his/her approval for that change is necessary and to alert physician to changes in client condition ...." 3. Clinical record review for patient #1 was completed on 9/19/2022. Record review		primary care physician for signature. For patient #5, the plan of care wascorrected, and the hours were adjusted to reflect the current insuranceauthorization and sent to the patient's primary care physician for signature. The Administrator immediatelyinstructed the Director of Nursing to always document every change to theservices rendered to patients, include them in the plan of care, and notify thepatient's other care providers for proper care coordination. All patients' charts were thoroughlyscrutinized to ensure that all changes to patients' services are accuratelydocumented and communicated with all other healthcare providers seen by thepatients. This will ensure 100% compliance. This was completed on 10/18/2022. All medical records will be reviewedquarterly to ensure that changes to patients' services are accuratelydocumented and	

	evidenced a plan of care for certification period 8/13/2022 – 10/11/2022, which indicated the patient was to receive home health aide services 5 hours per day/3 days per week. Review of visit notes evidenced the patient was receiving home health aide services 2 hours per day/3 days a week. Record review evidenced a prior authorization document dated 3/17/2022, which indicated the patient had only been approved for 6 hours of home health aide services per week. Record review failed to evidence the plan of care was revised to include accurate frequency and duration of home health aide visits. During an interview on 9/19/2022, at 1:43 PM, clinical manager #2 indicated the duration and frequency of aide visits was determined by the insurance authorization approval. Clinical manager #2 indicated patients' plans of care should be revised to match the current insurance authorizations.		promptly communicated with other healthcare providers. The Director of Nursing will beresponsible for this corrective action and monitor this and ensure 100%compliance. This will ensure that the deficiency will not recur.	

	4. Clinical record review for patient #2 was completed on 9/19/2022. Record review evidenced a plan of care for certification period 8/15/2022 – 10/13/2022, which indicated the patient was to receive home health aide services 6 hours per day/5 days per week. Review of visit notes evidenced the patient was receiving 3 hours per day/5 days per week. Record review evidenced a prior authorization document dated 9/1/2022, which indicated the patient had only been approved for 18 hours of home health aide services per week. Record review failed to evidence the plan of care was revised to include an accurate frequency and duration of home health aide visits. During an interview on 9/19/2022, at 2:29 PM, clinical manager #2 indicated they only revised the plan of care during recertification assessments. 5. Clinical record review for patient #3 was completed on 9/20/2022. Record review			

	certification period 8/18/2022 – 10/16/2022, which indicated the patient was to receive home health aide services 7 hours per day/5 days per week. Record review evidenced the patient was only receiving home health aide services 6 hours per day/5 days per week. Record review evidenced a prior authorization dated 8/24/2022, which indicated the patient was only approved for 30 hours of home health aide services per week. Record review failed to evidence the plan of care was revised to include the accurate frequency and duration of home health aide visits being performed. 6. Clinical record review for patient #4 was completed on 9/20/2022. Record review evidenced a plan of care for certification period 9/11/2022 – 11/9/2022, which indicated the patient was to receive home health aide services 9 hours per day/5 days per week. Record review evidenced the patient was receiving home health aide services 7 days per week, about 6 hours per visit. Record review			

	care was revised to reflect the actual frequency and duration of home health aide visits being performed. 7. Clinical record review for patient #5 was completed on 9/20/2022. Record review evidenced a plan of care for certification period 7/28/2022 – 9/25/2022, which indicated the patient was to receive home health aide services 10 hours per day/7 days per week. Record review evidenced the patient was receiving home health aide services 6 hours per day/6 days per week. Record review failed to evidence the plan of care was revised to reflect the actual frequency and duration of home health aide visits being performed. During an interview on 9/19/2022, at 3:41 PM, clinical manager #2 indicated the patient was only approved through her insurance for 6 hours per day/6 days per week.			
G0590	Promptly alert relevant physician of changes	G0590	For patient #1,the Director of Nursing called patient #3,	2022-11-30

	484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to ensure the physician was promptly notified of any changes in patients' condition which suggested goals were not being achieved or the plan of care should be altered in 2 of 5 active clinical records reviewed. (#1, 3) The findings include: 1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Plan of Treatment" which stated, "... the Plan of Care shall be completed in full to include: ... Type, frequency, and duration of all visits/services ... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ...."		coordinated care with agency #3, andgot the most recent progress note. The current plan of care was revised, andall missing information, services, diagnoses, and medication were included andfaxed to the patient's physician for signature. Forpatient #3, the Director of Nursing called patient #3, coordinated care with patient#3 primary care physician regarding the patient's physical therapy, and got themost recent progress note. The current plan of care was revised, and allmissing information, services, diagnoses, and medication were included andfaxed to the patient's physician for signature.	

	2. Clinical record review for patient #1 was completed on 9/19/2022, for certification period 8/13/2022 – 10/11/2022. Record review evidenced a comprehensive recertification assessment dated 8/8/2022, which indicated the patient had 2 or more falls within the last 12 months. Record review evidenced a plan of care from home health agency #3 which was faxed on 9/14/2022, which indicated the patient fell on 8/3/2022, while trying to get out of bed, and had some bruising to his right side. Record review failed to evidence any documentation from 1st Option Adult Day Services regarding this fall. Record review failed to evidence the primary care physician was notified of patient's fall or another comprehensive assessment completed. During an interview on 9/19/2022, at 2:21 PM, clinical		On 10/18/2022, the Director of Nursingaudited all patients' chart to ensure that the accurate services,diagnoses, and medication were included inevery patient's chart for clients who have services or has received servicesfrom other healthcare providers. They were faxed to their respective primarycare physicians for signatures. The Director of Nursing will auditevery patient's chart bimonthly to ensure all care is properly coordinated withother agencies providing services for the same client. The Director of Nursingin-serviced all office staff on the importance of promptly alerting thephysicians and all other healthcare providers providing services for everyclient of any change to the patient's services or condition. The Director of Nursing completedauditing every patient's chart on 10/18/2022 and will audit every client'schart bimonthly to ensure compliance. The Director of Nursing will beresponsible for monitoring corrective action to ensure this	

	physician should be notified if the patient fell and another comprehensive assessment completed. 3. Observation of a home visit for patient #3 was conducted on 9/20/2022, at 9:00 AM, to observe a routine skilled nurse visit. The patient was observed to be alert and oriented, sitting in a recliner. The patient indicated she lived alone. The patient indicated she had broken her right ankle and had been unable to walk since then. She indicated she wanted to be able to walk again, and indicated she was chairbound and only able to stand up long enough for the home health aide to wipe her bottom. The patient indicated she would like to receive physical therapy to meet her goal of walking. Clinical record review for patient #3 was completed on 9/20/2022, for certification period 8/18/2022 – 10/16/2022. Record review failed to evidence the patient received physical therapy or had been		deficiency does notrecur.	

	Record review failed to evidence any communication with the physician regarding patient's therapy need. During an interview on 9/20/2022, at 2:58 PM, clinical manager #2 indicated the patient received physical therapy a long time ago. Clinical manager #2 indicated the physician was not notified of patient's need for therapy because the home health agency did not offer therapy services. 410 IAC 17-13-2(a)(2)			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview, the home health agency failed to provide patients with written visit schedules in 3 of 3 home visits conducted. (#1, 2, 3)	G0614	For patient #1, the individualizedHome Health Aide visit schedule was printed and placed in the patient's homefolder. For patient #2, the individualizedHome Health Aide visit schedule was printed and placed in the patient's homefolder. For patient #3, the individualizedHome Health Aide	2022-11-30

	The findings include: 1. Record review evidenced an undated agency policy obtained 9/13/2022, titled "Client Bill of Rights and Responsibilities" which stated, "... Clients of 1st Option Home Health have the right to: ... Receive complete written information on the plan of care, including the name of the home aide and supervisor responsible for the services ...." 2. Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, a home folder was reviewed, which failed to evidence a written visit schedule was provided to the patient. During an interview on 9/19/2022, at 2:01 PM, clinical manager #2 indicated the agency verbally reviewed visit schedules with patients and encouraged them to put it in their phones. Clinical manager #2 indicated the agency did not		visit schedule was printed and placed in the patient's homefolder. On 10/20/2022, the Director of Nursinginstructed the Administrative Assistant to print all active patients' schedulesand make them available to the patients. Their respective Home Health Aides pickedthem up from the office and placed them in their patient's home folders. Thiswas verbally communicated with the patients and confirmed. The Administrative Assistant willreach out to all active clients weekly to constantly remind them of their visitschedules. This will be documented. The Administrative Assistant will beresponsible for monitoring this corrective action to prevent it from recurring.	

