STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	12/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMORE HOME HEALTH CARE SERVICES, INC	9209 WICKER AVENUE, SUITE WEST, SAINT JOHN, IN, 46373

(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 a re-licensure survey of a home health agency This visit took place from 12/07/2022-12/14/2022 Facility ID: 012121 Census: 15	N0000		2023-01-11
G0000	INITIAL COMMENTS This survey was a Recertification and Emergency Preparedness survey for a home health agency. Survey dates:12/07/2022-12/14/2022 Facility ID 012121	G0000		2023-01-11

	Census: 15 During this Federal Recertification Survey, Amore Home Health Care Services Inc., was found to be out of compliance with Conditions of Participation 42 CFR §484.60 Care Planning, Coordination, Quality of Care; 42 CFR §484.65 Quality Assessment/Performance Improvement; 42 CFR §484.70 Infection Prevention and Control; 42 CFR §484.102 Emergency Preparedness; and 42 CFR §484.105 Organization and Administration of Services. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Based on the condition-level deficiencies during the 12/13/2022 survey, Amore Home Health Care Services Inc. is precluded from providing its own home health aide training and competency evaluation for a period for two years which began on 12/14/2022 through 12/14/2024.			
E0000	Initial Comments An Emergency Preparedness	E0000		2023-01-11

	Survey was conducted by the Indiana Department of Health in accordance with 42 CFR §484.102 for Home Health Providers and Suppliers. Survey Dates: 12/07/2022-12/14/2022 Census: 15 At this Emergency Preparedness survey, Amore Home Health Care Services Inc. was found to be out of compliance with Conditions of Participation 42 CFR §484.102: Emergency Requirements for Medicare and Medicaid Participating Providers and Suppliers. QR Completed on 1/4/2023 A1			
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 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	E0001	The BOD met on January 9, 2022 (Pls see Attachment-1) and reviewed the Agency's Emergency Preparedness Plan. The BOD directed the Administrator to revise the Emergency Preparedness Plan to include review of emergency preparedness every two years. The Administrator revised the Emergency Preparedness Plan on January 10, 2023 (Pls see Attachment-4) to include the following: (1) emergency	2023-01-10

	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 record review and interview, the home health agency failed to: maintain an emergency preparedness plan that was reviewed and updated at least every 2 years (see tag E0004); maintain an emergency plan that included a facility-based and community-based risk assessment utilizing an all-hazards approach (see tag E0006); maintain a process		preparedness plan updated at least every 2 years, (2) completion of the Hazard Vulnerability Assessment (HVA) annually, (3) the contact information of the different local, tribal, regional, state, and federal emergency preparedness officials and the process of cooperation and collaboration with them, (4) Emergency Preparedness policies & procedures, (5) individualized patient emergency plan, (6) communication plan during emergency, (7) primary and alternate means for communication during emergency, (8) emergency preparedness training program, and (9) emergency preparedness testing program. The Administrator is responsible for reviewing the Emergency Preparedness Plan every 2 years and monitoring its timely completion by using the Agency's Annual Checklist Form (Please see Attachment-2) to ensure that this deficiency is corrected and will not recur. Target threshold is 100%.	

	with local tribal, regional, state and federal emergency preparedness officials (see tag E0009); document the policies and procedures were reviewed and updated every 2 years (see tag E0013); include an individualized plan for each patient during a natural or man-made disaster (see tag E0017); maintain an emergency preparedness communication plan which included names and contact information for staff (see tag E0030); maintain an emergency preparedness communication plan that include primary and alternate means for communication with the facility, staff, state, tribal, regional, and local emergency management (see tag E0032); to provide emergency preparedness training to staff every 2 years (see tag E0037); and failed to conduct exercises to test the emergency plan annually (see tag E0039). Findings include:			

	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 results in the agency being out of compliance with condition 42 CFR §484.102 Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.			
E0004	Develop EP Plan, Review and Update Annually 403.748(a),482.15(a),485.625(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop 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: (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 all of the following:	E0004	The BOD met on January 9, 2023 (Pls see Attachment-1) and reviewed the Agency's Emergency Preparedness Plan. The BOD directed the Administrator to revise the Emergency Preparedness Plan to include review of emergency preparedness every two years. The Administrator revised the Emergency Preparedness Plan on January 10, 2023 (Pls see Attachment-4) and re-educated herself about (1) the revised policy and, (2) the use of the Annual Checklist Form (Pls see Attachment-2) to ensure timely review of the Emergency Plan. The Administrator is responsible for reviewing the Emergency Preparedness Plan every 2 years and monitoring its timely	2023-01-10

	* [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [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. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . Based on record review and interview, the home health agency failed to maintain an emergency preparedness plan that was reviewed and updated at least every 2 years. Findings include: Record review on 12/13/2022, evidenced an agency policy dated April 2012, titled, "Emergency Management Plan," which stated, "... an annual evaluation of the organization's hazard vulnerability analysis and emergency management plan,		completion by using the Agency's Annual Checklist Form to ensure that this deficiency is corrected and will not recur. Target threshold is 100%.	

	functionality, and effectiveness will be conducted. The annual evaluation may be based on the drill evaluation or actual implementation of the emergency management plan ...." Record review on 12/08/2022, evidenced an agency document dated 01/18/2021, titled, "Board of Directors Meeting, Meeting Minutes," which indicated the board of directors discussed plan for emergency preparedness for COVID-19. Review of the emergency preparedness binder on 12/08/2022, failed to evidence documentation the emergency preparedness plan was reviewed or updated every 2 years. During an interview on 12/08/2022, at 12:25 PM, administrative staff #5 indicated the last emergency preparedness plan was reviewed on January 2021 board of directors meeting regarding COVID-19. Administrative staff #5 indicated they thought the agency was going to close so did not update the emergency plan.			

