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	12/14/2022

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 revisit for a State relicensure survey. Survey Dates: 12/9/2022, 12/12/2022, 12/13/2022, and 12/14/2022 Facility ID: 012812 Census: 11	N0000		2023-01-31
G0000	INITIAL COMMENTS This visit was for a Post Condition Revisit survey for a Federal Recertification and State Re-licensure survey. Facility ID: 012812 Survey Dates: 12/9/2022, 12/12/2022, 12/13/2022, and 12/14/2022.	G0000		2023-01-31

	Census: 11 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 12/14/2022 - 12/13/2023, due to being found out of compliance with Conditions of Participation: 42 CFR 484.102 Emergency preparedness, 42 CFR 484.60 Care Planning, Coordination of Care and Quality of Care, and 42 CFR 484.65 Quality Assessment and Performance Improvement. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Quality Review Completed 12/20/2022			
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: 12/9/2022, 12/12/2022, 12/13/2022, and 12/14/2022. Facility ID: 012812	E0000		2023-01-31
E0001	Establishment of the Emergency Program (EP) 403.748,482.15,485.625 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.625, §485.727, §485.920, §486.360, §491.12	E0001	**E0001** Effective immediately, 1st Option Adult Day Services & Home Health has updated its policy on emergencypreparedness to include all hazards, community risk assessment, The process of cooperationand collaboration with regional, state, state,	2023-01-31

	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 review, and interview, the home health agency failed to: ensure the emergency preparedness plan included an all-hazards,		and/or federal agencies, proceduresto inform local and/or state officials and finally ensured that individualcommunication plan containing the name and contact information ofpatient/physician, and procedure on howto notify state/ local emergency officials, and where to reach/connect withagency employees and patients during emergencies. The administrator instructed thedirector of nursing to in-service all field employees about the appropriateprocedure to follow when contacted by state/local emergency officials duringemergency events Agency will obtain, record, andmaintain contact information for state/ local emergency organizations. Thiswill enable the agency to report emergencies, and communicate with the agenciesduring emergencies. The administrator is responsible forthe implementation of this corrective action to ensure 100% compliance. Theadministrator will monitor this corrective action to ensure	

	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 included names and contact information for patients' physicians (see tag E0030); ensure the emergency preparedness communication plan included a primary and/or alternate means of communicating with federal, state, regional, and/or local emergency management agencies and facility staff (see tag E0032); and conduct any		that thisdeficiency is corrected and will not recur. 01/31/2023 to be implemented.	

	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)-(§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	E0006	**E0006** Effective immediately, the agency has reviewed and updatedits policy on emergency preparednessrisk assessment to include all hazards likelyto occur in this region including but not limited to fire, power outages, hazardous materials,accidents, and disease outbreaks/pandemic hurricanes,earthquake, Land/Mud Slide, snow storm, blizzard, bioterrorism, etc. The agency has initiated in-servicetraining of all employees on emergency preparedness via phone tree-quarter. Agency has reached out to the federal,	2023-01-31

	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 maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.		state,and regional emergency agencies in the region and has obtained the contactinformation for constant communication. Agency will endeavor to attend meetingsand workshops organized by regional/local emergency preparedness agencies to beabreast of events likely to occur in the region.Agency will develop and maintaincontact information of these agencies e. g. phone, numbers, e-mails, etc. The administrator is responsible for the implementation ofthis corrective action to ensure 100% compliance. The administrator willmonitor this corrective action to ensure that this deficiency is corrected andwill not recur. Implementation date 01/31/2023.	

	(2) Include strategies for addressing emergency events identified by the risk assessment. Based on record review and interview, the emergency preparedness plan failed to be based on and include a documented, facility-based and community-based risk assessment utilizing an all-hazards approach. The findings include: Record review on 12/13/2022, evidenced an emergency preparedness policy update dated 11/2022, which stated, "... 1st Option Adult Day Services & Home Health updated its policy on Emergency Preparedness to include all hazards likely to be experienced in its areas of operation to include the following events: ... Earthquake ... Hurricane ... Land/Mud Slide ...." Review on 12/13/2022, of the agency's emergency preparedness plan failed to evidence the risk assessment was facility based and			

	emergency preparedness plan included the following risks which were not likely to occur in the community and facility the home health agency and its patients were located: earthquake, hurricane, and land/mudslide. The emergency preparedness plan failed to identify only the risks most likely to occur in the community the home health agency served. During an interview on 12/13/2022, at 2:22 PM, administrator #2 indicated the agency conducted the risk assessment based on the news reports, and was focused mainly on storms, worker strikes, and infectious disease outbreaks. Administrator #2 indicated they then decided which risks were pertinent to the agency.			
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)	E0009	**E0009** Effective immediately, the agency hasupdated its policy on emergency preparedness to include a procedure on how tocooperate, collaborate, and notify state and local emergency officials of how,and	2023-01-31

	[(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Based on record review and interview, the home health agency failed to ensure the emergency preparedness plan included the process for collaborating and cooperating with federal emergency preparedness officials to maintain an integrated response during an emergency. The findings include: Review of the agency's emergency preparedness plan on 12/13/2022, evidenced an		where to reach and connect with agency employees and patients duringemergencies. The administrator has instructed thedirector of nursing to in-service all field employees about the appropriateprocedure to follow when contacted by state and local emergency officialsduring 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 thesegovernmental agencies 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 thisdeficiency is corrected and will not recur. Implemented 01/31/2023.	

	undated policy titled "Emergency Preparedness Policy" which stated, "... Local police, highway patrol, and sheriff's offices will be notified of clients with specific and imminent needs requiring services from agency staff ... The Red Cross and local authorities will be notified by the Director of high-risk clients ...." Review on 12/13/2022, of the emergency preparedness plan failed to include the process for collaborating with federal emergency preparedness officials.			

	During an interview on 12/13/2022, at 2:26 PM, administrator #2 indicated the process for collaborating with federal emergency preparedness officials was that the agency would be participating in future emergency preparedness meetings. Administrator #2 indicated the federal emergency preparedness officials contact information had been added to the communication plan.			
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 provisions at §484.55.	E0017	**E0017** **For patient #1,** the agency immediately reviewed and updatedits emergency preparedness to include specific evacuation locations such as a bathroom,basements, closets, salvation army, and the American red cross in the events ofstormy weather, blizzard, tornadoes, and extreme cold weather condition andupdated patients' contact person information. Agency included other shelters inthe region such as the salvation army and The American red cross. **For patient #3**, the agency	2023-01-31

	Based on observation and interview, the home health agency failed to ensure patients had individualized emergency preparedness plans, which were included as part of the comprehensive assessment in 2 of 3 home visits conducted. (#1, 3) The findings include: 1. Observation of a home visit for Patient #1 was conducted on 12/12/2022, at 12:00 PM, to observe a routine home health aide visit. During the visit, a home health folder was reviewed. The folder contained a document titled “Emergency Information” which failed to include a specific evacuation location. During an interview on 12/14/2022, at 10:33 AM, administrator #2 indicated the emergency plans didn’t include specific evacuation locations, and the patients would be directed to go to the hospital if there was an emergency. Administrator #2 indicated the patients were provided with a		immediatelyreviewed and updated its emergency preparedness to include evacuation locationsand updated patients’ contact person information. The agency will ensure that emergencypreparedness plan is specifically documented for each client and evacuationlocations and current contact person identified. All clients will be assessedand emergency preparedness plans established specifically to meet their needs. Agency will annually review allpatients’ clinical records to ensure that their emergency preparedness plan hasan evacuation location and current contact person. This will ensure that thedeficiency is corrected and will not recur. The administrator is responsible forthe implementation of this corrective action to ensure 100% compliance.	

	list of local shelters, and during an emergency the agency would call the local shelters to see if the patient was there. 2. Observation of a home visit for Patient #3 was conducted on 12/14/2022, at 1:15 PM, to observe a routine home health aide visit. During the visit, a home health folder was reviewed. The folder contained a document titled "Emergency Information" which failed to include a specific evacuation location.			
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	E0021	**E0021** Effective immediately, the agency hasupdated its policy on emergency preparedness to include a procedure on how tonotify state and local emergency officials of how, and where to reach andconnect with agency employees and patients during emergencies. The director of nursing willin-service all field employees about the appropriate procedure to follow whencontacted by state and	2023-01-31

	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 home health agency failed to develop and implement policies and procedures which included informing State and local officials of any on duty staff or patients who were unable to be contacted. The findings include: Record review evidenced an undated agency policy obtained on 12/13/2022, titled "Emergency Preparedness Policy" which stated, "... 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 ...." Review on 12/13/2022, of the emergency preparedness policy failed to include the process to inform State and local officials of any on duty staff or patients the agency was unable to contact. During an interview on		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 thesegovernment agencies 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 thisdeficiency is corrected and will not recur. Implemented 01/31/2023.	

	12/13/2022, at 2:35 PM, clinical manager #1 indicated if they couldn't get ahold of staff or patients, they would make a visit to the employee or patient's home, or if it was unsafe they would call 911, to do a wellness check.			
E0030	Names and Contact Information 403.748(c)(1),482.15(c)(1),485.625(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers.	E0030	**E0030** Effective immediately, 1st Option Adult Day Services & Home Health has updated its policy on emergencypreparedness communication plan and included contact information of the patient,physician name and contact, pharmacy, and hospital. Agency reviewed otherpatients' charts likely to be impacted by this deficiency and corrected them. The administrator instructed the director of nursing toreview all client's medical records ensuring that clients with the potential tobe affected by this same deficiency are identified, reviewed, and corrected ina timely manner to avoid this deficiency reoccurring again. The director of nursing has in-serviced support staff	2023-01-31

	*[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.		toreview clients' medical records quarterly to ensure an emergency Preparednesscommunication plan is in place, with the patient's name, contact information,physician's name, and contact, and pharmacy and hospital are up to date. 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 and will not recur. 01/31/2023.	

	*[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			

	communication plan included names and contact information for patients' physicians. The findings include: Review on 12/13/2022, of the agency's emergency preparedness communication plan failed to evidence any physicians' names or contact information. During an interview on 12/13/2022, at 2:39 PM, clinical manager #1 indicated the physicians' contact information wasn't in the emergency preparedness communication phone list, but it was in each patients' chart in the office.			
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).	E0032	**E0032** Effective immediately, 1st option Adult Day Services & Home health agency has revised its policy onemergency preparedness and included region 5, the department of health andhuman services	2023-01-31

	[(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: (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 communication plan included primary and alternate contact information for regional and state emergency preparedness staff. The findings include: Review on 12/13/2022, of the agency's emergency preparedness communication plan failed to include contact information for regional emergency preparedness officials such as the region 5,		emergency coordinator, district 1 hospital emergency planningcommittee contact information, and regional coalition contact information. Theagency included alternate means of communication with the state emergencypreparedness 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 ensure that their emergency preparednesscommunication plan is current and up to date. This will ensure that thedeficiency is corrected and will not recur. The Administrator is responsible forthe implementation of this corrective action scheduled to be completed on01/31/2023 to ensure 100% compliance. The Administrator will monitor thiscorrective action to ensure that this deficiency is corrected and will notrecur.	

	Department of Health and Human Services emergency coordinator, the District 1 Hospital Emergency Planning Committee contact information, or regional emergency preparedness coalition contact information. The communication plan failed to include an alternate means of communicating with State emergency preparedness officials. During an interview on 12/13/2022, at 2:42 PM, administrator #2 indicated the agency would mostly work with the local emergency preparedness officials. Administrator #2 indicated the state emergency preparedness official were very far away, so primarily the local emergency preparedness officials would be contacted.			
E0039	EP Testing Requirements 403.748(d)(2),482.15(d)(2),485.625(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2),	E0039	**E0039** The Administrator has directed thehuman resource manager to organize mock fire drill/tabletop drill exercises andto liaise with emergency preparedness	2023-01-31

	§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 exercises, and emergency events, and revise the [facility's] emergency plan, as needed.		agencies and other healthcareinstitutions in 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-basedemergency drills 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.	

	*[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 individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual			

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 home health agency failed to conduct a full-scale exercise, facility-based exercise, activation of emergency plan, mock disaster drill, or tabletop exercise or workshop to test the emergency plan.