	provide a written visit schedule to patients. 3. Observation of a home visit for patient #2 was conducted on 9/14/2022, at 12:30 PM, to observe a routine home health aide visit. During the visit, a home folder was reviewed, which failed to evidence a written visit schedule was provided to the patient. 4. Observation of a home visit for patient #3 was conducted on 9/19/2022, at 9:00 AM, to observe a routine skilled nurse visit. During the visit, a home folder was reviewed, which failed to evidence a written visit schedule was provided to the patient.			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record	G0616	For patient #1, the updated medicationprofile was printed and placed in the patient's home folder and this will berepeated each time there is a change to the patient's medication profile. For patient #3, the updated medicationprofile was printed	2022-11-30

	review, and interview, the home health agency failed to ensure patients received written medication schedule/instructions including medication name, dose and frequency of medications to be taken in 2 of 3 home visits conducted. (#1, 3) The findings include: 1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Medication Profile" which stated, "... The original Medication Profile shall be filed in the clinical record. A copy shall be retained by the Registered Nurse or staff member or placed in the client's home chart when extended hours of service are being provided ...."		and placed in the patient's home folder and this will berepeated each time there is a change to the patient's medication profile. On 10/20/2022, the Director of Nursingupdated all active patients' medication profiles and make them available to thepatients. Their respective Home Health Aides picked them up from the office andplaced them in their patient's home folders. This was verbally communicatedwith the patients and confirmed. The Director of Nursing will reach outto all active clients to constantly reconcile their medication profiles andnecessary adjustment will be made and documented. The Director of Nursing will beresponsible for monitoring this corrective action to prevent it from recurring.	

	2. Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, a home health folder was reviewed, which failed to include written medication schedule/instructions. During an interview on 9/19/2022, at 1:40 PM, clinical manager #2 indicated the written medication schedule/instructions would be provided to patients on their plan of care which would be provided to them during comprehensive assessments. 3. Observation of a home visit for patient #3 was conducted on 9/19/2022, at 9:00 AM, to observe a routine skilled nurse visit. During the visit, the patient's medication bottles were reviewed. The medications included but were not limited to: baclofen (muscle relaxer) 10 milligrams three times daily, as needed, oxycarbazepine (anti-seizure medication) 600 milligrams twice daily, gabapentin (to help nerve pain)			

	300 milligrams three times daily, and magnesium oxide 400 milligrams twice daily. During the visit, a home folder was reviewed, which contained a plan of care. This plan of care contained a list of medications which included but was not limited to: oxycarbazepine 300 milligrams twice daily, gabapentin 200 milligrams three times daily, and baclofen 10 milligrams three times daily. This medication list failed to include magnesium oxide. This medication list included the following medications the patient was not taking: lactulose (for constipation) and sodium chloride tablet.			

	During an interview on 9/20/2022, at 3:11 PM, clinical manager #2 indicated the patient's gabapentin order must have been changed. Clinical manager #2 indicated the medication list provided to the patient had the incorrect dosage of gabapentin and oxycarbazepine. Clinical manager #2 indicated all the medications the patient was taking should have been on her written medication list.			
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review, and interview, the home health agency failed to provide patients with written instructions outlining treatments to be administered by home health personnel or personnel acting on behalf of the home health agency in 1 of 3 home visits conducted. (#1)	G0618	For patient #1, the Director ofNursing immediately made a copy of the individualized plan of care, outliningthe services to be rendered by the Home Health Aide. This was placed in thepatient's home folder. The Administrator instructed theDirector of Nursing to always make available a comprehensive plan of care whichincludes the services to be rendered and be placed in every active patient'shome folder. All active patients' plan of care wasprinted out and placed in the respective home folder. This	2022-11-30

	The findings include: Record review evidenced an undated agency policy obtained 9/13/2022, titled "Client Bill of Rights and Responsibilities" which stated, "... Clients of 1st Option Home Health have the right to: ... Receive complete written information on the plan of care, including the name of the home aide and supervisor responsible for the services ...." Record review evidenced an undated agency policy obtained on 9/20/2022, titled "Home Health Aide Plan of Care" which stated, "... A copy of the Care Plan shall be placed in the client's home ...."		was completed on10/20/2022. The Director of Nursing will quarterlymonitor all patient's home folders to ensure that they all include the individualizedplan of care that outlines the services to be rendered by their respectivecaregivers. The Director of Nursing will beresponsible for monitoring this corrective action to prevent it from recurring.	

	Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, a home folder was reviewed, which failed to include a current plan of care outlining treatments to be administered by home health agency staff. During an interview on 9/19/2022, at 2:02 PM, clinical manager #2 indicated the agency provided patients with a copy of the plan of care.			
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. Based on observation, record review, and interview, the home health agency failed to ensure patients received written name and contact information for the clinical manager in 3 of 3 home visits conducted. (#1, 2, 3)	G0622	For patient #1, the updated ClinicalManager's name and contact information was printed and placed in the patient'shome folder. For patient #2, the updated ClinicalManager's name and contact information was printed and placed in the patient'shome folder. For patient #3, the updated ClinicalManager's name and contact information was printed and placed in the patient'shome folder.	2022-11-30

	The findings include: 1. Record review on 9/13/2022, evidenced a home folder which contained an undated document titled "Client Bill of Rights and Responsibilities" which stated, "... Clients of 1st Option Home Health have the right to: ... Receive complete written information on the plan of care, including the name of the home aide and supervisor responsible for the services and the agency phone number ...." 2. Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, a home folder was reviewed, which failed to include the name and contact information for the clinical manager. During an interview on 9/19/2022, at 1:41 PM, clinical manager #2 indicated the patients should have home folders with the clinical manager's name and contact information written on them.		On 10/20/2022, the Director of Nursingupdated all active patients' home folders with the Clinical Manager's name andcontact information. Their respective Home Health Aides picked them up from theoffice and placed them in their patient's home folders. This was verballycommunicated with the patients and confirmed. The Director of Nursing will reach outto all active clients to constantly ensure 100% compliance. The Director of Nursing will beresponsible for monitoring this corrective action to prevent it from recurring.	

	3. Observation of a home visit for patient #2 was conducted on 9/14/2022, at 12:30 PM, to observe a routine home health aide visit. During the visit, a home folder was reviewed, which failed to include the name and contact information for the clinical manager. 4. Observation of a home visit for patient #3 was conducted on 9/19/2022, at 9:00 AM, to observe a routine skilled nurse visit. During the visit, a home folder was reviewed, which failed to include the name and contact information for the clinical manager.			
G0640	Quality assessment/performance improvement 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	G0640	The Administrator and Director ofNursing immediately Updated the Quality Assurance and Performance Improvement(QAPI) Program to include measurable improvement indicators that would improvepatient health outcomes. All patient's clinical records werereviewed. Agency will call or send out questionnaires to	2022-11-30

	arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the home health agency failed to: to ensure the QAPI program demonstrated measurable improvement in indicators which would improve health outcomes, patient safety, and quality of care, and failed to measure, analyze, and track these indicators (see tag G642); collect and utilize quality indicator data in the QAPI program to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement (see tag G644); ensure performance improvement activities considered incidence, prevalence, and severity or problems (see tag G650); ensure performance improvement activities tracked adverse patient events, analyze their causes, and implement preventative actions (see tag G654); and conduct and document performance		patients to enquireabout the quality of services they are receiving. When data collected isstatical significant, the agency will analyze it, and a percentage taken todetermine/measure the quality of care and area of improvement. When datacollection does not offer meaningful information, Quality Assurance Nurse willbe tracking, monitoring, and documenting any identified indicators to determineimprovement or not. The Director of Nursing in-serviced allclinical staff and Quality Assurance Nurse to help explain to patientsunderstanding the importance and purpose of the questionnaires or agency callsbased on the quality of services they are receiving. Information collected willbe used for the Quality Assurance Performance Improvement program every quarter.The information collected or indicators tracking documentation will be used asan objective measure for the evaluation of agency quality of care. All data analysis of the survey ofQuality Assurance and	