E0006	Plan Based on All Hazards Risk Assessment 403.748(a)(1)-(2),482.15(a)(1)-(2),485.625(a)(1)-(§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [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.	E0006	The BOD met on January 9, 2023 (Pls see Attachment-1) and reviewed the Agency's Emergency Preparedness Plan. The BOD directed the Administrator to revise the Emergency Preparedness Plan to include completion of the Hazard Vulnerability Assessment (HVA) annually. The Administrator revised the Emergency Preparedness Plan (Pls see Attachment-4) on January 10, 2023 and re-educated herself about the revised policy, including the timely completion of the HVA using the Agency's Annual Checklist Form (Pls see Attachment-2). The Administrator completed a Hazard Vulnerability Assessment (Pls see Attachment-5) on January 11, 2023. The Administrator is responsible for reviewing the HVA annually and monitoring its timely completion by using the Agency's Annual Checklist Form to ensure that this deficiency is corrected and will not recur. Target threshold is 100%.	2023-01-11

(2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care.

*[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.

(2) Include strategies for addressing emergency events identified by the risk assessment.

*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.

(2) Include strategies for addressing emergency events identified by the risk assessment.

Based on record review and interview, the home health agency failed to maintain an emergency preparedness plan that included a facility-based and community-based risk assessment, utilizing an all-hazards approach that was updated every 2 years.

Findings include:

	Record review on 12/13/2022, evidenced an undated agency policy titled, "Hazard Vulnerability Analysis," which stated, "... this all-hazards approach to our emergency preparedness plan must be reviewed and updated at least annually in order to help identify gaps and challenges to be considered and addressed ...." Record review on 12/08/2022, evidenced an agency document dated 12/12/2019, titled, "Hazard Vulnerability Assessment." This document failed to evidence an updated hazard vulnerability assessment. During an interview on 12/08/2022, at 12:25 PM, administrative staff #5 indicated the emergency preparedness plan has not been updated or reviewed due to they thought the agency was going to close.			
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),	E0009	The BOD met on January 9, 2023 (Pls see Attachment-1) and reviewed the Agency's Emergency Preparedness Plan policy. The BOD directed the Administrator to revise the Emergency Preparedness Plan	2023-01-11

	§485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Based on record review and interview, the home health agency failed to maintain a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials. Findings include: Record review on 12/13/2022, evidenced an undated agency policy titled, "Emergency Preparedness Rule:" which indicated the communication plan will be well-coordinated		to include the process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials. The Administrator revised the Emergency Preparedness Plan on January 10, 2023 (Pls see Attachment-4) to include the phone numbers of the different local, tribal, regional, state, and federal emergency preparedness officials and the process of cooperation and collaboration with them. The Administrator conducted an in-service on January 11, 2023 to all field and office staff about the Emergency Preparedness Plan, including the contact information of the different emergency preparedness officials and the process for cooperation & collaboration with them. The Administrator is responsible for reviewing the Emergency Preparedness Plan every 2 years and monitoring its timely completion by using the Agency's Annual Checklist Form to ensure that this deficiency is corrected and will not recur. Target threshold is 100%.	

	care providers, and with state and local public health departments and emergency management agencies. Review of the emergency preparedness binder on 12/08/2022, failed to evidence a process for collaboration with local, tribal, regional, state, and federal emergency preparedness officials. During an interview on 12/08/2022, at 12:30 PM, the administrator indicated they had meetings for area updates with local officials and have the phone number for local officials for emergencies, but no federal information.			
E0013	Development of EP Policies and Procedures 403.748(b),482.15(b),485.625(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the	E0013	The BOD met on January 9, 2023 (Pls see Attachment-1) and reviewed the Agency's Emergency Preparedness Plan. The BOD directed the Administrator to revise the policies and procedures of the Emergency Preparedness Plan, including review of emergency preparedness plan every two years. The BOD directed the Secretary of BOD to document all details discussed during the meeting in the minutes. The	2023-01-10

	communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility 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 annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization 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 address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility 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. These emergencies include, but are not limited to, fire, equipment or		Administrator revised the Emergency Preparedness Plan (Pls see Attachment-4) on January 10, 2023 and re-educated herself about (1) the revised policy and, (2) the use of the Annual Checklist Form (Pls see Attachment-2) to ensure timely review of the Emergency Plan. The Administrator is responsible for reviewing the Emergency Preparedness Plan every 2 years and monitoring its timely completion by using the Agency's Annual Checklist Form to ensure that this deficiency is corrected and will not recur. Target threshold is 100%.	