The findings include:

Record review evidenced an

	undated agency policy obtained 12/13/2022, titled "Emergency 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 a disaster ...." Review on 12/13/2022, of the agency's emergency preparedness plan failed to evidence any drills or testing exercises had been conducted to test the effectiveness of the emergency plan. During an interview on 12/13/2022, at 2:44 PM, administrator #2 indicated the agency had not yet participated in or conducted any emergency preparedness testing, but would be participating in a community based drill in 2023.			
N0458	Home health agency administration/management 410 IAC 17-12-1(f)	N0458	**N0458** **For Home HealthAide #3,** theadministrator directed the human resource manager to	2023-01-31

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 included receipt of job description for 3 out of 7 home health aide personnel records reviewed. (#3, 4, 5)

The findings include:

1. Record review evidenced an undated agency policy obtained on 12/14/2022, titled "Personnel Records" which stated, "... The personnel record for an employee will include, but not

reviewemployee personnel records and immediatelydocumented employees' signed job descriptions.

For Home HealthAide #4, theadministrator directed the human resource manager to review employee personnel records and immediately documentedemployees' signed job descriptions

For Home HealthAide #5, theadministrator directed the human resource manager to reviewemployee personnel records and immediatelydocumented employees' signed job descriptions

The Administrator has an in-servicedhuman resource manager to review all active employee personnel records toidentify those likely to be affected by this deficiency to ensure all employeeshad their job descriptions in their employee files.

All employees' files have beencarefully reviewed to ensure copies of signed home health job descriptions arein

	be limited to: ... Signed job description ...."		and will be subsequently reviewed to ensurethis deficiency does not reoccur.	
	2. Personnel record review on 12/13/2022, evidenced a personnel file for home health aide #3, start date 8/22/2022, first patient contact date 9/7/2022, which failed to include a signed job description.		50% of all employees' personnelrecords will be quarterly to ensure 100%% compliance with this regulatoryrequirement. The human resource manager will be responsible for monitoring thiscorrective action scheduled to be implemented on 01/31/2023 to ensure 100%compliance.	
	3. Personnel record review on 12/13/2022, evidenced a personnel file for home health aide #4, start date 12/2/2021, first patient contact date 12/6/2021, which failed to include a signed job description.			
	4. Personnel record review on 12/13/2022, evidenced a personnel file for home health aide #5, start date 7/24/2019, first patient contact date 7/25/2019, which failed to include a signed job description.			
	During an interview on 12/13/2022, at 3:08 PM, clinical manager #1 indicated the			

	description upon hire, and it should have been kept in the employee file. Clinical manager #1 indicated it may have been somewhere besides the employee file.			
N0464	Home health agency administration/management 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	N0464	**N0464** **For home health aide #7,** thehuman resource manager reviewed the employee's personnel records andincluded a copy of current tuberculosis tests in the employee's file. The Administrator instructed the human resource manager toreview all active employee's records to ensure they all have a copy of theircurrent tuberculosis test to ensure 100% compliance. The Administrator in-serviced thehuman resource manager that a tuberculosis test should be done according to thestate regulation before every Home Health Aide's first contact with a patient.This was included in the onboarding process for every new field employee. The human resource manager will reviewall active employee's personnel records quarterly to	2023-01-31

	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 (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 ensure employees with direct patient contact had annual tuberculin screenings in 1 of 7 home health aide records reviewed. (#7) The findings include: Record review evidenced an undated agency policy obtained		ensure that they all havea copy of the current tuberculosis test. The human resource manager will beresponsible for monitoring this corrective action scheduled to be implemented on01/31/2023 to ensure 100% compliance.	

	Screening" which stated, "... Each employee having direct contact with clients must have ... tuberculin skin testing via the Mantoux method ... This testing includes the pre-placement evaluation, administration and interpretation of tuberculin Mantoux skin tests and periodic evaluation ... On any employee or contract personnel providing direct client care, there shall be documentation of completion of a tuberculin skin test, via the Mantoux method ... [Verify time frames with state requirements] ...." Personnel record review on 12/13/2022, evidenced a personnel file for home health aide #7, start date 11/21/2018, first patient contact date 11/23/2018, which included a tuberculin skin test dated 7/21/2021, but failed to include a skin test or screening for 2022. During an interview on 12/13/2022, at 3:10 PM, clinical manager #1 indicated employees should receive tuberculin skin tests yearly, and			

	was not sure why home health aide #7 did not have a test or screening for 2022 in their file.			
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 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.	N0488	**N0488** Theagency reviewed its policy on Discharge and included a 15 days' notice prior todischarge. 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. On 12/20/2022, the director of nursing reviewed all activepatients' charts ensuring pending discharge clients are notified by phone callsor emails (15) days before their discharge date. A discharge summary of the client was faxedto the patient's physician and a fax confirmation was obtained for recordpurposes. The Director of Nursing will review all active patients'charts bi-monthly for pending discharge of any client and notify them of theirdischarge date within 15 days of the	2023-01-31

	Based on record review and interview, the home health agency failed to develop a discharge policy which required 15 day notice prior to discharge. The findings include: Record review evidenced an undated agency policy obtained 12/14/2022, titled "Client Discharge Process" which stated, "... The agency will notify the client 5 DAYS before the discharged day ...."		stipulated time. This will ensurecompliance. TheAgency's 25% of the client's medical records will be audited quarterly toensure all discharged patients receive 15 days' notice prior to discharge, andto ensure 100% compliance. The administrator will be monitoring this processensuring that this deficiency will not recur. The Director of Nursingwill be responsible for monitoring this corrective action scheduled to beimplemented on 01/31/2023 to prevent the reoccurrence of this deficiency.	

	During an interview on 12/14/2022, at 11:49 AM, clinical manager #1 indicated the agency notified patients of discharge via letter 30 days prior to discharging, and also called the patients 5 days prior to verbally discuss discharge.			
G0526	Content of the comprehensive assessment 484.55(c) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: Based on record review and interview, the home health agency failed to ensure the comprehensive assessments accurately reflected the patients' status in 2 of 3 clinical records reviewed with comprehensive assessments completed after 11/30/2022. (#4, 6) The findings include: 1. Record review evidenced an undated agency policy obtained	G0526	**G0526** For the clinical record review of patient#4, Agency is unable to correct this deficiency of emergency contact personbecause the patient is deceased. For clinical record patient #6, the agency reviewed the clientchart immediately to identify missing assessment deficiency and corrected it tomeet agency policy and regulatory requirements. 100% of the client's charts werereviewed immediately and those likely to be affected were corrected to ensure theclient status change/new diagnosis is not missed during the comprehensiverecertification assessment. 50% of all client's charts will be auditedquarterly to ensure this deficiency will not reoccur again and to comply withthe regulatory requirements. The Director of Nursingis responsible for monitoring this corrective action and ensuring 100%compliance.	2023-01-31

	"Comprehensive Client Assessment" which stated, "... Purpose: ... To accurately reflect the current health status of the client and need for home care services ...." 2. Clinical record review for Patient #4 was completed on 12/14/2022, for certification periods 10/12/2022 – 12/10/2022, and 12/11/2022 – 2/8/2023. Record review evidenced a comprehensive recertification assessment dated 12/6/2022, which indicated the patient's caregiver/emergency contact was person #3, who was deceased. The comprehensive assessment indicated the patient was oxygen dependent in 2 sections and indicated in 1 section the patient did not use oxygen. During an interview on 12/14/2022, at 11:36 AM, clinical manager #1 indicated the comprehensive assessment was inaccurate. Clinical manager #1 indicated person #3 was deceased and they needed to update the paperwork for a new			

	At 11:38 AM, clinical manager #1 indicated the patient did not use oxygen but used the CPAP (machine used to help with breathing). 3. Clinical record review for Patient #6 was completed on 12/14/2022, for certification period 12/9/2022 – 2/6/2023. Record review evidenced a comprehensive recertification assessment dated 12/6/2022, which indicated the patient did not have any shortness of breath in 1 section, and in another section indicated the patient had severe shortness of breath. During an interview on 12/14/2022, at 12:06 PM, clinical manager #1 indicated they did not know why the assessment indicated the patient was not short of breath and was short of breath. 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 record review and interview, the home health agency failed to ensure the comprehensive assessments included the patient's current health and psychosocial status in 2 of 3 clinical records reviewed of patients who had a comprehensive assessment after 11/30/2022. (#4, 6) The findings include: 1. Record review evidenced an undated agency policy obtained 12/14/2022, titled "Comprehensive Client Assessment" which stated, "... Purpose: ... To identify client's medical, nursing, rehabilitative, social and discharge planning needs ... the agency comprehensive assessment tool will include: ... client history ... Respiratory status ... Sensory status ... Emergent care data ...."	G0528	**G0528** For the clinical record review of **patient #4**, Agencyis unable to correct this deficiency of emergency contact person because the patientis deceased. For the record review of **patient #6**, the agencyreviewed the patient's chart and identified the missing pain assessment duringrecertification. The director ofnursing went back to the patient's house and assessed her pain rating includinglocation, severity, quality, or impact of pain on daily life. The patient'sfistula site was also assessed and documented to ensure this deficiency doesnot reoccur. Agency reviewed all clients' charts likely to be impacted bythis deficiency and corrected them ensuring that missing pain assessment willnot occur again. The agency Directorof Nursing will audit clients' charts quarterly to ensure compliance withregulatory requirements. The Director of Nursing is also responsible for thiscorrective action.	2023-01-31

	2. Clinical record review for Patient #4 was completed on 12/14/2022, for certification periods 10/12/2022 – 12/10/2022, and 12/11/2022 – 2/8/2023. Record review evidenced comprehensive recertification assessment dated 12/7/2022, which indicated the patient experienced pain daily, but failed to include a complete pain assessment including rating of pain, location of pain, severity, quality, or impact of pain on daily life. The comprehensive assessment also failed to include patient's history of colitis (inflammatory disease of bowel) and pacemaker status. Clinical record review evidenced a transfer summary dated 12/8/2022, which indicated the patient was admitted to the intensive care unit due to dehydration, diarrhea, colitis, and electrolyte imbalance. Clinical record review evidenced a plan of correction with a correction date of 11/30/2022,			

	which indicated Patient #4's comprehensive assessment would be updated to include a complete pain assessment, assessment of colitis, history of pacemaker insertion, and use of CPAP machine (machine to help with breathing). During an interview on 12/14/2022, at 11:37 AM, clinical manager #1 indicated the pain assessment should have been included in all the comprehensive assessments. Clinical manager #1 indicated the pain assessment should have included rating, location, duration, and qualities/descriptors of pain. Clinical manager #1 indicated the patient was hospitalized due to stomach problems and dehydration. Clinical manager #1 indicated the comprehensive assessment should have included the pacemaker and CPAP use. 3. Clinical record review for Patient #6 was completed on 12/14/2022. Record review evidenced a plan of care for			

	2/6/2023, which indicated the patient was a dialysis (artificial blood filtering to treat kidney failure) patient and had a fistula (connection of a vein and an artery to allow access for dialysis) in their left forearm. Clinical record review evidenced a recertification assessment dated 12/5/2022, which indicated the patient experienced pain daily, but failed to include a complete pain assessment including rating of pain, location of pain, severity, quality, or impact of pain on daily life. The comprehensive assessment failed to include any assessment of the fistula site, including location, status, or care provided. During an interview on 12/14/2022, at 11:57 AM, clinical manager #1 indicated the comprehensive assessments for dialysis patients should have included an assessment of the dialysis access site.			