	improvement projects (see tag G658). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.65 Quality assessment and performance improvement (QAPI).		Performance Improvement (QAPI) will be reviewed annuallyto ensure 100% compliance. The Administrator is responsible for monitoring thiscorrective action to ensure that this deficiency is corrected and will notrecur.	
G0642	Program scope 484.65(a)(1),(2) 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. Based on record review and interview, the home health agency failed to ensure the QAPI program demonstrated measurable improvement in indicators which would improve	G0642	TheAdministrator and Director of Nursing immediately Updated the Quality Assuranceand Performance Improvement (QAPI) Program of the agency to include measurableimprovement indicators that would improve patient health outcomes. Allpatient's clinical records were reviewed. Agencywill call or send out questionnaires to patients to enquire about the qualityof services they are receiving. When data collected is staticalsignificant, the agency will analyze it, and a percentage is taken todetermine/measure the quality of care or see an area that needs improvement. Ifthe data is statically insignificant, or the data collected does not offermeaningful information, Quality Assurance Nurse has been directed to usetracking, monitoring methods, and documenting any identified indicators todetermine quality	2022-11-30

	health outcomes, patient safety, and quality of care, and failed to measure, analyze, and track these indicators. The findings include: Record review evidenced an undated agency policy obtained on 9/15/2022, titled "Quality Assurance/Performance Improvement" which stated, "... Agency shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes ... Objectives of the program ... To identify, address, track, and resolve problems in client care services and satisfaction to insure resolution and/or improvement ...." Review on 9/16/2022, of the agency's QAPI (quality assurance and performance improvement) program, indicated the agency would reduce the rate of falls with injury from 7% to 3% by December 2021, and would		improvement or otherwise. The Director of Nursing in-service to allclinical staff and Quality Assurance Nurses to help explain to patientsunderstanding the importance and purpose of the questionnaires or agency callsbased on the quality of services they are receiving. Information collected willbe used for the Quality Assurance Performance Improvement program every quarter.The information collected or indicators tracking documentation will be used asan objective measure for the evaluation of agency quality of care. Alldata analysis of the survey of Quality Assurance and Performance Improvement (QAPI)will be reviewed annually to ensure 100% compliance. The administrator isresponsible for monitoring this corrective action to ensure that thisdeficiency is corrected and will not recur.	

	patients who received flu and pneumonia vaccines from 61% to 90% by December 2023. Review failed to evidence any measurement, analysis, or tracking of falls or vaccination rates. Review of the QAPI program failed to evidence any baseline data, or measurable improvement in falls or vaccination rates. During an interview on 9/16/2022, at 11:36 AM, administrator #1 indicated the agency was tracking fall risk assessments but did not have any documentation of the tracking of fall risk assessments. Clinical manager #2 indicated they were tracking general improvements in patient care, and would call the physician if the patient was improving or declining. 410 IAC 17-12-2(a)			
G0644	Program data 484.65(b)(1),(2),(3)	G0644	The Administrator and Director ofNursing immediately Updated the Quality Assurance and Performance Improvement(QAPI) Program of	2022-11-30

	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 home health agency failed to collect and utilize quality indicator data in the QAPI program to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement. The findings include: Record review evidenced an undated agency policy obtained 9/15/2022, titled "Quality Assurance/Performance Improvement" which stated, "... Data will be collected to allow the agency to monitor its performance ... Data will be systematically collected to		the agency to include measurable improvement indicators thatwould improve patient health outcomes. For the clinical record reviewcompleted on 9/2022 3 patients with wounds (#3,4,5) and 1. The agency does notat the time of the survey have a skilled nursing patient with wound care. So,there is no data to collect, analyze nor track or measure. For the patient who fell,the director of Nursing has been directed to use Morse Fall Scale to track therisk level of the patient. All patient's clinical records werereviewed by the Director of Nursing to ensure that patients likely to beimpacted by this deficiency are corrected. The Agency will call or send outquestionnaires to patients to enquire about the quality of services they arereceiving. When data collected is statical significant, the agency will analyzeit, and a percentage is taken to determine/measure the quality of care or see anarea that needs improvement. If the data is statically insignificant, or the datacollected does not offer	

	...." Review of the QAPI (quality assurance performance improvement) program on 9/16/2022, indicated the agency's goal was to reduce the rate of falls with injury from 7% to 3% by December 2021, and increase flu and pneumonia vaccination rate from 61% to 90% by December 2023, but failed to evidence collection or utilization of any quality indicator data regarding falls or vaccinations. Clinical record review completed on 9/20/2022, evidenced 3 patients with wounds (#3, 4, 5) and 1 patient hospitalized (#5) out of 5 active clinical records reviewed. Record review evidenced 1 patient was hospitalized (#7) and 1 patient fell (#7) out of 2 discharged clinical records reviewed. During an interview on 9/16/2022, at 11:39 AM,		meaningful information, Quality Assurance Nurse hasbeen directed to use tracking, monitoring methods, and documenting anyidentified indicators to determine/measure quality improvement or otherwise. Alldata analysis of the survey of Quality Assurance and Performance Improvement(QAPI), and tracking documentation will be reviewed annually to ensure 100%compliance. The administrator is responsible for monitoring this correctiveaction to ensure that this deficiency is corrected and will not recur	

	patient population was too insignificant, there was no data to collect. Clinical manager #2 indicated the QAPI program should collect and measure data from OASIS (outcome and assessment information set). At 11:41 AM, administrator #1 indicated the agency didn't have any data to collect. 410 IAC 17-12-2(a)			
G0650	Incidence, prevalence, severity of problems 484.65(c)(1)(ii) (ii) Consider incidence, prevalence, and severity of problems in those areas; and Based on record review and interview, the home health agency failed to ensure performance improvement activities considered incidence, prevalence, and severity or problems. The findings include: Record review evidenced an undated agency policy obtained 9/15/2022, titled "Quality	G0650	The Administrator immediatelyinstructed the Director of Nursing to always document all incidents andpatients' conditions including falls, infections, and log them in the necessary log sheet. All patients' chats were reviewed andall missing incidents not logged were documented and logged in the proper logsheet, this was completed on 10/18/2022. The Director of Nursing in-servicedall field staff on the importance of reporting any incident immediately afterthey happen. The Director of Nursing will	2022-11-30

	Assurance/Performance Improvement" which stated, "... Objectives of the program ... to identify, address, track and resolve problems in client care services and satisfaction to insure resolution and/or improvement ...." Review of the QAPI (quality assurance performance improvement) program on 9/16/2022, indicated the agency's goal was to reduce the rate of falls with injury from 7% to 3% by December 2021, and increase flu and pneumonia vaccination rate from 61% to 90% by December 2023. Review failed to evidence consideration of incidence, prevalence, or severity of issues such as wounds, hospitalizations, or infections. Clinical record review completed on 9/20/2022, evidenced 3 patients with wounds (#3, 4, 5) and 1 patient hospitalized (#5) out of 5 active clinical records reviewed. Record review evidenced 1 patient was hospitalized (#7)		auditevery active patient's chart quarterly to monitor every incident report. Thiswill ensure 100% compliance. The Director of Nursing will beresponsible for monitoring this corrective action to avoid the recurrence ofthis deficiency.	

	discharged clinical records reviewed. Record review on 9/15/2022, evidenced a blank fall log and infection log. Record review failed to evidence any tracking of hospitalizations or wounds. During an interview on 9/16/2022, at 11:42 AM, clinical manager #2 indicated the most prevalent areas of concern would be immobile patients who were at a higher risk for infections and pressure ulcers, and patients with dementia who would be at higher risk for falls. Administrator #1 indicated the agency did not look at patient hospitalizations or wound tracking. Administrator #1 did not know why patient #7's fall was not recorded in the fall log.			
G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions.	G0654	The Administrator immediatelyinstructed the Director of Nursing to always document all incidents,hospitalization, wounds, and patients' conditions including falls, and log themin the necessary log	2022-11-30