	water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the home health agency failed to document the policies and procedures had been reviewed and updated at least every 2 years. Findings include: Record review on 12/13/2022, evidenced an agency policy dated April 2012, titled, "Emergency Management Plan," which indicated an annual evaluation of the organization's emergency management plan will be conducted. Review of the emergency preparedness binder on 12/08/2022, failed to evidence documentation the policies and procedures have been reviewed and updated every 2 years. During an interview on 12/08/2022, at 12:25 PM, administrative staff #5 indicated the last discussion of emergency preparedness was at the board of directors meeting in January of 2022, and they discussed COVID only.			
E0017	HHA Comprehensive Assessment in Disaster	E0017	The BOD met on January 9, 2023 (Pls see Attachment-1) and reviewed the Agency's	2023-01-11

	484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on record review and interview, the home health agency failed to ensure an individualized plan for each patient during a natural or man-made disaster was included in the patient's comprehensive assessment in 7 of 7 clinical records reviewed. (#1, #2, #3, #4, #5, #6, #7) Findings include: 1. Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, "OASIS-D1 [Outcome and Assessment Information Set] Start of Care" dated 8/19/2022. Review indicated emergency preparedness was performed.		Emergency Preparedness Plan policy. The BOD directed the Administrator to revise the Emergency Preparedness Plan. The Administrator revised the Emergency Preparedness Plan on January 10, 2023. The Administrator directed the DON to revise the Patient Assessment Book to include the contact information of the different emergency officials, as well as create an Individualized Patient Emergency Plan to be incorporated in the Patient Assessment Book and become part of the comprehensive patient assessment. The DON revised the Patient Assessment Book on January 10, 2023 to reflect the contact information of the different emergency officials (Pls see Attachment-6). The DON created an Individualized Patient Emergency Plan (Pls see Attachment-7) on January 10, 2023 which was also incorporated in the Patient Assessment Book. The DON conducted an in-service on January 11, 2023 to all field staff regarding (1) the inclusion of the contact information of the different emergency officials in the Patient Assessment Book, and (2) the inclusion of	

	individualized emergency plan. 2. Clinical record review on 12/12/2022, for Patient #6, start of care 11/30/2022, evidenced an agency document titled "OASIS-D1 Start of Care (PT) [Physical Therapy]" dated 11/30/2022. Review indicated emergency preparedness was performed. Review failed to evidence an individualized emergency plan. 3. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document titled "OASIS-D1 Start of Care (PT)" dated 5/3/2022. Review indicated emergency preparedness was performed. Review failed to evidence an individualized emergency plan. 3. During an interview on 12/9/2022, at 11:19 AM, the administrator indicated the extent of the agency's emergency preparedness plans for their patients was the patients were instructed to call 911 in the event of an emergency. 1. Record review on 12/13/2022, evidenced an		Individualized Patient Emergency Plan as part of the comprehensive patient assessment. During the in-service, the DON distributed (1) a page with contact information of the different emergency officials, and (2) the Individualized Patient Emergency Plan form to the field staff to complete and incorporate in the Patient Assessment Book of current patients. The DON instructed the secretary to produce new Patient Assessment Books that will be used for new patient admissions. The Administrator is responsible for reviewing the Emergency Preparedness Plan every 2 years and monitoring its timely completion by using the Agency's Annual Checklist Form (Please see Attachment-2) to ensure that this deficiency is corrected and will not recur. Target threshold is 100%.	

	titled, "Natural Disasters/Emergencies," which stated, "… upon admission the patient and family/caregiver will be assessed regarding their emergency management plan for the home, and any special needs will be noted …." 2. Record review on 12/13/2022, evidenced an agency policy dated April 2012, titled, "Emergency Management Plan, which stated, "…detailed written instructions will be given to patients and/or family members to ensure an appropriate and timely response in the event of an emergent event that may cause interruptions of service …."			

	3. Record review on 12/13/2022, evidenced an agency policy dated April 2012, titled, "Initial and Comprehensive Assessment," which stated, "... during the initial and comprehensive patient assessment ... will be documented in the patient's clinical record, including at least the following information ... an evaluation of the home environment and assessment of emergency preparedness of the patient ...." 4. Record review on 12/08/2022, for patient #1, start of care 09/28/2022, evidenced an agency document titled, "OASIS [outcome and assessment information set] -D1 Recertification," for certification period 11/27/2022-01/25/2023 which stated, "... emergency care plan review: instructed patient/caregiver on the purpose of an emergency care plan ...." This comprehensive assessment failed to include an individualized emergency plan. 5. Record review on 12/08/2022, for patient #2, start of care 11/10/2022, evidenced an agency document titled, "OASIS [outcome and			