	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 ensure the comprehensive assessment included a review of all medications the patient was currently using to identify any drug interactions and/or duplicative drug therapy in 3 of 3 active clinical records reviewed, in which a comprehensive assessment was conducted after 11/30/2022. (#1, 4, 6) The findings include: 1. Record review evidenced an undated agency policy obtained 12/14/2022, titled "Comprehensive Client Assessment" which stated, "...	G0536	**G0536** the director of nursing immediatelyreviewed the client chart affected by this deficiency and included all themedications client is currently taking in the client's list of medications. The director of nursing printed medicationteachings on all the potential drug reactions, drug-druginteractions, adverse effects, ineffective therapy, duplicate drug therapy,side effects, and non-compliance with therapy and educated the client. All clients' charts likely to beaffected by this deficiency have been reviewed, and 60-day recertification toinclude clients' potential drug reactions, adverse effects, ineffectivetherapy, duplicate drug therapy, side effects, non-compliance of patientmedications in their comprehensive assessment have been outlined for each patientlikely to be affected.	2023-01-31

	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, duplicate drug therapy and non-compliance with therapy ….” 2. Observation of a home visit for Patient #1 was conducted on 12/12/2022, at 12:00 PM, to observe a routine home health aide visit. During the visit, the patient’s medication bottles were reviewed. The following medication bottles were observed, which were not included in the patient’s medication profile: propranolol (to lower heart rate and blood pressure), ibuprofen (for pain/fever), Tylenol (for pain/fever), and Imodium (for diarrhea). During an interview on 12/14/2022, at 10:39 AM, clinical manager #1 indicated the medication profile was completed during the		Quarterly audits of 50% of patients’charts will be audited to ensure 100% compliance and to ensure this deficiencydoes not reoccur again. The director of nursing is responsiblefor monitoring this corrective action scheduled to be implemented on 01/31/2023 The agency immediately identified **patient #1** chartwith the deficiency and reviewed the patient’s medications. The director ofnursing updated the patient medication bottles that were not included in her medicationprofile. Agency faxed an updated patient plan of care with currentmedication lists to her physician for signature. 100% of all client charts were reviewed ensuring theirmedications are up to date. This will prevent this deficiency from reoccurringagain.	

	comprehensive assessment and should have included all the medications the patients were taking. 3. Clinical record review for Patient #4 was completed on 12/14/2022, for certification period 10/12/2022 – 12/10/2022. Record review evidenced a comprehensive recertification assessment dated 12/6/2022, which failed to indicate any drug-drug interactions were identified. Clinical record review evidenced a medication profile dated 12/13/2022, which included orders for: Clotrimin (antifungal cream) topical, but failed to include a location to be applied, and Narcan (medication to treat opioid overdose) 0.4 milligrams oral spray daily. The medication profile indicated the patient was taking the following medications: Aspirin (to prevent stroke and heart attack), atorvastatin (to lower cholesterol), Fioracet (to prevent headaches), albuterol (to help breathing), buspirone		50% of all client's charts will be audited quarterly toensure this deficiency will not reoccur again and to comply with the regulatoryrequirements. The Director of Nursing is responsible for monitoring thiscorrective action and ensuring 100% compliance scheduled to be implemented on01/31/2023 For the clinical record review of **patient #4,** the director of nursing immediately reviewed the clientchart and identified the client affected by this deficiency. The director of nursingreviewed the client's drug regimen to identify drug-drug interactions andupdated the client's medications list to include the location and route ofadministration. Patient medicationteachings that included drug-drug interactions were printed and given to theclient and the patient was educated to ensure this deficiency does not happenagain. All clients' charts likely to beaffected by this deficiency have been reviewed, and 60-day	

	help pain), Cymbalta (anti-depressant), gabapentin (for nerve pain), Norco (pain medicine), Meloxicam (for arthritis pain), Metoprolol (to lower heart rate and blood pressure), Narcan (to reverse opioid overdose), oxaprozin (arthritis pain medication), oxybutynin (to help with bladder spasms), pantoprazole (to decrease stomach acid), prednisone (steroid), sertraline (anti-depressant), topiragen (anti-convulsant), and trazadone (anti-depressant). Review on 12/14/2022, of a web based source, https://www.drugs.com/interactions-check.php, included the following 11 major drug-drug interactions between medications on the patient's medication list: butalbital (medication for tension headaches) and hydrocodone (pain medicine) – can cause respiratory distress, coma, and death; hydrocodone and gabapentin (for nerve pain) – can cause respiratory distress, coma and death; trazodone (medication to stabilize mood)		recertification toinclude all clients' current medications in their medication list duringcomprehensive assessment and to identify drug-drug interactions or duplicatedrug therapy have been outlined for each patient likely to be affected. 50% of patients' charts will beaudited quarterly to ensure 100% compliance. Web-based drug interactions willbe sourced and 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 01/31/2023. For the clinical record review of **patient #6**, the director of nursing reviewed the client chartand identified the client affected by this deficiency. The director of nursingreviewed the client's drug regimen to identify drug-drug interactions, and duplicatedrug therapy and updated the client's medications list to include the locationand route of medication	

	– can cause confusion, hallucination, seizure, changes in blood pressure, muscle spasm, nausea, vomiting, and diarrhea; buspirone (anti-anxiety) and sertraline - confusion, hallucination, seizure, changes in blood pressure, muscle spasm, nausea, vomiting, and diarrhea; sertraline and duloxetine (anti-depressant) - confusion, hallucination, seizure, changes in blood pressure, muscle spasm, nausea, vomiting, and diarrhea; buspirone and hydrocodone – can cause respiratory distress, coma, and death; buspirone and trazodone – confusion, hallucination, seizure, changes in blood pressure, muscle spasm, nausea, vomiting, and diarrhea; trazodone and duloxetine - confusion, hallucination, seizure, changes in blood pressure, muscle spasm, nausea, vomiting, and diarrhea; buspar and duloxetine - confusion, hallucination, seizure, changes in blood pressure, muscle spasm, nausea, vomiting, and diarrhea; oxybutynin (to prevent bladder spasms) and topiramate (anti-seizure) – can cause increased body temperature and decreased sweating, heat		administration. Patient medication teachings thatincluded drug-drug interactions were printed and given to the client and the patientwas educated to ensure this deficiency does not happen again. All clients' charts likely to beaffected by 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 or duplicatedrug therapy have been outlined for each patient likely to be affected. Quarterly audits of 50% of patients'charts will be audited to ensure 100% compliance. Web-based drug interactionswill be sourced and 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 01/31/2023.	

	stroke and hospitalization; and oxaprozin (for pain) and meloxicam (for pain) – increased risk of inflammation, bleeding, ulceration, and perforation of gastrointestinal tract. During an interview on 12/9/2022, at 10:54 AM, clinical manager #1 indicated if the patient did not receive skilled nursing services, the medications were not reviewed for interactions. Clinical manager #1 indicated if a drug regimen review was completed and interactions found, the interactions report should be provided to the physician. During an interview on 12/14/2022, at 11:34 AM, clinical manager #1 indicated the medication list should have included an application location for clotrimin. Clinical manager #1 indicated the Narcan order should have read Narcan 0.4 milligrams nasal spray as needed for opioid overdose. Clinical manager #1 indicated if there were drug interactions or duplicative drug therapies			

	found during the drug regimen review, they should have let the physician's office know. Clinical manager #1 indicated there were no patients with severe drug interactions so far. 4. Clinical record review for Patient #6 was completed on 12/14/2022, for certification period 12/9/2022 – 2/6/2022. Record review evidenced a comprehensive recertification assessment dated 12/5/2022, which failed to indicate any drug-drug interactions or duplicative drug therapy was identified with a drug regimen review. Clinical record review evidenced a medication profile dated 12/5/2022, which included duplicates of the following medications: allopurinol (for joint pain in gout), carvedilol (to lower heart rate and blood pressure), Renvela (to lower phosphorus levels), colace (stool softener), gabapentin (for nerve pain), melatonin (to help with sleep), Keppra (to prevent seizures), vitamin D3, Temovate			

	(anti-depressant), hydrocortisone (steroid cream), Lidoderm patch (to help with pain), Bactroban (antibacterial ointment), Bystolic (to lower blood pressure), Rena-vite (multivitamin), Zoloft (anti-depressant), Voltaren gel (to help with pain), and Ozempic (to lower blood sugar). The medication profile included the following topical medications with no application location: Clotrimazole-betamethadone (antifungal), hydrocortisone, Bactroban, Voltaren gel and Lidoderm. The medication profile included an order for Tylenol as needed but failed to include an indication for use. Review on 12/14/2022, of a web based source, https://www.drugs.com/interactions-check.php, included the following 3 major drug-drug interactions between medications on the patient's medication list: sertraline and cyclobenzaprine (muscle relaxer) – can cause confusion, hallucination, seizure, changes in blood pressure and heart rate, nausea, vomiting, diarrhea;			

	cyclobenzaprine and duloxetine - can cause confusion, hallucination, seizure, changes in blood pressure and heart rate, nausea, vomiting, diarrhea; and sertraline and duloxetine - can cause confusion, hallucination, seizure, changes in blood pressure and heart rate, nausea, vomiting, diarrhea. The web based source included the following duplicative drug therapies: cardiovascular agents – 2 beta blockers – carvedilol and Bystolic; central nervous system drugs (drugs that slow brain activity) – duloxetine, gabapentin, Keppra, and sertraline.			

	During an interview on 12/14/2022, at 11:53 AM, clinical manager #1 indicated the medication profile included many duplicate orders because they were trying to remove the medications the patient was no longer taking. Clinical manager #1 indicated as needed medications should have included an indication for use. Clinical manager #1 indicated topical medications should have had an application location in the order. 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 all necessary medical information	G0564	**G0564** 1. The director of nursing reviewed clients' charts and identified thepatients affected with deficiency. The director of nursing immediately refaxedtransfer/discharge summaries of the affected patients containing medicalinformation about their current course of illness and treatment to thereceiving facility or their physician. A fax confirmation was obtained and keptfor record purposes.	2023-01-31

	pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences to the receiving health facility or health care practitioner in 1 of 1 discharged records reviewed (#5), and 1 of 1 transferred records reviewed (#4). The findings include: 1. Record review evidenced an undated agency policy obtained 12/14/2022, titled, "... Discharge Summary" which stated, "... When a client is discharged from the agency, the supervising professional shall complete a Discharge Summary form within the time frame defined by the agency ... A copy will be mailed to the physician upon request ... The Discharge Summary will incorporate findings from the discharge assessment and shall include, but not be limited to: ... Services provided ... Status at time of discharge ... Unmet needs, referrals made ...." 2. Record review evidenced an		The director of nursing reviewed otherclients' charts likely to be affected. The director of nursing further in-servicedsupporting staff to immediately fax transfers/discharges to the receivingfacility or the health care provider and obtain fax confirmation for recordpurposes. The Director of Nursing will audit the patient'schart every 60 days to ensure all patient transfers/discharges are faxed to thereceiving facility or their physicians to deficiency does not reoccur. 25% of all client's charts will besubsequently audited quarterly to ensure 100% compliance. The director ofnursing is responsible for monitoring this corrective action scheduled to be completedon 01/31/2023. **For patient #5,** the director of nursing immediately reviewedthe patient's discharged papers and identified the patient affected withdeficiency. The director of nursing immediately refaxed discharged summaries tothe	

	undated agency policy obtained 12/14/2022, 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 ... 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 ...." 3. Clinical record review for Patient #5 was completed on 12/14/2022, for certification period 11/9/2022 – 1/7/2023, discharged 12/6/2022. Record review evidenced a discharge summary dated 12/6/2022, which failed to include any post-discharge goals of care or treatment preferences. Record review failed to evidence the discharge summary was sent to the patient's physician upon		patient-physician, and a fax confirmation was obtained for record purposes. Thedirector of nursing reviewed other clients' charts likely to be affected. Thedirector of nursing further in-serviced supporting staff to immediately fax transfers/dischargesto the receiving facility or the health care provider and obtain faxconfirmation for record purposes. The directorof nursing will audit the patient's chart every 60 days to ensure all patient transfers/dischargesare faxed to the receiving facility or their physicians to deficiency does notreoccur. 25% of all client's charts will besubsequently audited quarterly to ensure 100% compliance. The director ofnursing is responsible for monitoring this corrective action scheduled to be completedon 01/31/2023. **For patient #4** the agency is unable to correct thisdeficiency because the client is deceased and was discharged and is no longerbeing serviced. The patient discharge summary was faxed to the healthcareprovider and a fax confirmation was obtained to ensure this	

	discharge. During an interview on 12/14/2022, at 11:47 AM, clinical manager #1 indicated transfer summaries and discharge summaries were sent to the receiving physician via fax or mail. Surveyor requested a fax confirmation that the discharge/transfer summaries had been sent. At 4:00 PM, secretary/care coordinator #10 indicated they did not have the fax confirmations for the transfer or discharge summaries because they threw them away because the patient was no longer an active patient.		deficiency does notreoccur. The director of nursing reviewed otherclients' charts likely to be affected. The director of nursing further in-servicedsupporting staff to immediately fax transfers/discharges to the receivingfacility or the health care provider and obtain fax confirmation for recordpurposes. The director of nursing will audit the patient'schart every 60 days to ensure all patient transfers/discharges are faxed to thereceiving facility or their physicians to deficiency does not reoccur. 25% of all client's charts will besubsequently audited quarterly to ensure 100% compliance. The director ofnursing is responsible for monitoring this corrective action scheduled to be completedon 01/31/2023.	