	Based on record review and interview, the home health agency failed to ensure performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventative actions. The findings include: Record review evidenced an undated agency policy obtained 9/15/2022, titled "Quality Assurance/Performance Improvement" which stated, "... Objectives of the program ... to identify, address, track and resolve problems in client care services and satisfaction to insure resolution and/or improvement ...." Review of the QAPI (quality assurance performance improvement) program on 9/16/2022, indicated the agency's goal was to reduce the rate of falls with injury from 7% to 3% by December 2021, and increase flu and pneumonia vaccination rate from 61% to 90% by December 2023.		sheet to ensure proper tracking of the patient'scondition. All patients' chats were reviewed andall missing incidents not logged were documented and logged in the proper logsheet, this was completed on 10/18/2022. The Director of Nursing in-servicedall field staff on how to prevent major adverse events and the importance ofreporting all incidents immediately to the office. The Director of Nursing will auditevery active patient's chart quarterly to monitor every incident reportincluding falls, wounds, and hospitalizations. This will ensure 100%compliance. Find attached the supporting document. The Director of Nursing will beresponsible for monitoring this corrective action to avoid the recurrence ofthis deficiency.	

Clinical record review completed on 9/20/2022, evidenced 3 patients with wounds (#3, 4, 5) and 1 patient hospitalized (#5) out of 5 active clinical records reviewed. Record review evidenced 1 patient was hospitalized (#7) and 1 patient fell (#7) out of 2 discharged clinical records reviewed.

Record review on 9/15/2022, evidenced a blank fall log and infection log. Record review failed to evidence any tracking of hospitalizations or wounds. Record review failed to evidence any analysis or implementation of preventative actions regarding adverse events such as falls, hospitalizations, wounds, or infections.

During an interview on 9/16/2022, at 11:42 AM, administrator #1 indicated the agency did not look at patient hospitalizations or wound tracking. Administrator #1 did

	was not recorded in the fall log. Clinical manager #2 indicated the performance improvement activities were assessing the patient's home environment for supplies needed. 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 home health agency failed to conduct and document performance improvement projects.	G0658	The Administrator instructed theDirector of Nursing on 10/17/2022 to conduct a performance improvement projectevery 6 months and that proper documentation should be made in that regard. Weekly calls will be made to everyactive patient to ascertain all specific areas of performance deficiencies,this will allow the agency to identify skills and training gaps to be filledand to set clear expectations for performance improvement. The Director of Nursing will conduct athorough performance project on every active patient every 6 months anddocument every finding. This will ensure 100% compliance and avoid suchdeficiencies to recur.	2022-11-30

	The findings include: Record review evidenced an undated agency policy obtained 9/15/2022, titled "Quality Assurance/Performance Improvement" which stated, "... The development of a performance improvement plan will be guided by the mission, vision and strategic goals of the organization. Additional activities for performance improvement will be prioritized by the agency's management team ... The plan will target the performance of existing processes and outcomes and identify/design new processes based on priorities, standards, and resources ...." Review on 9/16/2022, of the agency's QAPI (quality assurance and performance improvement) plan failed to evidence any performance improvement projects. During an interview on 9/16/2022, at 11:45 AM, clinical manager #2 indicated the agency's performance		The Director of Nursing will beresponsible for monitoring this deficiency. This will prevent it fromrecurring.	

	assess patients' home environments for any unmet needs. Clinical manger #2 indicated the performance improvement activities were only discussed verbally, not documented.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on observation, record review, and interview, the home health agency failed to ensure clinical notes were prepared accurately in 2 of 3 home visits conducted. (#2, 3) The findings include: 1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Clinical Documentation" which stated, "... Purpose ... To ensure that there is an accurate record of the services provided ... To document conformance with the plan of care ...."	G0716	All patient's medical records wereimmediately reviewed and scrutinized for data accuracy and the affectedpatients' records were properly reviewed, this review was completed on10/19/2022. Patient #2 allergies were correctedaccordingly and the exact patient's allergies were documented. Patient #3 clinical record was takenout and corrected. The Administrator in-serviced theclinical staff on the importance of accurate health records as it is verycrucial in the delivery of quality health care services. All patients' clinicaldocumentation was thoroughly reviewed to ensure health data accuracy. The Administrator instructed theDirector of Nursing to thoroughly go through every	2022-11-30

	2. Observation of a home visit for patient #2 was conducted on 9/14/2022, at 12:30 PM, to observe a routine home health aide visit. During the visit, a home health folder was reviewed, which contained an individual emergency preparedness plan, which indicated the patient was allergic to seafood, fish, and heparin. Clinical record review for patient #2 was completed on 9/19/2022. Record review evidenced a plan of care for certification period 8/15/2022 – 10/13/2022, which indicated the patient was allergic to aspirin and sulfa. During an interview on 9/19/2022, at 2:43 PM, clinical manager #2 indicated the plan of care probably defaulted when they clicked on allergies. Clinical manager #2 indicated the plan of care was probably inaccurate, and the patient was probably allergic to heparin and seafood.		clinical record beforeapproval. This will ensure that this deficiency does not recur. The Director of Nursing will beresponsible for monitoring and scrutinizing clinical records to avoid mistakesand inaccurate data. This will be done before every clinical documentation isapproved.	

	3. Clinical record review for patient #3 was completed on 9/20/2022, for certification period 8/18/2022 – 10/16/2022. Record review evidenced a comprehensive assessment dated 8/15/2022, which indicated the patient had both a mild and severe cognitive impairment. This document indicated physical therapy was working with the patient. During an interview on 9/20/2022, at 3:02 PM, clinical manager #2 indicated the assessment was documented in error, and the accurate assessment should have only included mild cognitive impairment. Clinical manager #2 indicated the patient was not currently receiving physical therapy, and it was probably carried over documentation from a previous certification period. 410 IAC 17-14-1(a)(2)(E)			
G0718	Communication with physicians	G0718	For patient #2, the plan of care	2022-11-30

	484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, the home health agency failed to ensure skilled professionals communicated with all physicians involved in the plan of care regarding the plan of care in 4 of 5 active clinical records reviewed. (#2, 3, 4, 5) The findings include: 1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Medical Supervision" which stated, "... Physician will be contacted when any of the following occurs: ... Condition changes ... Expected response to treatment or medication changes ... Any change in client condition or agency services ...." 2. Clinical record review for patient #2 was completed on 9/20/2022. Record review		wascorrected, and the hours were adjusted and sent to the patient's primary carephysician for signature. For patient #3, the plan of care wascorrected, and the hours were adjusted and sent to the patient's primary carephysician for signature. For patient #4, the plan of care wascorrected, and the hours were adjusted and sent to the patient's primary carephysician for signature. For patient #5, the plan of care wascorrected, and the hours were adjusted and sent to the patient's primary carephysician for signature. The Administrator immediatelyinstructed the Director of Nursing to always document every change to theservices rendered to patients, include them in the plan of care, and notify thepatient's other care providers for proper care coordination. All patients' charts were thoroughlyscrutinized to ensure that all changes to patients'	

	evidenced a plan of care for certification period 8/15/2022 – 10/13/2022, which indicated the patient was to receive home health aide services 6 hours per day/5 days per week. Review of visit notes indicated the patient was receiving home health aide services 3 hours per day/5 days per week. Record review evidenced a prior authorization document dated 9/1/2022, which indicated the patient was only approved for 18 hours of home health aide services per week. Record review failed to evidence the physician was notified of the change in the amount of home health aide services provided. During an interview on 9/19/2022, at 2:29 PM, clinical manager #2 indicated the physician should be notified if the services change, or hours are adjusted. 3. Clinical record review for patient #3 was completed on 9/20/2022. Record review evidenced a plan of care for certification period 8/18/2022 –		areproperly communicated with all other healthcare providers seen by the patients.This will ensure 100% compliance. This was completed on 10/18/2022. All medical records will be reviewedquarterly to ensure that changes to patients' services and conditions are dulyand promptly communicated with other healthcare providers. The Director of Nursing will beresponsible for this corrective action and monitor this and ensure 100%compliance. This will ensure that the deficiency will not recur.	

	patient was to receive home health aide services 7 hours per day/5 days per week. Record review evidenced the patient was only receiving home health aide services 6 hours per day/5 days per week. Record review evidenced a prior authorization dated 8/24/2022, which indicated the patient was only approved for 30 hours of home health aide services per week. Record review failed to evidence the physician was notified of the change in the amount of home health aide services provided.			