	assessment information set]-D1 Start of Care," for certification period 11/10/2022-01/08/2023. This comprehensive assessment did not include an emergency care plan review. This document failed to evidence an individualized emergency plan. 6. Record review on 12/08/2022, for patient #3, start of care 04/28/2022, evidenced an agency document titled, "OASIS [outcome and assessment information set]-D1 Recertification," for certification period 06/27/2022-08/25/2022, which stated, "... emergency care plan review instructed patient/caregiver on the purpose of an emergency care plan ...." This comprehensive assessment failed to evidence an individualized emergency plan. 7. Record review on 12/12/2022, for patient #4, start of care 11/10/2022, evidenced an agency document titled, "OASIS [outcome and assessment information set]-D1 Start of Care," for certification period 11/10/2022-01/08/2023. This comprehensive assessment did not include an emergency care plan review. This			

	document failed to evidence an individualized emergency plan. 8. During an interview on 12/09/2022, at 11:17 AM, the clinical manager indicated there is not an individualized emergency plan on the comprehensive assessment, the patients are informed to call 911 for emergency.			
E0030	Names and Contact Information 403.748(c)(1),482.15(c)(1),485.625(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities].	E0030	The BOD met on January 9, 2023 (Pls see Attachment-1) and directed the Administrator to revise the Emergency Preparedness Plan policy. The Administrator revised the Emergency Preparedness Plan (Pls see Attachment-4) on January 10, 2023 to include the information that must be incorporated and continually updated in the Emergency Preparedness binder. The Administrator gave in-service to the Agency secretary on January 11, 2023 to educate her about the Emergency Preparedness binder and her weekly tasks as stated in the Emergency Preparedness Plan policy which includes: (1) updating all information weekly, and (2) signing the log sheet every update. (Pls see Attachment-8).	2023-01-11

	(v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers.		The Agency secretary started updating the Emergency Preparedness binder on January 11, 2023. The Administrator is responsible for reviewing the Emergency Preparedness Plan every 2 years and monitoring the secretary as she updates the Emergency Preparedness binder every week to ensure that this deficiency is corrected and will not recur. Target threshold is 100%.	

	*[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 the home health agency failed to maintain an emergency preparedness communication plan which			

	included names and contact information for staff. Findings include: Clinical record review on 12/13/2022, evidenced an undated agency policy titled, "Communication During An Emergency," which stated, "... during an emergency, the emergency incident commander is responsible for contacting staff to inform of the emergency ... emergency incident commander calls-succession incident commander ... Operations Manager ... finance manager ... utility companies, nurses and all other disciplines ...." Review of the emergency preparedness binder on 12/08/2022, evidenced an agency document revised 12/2015, titled, "Disaster Preparedness Phone Tree," which stated, "In the event of a natural disaster, the following personnel will be responsible in contacting ... personnel and agency clients ...." The personnel list included the administrator, the alternate administrator and the alternate clinical manager names and phone numbers. This list failed			

	to include a communication plan for all staff with names and phone numbers. Review of the emergency preparedness binder on 12/08/2022, evidenced the last staff phone tree was dated 09/2019. During an interview on 12/08/2022, at 12:35 PM, the administrator was informed there was not an updated emergency preparedness staff phone tree in the emergency preparedness binder. The administrator remained silent.			
E0032	Primary/Alternate Means for Communication 403.748(c)(3),482.15(c)(3),485.625(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3), §483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:	E0032	The BOD met on January 9, 2023 (Pls see Attachment-1) and directed the Administrator to revise the Emergency Preparedness Plan policy. The Administrator revised the Emergency Preparedness Plan (Pls see Attachment-4) on January 10, 2023 to include the communication plan during emergency with alternate means of communication and back-up. The Administrator named the designated runner as part of the communication plan. The Administrator conducted an in-service to all	2023-01-11

	(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 develop and maintain an emergency preparedness communication plan that included primary and alternate means for communication with the facility, staff, federal, state, tribal, regional, and local emergency management. Findings include: Record review evidenced an undated agency policy received 12/13/2022, titled, "Communications During An Emergency," which stated, "... when the telephone lines are down or cellular phones are not functioning, the Emergency Incident Commander should utilize the runner messenger system (when safe) as alternate communications and back-up ...." Review of the emergency preparedness binder on 12/08/2022, failed to evidence		field and office staff on January 11, 2023 about the Communication Plan during Emergency as part of the Emergency Preparedness Plan. The Administrator is responsible for reviewing the Emergency Preparedness Plan every 2 years and monitoring its timely completion by using the Agency's Annual Checklist Form (Please see Attachment-2) to ensure that this deficiency is corrected and will not recur. Target threshold is 100%.	