	4. Clinical record review for Patient #4 was completed on 12/14/2022, for certification period 10/21/2022 – 12/10/2022, transfer date 12/8/2022. Record review evidenced a transfer summary dated 12/8/2022, which failed to include any post-transfer goals of care or treatment preferences. Record review failed to evidence the transfer summary was sent to the receiving hospital upon transfer.			
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	G0570	**G0570** The directorof nursing immediately revised all active patients' plans of care to meet theirindividualized needs and included all pertinent diagnoses, equipment supplies,nutritional requirements, and medications as ordered, and all other missinginformation was included and faxed to the patient's physician for signature.This will ensure a patient-centered plan of care for all active patients and aswell improve the delivery of quality healthcare services to all patients.	2023-01-31

	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 (see tag G572); ensure 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); and provide patients with written instructions outlining treatments to be administered by home health personnel or personnel acting on behalf of		On 12/19/2022, the director of nursingreviewed other patients' chart likely to be affected by this deficiency andensured there was written documentation of care coordination in every patient'schart who are receiving services from other healthcare agencies. The director of nursing will auditevery patient's chart bimonthly ensuring care is 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 will audit 50%client's chart quarterly to ensure proper documentation of care coordinationwith other agencies providing services for the same client are well documented.The director of nursing will be responsible for monitoring this correctiveaction to ensure this deficiency does not recur.	

	the home health agency (see tag G618). 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 all services written in the plan of care, and/or failed to ensure the plans of care were individualized in 5 of 5 active	G0572	**G0572** Agency reviewedits Plan of Care policy and identified affected patients with this deficiencyof an individualized plan of care that includes types of visits, frequency,client's needs, Education, duration of services, and Measurable outcomes/goals. All patients'plan of care likely to be impacted by this deficiency was revised, tailored,and individualized per patient needs, sent to the physician for signature, andlogged in the client's medical charts. All clients'chart was immediately reviewed and will be subsequently audited every 60 daysto ensure that plan of care is individualized, specific, accurate, up-to-date,and signed by a physician. The director ofnursing is responsible for auditing quarterly clients' records and monitoringthis corrective action to ensure 100% compliance and avoid itsreoccurrence.	2023-01-31

	clinical records reviewed. (#1, 2, 3, 4, 6) The findings include: 1. Record review evidenced an undated agency policy obtained 12/14/2022, 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 ...." 2. Clinical record review for Patient #1 was completed on 12/14/2022. Record review evidenced plans of care for certification periods 10/8/2022 – 12/6/2022, and 12/7/2022 – 2/4/2023, which indicated the home health aide was to assist with bathing, dressing, and personal care such as grooming, hair care, shampoo, and oral care, and report any refusal to the director of nursing. The plans of care stated, "... Goals/Rehabilitation Potential/Discharge Plans: ... Able to understand medication regime and care related to diagnoses ... medical condition		**For patient #1,** the agency reviewed its Plan of Carepolicy and identified likely affected patients with this deficiency. Agencyindividualized the affected client's plan of care/485 to include measurablegoals per the client'shealth status and sent it to the physician for signature. The director ofnursing immediately in-serviced aide assigned to care for the client todocument in their notes any hands-on care rendered to the client such asbathing, dressing, oral care, and hair care as outlined to address their individualizedneeds and interventions in their plan of care/485 and to ensure that thisdeficiency does not reoccur. The director of nursing in-serviced supporting staff to ensure allhome health aides are documenting in their aide's notes hands-on care renderedto the client assigned to them to ensure the client receives all servicesaccording to the client's individualized plan of care. 50% of allclients' charts will be audited quarterly by the director of nursing, andfindings of refusal/ noncompliance as outlined in their individualized plan ofcare will be reported to their physician. The director ofnursing will be	

	stabilizes ... when maximum functional potential reached ... discharge at the end of the episode if the patient is hospitalized ...." The plan of care failed to include any individualized goals or discharge plans. Clinical record review evidenced home health aide visit notes dated 12/1/2022, 12/2/2022, 12/3/2022, and 12/6/2022, which all failed to evidence the patient received assistance with showering/bathing, dressing, or other personal care items. During an interview on 12/12/2022, at 12:15 PM, home health aide #9 indicated they occasionally helped Patient #1 with hygiene such as showering or dressing, but mostly helped the patient with laundry and housekeeping. During an interview on 12/14/2022, at 10:26 AM, clinical manager #1 indicated the aide should have been assisting the patient with		corrective action scheduled tobe completed on 01/31/2023 to ensure 100% compliance and avoid itsreoccurrence. **For patient #2,** the agency reviewed its Plan of Carepolicy and identified likely affected patients with this deficiency. Theadministrator immediately instructed the director of nursing to in-service the aideassigned to care for the client on the importance of not splitting the shiftwork assigned per the patient's plan of care. The director of nursingimmediately in-serviced aide assigned to care for the client to document intheir notes any hands-on care rendered to the client such as bathing, dressing,oral care, and hair care as outlined toaddress their individualized needs and interventions in their plan of care/485and to complete the hours assigned every Tuesdays and Thursdays. Home health aidesare instructed to report any split hours of service per client request to theagency which in turn reports it to the physician to ensure that this deficiencydoes not reoccur. The director of nursing in-serviced supporting staff to ensure allhome health aides are documenting in their aide's	

	bathing, dressing, and going to the bathroom. Clinical manager #1 indicated the home health aides should have been performing the tasks included on the plan of care. Clinical manager #1 indicated the plans of care should have been individualized for each patient according to their specific needs at the time of the assessment. Clinical manager #1 did not know why all the plans of care included the same goals. 3. Clinical record review for Patient #2 was completed on 12/14/2022. Record review evidenced a plan of care for certification period 11/14/2022 – 1/12/2023, which indicated the patient was to receive home health aide services home health aide visits 6 hours on Tuesdays and 7 hours on Thursdays, and the home health aides were to assist with bathing, dressing, personal care such as grooming, hair care, and shampoo. The plan of care stated, "… Goals/Rehabilitation Potential/Discharge Plans: … Able to understand medication regime and care related to diagnoses … medical condition		notes the hands-on carerendered to the client assigned to them and completing a shift work assigned toensure the client receives all services according to the client'sindividualized plan of care. 50% of all clients' charts will be audited quarterly by the directorof nursing, and findings of refusal/ noncompliance as outlined in their individualizedplan of care will be reported to their physician. The director of nursing will be responsible for monitoring thiscorrective action scheduled to be completed on 01/31/2023 to ensure 100%compliance and avoid its reoccurrence. **For patient #3** the agency reviewed its Plan of Care policy and identified likelyaffected patients with this deficiency. The administrator immediatelyinstructed the director of nursing to in-service	

	stabilizes ... when maximum functional potential reached ... discharge at the end of the episode if the patient is hospitalized ...." Clinical record review evidenced home health aide visit notes which indicated the patient received 6.5 hours on Thursday, 12/1/2022, 4 hours on Tuesday, 12/6/2022, 3 hours on Thursday, 12/8/2022, and 6 hours on Tuesday 12/13/2022. Record review evidenced home health aide visit notes dated 11/29/2022, and 12/1/2022, which indicated the home health aide failed to assist the patient with bathing, dressing, or any personal care activities. During an interview on 12/13/2022, at 9:05 AM, Patient #2 indicated they required the assistance of the home health aide to shower and dress. During an interview on 12/14/2022, at 10:55 AM, clinical manager #1 indicated		client on the importance of not splitting the shift work assigned perpatient plan of care. The director of nursing immediatelyin-serviced aide assigned to care for the client to document in their notes anyhands-on care rendered to the client such as bathing, dressing, oral care, haircare as outlined to address theirindividualized needs and interventions in their plan of care/485 and to completethe hours assigned every Tuesdays and Thursdays. Home health aide instructed toreport any split hours of service per client request to the agency who in turnreport it to the physician to ensure that this deficiency does not reoccur. The directorof nursing in-serviced supporting staff to ensure all home health aide aredocumenting in their aide's notes hands-on care rendered to the client assignedto them and completing a shift work assigned to ensure the client receives allservices according to the client's individualized plan of care. 50% ofall clients' charts will be	

	ordered hours because of appointments. Clinical manager #1 indicated the patient should have been receiving 13 hours of home health aide services per week as ordered on the plan of care. At 11:19 AM, clinical manager #1 declined to answer when queried why the home health aide was not completing bathing or personal care activities with Patient #2. 4. Observation of a home visit for Patient #3 was conducted on 12/14/2022, at 1:15 PM, to observe a routine home health aide visit. During the visit, the aide was observed assisting the patient to the shower. The patient indicated they needed the assistance of the home health aide to shower. Clinical record review for Patient #3 was completed on 12/14/2022. Record review evidenced a plan of care for certification period 11/22/2022 – 1/20/2023, which indicated the patient was to receive home health aide visits 5 hours per day, 5 days per week. The plan		audited quarterly by the director of nursing, andfindings of refusal/ noncompliance as outlined in their individualized plan ofcare will be reported to their physician. The directorof nursing will be responsible for monitoring this corrective action scheduledto be completed on 01/31/2023 to ensure 100% compliance and avoid itsreoccurrence. **For patient #4**, the agencyreviewed its “Plan of Care” policy and identified likely affected patients withthis deficiency. Agency individualized the affected patient’s plan of care toinclude the patient medical condition, functional limitations, measurable goalsand outcomes, and discharge plans and faxed it to the physician for signature.	

	health aide was to assist the patient with bathing, dressing, and personal care. The plan of care stated, "… Goals/Rehabilitation Potential/Discharge Plans: … Able to understand medication regime and care related to diagnoses … medical condition stabilizes … when maximum functional potential reached … discharge at the end of the episode if the patient is hospitalized …." Clinical record review evidenced home health aide visit notes dated 11/30/2022, 12/1/2022, and 12/2/2022, which all failed to evidence the home health aide assisted the patient with bathing, dressing, or personal care as ordered on the plan of care. Review evidenced missed home health aide visit notes for dates 11/28/2022 and 11/29/2022. Review of the home health aide visit notes indicated the patient did not receive a bath or shower the week of 11/27/2022. Record review evidenced home health aide visit notes which indicated the patient received 4 hours of home health aide services on		Agency audited otherclients' charts likely to be affected and 60-day recertification has beenoutlined to address affected patients' individualized needs and interventionsin their plan of care/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% ofall clients' 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 #6**, the agencyreviewed its "Plan of Care" policy and identified likely affected patients withthis deficiency. Agency individualized the affected patient's plan of care toinclude	

	11/30/2022, 6 hours on 12/1/2022, 3 hours on 12/2/2022, 4 hours on 12/5/2022, 12/6/2022, 12/7/2022, and 12/10/2022. Review failed to evidence the patient received 5 hours of home health aide services 5 days per week as ordered on the plan of care. During an interview on 12/14/2022, at 3:05 PM, clinical manager #1 indicated the patients should have received the number of hours which were ordered on the plan of care. 4. Clinical record review for Patient #4 was completed on 12/14/2022. Record review evidenced plans of care for certification period 10/12/2022 – 12/10/2022, and 12/11/2022 – 2/8/2023, which failed to be individualized. These plans of care stated, "… Goals/Rehabilitation Potential/Discharge Plans: … Able to understand medication regime and care related to diagnoses … medical condition stabilizes … when maximum		functional limitations, measurable goalsand outcomes, and discharge plans and faxed it to the physician for signature. Agency audited otherclients' charts likely to be affected and 60-day recertification has beenoutlined to address affected patients' individualized needs and interventionsin their plan of care/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% ofall clients' 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.	