	4. Clinical record review for patient #4 was completed on 9/20/2022. Record review evidenced a plan of care for certification period 9/11/2022 – 11/9/2022, which indicated the patient was to receive home health aide services 9 hours per day/5 days per week. Record review evidenced the patient was receiving home health aide services 7 days per week, about 6 hours per visit. Record review failed to evidence the physician was notified of the change in the amount of home health aide services provided. 5. Clinical record review for patient #5 was completed on 9/20/2022. Record review evidenced a plan of care for certification period 7/28/2022 – 9/25/2022, which indicated the patient was to receive home health aide services 10 hours per day/7 days per week. Record review evidenced the patient was receiving home health aide services 6 hours per day/6 days per week. Record review failed to evidence the physician was notified of the change in frequency and			

visit.

Record review evidenced a comprehensive assessment dated 7/25/20222, which failed to include an assessment of the wound the patient had. Record review failed to evidence the physician was notified the wound could not be assessed.

During an interview on 9/19/2022, at 3:41 PM, clinical manager #2 indicated the patient was only approved through her insurance for 6 hours per day/6 days per week. At 3:53 PM, clinical manager #2 indicated the patient was too "... feisty ..." and she was unable to turn the patient to assess the wound. Clinical manager #2 indicated the wound was not assessed during the recertification assessment. Clinical manager #2 indicated it was the other home health agency providing skilled nursing to the patient, so they should have notified the physician of any wound care needs.

	410 IAC 17-14-1(a)(1)(G)			
G0750	Home health aide services 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Based on observation, record review, and interview, agency failed to: ensure home health aides received competency training (see tag G768); ensure home health aide services were provided appropriately and as ordered on the plan of care, and allowed by state law (see tag G800); and ensure home health aides were directly supervised every 60 days for home health aide only patients (see tag G814). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.80 Home health aide services.	G0750	The Administrator immediately instructedthat all Home Health Aides should be scheduled for a competency test. He alsoinstructed the Director of Nursing to strictly adhere to the 60-day supervisoryvisits to ensure compliance with the state law. All active Home Health Aides wereimmediately scheduled for a competency assessment which was outsourced to anexternal Registered Nurse. This will ensure 100% compliance with state law. The Administrator instructed theDirector of Nursing to conduct a periodic competency assessment for everyactive Home Health Aide and this will be done yearly to ensure that thisdeficiency does not occur. The Director of Nursing will monitorthis and coordinate this to ensure adherence to state law and avoid therecurrence of such deficiency.	2022-11-30

G0768	Competency evaluation 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. Based on record review and interview, the home health agency failed to ensure home health aides completed competency evaluations prior to providing patient care in 6 of 7	G0768	Home Health Aide #3 was scheduled fora competency assessment which will be conducted by the Director of Nursing. Home Health Aide #6 was scheduled fora competency assessment which will be conducted by the Director of Nursing. Home Health Aide #7 was scheduled fora competency assessment which will be conducted by the Director of Nursing. Home Health Aide #8 was scheduled fora competency assessment which will be conducted by the Director of Nursing. Home Health Aide #9 was scheduled fora competency assessment which will be conducted by the Director of Nursing. Home Health Aide #10 was scheduled fora competency assessment which will be conducted by the Director of Nursing. The Administrator has directed	2022-11-30

	records reviewed. (#3, 6, 7, 8, 9, 10) The findings include: 1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Competency Evaluation of Home Care Staff" which stated, "... A home health aide will not be permitted to provide home health aide services until evidence of adequate training and/or competency has been determined by the designated professional in the agency ... Documentation of individual Home Health Aide training and/or competency shall be maintained in the Home health aide's personnel file ...." 2. Personnel record review for home health aide #3, start date 11/20/2019, first patient contact date 1/21/2020, failed to evidence a skills competency evaluation was completed prior to performing patient care. 3. Personnel record review for		that athorough competency assessment is done according to the state regulation beforeevery Home Health Aide's first contact with a patient. The Director of Nursing was instructedto always conduct a visual examination of the aide's performance with a patientbefore being allowed to make their first individual visit. All active Home Health Aides werescheduled for a competency assessment which will be outsourced to an externalregistered nurse. Find attached the supporting document. The agency has directed that no firstcontact visit will be made by a Home Health Aide without them completing thecompetency assessment which will be monitored by the Director of Nursing. The Director of Nursing will beresponsible for monitoring this corrective action to ensure 100% compliance.	

	home health aide #6, start date 8/22/2022, first patient contact date 9/7/2022, failed to evidence a skills competency evaluation was completed prior to performing patient care. 4. Personnel record review for home health aide #7, start date12/2/2021, first patient contact date 12/6/2021, failed to evidence a skills competency evaluation was completed prior to performing patient care. 5. Personnel record review for home health aide #8, start date 5/18/2022, first patient contact date 8/25/2022, failed to evidence a skills competency evaluation was completed prior to performing patient care. 6. Personnel record review for home health aide #9, start date 10/18/2018, first patient contact date 10/29/2018, failed to evidence a skills competency evaluation was completed prior to performing patient care.			

	7. Personnel record review for home health aide #10, start date 7/22/2016, first patient contact date 8/7/2016, failed to evidence a skills competency evaluation was completed prior to performing patient care. 8. During an interview on 9/16/2022, at 11:52 AM, clinical manger #2 indicated upon hire, the home health aides were brought to the patient's home who they would be taking care of to shadow the other home health aide for about 2 – 3 hours. Clinical manager #2 indicated this was done so the new home health aide knew what to do with the specific patient. Clinical manager #2 indicated the next day after shadowing, the new hire home health aide would go see the patient alone.			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner;	G0800	Home Health Aide #5 was immediatelyscheduled for an in-service by the Director of Nursing. Home Health Aide #5 wasin-serviced on medication administration. Home Health Aide #5 was retrainedthat Home Health Aides can only do	2022-11-30

	(ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review, and interview, the home health agency failed to ensure home health aides provided services which were included in the plan of care, permitted to be performed under state law, and consistent with home health aide training in 1 of 3 home visits conducted. (#1) The findings include: Record review evidenced an undated agency policy obtained 9/20/2022, titled "Home Health Aide Plan of Care" which stated, "... The home health aide cannot be responsible for performing any procedure that is not assigned to him/her inwriting by the registered nurse/therapist or that is beyond his/her ability ... The home health aide tasks must be related to the physical care needs of the client ...." Record review evidenced an		medication reminders and not administerthem. This was done on 10/20/2022. All active Home Health Aides wererereminded of their limitations when dealing with patients' medication. Materialsregarding that were put together and sent to all active Home Health Aides as apoint of reference. The Administrator instructed that aperiodic reminder should be sent to all active aides as regards medicationhandling and that more attention should be given to medication training duringevery in-service. The Director of Nursing will beresponsible for monitoring this corrective action to ensure 100% compliance.	

	undated agency policy obtained 9/20/2022, titled "Medication Administration by Home Health Aides" which stated, "... Home Health aides can not administer medication to the client it is against the state law ... State laws allow home health aid to only remind patients ... Home health aide shall not act in the following capacities: ... Become or act as a power of attorney ...." Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, patient's medications were observed to be in a locked box for which home health aide #5 had the key. This box failed to include Norco (pain medicine) and Klonopin (anti-anxiety medication). Clinical record review for patient #1 was completed on 9/19/2022. Record review evidenced a plan of care for certification period 8/13/2022 – 10/11/2022, which indicated the			

	health aide services 3 times weekly for bathing, housekeeping, picking up prescriptions and groceries, and activities of daily living. This document indicated the home health aide was to verbally remind patient to take medications, not physically prepare or administer medications. The plan of care indicated the home health aide should report refusal to the skilled nurse. Record review evidenced an agency document signed by home health aide #5 on 12/15/2021, titled "Medication Distribution" which stated, "... I [home health aide #5] understand that I will not and cannot dispense, distribute, or administer medication in any form i.e. pill, liquid, cream, shot, that have been prescribed by the doctor or purchased over the counter ...." During an interview on 9/14/2022, at 8:15 AM, home health aide #5 indicated they kept patient #1's Klonopin (anti-anxiety medication) and			