	the runner messenger system instructions/plan. During an interview on 12/08/2022, at 12:40 PM, the administrator indicated they will have a runner messenger system for alternate means of communication and asked administrative staff #5 who the runner was. The administrator indicated the messenger system was not set up.			
E0037	EP Training Program 403.748(d)(1),482.15(d)(1),485.625(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency	E0037	The BOD met on January 9, 2023 (Pls see Attachment-1) and directed the Administrator to revise the Emergency Preparedness Plan policy. The Administrator revised the Emergency Preparedness Plan (Pls see Attachment-4) on January 10, 2023 to include training program of the Emergency Preparedness Plan. The Administrator also created an Emergency Training & Testing Program log sheet (Pls see Attachment-9) for documentation and monitoring that will be incorporated in the Emergency Preparedness binder. On January 11, 2023, the Administrator conducted a training with all field and office staff on activities and	2023-01-11

	preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.		procedures stated in the Emergency Plan. The Administrator is responsible for reviewing the Emergency Preparedness Plan every 2 years and monitoring its timely completion by using the Agency's Annual Checklist Form (Please see Attachment-2). Target threshold is 100%. The Administrator is also responsible for conducting emergency training activities for the Agency to ensure the Agency's compliance to the Emergency Preparedness policy and to ensure that this deficiency is corrected and will not recur. Target threshold is 100%.	

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

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

	(iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interviewx, the home health agency failed to provide emergency preparedness training at least every 2 years, and failed to maintain documentation of all emergency preparedness training. Findings include:			

	Record review on 12/13/2022, evidenced an agency policy dated April 2012, titled, "Emergency Management Plan," which stated, "... organization leadership will provide for orientation and education of all personnel regarding participation in the emergency plan. Education will be provided during orientation and annually ...." Review of the emergency preparedness binder on 12/08/2022, evidenced documentation of the last staff training was on COVID-19 in June 2020. During an interview on 12/08/2022, at 12:50 PM, the administrator indicated there has been no emergency preparedness training done with the staff since the pandemic started and no new hires since the pandemic. The administrator indicated there was not any formal training and no documentation of staff training since 2020.			
E0039	EP Testing Requirements 403.748(d)(2),482.15(d)(2),485.625(d)(2)	E0039	The BOD met on January 9, 2023 (Pls see Attachment-1) and directed the Administrator	2023-01-11

	§416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.		to revise the Emergency Preparedness Plan policy. The Administrator revised the Emergency Preparedness Plan (Pls see Attachment-4) on January 10, 2023 to include testing program of the Emergency Preparedness Plan. The Administrator also created an Emergency Training & Testing Program log sheet (Pls see Attachment-9) for documentation and monitoring that will be incorporated in the Emergency Preparedness binder. On December 22, 2022, the Administrator activated the Emergency Preparedness plan. (Pls see Attachment-10).	

	(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (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		The Administrator is responsible for reviewing the Emergency Preparedness Plan every 2 years and monitoring its timely completion by using the Agency's Annual Checklist Form (Please see Attachment-2). Target threshold is 100%. The Administrator is also responsible for conducting emergency testing activities for the Agency to ensure the Agency's compliance to the Emergency Preparedness policy to ensure that this deficiency is corrected and will not recur. Target threshold is 100%.	

	(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			

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

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

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

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 or participate in a full scale community based drill, a facility based exercise or a tabletop

plan annually.

Findings include:

Record review on 12/03/2022, evidenced an agency policy titled, "Training and Testing of the Emergency Preparedness Plan," which stated, "... two tests of the emergency preparedness plan need to be conducted annually ... home health will participate in a full-scale exercise that is community based ... a full-scale exercise ... agency will document the date, personnel, and any agency or healthcare coalition they contact. Agency will resource participation and ensure all documentation is developed and available to demonstrate compliance ... if ... unable to participate in a full-scale, community based event, the Agency will maintain documentation of the attempts to participate, but then MUST conduct a facility based event ... the second drill should be full-scale community based or facility-based, OR if unable to participate in either of theses drills, then a tabletop exercise can be conducted ...."

Review of the emergency

	preparedness binder on 12/08/2022, evidenced a real event on 06/01/2020, 02/25/2020, and 01/24/2019; an emergency drill on 12/12/2019; a tabletop exercise on 09/18/2019 and 01/14/2018; and a full scale exercise on 11/07/2018. This binder failed to evidence a training and testing program annually. During an interview on 12/08/2022, at 12:00 PM, the administrator indicated the last real event was June of 2020. There were no recent drills, or tabletop exercises.			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2.	N0458	The Board ofDirectors (BOD) met on January 9, 2023 (Pls see Attachment-1) and reviewedpolicies regarding personnel performance evaluations. The BOD directed the Administrator to (1)give an in-service to the Human Resource Director regarding personnelperformance evaluations, and (2) direct the HR director to complete theperformance evaluation of the Assistant Director of Nursing (ADON). The BOD directed the Administrator to	2023-01-11