	functional potential reached … discharge at the end of the episode if the patient is hospitalized ….” 5. Clinical record review for Patient #6 was completed on 12/14/2022. Record review evidenced a plan of care for certification period 12/9/2022 – 2/6/2022, which failed to be individualized. The plan of care stated, “… Goals/Rehabilitation Potential/Discharge Plans: … Able to understand medication regime and care related to diagnoses … medical condition stabilizes … when maximum functional potential reached … discharge at the end of the episode if the patient is hospitalized ….” 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses;	G0574	**G0574** Agencyreviewed its Plan of care policy, to ensure an individualized plan of care/485that includes all	2023-01-31

	(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 pertinent diagnoses, the types of supplies and equipment required, all medications and treatments, patient-specific education, and/or a description of the patient's risk for emergency department		pertinent diagnoses, types of supplies, medications andtreatments, patient-specific education, the risk for emergency visit/hospitalreadmission, and other necessary interventions were identified and included inthe affected client's plan of care. Allpatients' plan of care likely to be impacted by this deficiency was revised,tailored, and individualized per patient needs, sent to the physician forsignature, and logged in the client's medical charts. Allclients' chart was immediately reviewed and will be subsequently auditedbimonthly. On 12/19/2022, the administrator in-serviced the director of nursingand support staff to ensure that plan of care is individualized, specific,accurate, up-to-date, and signed by the physician. All the client'srecords will be audited quarterly by the director of nursing, and findingsreported to the	

	visits/hospital re-admission and all necessary interventions to address the underlying risk factors in 5 of 5 active clinical records reviewed. (#1, 2, 3, 4, 6) The findings include: 1. Record review evidenced an undated agency policy obtained 12/14/2022, titled "Plan of Treatment" which stated, "... The Plan of Care shall be completed in full to include: ... All pertinent diagnoses[es], principle and secondary ... Medications ... Medical supplies and equipment required ... Instructions to client/caregiver ...." 2. Observation of a home visit was conducted on 12/12/2022, at 12:00 PM, to observe a routine home health aide visit. During the visit, the patient was observed to be alert and oriented with visible tremors to arms and hands. The patient's medication bottles were observed, and included Tylenol (for pain), ibuprofen (for pain), propranolol (to decrease tremors caused by multiple		for monitoring thiscorrective action to ensure 100% compliance and avoid its reoccurrence. **For patient # 1,** the director of nursingrevised the patient's plan of care to include the patient's education, the riskfor hospitalization, diagnoses of arthritis and multiple sclerosis, and an anklebrace for ambulation. This was documented and sent to the patient's physicianfor signature. Theagency audited all client's medical records to ensure that clients likely to beimpacted by this deficiency are corrected. The plan of care will be documentedand logged in the client's medical charts. Theadministrator has in-serviced the director of nursing and support staff toensure that plan of care is individualized, accurate, complete, up to date, andsigned by the physician. 50% ofthe client's records will be audited quarterly by the director of nursing thatis	

	sclerosis), and primidone (to decrease tremors related to multiple sclerosis). Clinical record review for Patient #1 was completed on 12/14/2022. Record review evidenced a plan of care for certification period 12/7/2022 – 2/4/2023, which failed to include any patient education, and failed to address the patient's risk for hospitalization. The plan of care failed to include patient's diagnoses of arthritis and multiple sclerosis (disease which causes nerve damage and disrupts communication between the brain and the body). Clinical record review evidenced a recertification assessment dated 12/2/2022, which included the following risks for hospitalization: history of falls, unintentional weight loss of 10 pounds or more, currently reports exhaustion, and currently taking 5 or more medications. The recertification assessment indicated the patient required an ankle brace for ambulation, which was not		corrective action to ensure 100% complianceand avoid its reoccurrence **For patient #2,** the director of nursingidentified the client affected with this deficiency and revised the patient'splan of care to include the patient's risk for hospitalization and patienteducation. This was documented and sent to the patient's physician forsignature. Theagency audited all client's medical records to ensure that clients likely to beimpacted by this deficiency are corrected. The plan of care will be documentedand logged in the client's medical charts. Theadministrator has in-serviced the director of nursing and support staff toensure that plan of care is individualized, accurate, complete, up to date, andsigned by the physician. 50% ofthe client's records will be audited quarterly by the director of nursing thatis responsible for monitoring this corrective action to ensure 100% complianceand avoid its reoccurrence	

	included in the plan of care. During an interview on 12/12/2022, at 12:20 PM, Patient #1 indicated they had diagnoses of arthritis and multiple sclerosis. During an interview on 12/14/2022, at 10:22 AM, clinical manager #1 indicated they did not include interventions to address patients' risk for hospitalization on the plans of care because they discussed it verbally during assessments. Clinical manager #1 indicated education was not included in plans of care, but verbally discussed with patients during assessments. At 10:27 AM, clinical manager #1 indicated the plans of care should have included whatever equipment the patient had in their homes. At 10:40 AM, clinical manager #1 indicated Patient #1 did not have multiple sclerosis or arthritis, because they would have been taking medication for those diagnoses.		**For patient #3**, the agency reviewed its policy on theplan of care, identified the client affected with this deficiency, and revisedthe client's plan of care to specifically include 2 liters of oxygen via nasal cannula,shower chair, and appropriate medications prescribed, the risk for hospitalization,patient education and sent to the physician for signature and documented in theclient 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 theclient likely to be impacted by this deficiency is corrected and logged in theclient's medical charts. The director of nursing will subsequently audit other clients' chartsevery 60 days and during recertification of care ensuring their individualized plansof care are up-to-date tailoring only what is appropriate to the client's needsduring assessments/ recertification and admission and signed by the physician. The Agency's 25% of the client's medical records will be auditedquarterly to ensure 100% compliance. The director of nursing will be monitoringthis process ensuring that this deficiency will not recur. **For patient #4,** the agency reviewed its policy on the plan ofcare, identified the client affected with this deficiency and	

	3. Clinical record review for Patient #2 was completed on 12/14/2022. Record review evidenced a plan of care for certification period 11/14/2022 – 1/12/2023, which failed to include any patient education, and failed to address the patient's risk for hospitalization. Clinical record review evidenced a start of care assessment dated 11/14/2022, which included the following risks for hospitalization: multiple hospitalizations, multiple emergency department visits, currently taking 5 or more medications, and currently reports exhaustion. 4. Observation of a home visit for Patient #3 was conducted on 12/14/2022, at 1:15 PM, to observe a routine home health aide visit. During the visit, the patient was observed wearing 2 liters of oxygen via a nasal cannula. The patient had a shower chair which was not included in the plan of care. The following medications the patient was taking were observed, and not included in		revised theclient's plan of care to specifically include patient education, risk forhospitalization, and sent to the physician for signature and documented in theclient 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 will subsequently audit other clients' chart every 60 days andduring recertification of care ensuring their individualized plan of care areup-to-date tailoring only what is appropriate to the client's needs duringassessments/ recertification and signed by the physician. TheAgency's 50% of the client's medical records will be audited quarterly toensure 100% compliance. The Director of Nursing will be monitoring this processensuring that this deficiency will not recur.	

	the plan of care: aspirin (to prevent stroke and heart attack), and rosuvastatin (to lower cholesterol). Clinical record review for Patient #3 was completed on 12/14/2022. Record review evidenced a plan of care for certification period 11/22/2022 – 1/20/2023, which failed to include any patient education, and failed to address the patient's risk for hospitalization. The plan of care failed to include oxygen orders or equipment. Clinical record review evidenced a recertification assessment dated 11/17/2022, which included the following risks for hospitalization: multiple hospitalizations, multiple emergency department visits, decline in mental, emotional, or behavioral status, currently taking 5 or more medications, and currently reports exhaustion. During an interview on		**For patient #6,** the agency reviewed its policy on the plan ofcare, identified the client affected with this deficiency, and revised theclient's plan of care to specifically include patient education, the risk forhospitalization, and sent it to the physician for signature and documented inthe 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 will subsequently audit other clients' charts every 60 days andduring recertification of care ensuring their individualized plan of care isup-to-date tailoring only what is appropriate to the client's needs duringassessments/ recertification and signed by the physician. TheAgency's 50% of the client's medical records will be audited quarterly toensure 100%	

	12/14/2022, at 10:39 AM, clinical manager #1 indicated the plan of care should have included all medications the patient was taking. 5. Clinical record review for Patient #4 was completed on 12/14/2022. Record review evidenced plans of care for certification periods 10/12/2022 – 12/10/2022, and 12/11/2022 – 2/8/2023, which failed to include any patient education, and failed to address the patient's risk for hospitalization. Clinical record review evidenced a recertification assessment dated 12/6/2022, which included the following risks for hospitalization: history of falls, unintentional weight loss of 10 pounds or more, multiple emergency department visits, reported or observed difficulty complying with medical instructions, and currently taking 5 or more medications. 6. Clinical record review for		compliance. The director of nursing will be monitoring this processensuring that this deficiency will not recur.	

	12/14/2022. Record review evidenced a plan of care for certification period 12/9/2022 – 2/6/2023, which failed to include any patient education, and failed to address the patient's risk for hospitalization. Clinical record review evidenced a recertification assessment dated 12/5/2022, which included the following risks for hospitalization: history of falls, unintentional weight loss, multiple hospitalizations, reported or observed history of difficulty complying with medical instructions, currently taking 5 or more medications, and currently reports exhaustion. 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, ix, xiii)			
G0580	Only as ordered by a physician 484.60(b)(1)	G0580	**G0580** The director of nursing immediatelyreviewed the	2023-01-31

	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 treatments were administered only as ordered by a physician in 1 of 3 home visits conducted. (#2) The findings include: Record review evidenced an undated agency policy obtained 12/14/2022, titled "Physician Orders" which stated, "... All medications, treatments, and services provided to clients must be ordered by a physician ...." Clinical record review for Patient #2 was completed on 12/14/2022. Record review evidenced a plan of care for certification period 11/14/2022 – 1/12/2023, which failed to include any orders for compression wrap removal. During an interview on		clients' charts and identified patient #2 affected with thisdeficiency and updated the client's plan of care/485 to reflect the patient'suse of compression wraps at the lymphedema clinic and faxed it to the physicianfor signature. The director of nursing immediatelyin-serviced the aide assigned to care for the client to only perform serviceswithin her scope of practice and with the patient's physician's order. Thedirector of nursing further in-serviced all aides to care for their assignedclients according to their plan of care signed by the physician and not toperform services outside their scope of practice and without the physician'sorder. Agency will audit all client's chartsevery 60 days of recertification ensuring other clients likely to be affected bythis deficiency are corrected in a timely manner. Agency supporting staff willremind aides from time to time to perform duties within their scope of practiceand according to the client's plan of care. TheAgency's 50% of the client's	