	Norco (narcotic pain medication) in a locked box in their car due to patient's history of overdose. Home health aide #5 indicated they had the Klonopin and Norco in their car currently. During an interview on 9/14/2022, at 1:57 PM, person #2 (registered nurse caring for patient #1 from home health agency #3) indicated home health aide #5 was filling patient #1's medication planner and administering all the medications. During an interview on 9/14/2022, at 3:19 PM, clinical manager #2 indicated they did not know anything about home health aide #5 administering medications, keeping medications in their personal car, or filling the patient's medication planner. Clinical manager #2 indicated it was home health agency #3's responsibility to let her know the aide was filling the medication planner. Clinical manager #2 indicated the home health aide should not have			

	been filling a medication planner, keeping medications in the car, or administering medication as this was out of the scope of practice for home health aides. Clinical manager #2 indicated the agency doesn't do anything with the patient's medications, and home health agency #3 should be the ones responsible. During an interview on 9/15/2022, at 9:45 AM, home health aide #5 indicated they only touch patient #1's medication when they were off the clock. Home health aide #5 indicated they went on their off days and hours to patient #1's home to assist them with medication administration.			
G0814	Non-skilled direct observation every 60 days 484.80(h)(2) If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care.	G0814	The Administratorin-serviced the Director of Nursing to conduct supervisory visits every 60days. Effective 10/17/2022, the agencyhas initiated a 60-day supervisory visit with all clients and documented themin all clients' charts. For patient #1,the supervisory visit has been conducted and	2022-11-30

	Based on observation, record review and interview, the home health agency failed to ensure the registered nurse made an on-site visit every 60 days to observe and assess the home health aide performing care in 3 of 7 clinical records reviewed. (#1, 5, 7) The findings include: 1. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Clinical Supervision" which stated, "... On-site supervision of clients receiving services will be performed by a Registered Nurse/Therapist to direct, demonstrate, and evaluate the implementation of the Plan of Care and the delivery of services ... The frequency and method of supervision will be based on the amount and type of care provided, client complaints, and changes in client condition ...." 2. Record review evidenced an undated agency policy obtained 9/20/2022, titled "Home Health Aide Supervision" which stated, "... Supervisory visits are to be		documented in the client's recordto correct this deficiency. For patient #5,the supervisory visit has been conducted and documented in the client's recordto correct this deficiency. The unsigned recertification assessment was takenback to the patient and signed. For patient #7,the supervisory visit has been conducted and documented in the client's recordto correct this deficiency. Allclients' records thorough review was completed on 10/18/2019 and will besubsequently audited quarterly to ensure 100% compliance. Theadministrator is responsible for monitoring this corrective action to ensurethat this deficiency is corrected and will not recur.	

	documented in the client's chart on the home health aide supervision form ...." 3. Clinical record review for patient #1 was completed on 9/19/2022. Record review evidenced a plan of care for certification period 8/13/2022 – 10/11/2022, which indicated the patient was to receive home health aide services 3 times weekly for bathing, housekeeping, picking up prescriptions and groceries, and activities of daily living. Clinical record review failed to evidence a home health aide supervisory visit was completed during the recertification assessment on 8/8/2022. During an interview on 9/14/2022, at 8:15 AM, patient #1 indicated the skilled nurse from 1st Option Adult Day Services and Home Health came to his home for a supervisory visit maybe every 4 months. During an interview on			

	manager #2 indicated home health aide supervisory visits should be conducted with the home health aide every 60 days, but sometimes, they are done over the phone instead. 4. Clinical record review for patient #5 was completed on 9/20/2022. Record review evidenced a plan of care for certification period 9/11/2022 – 11/9/2022, which indicated the patient was receiving home health aide services 9 hours per day/5 days per week for activities of daily living, bathing, and housekeeping. Record review evidenced a comprehensive recertification assessment completed 9/6/2022, which failed to include a supervisory visit. Record review failed to evidence documentation of supervisory visits were completed every 60 days for home health aide only patients. 5. Clinical record review for patient #7 was completed on 9/20/2022. Record review evidenced a plan of care for certification period 7/6/2022 –			

	9/3/2022, which indicated the patient was receiving home health aide services 6 hours per day/5 days per week for activities of daily living, bathing, and housekeeping. Record review evidenced a comprehensive recertification assessment dated 7/1/2022, which failed to be signed by the patient. Record review failed to evidence a supervisory visit had been conducted every 60 days to observe the home health aide providing care. During an interview on 9/20/2022, at 11:00 AM, clinical manager #2 indicated the recertification assessment was not signed by the patient because when she arrived to complete the assessment and supervisory visit, the patient was not home. Clinical manager #2 indicated the only in-person visits conducted for home health aide patients were comprehensive assessments at recertification every 60 days. Clinical manager #2 indicated patient #7's recertification and supervisory visit was completed over the phone.			

G0940	Organization and administration of services 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. Based on observation, record review, and interview, the home health agency failed to: ensure the administrator was appointed by the governing body (see tag G946); ensure the administrator was responsible for all day-to-day operations of the home health agency (see tag G948); ensure the clinical manager provided oversight of all patient care services and personnel (see tag G958); ensure the clinical manager coordinated patient care with other home health agencies and the physician (see tag G962); and ensure the clinical manager	G0940	This deficiencycannot be corrected at this time. This incident happened 12 years ago.	2022-11-30

	the individualized plan of care (see tag G968). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR 484.105 Organization and administration of services.			
G0946	Administrator appointed by governing body 484.105(b)(1)(i) (i) Be appointed by and report to the governing body; Based on record review and interview, the home health agency failed to ensure the administrator was appointed by the governing body. The findings include: Record review evidenced an undated agency policy obtained 9/15/2022, titled "Governing Body" which stated, "... The duties and responsibilities of the Governing Body shall include: ... Appoint a qualified	G0946	This deficiencycannot be corrected at this time. This incident happened 12 years ago.	2022-11-30

	administrator ….” Record review on 9/15/2022, evidenced a personnel record for administrator #1. This record failed to evidence the administrator was appointed by the governing body. During an interview on 9/20/2022 at 11:46 AM, administrator #1 indicated there was no documentation that the administrator was appointed by the governing body. 410 IAC 17-12-1(b)(1)			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to be responsible for all day-to-day operations of the home health agency.	G0948	The Administrator has directed the Director ofNursing to brief him daily on the activities of clinical staff and provide updatesthrough executive summary of changes taking place in the clinical department. Intake/referral staff has beendirected to send a list of the referred patient to the administrator monthly,stating	2022-11-30

	The findings include: Record review evidenced a signed job description for administrator dated and signed by administrator #1 on 11/28/2019, which stated, "... the administrator oversees all aspects of the agency including planning, staffing and salary ... Responsibilities: ... Coordinate with doctors, nurses and other healthcare professionals to identify their issues and needs ... Ensure patient medical records are kept up to date ... Ensure all departments comply with the current healthcare laws and regulations ...." During an interview at the entrance conference on 9/13/2022, at 11:20 AM, administrator #1 indicated he would like to wait for the clinical manager to arrive to answer questions because he did not want to answer incorrectly. Administrator #1 did not know what the agency's process was for making corrections in the clinical record. Administrator #1		is receiving, and transfer of patientsout from 1st Option Adult Services & Home health to other healthcare institutions/facilities. The Administrator will develop andmaintain a comprehensive patient census list, detailing all the services thepatients are receiving, and other agencies providing services to the same agency'spatients, physicians, and other health care professionals involved in thepatient's care. And randomly select patients' charts for review. The administrator is responsible forthis corrective action to ensure 100% compliance. The administrator willmonitor this corrective action to ensure that this deficiency is corrected andwill not recur.	