	(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 include documentation of annual performance evaluation in 1 of 1 alternate clinical manager record reviewed. (#2) Findings include: Review evidenced an undated agency policy received 12/13/2022, titled, "Policy and Record Procedures Responsibilities of Staff Members and Field Personnel," which stated, "... participate in the annual job performance review done by your ... home health care services administrator/supervisor." Record review for alternate clinical manager #2 completed on 12/09/2022 failed to evidence an annual performance evaluation. The last annual performance evaluation was done 11/14/2018. During an interview on 12/09/2022, at 3:45 PM,		create &implement an Annual Checklist Form with all the annual tasks listed to check forcompletion before the end of each year. (Pls see Attachment-2). TheAdministrator gave an in-service to the HR Director regarding personnel performanceevaluation on 1/11/2023. Note: 100%of the personnel records were reviewed during the survey period (12/7-12/14/22)and were all found to be in compliance, except for one which was correctedright away. The HR Director is responsible for coordinatingall the employee performance evaluations annually before the year ends. The Administrator is responsible for checkingthat the HR Director completes the performance evaluation for all employees toensure that this deficiency is corrected and will not recur. Target threshold is 100%.	

	discussed with the clinical manager and administrative staff #4 that there is not an annual performance evaluation since 2018 for alternate clinical manager #2. Administrative staff #4 indicated alternate clinical manager #2 did not work during the pandemic and returned to work in May of 2022.			
G0520	5 calendar days after start of care 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on record review and interview, the comprehensive assessment failed to be completed to include the assessment of the wounds within 30 days of the start of care in 1 of 2 clinical records reviewed with wounds. (#5) The findings include: Review of an agency policy obtained 12/14/2022, and dated April 2012, titled "Initial and Comprehensive Assessment" stated, "... A	G0520	The DON reviewed 100% of all clinical records of patients with wounds on January 6 - 8, 2023 as part of the post-survey chart audit to check for proper assessment of wounds & pressure ulcers. (Please see Attachment-20 for the tool that was and will be used for the first 3 monthly post-survey chart audits.) The BOD met on January 9, 2023 (Pls see Attachment-1) and directed the DON to revise the Wound Care Management policy to include assessment of pressure	2023-01-11

	comprehensive patient assessment will be completed within five (5) calendar days of the patient's start of care. ... The assessment will be patient-specific and comprehensive to include the patient's need for home care ... The comprehensive assessment should determine ... Baseline information to be used to measure the patient's progress toward achievement of desired outcomes ...." Review of an undated agency policy obtained 12/14/2022, titled "Wound Care Management" stated, "... Documentation of wounds must include type of wound, measurements including length, depth, and width, description of the wound bed, surrounding area, undermining, staging, color, odor and estimated amount of drainage...." Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 8/19/2022-10/17/2022, which indicated the patient was to receive skilled nursing services,		ulcers and staging of pressure ulcer. The DON revised the Wound Care Management policy on January 10, 2023. (Pls see Attachment-11). The DON conducted an in-service to all nurses on January 11, 2023 about the revised Wound Care Management policy, with emphasis on proper assessment of the wounds which includes measurements and appearance of the wound. The DON is responsible for monitoring the proper documentation of wound assessment in the Comprehensive Assessment and Skilled Nursing (SN) notes. The DON or its designee will audit 20% of charts monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3 months of monthly chart audits, the contents of this post-survey chart audit tool will be incorporated into the quarterly clinical record	

	to include but not limited to, wound care. Review indicated the patient's goals included, but were not limited to, maintaining skin integrity. Review of an agency document titled "OASIS-D1 [Outcome and Assessment Information Set] Start of Care" completed by the clinical manager and dated 8/19/2022, indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (a type of open pressure ulcer with partial thickness loss of skin) to the right buttocks. Review failed to evidence the comprehensive assessment included the depth of the wound and the appearance of the wound base. Review indicated the patient had a pressure ulcer stage I (a type of pressure ulcer with reddened, nonblanching, intact skin) to the right buttock and failed to evidence comprehensive assessment included the measurements and appearance of the wound. During an interview on 12/12/2022, at 10:52 AM, the clinical manager indicated the		Attachment-15). This tool will be used to continue monitoring 20% of patient's charts quarterly to ensure that this deficiency is corrected and will not recur.	

	should be included in the comprehensive assessment. The clinical manager indicated she was told that a stage I pressure ulcer did not need to be measured.			
N0529	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1(a)(2) A written summary report for each patient shall be sent to the: (A) physician; (B) dentist; (C) chiropractor; (D) optometrist or (E) podiatrist; at least every two (2) months. Based on record review and interview, the agency failed to ensure a complete summary of the care provided and the patient's status was written and sent to the physician at least every 60 days in 1 of 3 clinical records reviewed with falls. (#7) The findings include: Review of an agency policy obtained 12/14/2022, and dated April 2022, titled “60-Day	N0529	The DONreviewed 100% of all active patient charts on January 6 - 8, 2023 as part of thepost-survey chart audit to check for proper documentation of the 60-DaySummary. (Please see Attachment-20 for the tool that was and will beused for the first 3 monthly post-survey chart audits.) On January 11, 2023,the Director of Nursing (DON) conducted an in-service with the field staff,including Quality Assurance (QA), to re-educate them on the proper documentationof the 60-day Summary, including, but not limited to, change of medications andoccurrence of falls. (Pls see Attachment-3) The DON is responsible for monitoring properdocumentation of the 60-Day Summary and ensure that the deficient practice	2023-01-11