	12/13/2022, at 12:05 PM, Patient #2 indicated the home health aide would remove their compression wraps. Patient #2 indicated they went to the lymphedema clinic weekly to have legs wrapped. During an interview on 12/14/2022, at 11:13 AM, clinical manager #1 indicated they didn't know the home health aide was removing the compression wraps. Clinical manager #1 indicated they thought a family member was removing the compression wraps. 410 IAC 17-13-1(a)		medical records will be audited quarterly toensure 100% compliance. The nursing director will monitor this process toensure that this deficiency will not recur.	
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 ensure the plans of care were reviewed and revised in 2 of 5 active clinical	G0586	**G0586** Theagency is unable to correct this deficiency of patient #1 because the patientaffected with this deficiency is deceased, discharged, and has no servicesrendered. The agency reviewed other clients' chartslikely to be impacted with deficiency and corrected their scheduled hours intheir plan of care and faxed them to their physician for signature. Thedirector of nursing further in-serviced	2023-01-31

	records reviewed. (#1, 6) The findings include: 1. Record review evidenced an undated agency policy obtained 12/14/2022, titled "Coordination of Client Services" which stated, "... Each staff Registered Nurse shall meet with the Nursing Supervisor/Team Leader weekly or as necessary to review all areas of client needs, including: ... The physician's Plan of Care ... 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 ..." 2. Clinical record review for Patient #1 was completed on 12/14/2022. Record review evidenced plans of care for certification periods 10/8/2022 – 12/6/2022, and 12/7/2022 – 2/4/2023, which indicated the		supporting staff on the importance of schedulingaides according to clients' approve hours signed by their physician. The director ofnursing will audit all client's charts bimonthly ensuring their scheduled hoursare reflected according to their signed plan of care. The Agency's 50%of the client's medical records will be audited quarterly to ensure 100%compliance. The director of nursing will be monitoring this process scheduledto be completed on 01/31/2023 ensuring that this deficiency will not recur. **For record review of patient #6,** Thedirector of nursing immediately reviewed the client chart affected by thisdeficiency and revised the client's plan of care/485 to reflect the patient's numberof visits and hours the client was receiving and faxed it to the physician forsignature. Theagency reviewed other clients' charts likely to be impacted with deficiency andcorrected their scheduled hours in their plan of care and faxed to theirphysician for signature. The director of nursing further in-serviced supportingstaff on the	

	patient was to receive home health aide visits 3 hours per day, 3 days per week, or 9 hours per week. Clinical record review evidenced home health aide visit notes which indicated the patient received 4 home health aide visits or 15 hours from 11/30/2022 – 12/3/2022, and 3 visits and 18 hours for the week of 12/4/2022. Record review failed to evidence the plan of care was revised to reflect the number of visits and hours per week the patient was receiving. During an interview on 12/14/2022, at 10:12 AM, clinical manager #1 indicated the patient was receiving visits 5 days per week. Clinical manager #1 indicated plans of care were only revised every 60 days, during recertification assessments. 3. Clinical record review for Patient #6 was completed on 12/14/2022. Record review		importance of scheduling aides according to clients' approve hourssigned by their physician. Thedirector of nursing will audit all client's charts bimonthly ensuring theirscheduled hours are reflected according to their signed plan of care. TheAgency's 50% of the client's medical records will be audited quarterly toensure 100% compliance. The director of nursing will be monitoring this processscheduled to be completed on 01/31/2023 ensuring that this deficiency will notrecur.	

	certification period 10/10/2022 – 12/8/2022, which indicated the patient was to receive home health aide visits 4 hours per day 5 days per week, or 20 hours per week. Clinical record review evidenced home health aide visit notes which indicated the weeks of 11/27/2022, and 12/4/2022, the patient received home health aide visits only 4 days per week, for a total of 31 hours each week instead of the 20 hours as ordered on the plan of care. Record review failed to evidence the plan of care was revised to reflect the number of visits and hours per week the patient was receiving. During an interview on 12/14/2022, at 11:52 AM, clinical manager #1 indicated the patients hours were increased to 30 hours per week in October 2022. Clinical manager #1 indicated the plan of care should have been revised.			

G0590	Promptly alert relevant physician of changes 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 observation, record review, and interview, the home health agency failed to promptly alert the relevant physician of changes in the patient's condition or needs which suggested the plan of care should have been altered or the outcomes were not being achieved in 1 of 5 active clinical records reviewed. (#2) The findings include: Record review evidenced an undated agency policy obtained 12/14/2022, titled "Plan of Treatment" which stated, "... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ...." Observation of a home visit for	G0590	**G0590** **For patient #2**, the director of nursing called the client's physician's officeand alerted them the patient is taking Norco every 4 hours instead of every 8hours as ordered by her physician. The director of nursing further faxed acommunication note to the physician's office and obtained a fax confirmationfor record purposes. Thedirector of nursing audited other clients' medication profiles on painmedication ensuring that clients likely to be impacted by this deficiency arecorrected and logged in the client's medical charts. The directorof nursing will subsequently audit other clients' charts every 60 days andduring recertification of care to ensure clients are taking their medication asordered. Findings will be alerted to their physician and documented in theircharts. TheAgency's 50% of the client's medical records will be audited quarterly toensure 100% compliance. The director of	2023-01-31

	12/13/2022, at 9:00 AM, to observe a routine home health aide visit. During the visit, the patient's medication list was reviewed. Review evidenced an order for Norco (pain medication) every 8 hours. During the visit, the patient indicated they took Norco every 4 hours for pain. Clinical record review for Patient #2 was completed on 12/14/2022, for certification period 11/14/2022 – 1/12/2022. Record review failed to evidence the physician was notified the patient was not taking pain medication as ordered. During an interview on 12/14/2022, at 11:10 AM, clinical manager #1 indicated the patient should have been taking Norco every 8 hours or three times per day. Clinical manager #1 indicated the physician was aware the patient was taking the pain medication more frequently than ordered, and that was why the patient had a prescription for Narcan (medication to reverse opioid		nursing will be monitoring this processscheduled to be completed on 01/31/2023 ensuring that this deficiency will notrecur.	

	overdose). Clinical manager #1 did not answer when asked if this physician communication was documented. 410 IAC 17-13-1(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 and interview, the home health agency failed to ensure patients received a written visit schedule in 1 of 3 home visits conducted. (#3) The findings include: Observation of a home visit for Patient #3 was conducted on 12/14/2022, at 1:15 PM, to observe a routine home health aide visit. During the visit, a home folder was reviewed, which failed to include a written visit schedule.	G0614	**G0614** **For patient #3**, the agency identified the client affectedwith this deficiency, and an individualized Home Health Aide visit schedule wasreprinted and placed in the patient's home folder. The agency encouraged the clientto keep the individualized schedule in her home folder after looking at it asshe desired. On 12/20/2022, the director of nursinginstructed the administrative assistant to print all active patients' schedulesand make them available to the patients. Their respective Home Health Aidespicked them up from the office and placed them in their patient's home folders.This was verbally communicated with the patients and confirmed. The Administrative Assistant	2023-01-31

	During an interview on 12/14/2022, at 10:43 AM, clinical manager #1 indicated the patients should have received a schedule, but the agency primarily verbally discussed when the staff was coming with the patients.		willreach out to all active clients weekly to constantly remind them of their visitschedules. This will be documented. The Administrative Assistant will be responsiblefor monitoring this corrective action to prevent it from recurring.	
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 and interview, the home health agency failed to ensure patients received written medication schedules which included the medication name, dosage, and frequency in 3 of 3 home visits conducted. (#1, 2, 3) The findings include: 1. Observation of a home visit for Patient #1 was conducted on 12/12/2022, at 12:00 PM, to	G0616	**G0616** **For patient #1**, the agencyidentified the patient with this deficiency and updated the medication profileto include the medications, frequency, and route of administration not listedin the written medication profile, printed and placed in the patient's homefolder. The agency will ensure that thisis done each time there is a change to the patient's medication profile. **For patient #2**, the agency identified the patient with thisdeficiency and updated the medication profile to include the medications,frequency, and route of administration not listed in the written medicationprofile, printed and placed in the patient's home folder. The agency will ensure that this is done eachtime there is a change to the patient's medication profile. **For Patient #3**, the agency identified the patient with	2023-01-31

	aide visit. During the visit, a written medication list was observed in the patient's home folder and was dated 12/10/2022. Observation evidenced the following medications the patient was taking, which were not included on the patient's written medication list: propranolol (to lower heart rate and blood pressure), ibuprofen (for pain/fever), Tylenol (for pain/fever), and Imodium (for diarrhea). The medication list failed to include a frequency for vitamin E, vitamin C, and vitamin B12. During an interview on 12/12/2022, at 10:39 AM, clinical manager #1 indicated the patients received a copy of their medication list which was completed at recertification assessments. Clinical manager #1 indicated the medication list should have included all medications the patients were taking. Clinical manager #1 indicated all medications should have included a frequency of administration.		thisdeficiency and updated the medication profile to include the medications,frequency, and route of administration not listed in the written medicationprofile, printed and placed in the patient's home folder. The agency will ensure that this is done eachtime there is a change to the patient's medication profile. The director of nursing reviewed otherclients' charts likely to be affected by this deficiency and updated all activepatients' medication profiles. The medication profile was printed and put intheir individual home folders. 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 #2 was conducted on 12/13/2022, at 9:00 AM, to observe a routine home health aide visit. During the visit, a medication list was reviewed, which indicated the patient was to take Narcan (medication to treat opioid overdose) 4 milligrams daily but failed to include a route. The medication list indicated the patient was to use aspercreme (pain cream) but failed to indicate where it was to be applied. During an interview on 12/14/2022, at 11:20 AM, clinical manager #1 indicated the written medication list should not have indicated Narcan was to be taken daily and indicated complete medication instructions should have included route and location for topical medication to be applied. 3. Observation of a home visit for Patient #3 was conducted on 12/14/2022, at 1:15 PM, to observe a routine home health aide visit. During the visit, the patient's home folder was			

	reviewed, which contained a medication list. The medication list included an order for Tylenol as needed for pain but failed to include a frequency. The following medications were observed, which were not included in the patient's written medication list: aspirin (to prevent stroke and heart attack) and rosuvastatin (to lower cholesterol). During an interview on 12/14/2022, at 10:29 AM, clinical manager #1 indicated the written medication list should have included all medications the patient was taking. At 3:00 PM, clinical manager #1 indicated the medication list should have included the frequency of administration for Tylenol.			
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation and interview, the home health	G0618	**G0618** Thedirector of nursing immediately reviewed all client's chart and identified theaffected client with this deficiency. The current plan of care was reprintedand put in patient's her home folder. Client was	2023-01-31

	agency failed to ensure the patients were provided with written treatment instructions in 1 of 3 home visits conducted. (#3) The findings include: Observation of a home visit for Patient #3 was conducted on 12/14/2022, at 1:15 PM, to observe a routine home health aide visit. During the visit, a home health folder was reviewed, which contained a plan of care for certification period 9/23/2022 – 11/21/2022. The home folder failed to include a current plan of care. During an interview on 12/14/2022, at 3:01 PM, clinical manager #1 indicated the patient should have had a current plan of care in their home health folder.		encouraged to allow thecurrent plan of care to stay in her home fold after she looked at it as much asshe desired. On 12/22/2022, the director of nursingcalled all active patients ensuring that their current plan of care is in theirhome folders. Agency reprinted currentplan of care and made them available to some of the active patients asrequested. Their respective Home Health Aides picked them up from the officeand placed 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 bimonthly to ensure current plan of care is in their homefolders. The directorof nursing in-serviced supporting staff on the importance of having currentplan of care of all active patients in their respective home folders. The director of nursing will quarterlymonitor all patient's home folders to ensure that they all include theindividualized plan of care that outlines the services to be	

			rendered by theirrespective caregivers. The director of nursing will be responsible formonitoring this corrective action scheduled to prevent this deficiency fromrecurring.	
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 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	G0640	**G0640** The administrator and director of nursingUpdated the Quality Assurance and Performance Improvement (QAPI) Program andincluded measurable indicators, preventative measures, patient safety, improvementof patient health outcomes that minimizes hospitalization frequency. The director of nursing reviewed allclients' medical records and in-serviced all support staff to explain topatients the importance and purpose of the questionnaires or agency calls tothem based on the quality of services they are receiving. Information collectedwill be used for the Quality Assurance Performance Improvement program everyquarter. The indicators tracking documentation will be used as an objectivemeasure for the evaluation of agency quality	2023-01-31

	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 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).		of care. Agency will call/visit/send out questionnairesto patient to enquire about the quality of services received. When datacollected is significant, the agency will analyze it, and percentage data willbe used to determine measurable outcome and area of improvement of patienthealth outcome and reduction of hospitalization. When data collection does notoffer meaningful information, director of nursing will track, monitor, anddocument any identified indicators to determine improvement or not. All data analysis of the survey ofQuality Assurance and Performance Improvement (QAPI) will be reviewed semiannuallyto see how agency QAPI program can be improved, and to ensure 100% compliance.The Administrator is responsible for monitoring this corrective action toensure that this deficiency is corrected and will not recur.	