	indicated they did not know what services the agency's patients were currently receiving. Administrator #1 did not know if any patients were shared with another agency or how care was coordinated with other agencies. Administrator #1 did not know how medication review was completed. 410 IAC 17-12-1(b)(3) 410 IAC 17-12-1(c)(1)			
G0958	Clinical manager 484.105(c) Standard: Clinical manager. One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following-- Based on observation, record review, and interview, the home health agency failed to ensure the clinical manager provided oversight of all patient care services and personnel.	G0958	A copy of the Director of Nursing'sjob description was given to the clinical manager for a better understanding ofwhat the job description entails. The Administrator in-serviced the clinicalmanager in adhering to the job description. This was completed on 10/17/2022. The Administrator in-serviced theoffice staff on the importance of adhering strictly to their job descriptionand gave all staff a copy of their job description. The agency will periodically	2022-11-30

	The findings include: Record review on 9/15/2022, evidenced a director of nursing job description signed by clinical manager #2 on 8/18/2011, which stated, "... the primary function is for the overall administration of the clinical departments and monitoring of appropriate staffing and productivity in the agency ... Directs and coordinates clinical departments; assumes responsibility for continuity, quality, and safety of services delivered in compliance with State and Federal regulations ... Supervises and provides direction to subordinates, in an effort to ensure quality, compliance with Plan of care and assessment and reassessment of patient's needs and continuity of services by appropriate health care personnel ...." Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. The patient was		evaluation for all staff by their respective job description. Thiswill ensure 100% compliance. The Administrator will be responsiblefor and monitor this corrective action to ensure that this deficiency is correctedand will not recur.	

	oriented. During the visit, home health aide #5 indicated she kept the patient's Klonopin (anti-anxiety medication) and Norco (pain medication), in a locked box in her car to administer to the patient because the patient had a history of drug overdose. During an interview on 9/14/2022, at 1:57 PM, person #2 (patient #1's registered nurse from home health agency #3) indicated they did not administer or fill a medication planner box for patient #1 because home health aide #5 was filling the patient's medication planner. During an interview on 9/14/2022, at 3:19 PM, clinical manager #2 indicated they did not know anything about home health aide #5 keeping medications in a lock box or filling patient #1's medication planner. Clinical manager indicated this was out of the home health aide's scope of practice. Clinical manager #2 indicated it was home health agency #3's responsibility to let			

	them know home health aide #5 was filling the medication planner. Clinical manager #2 indicated there was no way for them to know the home health aide was filling the medication planner or keeping medications in a lock box in their car. During an interview on 9/19/2022, at 2:06 PM, clinical manager #2 indicated they perform in person supervisory visits every 60 days to monitor the home health aides. Clinical manager #2 indicated sometimes supervisory visits were completed over the phone if the patient refused to let them in. 410 IAC 17-12-1(d)			
G0962	Coordinate patient care 484.105(c)(2) Coordinating patient care, Based on observation, record review, and interview, the home health agency failed to ensure the clinical manager	G0962	For patient #1,the current plan of care was revised, and all missing information, diagnoses,and medications were included and faxed to the patient's physician forsignature. For patient#4, the Director of	2022-11-30

	coordinated patient care with other home health agencies and the physician in 3 of 5 active clinical records reviewed. (#1, 4, 5) The findings include: 1. Record review evidenced an undated agency policy obtained on 9/20/2022, titled "Coordination of Client Services" which stated, "... All personnel providing services shall maintain a liaison to assure that their efforts are coordinated effectively and support the objectives outlined in the Plan of Care ... This may be done through formal care conferences; maintaining completed, current Care Plans; and written and verbal interaction ...." 2. Record review on 9/15/2022, evidenced an agency document signed by clinical manager #2 on 8/11/2011, titled "Job Description for Director of Nursing" which stated, "... The director of nursing coordinates care with the interdisciplinary team, patient/family and		Nursing called and coordinated care with agency #7 and gotthe most recent progress note. The current plan of care was revised, and allmissing information, diagnoses, and medication were included and faxed to thepatient's physician for signature. Forpatient #5, the Director of Nursing called and coordinated care with agency #8and got the most recent progress note. The current plan of care was revised,and all missing information, diagnoses, and medication were included and faxedto the patient's physician for signature. On 10/18/2022, the Director of Nursingaudited all patients' chart to ensure there was written documentation of carecoordination in every patient's chart for clients who have services or hasreceived services from other healthcare providers. The Director of Nursing will auditevery patient's chart bimonthly to ensure all care is	

	referring agency ... Directs and coordinates clinical departments; assumes responsibility for continuity, quality, and safety of services delivered in compliance with State and Federal regulations ...." 3. Observation of a home visit for patient #1 was conducted on 9/14/2022, at 8:00 AM, to observe a routine home health aide visit. During the visit, the patient indicated he received home health care from home health agency #3. The patient indicated the nurse from home health agency #3 came one time per week to do vitals. The patient indicated he did not wear oxygen, and had liver cancer and surgery to remove it. Patient #1 indicated he also had colitis (inflammation of colon) and a pacemaker. Patient #1 indicated he wore a CPAP (machine which provides air through a mask, while sleeping) nightly, which was not included in the plan of care. Clinical record review for patient		properly coordinated withother agencies providing services for the same client. The Director of Nursingin-serviced all office staff on the importance of care coordination with otheragencies providing services for every client. The Director of Nursing completedauditing every patient's chart on 10/18/2022 and will audit every client'schart bimonthly to ensure proper documentation of care coordination with otheragencies providing services for the same client The Director of Nursing will beresponsible for monitoring corrective action to ensure this deficiency does notrecur.	

	9/19/2022, for certification period 8/13/2022 – 10/11/2022. Record review failed to evidence any care coordination with home health agency #3. Review evidenced a plan of care for certification period 8/13/2022 – 10/11/2022, which indicated the patient wore 3 liters of oxygen continuously, and failed to include history of liver cancer, pacemaker placement, or colitis. This document indicated the patient's primary diagnosis was chronic obstructive pulmonary disease (damage to the lungs, which causes progressive worsening in ability to breathe). This document indicated the patient's physician was physician #6. Clinical record review on 9/14/2022, evidenced a faxed plan of care from home health agency #3 for certification period 8/9/2022 – 10/7/2022, which indicated the patient's primary diagnosis was hypertensive chronic kidney disease (high blood pressure which causes kidney disease), and also included the following			

	included in the home health agency's plan of care: peripheral vascular disease (problem with circulation, decreasing blood flow to legs), chronic pain syndrome, gastro-esophageal reflux disease with esophagitis (inflammation of esophagus due to stomach acid), liver cancer, repeated falls, and presence of cardiac pacemaker. This document indicated the patient fell on 8/3/2022, while getting out of bed, and had bruising to his right arm as a result. This document indicated the patient's physician was physician #5. This document included the following medications which were not included in 1st Option Adult Day Services and Home Health's plan of care: Nurtec (for migraines), furosemide (to pull water off the body), tramadol (for pain), Narcan (to reverse opiate overdose), cholestyramine (to lower cholesterol), lomotil (to stop diarrhea), gabapentin (for nerve pain), norco (for pain), Ativan (for anxiety), metoprolol (to lower blood pressure and heart rate), flonase (for stuffy nose), oxybutynin (for overactive bladder), psyllium husk (probiotic), albuterol (to open			

	airways), and delysm (for cough). During an interview on 9/19/2022, at 1:52 PM, clinical manager #2 indicated home health agency #3 was responsible for skilled nursing services, so they were not doing anything with his oxygen. Clinical manager #2 indicated the plan of care included oxygen because the other home health agency was providing skilled nursing. Clinical manager #2 indicated the plan of care was not altered, and the physician was not notified that the patient was not wearing oxygen, was using a CPAP, or that the patient had colitis, liver cancer, peripheral vascular disease, chronic kidney disease, and a pacemaker because the other home health agency managed all that. Clinical manager #2 did not know patient #1 fell and indicated the agency providing skilled nursing services was responsible for notifying the physician of this. Clinical manager #2 indicated they did not review patient's medications because this was the responsibility of home			

	health agency #3. Clinical manager #2 indicated the agency coordinated care with home health agency #3 by calling and making sure they were still seeing the patient. Clinical manager #2 indicated care coordination was not documented anywhere. 4. Clinical record review for patient #4 was completed on 9/20/2022, for certification period 9/11/2022 – 11/9/2022. Record review evidenced a comprehensive assessment dated 9/6/2022, which indicated the patient was also receiving care from home health agency #7 for skilled nursing services, but failed to include what interventions were being provided, or what frequency of visits was. The comprehensive assessment indicated the patient had 2 pressure ulcers, and also indicated the patient had no pressure ulcers. This document failed to include an assessment of any wounds. The comprehensive assessment indicated the patient had a foley catheter (tube inserted in the urethra to drain urine from the bladder), but failed to			

include an assessment of the catheter, and indicate when it was changed, or how frequently it should have been changed. Record review failed to evidence any documented care coordination with home health agency #7.