	Summary Report" stated, "… Information required in the 60-day summary report to the physician may include: … A summary of care and treatments/procedures provided … A summary of the patient's response to treatment … A summary of changes to the plan of care … The summary report will also be sent to the patient's attending physician every sixty days …." Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document titled "OT [occupational therapy] Discharge" dated 6/10/2022, which indicated the patient was discharged from OT services. Review of agency documents titled "Communication Note" dated 5/16/2022 and 6/14/2022, indicated the patient had a total of 3 falls. Review of an agency document titled "60-Day Summary/Case Conference" dated 6/30/2022, failed to evidence the summary included the OT services that were provided during the summary period of 5/3/2022 –		The DON or its designee will audit 20% of charts monthlyfor 3 months. Target threshold is100%. Once threshold is met and aftercompleting 3 months of monthly chart audits, the contents of this post-surveychart audit tool will be incorporated into the quarterly clinical record reviewtool (Pls see Attachment-15). This toolwill be used to continue monitoring 20% of patient's charts quarterly to ensurethat this deficiency is corrected and will not recur.	

	evidence the summary included the patient's falls that occurred during the summary period. During an interview on 12/9/2022, at 11:14 AM, the administrator indicated the summary should include the OT services the agency provided to the patient and the patient's falls.			
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 record review and interview, the home health agency failed to ensure all medications were reviewed as part of the comprehensive assessment the patient was currently using, to identify any potential adverse effects, drug reactions, significant side effects, significant drug interactions and duplicate medications in 4 of 7 clinical records reviewed. (#1, #5, #6, #7) Findings include: 1. Clinical record review on	G0536	The DON reviewed 100% of all active patient charts on January 6 - 8, 2023 as part of the post-survey chart audit to check for proper procedures and documentation of patient's medications in the Comprehensive Assessment and regular visit notes. (Please see Attachment-20 for the tool that was and will be used for the first 3 monthly post-survey chart audits.) The BOD met on January 9, 2023 (Pls see Attachment-1) and directed the DON to revise the Medication Profile policy to include (1) patient education on new medication's adverse effects, drug reactions, significant	2023-01-11

	12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "Medication Profile", which was signed by the clinical manager on 8/19/2022. Review indicated the patient's medications included, but were not limited to, Tramadol (a medication used to treat pain), ondansetron (a medication used to treat nausea), hydrocodone-acetaminophen (a medication used to treat pain), gabapentin (a medication used to treat seizures and nerve pain), mirtazapine (a medication used to treat depression), and Soma (a medication also known as carisoprodol used to treat musculoskeletal pain).		side effects, significant drug interactions, and duplicate medications, using written materials (2) notification of physician regarding any moderate to major drug interactions, (3) and proper documentation of patient's drug reactions and interactions in the Comprehensive Assessment and regular visit notes. The DON revised the Medication Profile policy (Pls see Attachment-12) on January 10, 2023. The DON conducted an in-service on January 11, 2023 to Field Staff about (1) handing out written materials on new medication's adverse effects, drug reactions, significant side effects, significant drug interactions, and duplicate medications, (2) notification of physician regarding any moderate to major drug interactions, (3) proper documentation of patient's drug reactions and interactions in the Comprehensive Assessment and regular visit notes (4) re-education on reviewing the medication profile every medication change, new and/or discontinued	

	Review of an agency document titled "Drug-Drug Interactions" dated 12/12/2022, indicated 8 major drug interactions. Review indicated a major drug interaction between acetaminophen-hydrocodone and Tramadol, Tramadol and mirtazapine, ondansetron and Tramadol, ondansetron and mirtazapine, carisoprodol and acetaminophen-hydrocodone, gabapentin and acetaminophen-hydrocodone, and gabapentin and Tramadol. Review of an agency document titled "OASIS-D1 [Outcome and Assessment Information Set] Start of Care" completed by the clinical manager and dated 8/19/2022, failed to evidenced medication interactions were identified. During an interview on 12/12/2022, at 10:40 AM, the clinical manager indicated the medication interactions should have been identified during the medication review at the start of care. Review of an agency document titled "Communication Note" electronically signed by the		medications, and (5) signing the medication profile after every review. The DON is responsible for monitoring the proper procedures and documentation of patient's medications in the Comprehensive Assessment and regular visit notes. The DON or its designee will audit 20% of charts monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3 months of monthly chart audits, the contents of this post-survey chart audit tool will be incorporated into the quarterly clinical record review tool (Pls see Attachment-15). This tool will be used to continue monitoring 20% of patient's charts quarterly to ensure that this deficiency is corrected and will not recur.	