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 measure, track, and analyze quality indicators, including adverse patient events, and failed demonstrate measurable improvement in quality indicators which would improve health outcomes, patient safety, and quality of care. The findings include: Record review evidenced an undated agency policy obtained 12/14/2022, titled "Quality Assurance/Performance Improvement" which stated, "…	G0642	**G0642** The administrator and director of nursingUpdated the Quality Assurance and Performance Improvement (QAPI) Program andincluded measurable indicators, preventative measures, patient safety, and improvementof patient health outcomes that minimize hospitalization frequency. The director of nursing reviewed allclients' medical records and in-serviced supporting staff to explain topatients the importance and purpose of the questionnaires or agency calls tothem based on the quality of services they are receiving. Information collectedwill be used for the Quality Assurance Performance Improvement program every quarter.The indicators tracking documentation will be used as an objective measure forthe evaluation of agency quality of care. Agency will call/visit/send outquestionnaires to patients to enquire about the quality of services received.When the data collected is significant, the agency will analyze it,	2023-01-31

	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 ….” Record review on 12/9/2022, evidenced a hospitalization log which indicated the agency had 6 patient hospitalizations in the past 3 months. On 12/9/2022, the census was 11 patients, and 4 out of 11 active patients (36%) had been hospitalized within the past 3 months. The hospitalization log indicated 1 patient had been hospitalized due to a urinary tract infection, and 1 patient had been hospitalized due to a fall. Record review on 12/9/2022, evidenced a fall log and infection log, which were blank. Review of the agency’s QAPI (quality assurance and performance improvement) program on 12/13/2022,		andpercentage data will be used to determine the measurable outcome, preventativemeasures, areas of improvement of patient health outcome, and reduction ofhospitalization frequency. When data collection does not offer meaningfulinformation, the director of nursing will track, monitor, and document anyidentified indicators to determine improvement or not. All data analysis of the survey ofQuality Assurance and Performance Improvement (QAPI) will be reviewed semiannuallyto see how agency QAPI program can be improved, and to ensure 100% compliance.The Administrator is responsible for monitoring this corrective action toensure that this deficiency is corrected and will not recur.	

	indicated the agency would increase the number of long-term clients with vaccination against influenza and pneumonia from 61% to 90% by December 2023. Review of the QAPI program failed to evidence any vaccination tracking or analysis. The QAPI program failed to evidence measurable improvement in vaccination rates. Review of the QAPI program failed to evidence any analysis or measurable improvement in hospitalization rates. During an interview on 12/13/2022, at 2:48 PM, administrator #2 indicated the agency was tracking wounds and falls for the QAPI program, but since there were no patients who had wounds or falls, there was no data to track or analyze for QAPI. 410 IAC 17-12-2(a)			
G0644	Program data 484.65(b)(1),(2),(3)	G0644	**G0644** The administrator and director of nursingUpdated the Quality	2023-01-31

	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 utilize quality indicator data and other relevant data in the QAPI program to monitor the safety and effectiveness of services and identify opportunities for improvement. The findings include: Record review evinced an undated agency policy obtained 12/13/2022, titled "Quality Assurance/Performance Improvement" which stated, "... Data will be collected to allow the agency to monitor its performance ... Data that may		Assurance and Performance Improvement (QAPI) Program andincluded measurable indicators of patients with vaccinations high-rate datacollection, preventative measures, patient safety, and improvement of patienthealth outcomes that minimize hospitalization frequency. The director of nursing reviewed allpatient's clinical records and in-serviced supporting staff to explain topatients the importance and purpose of the questionnaires or agency calls tothem based on the quality of services they are receiving. Information collectedwill be used for the Quality Assurance Performance Improvement program everyquarter. The indicators tracking documentation will be used as an objectivemeasure for the evaluation of agency quality of care. Agency will call/visit/send out questionnairesto patients to enquire about the quality of services received. When the datacollected is significant, the agency will analyze it, and percentage data willbe used to determine the measurable	

	include the following: … Utilization of services … Outcomes of processes or services … Infection control surveillance and reporting … Data will be assessed to: … Identify current level of performance … identify areas to be improved … Identify strategies to stabilize or improve processes … Evaluate whether outcomes were achieved ….” Record review on 12/9/2022, evidenced a hospitalization log, which indicated the agency had 6 hospitalizations in the last 3 months. The agency’s current census was 11, and 4 of 11 active patients had hospitalizations (36%). Review of the agency’s QAPI program on 9/13/2022, indicated the agency would increase the number of long-term clients with vaccination against flu and pneumonia from 61% to 90% by December 2023. The QAPI program failed to evidence any data was collected regarding		outcome, preventative measures, areas ofimprovement of patient health outcome, and reduction of hospitalizationfrequency. When data collection does not offer meaningful information, the directorof nursing will track, monitor, and document any identified indicators todetermine improvement or not. All data analysis of the survey ofQuality Assurance and Performance Improvement (QAPI) will be reviewed semiannuallyto see how the agency’s QAPI program can be improved and to ensure 100%compliance. The Administrator is responsible for monitoring this correctiveaction to ensure that this deficiency is corrected and will not recur.	

	program failed to include any data collected regarding hospitalizations. The QAPI program failed to identify opportunities to improve the hospitalization rates. During an interview on 12/13/2022, at 2:53 PM, administrator #2 indicated the agency did not use data, because there was no data available to utilize. Clinical manager #1 indicated the hospitalization rates were just added to the hospitalization log. Clinical manager #1 indicated there was no action that could be taken to improve the hospitalization rates since the patients had co-morbidities and were declining. 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	G0650	**G0650** Agency is unable to correct thisdeficiency secondary to the patient never receiving home health aide servicesdue to reimbursement issues. The patient was discharged while	2023-01-31

	interview, the home health agency failed to ensure the QAPI program activities considered incidence, prevalence, and severity of problems in the high-risk, problem-prone, and high-volume areas. The findings include: Record review evidenced an undated agency policy obtained 12/13/2022, titled "Quality Assurance/Performance Improvement" which stated, "... Data will be collected will be prioritized based on the organization's mission, services provided, and population served ... The activities will meet the needs of clients, staff, and others, and will unite new and existing improvement activities into a system wide approach ...." Record review on 12/9/2022, evidenced a hospitalization log which indicated the agency had 6 hospitalizations in the last 3 months, and 4 out of 11 current active patients (36%) had been hospitalized within the last 3		admitted to thehospital with a fall episode. The administrator and director of nursing Updatedthe Quality Assurance and Performance Improvement (QAPI) Program and includedmeasurable indicators of patients with vaccinations high-rate data collection,Falls, infections and preventative measures, patient safety, and improvement ofpatient health outcomes that minimize hospitalization frequency. The Administratorimmediately in-serviced the director of nursing on the importance of documentingall incidents and patients' conditions in the infection and fall to their respectivelog sheets. All patients' chats were reviewed andall missing incidents not logged were documented and logged in the proper logsheet, this was completed on 12/22/2022. The director of nursing in-serviced supportstaff on the need of reporting any incident immediately after they happen. The director of nursing will auditevery active patient's chart quarterly to monitor every	

	indicated 1 patient was hospitalized due to a urinary tract infection, and 1 patient was hospitalized due to a fall. Record review on 12/9/2022, evidenced a blank fall log and infection log. Review on 12/13/2022, of the agency's QAPI program indicated the agency would take into consideration the importance of issues which were high-risk, problem prone, and/or high frequency, and decide which problems would become the focus of the performance improvement activities. The QAPI program included a goal of increasing flu and pneumonia vaccination rates, but failed to address the hospitalizations, infections or falls. During an interview on 12/13/2022, at 2:55 PM, administrator #2 indicated they did not know why the QAPI program did not take into consideration the hospitalizations, falls, or infection rates. Administrator #1 indicated the census was too		incident report. Thiswill ensure 100% compliance. The director of nursing will be responsible formonitoring this corrective action to avoid the recurrence of this deficiency.	

	small to collect meaningful data.			
G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview, the 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 12/14/2022, 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,	G0654	**G0654** Agency is unable to correct thisdeficiency secondary to the patient never receiving home health aide servicesdue to reimbursement issues. The patient was discharged while admitted to thehospital with a fall episode. The administrator and director of nursing Updatedthe Quality Assurance and Performance Improvement (QAPI) Program and includedmeasurable indicators of patients with vaccinations high-rate data collection,Falls, infections and preventative measures, patient safety, and improvement ofpatient health outcomes that minimize hospitalization frequency. The Administrator immediately in-serviced the director of nursing on theimportance of documenting all incidents and patients' conditions in theinfection and fall to their respective log sheets. All patients' chats were reviewed andall missing	2023-01-31

	problems in client care services and satisfaction to insure resolution and/or improvement ….” Record review on 12/9/2022, evidenced a hospitalization log which indicated the agency had 6 hospitalizations within the past 3 months, and 4 out of 11 active patients (36%) were hospitalized within the last 3 months. The hospitalization log indicated 1 patient was hospitalized for a urinary tract infection, and 1 patient was hospitalized for a fall. Record review on 12/9/2022, evidenced a blank fall log and infection log. Review on 12/13/2022, of the agency’s QAPI program failed to evidence falls, infections, or hospitalizations were analyzed for causes and failed to evidence any preventative action was implemented to improve hospitalizations, falls, or infections. During an interview on		incidents not logged were documented and logged in the proper logsheet, this was completed on 12/22/2022. The director of nursing in-serviced supportstaff on the need of reporting any incident immediately after they happen. The director of nursing will auditevery active patient’s chart quarterly to monitor every incident report. Thiswill ensure 100% compliance. The director of nursing will be responsible formonitoring this corrective action scheduled to be completed on 01/31/2023 toavoid the recurrence of this deficiency.	

	12/13/2022, at 2:56 PM, administrator #2 indicated the performance improvement project was focused on falls and wounds but indicated there had been no patients with falls or wounds, thus no performance improvement activities had been implemented. Administrator #2 did not know why the fall log did not contain the fall which led to hospitalization. 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.	G0658	**G0658** The administrator and director of nursingUpdated the Quality Assurance and Performance Improvement (QAPI) Program andincluded measurable indicators of patients with vaccinations high-rate datacollection, Falls, infections and preventative measures, patient safety, and improvementof patient health outcomes that minimize hospitalization frequency. The administratorhas outlined a performance improvement project every 6 months and	2023-01-31

	Based on record review and interview, the home health agency failed to conduct performance improvement projects which reflected the scope, complexity, and past performance of the agency's services and operations, and the agency failed to document the performance improvement projects undertaken, and measurable progress achieved on these projects. The findings include: Record review on 12/13/2022, evidenced an undated document titled "QAPI program" which stated, "... The QAPI team will determine which problems will become the focus for a performance improvement project ... Depending on the performance improvement project to be started, the QAPI team will charter a performance improvement project team who is entrusted with a mission to look into a problem area and come up with plans of correction and/or improvement to be implemented ...."		properdocumentation should be made. 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 administrator will conduct athorough performance improvement project on every active patient every 6 monthsand findings will be documented. This will ensure 100% compliance and avoidsuch deficiencies to recur. The administrator will be responsiblefor monitoring this deficiency. This will prevent it from recurring.	