Record review evidenced a plan of care from home health agency #7, which was faxed to surveyor on 9/20/2022, for certification period 8/29/2022 – 10/27/2022. This document indicated the patient was receiving skilled nursing visits 3 times weekly for 8 weeks, and a physical therapy evaluation. This document included a primary diagnoses of diabetes (problem regulating blood sugar) with foot ulcer (wound to foot), and the following diagnoses, non-pressure ulcer of right foot, pressure ulcer of sacral region, pressure ulcer of other site, urethral stricture (narrowing of urethra), hypertensive heart disease (high blood pressure causing heart disease), heart failure, chronic kidney disease, and chronic obstructive pulmonary disease (lung

	increasingly difficult to breathe), which were all not included in the home health agency's plan of care or comprehensive assessment. This document included the following 11 medication orders, which were not included the home health agency's plan of care: Lexapro (anti-depressant), Floranex (probiotic), glipizide (to lower blood sugar), Lantus (insulin/to lower blood sugar) 40 units nightly, Rexulti (antipsychotic), trazodone (antipsychotic), calcium alginate (wound dressing), Nuedexta (to treat uncontrollable laughing or crying), Ramipril (to lower blood pressure), Tylenol (for pain or fever), and Gabapentin (for nerve pain) 300 milligrams three times daily. This document indicated the patient had 3 wounds, to the right top of foot (diabetic wound), right great toe (pressure wound), and sacral area (pressure wound). This document indicated the patient was to be turned by the caregiver every 2 hours for pressure wound prevention and patient's heels were to be floated to prevent pressure sores. This document indicated the patient had a suprapubic catheter (tube inserted through			

	the skin, directly into the bladder to drain urine), which was to be changed monthly by the skilled nurse. This document did not indicate home health agency #7 was performing catheter care. Record review evidenced a plan of care for certification period 9/11/2022 – 11/9/2022, which indicated the patient was to receive home health aide services 9 hours per day/5 days per week. This document failed to include orders for turning the patient every 2 hours or floating patient's heels to prevent further pressure wounds. This document failed to include any orders for catheter care such as cleaning the site to prevent urinary tract infection. This document failed to include any information regarding services provided by home health agency #7. During an interview on 9/19/2022, at 3:32 PM, clinical manager #2 indicated home health agency #7 was providing skilled nursing for patient #4. Clinical manager #2 indicated			

	home health agency #7 was doing skilled nursing for foley catheter care. Clinical manager #2 indicated home health agency #7 provided skilled nursing visits once or twice per week. Clinical manager #2 indicated the patient did not have any wounds. Clinical manager #2 indicated care was coordinated through a phone call with home health agency #7. Clinical manager #2 indicated care coordination was not documented. Clinical manager #2 indicated the home health aides only empty the catheter, because the other home health agency was performing catheter care. Clinical manager #2 did not know exactly what interventions home health agency #7 was performing for patient #4. Clinical manager #2 indicated the patient's caregiver did not live with him, but would visit him before and after work. 5. Clinical record review for patient #5 was completed on 9/19/2022, for certification period 7/28/2022 – 9/25/2022. Record review evidenced a resumption of care assessment			

	dated 6/22/2022, which indicated the patient was receiving services from home health agency #8 for skilled nursing services. Record review evidenced a comprehensive assessment dated 7/25/2022, which indicated the patient had 1 pressure wound, a jejunostomy, was a dialysis patient, and incontinent. This document failed to include an assessment or location of wound, type of tube feedings provided to patient, or type of dialysis access. Record review failed to evidence any care coordination with home health agency #8. Record review evidenced a plan of care from home health agency #8, for certification period 8/14/2022 – 10/12/2022, which was faxed to surveyor on 9/21/2022. This document indicated home health agency #8 provided skilled nursing 2 times per week. Home health agency #8's plan of care included the following diagnoses, which were not included in the home health agency's plan of care: pressure			

	caused by pressure on the area at the base of the spine), end stage renal disease (kidney failure, requiring artificial kidney filtration), aphasia (loss of ability to understand or express speech), hepatitis C (virus which attacks the liver), Alzheimer's disease (progressive disease which destroys memory and mental functions), bipolar disorder (a disorder with mood swings), open wound of left breast, and hypertension (high blood pressure). This document also included the following medications which were not include in the home health agency's plan of care: clonazepam (anti-anxiety), and ferrous sulfate (iron supplement). This document indicated the patient received Novasource tube feedings, 3 cans per day with a 75 milliliter water flush. This document indicated the patient had a sacral wound which measured 3 centimeters (cm) x 3 cm x 0.1 cm, and a wound under left breast which measured 1cm x 2 cm. During an interview on			

	manager #2 indicated home health agency #8 provided skilled nursing 2 times per week to check patient's wound. Clinical manager #2 did not know what dressing was being applied, or how large the wounds were. Clinical manager #2 indicated care coordination was a phone call in which she confirmed that the other agency was still seeing the patient. Clinical manager #2 indicated she only added diagnoses which the patient told her about to the plan of care. Clinical manager #2 indicated the medication for home health aide only patients is completely managed by the other home health agency, so no medication review on her part is completed. Clinical manager #2 indicated they don't request a copy of they other home health agency's care plan.			
G0968	Assure implementation of plan of care 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. Based on record review and interview, the home health	G0968	For patient #1, the Director ofNursing reviewed the patient's plan of care, visit frequency was corrected. TheDirector of Nursing in-serviced the Administrative Assistant on how importantit is to document every missed visit and reschedule missed visits	2022-11-30

	agency failed to ensure the clinical manager assured the implementation of the individualized plan of care in 1 of 3 home visits conducted. (#1) The findings include: Record review on 9/15/2022, evidenced a document signed by clinical manager #2 on 8/18/2011, titled "Job Description for Director of Nursing" which stated, "... Supervises and provides direction to subordinates, in an effort to ensure quality, compliance with Plan of care and assessment and reassessment of patient's needs and continuity of services by appropriate health care personnel ...." Clinical record review for patient #1 was completed on 9/19/2022. Record review evidenced a plan of care for certification period 8/13/2022 – 10/11/2022, which indicated the patient was to receive home health aide visits 3 days per week. Record review evidenced the patient only received 1		with theconsent of the patient. This was completed on 10/19/2022. All patients' charts were reviewed andall missed visits were properly documented with reasons. The Director of Nursing instructed theAdministrative Assistant to always document every missed visit going forward.The Director of Nursing will review all patients' chart quarterly to ensure100% compliance. The Director of Nursing will beresponsible for monitoring this corrective action to ensure the deficiency doesnot recur.	

home health aide visit the week of 8/28/2022, and 2 home health aide visits the week of 9/4/2022. Review failed to evidence a missed visit note or documentation of why the visits were not completed.

During an interview on 9/19/2022, at 1:46 PM, clinical manager #2 indicated she did not know why patient #1 did not receive 3 home health aide visits the weeks of 8/28/2022 and 9/4/2022. Clinical manager #2 indicated the agency would only reschedule the missed visits if the patient called and requested it to be rescheduled. Clinical manager #2 did not know why the reason for the visit was missed was not documented.

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