	Review of the agency's QAPI program failed to evidence any performance improvement projects were documented or implemented. During an interview on 12/13/2022, at 2:58 PM, administrator #2 indicated the performance improvement project was focused on falls and wounds, but the agency did not have any patients with falls or wounds, so no action had been taken to implement a performance improvement project.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the home health agency failed to ensure skilled nurses accurately prepared clinical notes in 3 of 5 active clinical records reviewed. (#1, 2, 4)	G0716	**G0716** **For patient #1,** agency immediately reviewed and corrected theaffected patient recertification assessment information and removed skillednurse service patient is not currently receiving. **For patient #2,** agency reviewed the patient'smedications and corrected missing route and frequency of administration in thepatient's medication profile.	2023-01-31

	The findings include: 1. Record review evidenced an undated agency policy obtained on 12/14/2022, titled "Clinical Documentation" which stated, "... To ensure there is an accurate record of the services provided ...." 2. Clinical record review for Patient #1 was completed on 12/14/2022, for certification period 12/7/2022 – 2/4/2023. Record review evidenced a recertification assessment dated 12/2/2022, which indicated the patient was receiving skilled nursing services from another home health agency. During an interview on 12/12/2022, at 12:10 PM, Patient #1 indicated they had not received skilled nursing home health services in about 2 years. During an interview on 12/14/2022, at 10:29 AM, clinical manager #1 indicated the patient does not receive		medication profile wasprinted and documented in the patient chart. **For patient #4,** agency unable to correct thisdeficiency because patient is deceased and discharged. The director ofnursing reviewed other clients' charts that may be likely affected for data accuracy and corrected them. The administrator instructed the director of nursingto always update and document any changes in patient care as soon as possible. The director of nursing has outlined charts reviewed of allpatients every 60 days ensuring that their medications, services, and currenthealth status are up to date. This will prevent this deficiency fromreoccurring again. 50% of all client's charts will be audited quarterly toensure this deficiency will not reoccur again and to comply with the regulatoryrequirements. The director of nursing is responsible for monitoring thiscorrective action and ensuring 100% compliance	

	skilled nursing services from another home health agency, and the recertification assessment had included the information as an oversight. 3. Clinical record review for Patient #2 was completed on 12/14/2022. Record review evidenced a plan of care for certification period 11/14/2022 – 1/12/2023, which indicated the patient was to take Narcan (medication to treat opioid overdose) daily. During an interview on 12/14/2022, at 11:20 AM, clinical manager #1 indicated the patient was not taking Narcan daily and it was a mistake in documentation. 4. Clinical record review for Patient #4 was completed on 12/14/2022, for certification period 10/12/2022 – 12/10/2022. Record review evidenced a transfer assessment dated 12/8/2022, which indicated the certification period did not include any		on01/31/2023.	

	dates between October 1 and March 31, in regard to vaccination status. During an interview on 12/14/2022, at 11:27 AM, clinical manager #1 indicated the transfer assessment was not accurate. 410 IAC 17-14-1(a)(1)(E)			
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. Based on record review and interview, the home health agency failed to ensure the registered nurse made an on-site visit to the patient's home to observe and assess each aide while they were providing care for patients not receiving skilled nursing care in	G0814	**G0814** **For patient #1,** the agency is unable to correct thisdeficiency because the patient is deceased. The agency has reviewed other clients' chartsthat may be impacted by this deficiency and scheduled a 60-day supervisoryvisit with the home health aide and patient present to observe the hands-oncare provided. The administratorin-serviced director of nursing to conduct supervisory visits every 60 days tocomply with the regulatory requirements and when the home health is present	2023-01-31

	1 of 5 active clinical records reviewed. (#1) The findings include: Record review evidenced an undated agency policy obtained 12/14/2022, titled "Home Health Aide Supervision" which stated, "... Supervisory visits of Home Health Aides shall be according to the following frequency: ... When skilled services are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client's residence at least every 2 weeks ... to assess relationships and determine whether goals are being met ... Supervisory visits are to be documented in the client's chart on the Home Health Aide Supervision Form ...." Clinical record review for Patient #1 was completed on 12/14/2022. Record review evidenced a plan of care for certification periods 10/8/2022 – 12/6/2022, and 12/7/2022 – 2/4/2023, which indicated the patient was only receiving home		toobserve hands-on care rendered to the client. The director of nursing will encouragethe signatures(optional) of both the patient and home health aide at the timeof the supervisory visit. 50% ofclients' records will be subsequently audited quarterly to ensure 100%compliance. Thedirector of nursing is responsible for monitoring this corrective action toensure that this deficiency is corrected and will not recur.	

	health aide visits. Clinical record review on 12/9/2022, failed to evidence any documented supervisory visits. Clinical record review on 12/12/2022, evidenced a recertification assessment completed on 12/2/2022, which indicated a supervisory visit was conducted, but the home health aide was not present. On 12/12/2022, clinical manager #1 provided the surveyor with written supervisory visit notes dated 10/2022, and 11/2022, which were not in the clinical record previously. The supervisory visit note dated 10/2022, signed by clinical manager #1 and Patient #1, failed to indicate on which day the supervisory visit was conducted, and failed to indicate whether the home health aide was directly observed providing care. The supervisory visit dated 11/2022, indicated the home health aide was not present during the supervisory visit.			

	During an interview on 12/12/2022, at 3:13 PM, clinical manager #1 indicated they completed supervisory visits monthly. Clinical manager #1 indicated the supervisory visits don't specify a date, and they only indicated which month the supervisory visit was conducted. Clinical manager #1 indicated the supervisory visits were not all conducted with the home health aide present. Clinical manager #1 indicated if the home health aide was not present during the supervisory visit, they would interview the patient about the service provided by the home health aide.			
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	G0958	**G0958** The director of nursing reviewed clients'charts and identified patient #2 affected with this deficiency and updated the client'splan of care/485 to reflect the patient's use of bilateral lower extremitiescompression wraps done at the lymphedema clinic	2023-01-31

	oversight of all patient care services and personnel in 1 of 3 home visits conducted. (#2) The findings include: Record review on 12/13/2022, 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 ...."		every Wednesday and faxed it tothe physician for signature. The director of nursing immediatelyin-serviced the aide assigned to care for the client to only perform serviceswithin her scope of practice, following the patient's plan of care per thephysician's order. The director of nursing further in-serviced all aides tocare for their assigned clients according to their plan of care signed by thephysician and not to perform services outside their scope of practice andwithout the physician's order. Agency will audit all client's chartsevery 60 days of recertification ensuring other clients likely to be affected bythis deficiency are corrected in a timely manner. Agency supporting staff willremind aides from time to time to perform duties within their scope of practiceand according to the client's plan of care. TheAgency's 50% of the client's medical records will be audited quarterly toensure 100% compliance. The director of nursing will be monitoring this processensuring that this	

	Observation of a home visit for Patient #2 was conducted on 12/13/2022, at 9:00 AM, to observe a routine home health aide visit. Patient #1 was observed to have a large amount of swelling to bilateral lower extremities. During the visit, the patient indicated they had lymphedema (swelling to an extremity caused by a disruption of lymphatic fluid drainage), and used compression wraps on their legs, which were applied in a clinic every Wednesday. The patient indicated the home health aide removed the wraps from their legs every week. Clinical record review for Patient #2 was completed on 12/14/2022. Record review evidenced a plan of care for certification period 11/14/2022 – 1/21/2023, which failed to indicate the home health aide was to remove the patient's compression wraps. The plan of care failed to include any instructions or information regarding the compression wraps.		deficiency will not recur.	

	During an interview on 12/15/2022, at 11:13 AM, clinical manager #1 indicated they didn't know anything about the patient's compression wraps until the home visit on 12/13/2022. Clinical manager #1 indicated they did not know the home health aide was removing the compression wraps. Clinical manager #1 indicated they did not know what the orders were for removing the compression wraps, or if they were supposed to be re-applied. 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 coordinated patient care in 2 of 3 active clinical records reviewed. (#2, 3)	G0962	**G0962** **Forpatient #2**, thepatient current plan of care was revised to include missing diagnoses ofrespiratory distress, Bilateral knee arthritis, Cellulitis, and compressionwraps, and medications were included and faxed to the patient's physician forsignature. Agency faxed carecoordination to the Lymphedema clinic and obtained fax confirmation for	2023-01-31

	The findings include: 1. Record review on 12/13/2022, evidenced a director of nursing job description signed by clinical manager #2 on 8/18/2011, which stated, "... The director of nursing coordinates care with the interdisciplinary team, patient/family and referring agency ... Directs and coordinates clinical departments; assumes responsibility for continuity, quality, and safety of services delivered in compliance with State and Federal regulations...." 2. Observation of a home visit for Patient #2 was conducted on 12/13/2022, at 9:00 AM, to observe a routine home health aide visit. During the visit, the patient was observed to have lymphedema (swelling caused by inadequate lymphatic fluid drainage) to bilateral lower extremities. The patient indicated they went to lymphedema clinic #1 to have their legs compression wrapped weekly. Patient #1 indicated the home health aide removed the compression wraps. The patient was observed to be alert and		recordpurposes. The agency further requested the client's history & physicalsfrom the client's physician. **Forpatient #3**, Thepatient current plan of care was revised to include the use of oxygen via nasalcannula at 2 liters and faxed to the patient's physician for signature. Agencyfaxed care coordination to the patient current physician and requested the client'shistory and physical from the doctor's office. The director of nursing audited all patients' chartsensuring the plan of care was up to date with their diagnoses and medications,and there was written care coordination in the patient's chart receivingservices from other healthcare providers. 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 care coordination with otheragencies	

	oriented, and severely short of breath when ambulating with walker. Clinical record review for Patient #2 was completed on 12/14/2022, for certification period 11/14/2022 – 1/12/2023. Record review evidenced a start of care assessment dated 11/14/2022, which indicated the patient had stomach cancer. Clinical record review evidenced a referral form dated 11/14/2022, which indicated the patient was referred by physician #2 for home health aide services. The referral included only a diagnosis of cancer. Clinical record review evidenced a progress note from lymphedema clinic #1, faxed to surveyor on 12/14/2022, dated 11/30/2022, which indicated the patient was receiving radiation treatments for endometrial cancer, and had a diagnosis of asthma, which was not included		providing services for every client. The director of nursing will auditevery client's chart bimonthly to ensure proper documentation of patient careservices is done in a timely manner and to comply with the regulations. The directorof nursing will be responsible for monitoring corrective action to ensure thisdeficiency does not recur.	

progress note indicated the patient was to wear compression wraps on bilateral lower extremities to decrease swelling. The progress note indicated the patient had only been able to wear the compression wraps for 48 hours at a time.

Clinical record review evidenced a history and physical from physician #2's office which was faxed to surveyor on 12/15/2022, dated 12/7/2022, which indicated the patient had diagnoses of respiratory distress (trouble breathing), bilateral knee arthritis, and cellulitis, which were not included in the patient's plan of care. This document indicated the patient was taking the following medications which were not included in the plan of care: alprazolam (for anxiety), Vitamin C, chlorthalidone (diuretic to pull water off body), clyclobenzaprine (muscle relaxer), and Breo-Ellipta (inhaler for shortness of breath).

Clinical record review evidenced

period 11/14/2022 – 1/12/2023, which indicated the patient had a diagnosis of endometrial cancer. This document failed to include compression wraps, or any instructions regarding compression wraps.

Clinical record review failed to evidence any coordination of care, communication, or review of documentation with the lymphedema clinic or physician #2 regarding patient's diagnoses, orders, or medications. Record review failed to evidence a history and physical or additional medical records on file for Patient #2.

During an interview on 11/14/2022, at 11:06 AM, clinical manager #1 indicated they did not request any documentation from the physician's office or lymphedema clinic. Clinical manager #1 indicated upon start of care, they would call the physician's office and ask them to confirm any diagnoses. Clinical manager #1 indicated they based the plan of care off which diagnoses, treatments,

	and concerns the patient tells them about during the start of care assessment. Clinical manager #1 indicated they did not have history and physicals on file for any patients. 3. Observation of a home visit for Patient #3 was conducted on 12/14/2022, at 1:15 PM, to observe a routine home health aide visit. During the visit, the patient was observed wearing 2 liters of oxygen. The patient indicated they wore oxygen all the time. Clinical record review for Patient #3 was completed on 12/14/2022. Record review evidenced a plan of care for certification period 11/22/2022 – 1/20/2023, which failed to include a diagnosis to support patient's oxygen use. Record review failed to evidence any history and physical on file, or care coordination documented between the physician and the home health agency regarding patient's history and current plan of care.			

	During an interview on 12/14/2022, at 3:05 PM, clinical manager #1 indicated the patient wore oxygen because the doctor prescribed it. Clinical manager #1 indicated they did not know if the patient had a diagnosis which supported oxygen use. Clinical manager #1 indicated they did not think the patient used oxygen all the time. Clinical manager #1 was unsure of when the patient was supposed to wear oxygen.			

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Willy Okwara	Administrator	12/29/2022 2:14:47 PM