	10/19/2022, indicated the patient was to start Nitrofurantoin (an antibiotic) and Fluconazole (a medication used to treat fungal infections). Review failed to evidence the medication profile was updated to include a review of the new medications for potential drug interactions. During an interview on 12/12/2022, at 11:35 AM, the clinical manager indicated the medication profile should be reviewed when a new medication is added. The clinical manager indicated the new medications were not reviewed for potential drug interactions. 2. Clinical record review on 12/12/2022, for Patient #6, start of care 11/30/2022, evidenced an unsigned, undated agency document titled "Medication Profile", which indicated the patient's medications included, but were not limited to Tramadol (a medication used to treat pain), Keppra (a medication used to treat seizures), aspirin (a medication used to treat pain/fever, and/or to thin the blood to prevent blood clots), and losartan (a			

	medication used to treat high blood pressure). The medication profile stated, "... I have reviewed all the listed medications for potential ... significant drug interactions ...." Review failed to evidence the drug profile was signed to verify the medications were reviewed since the start of care on 11/30/2022. Review of an agency document titled "Drug-Drug Interactions" dated 12/12/2022, indicated there were 5 moderate drug interactions, to include, but not limited to: tramadol and Keppra and aspirin and losartan. Review of an agency document titled "OASIS-D1 Start of Care (PT) [Physical Therapy]" completed by the PT and dated 11/30/2022, failed to evidenced medication interactions were identified. During an interview on 12/12/2022, at 3:43 PM, the administrator indicated the PT should have reviewed the medications to identify the drug interactions. The administrator indicated the PT should have signed the medication profile after reviewing the medications.			

	3. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/3/2022-7/1/2022, which indicated the patient's medications included, but were not limited to, aspirin (a medication used to treat pain/fever and/or to thin the blood to prevent blood clots) and Lexapro (a medication used to treat depression). Review indicated an increased risk in bleeding with the use of both aspirin and Lexapro. Review of an agency document titled "OASIS-D1 Start of Care (PT)" dated 5/3/2022. Review evidenced no issues were found during the drug review and failed to evidence the increased risk of bleeding between aspirin and Lexapro. During an interview on 12/9/2022, at 11:42 AM, the clinical manager indicated the PT should have identified the interaction of increased risk of bleeding during the drug review. 1. Record review evidenced an			

	agency policy dated April 2012, received 12/13/2022 titled, "Initial and Comprehensive Assessment," which stated "...the comprehensive patient assessment ... including at least the following information ... review of medication history ... and current medication use ... identifying drug interactions, duplicate drug therapy, and noncompliance with therapy ...." 2. Clinical record review for patient #1 on 12/08/2022, start of care 09/28/2022, evidenced an agency document titled, "Oasis [outcome and assessment information set]-D1 Recertification" for certification period 11/27/2022-01/25/2023 that indicated the medications were reconciled. This comprehensive assessment failed to evidence the medications were reviewed for drug interactions. Review evidenced an agency document titled, "Drug-Drug Interaction" dated 12/12/2022, indicated major drug interactions noted between fluoxetine (antidepressant) and ondansetron (prevent nausea and vomiting), fluoxetine and mirtazapine (antidepressant),			

	and ondansetron and mirtazapine. This document failed to evidence the physician was notified of the major drug interactions. During an interview on 12/12/2022, at 12:06 PM, the clinical manager indicated drug interactions are noted in Axxess (electronic medical record system) and should be noted on the comprehensive assessment that medications were reviewed, and the physician was notified of drug interactions. The clinical manager indicated there is no documentation of physician notification. 410 IAC 17-14-1(a)(1)(B)			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on record review and interview, the agency failed to update the comprehensive	G0544	The DON reviewed 100% of all active patient charts withComprehensive Reassessments on January 6 - 8, 2023 as part of the post-survey chartaudit to check if updates were made to reflect changes in health status or declinein patient's condition. (Please see Attachment-20 for the tool that was andwill be used for the first 3 monthly post-survey chart audits.) The DONconducted an	2023-01-11

	assessment after significant decline in the patient's health status in 1 of 1 clinical record reviewed with an injury sustained from a fall. (#7) The findings include: Review of an agency policy obtained 12/14/2022, and dated April 2012, titled "Reassessment/Recertification" stated, "... Each patient will be reassessed using a comprehensive OASIS [Outcome and Assessment Information Set] assessment tool for the review and revision of the plan of care when: ... There is a significant change in the patient's condition ...." Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced agency documents titled "Communication Note", which indicated the patient had falls on 5/15/2022, 5/29/2022, 6/11/2022, 6/20/2022, and 6/28/2022. Review indicated the patient hit their head, which required staples to the wound, during the fall on 6/11/2022. Review failed to evidence an updated comprehensive		in-service on January 11, 2023 to all field staff about updating& revising the Comprehensive Assessment as frequently as the patient'scondition warrants due to a major decline in the patient's health status, asstated in the Reassessment Policy. The DON is responsible for ensuring that ComprehensiveReassessments are updated or revised on patients who have major decline incondition. The DON or its designee will audit 20% of charts monthly for 3months. Target threshold is 100%. Once threshold is met and after completing 3months of monthly chart audits, the contents of this post-survey chart audittool will be incorporated into the quarterly clinical record review tool (Plssee Attachment-15). This tool will beused to continue monitoring 20% of patient's charts quarterly to ensure thatthis deficiency is corrected and will not recur.	

	assessment was completed after the start of care assessment on 5/3/2022 and prior to the recertification assessment on 6/30/2022. Review failed to evidence an assessment of the head wound. During an interview on 12/9/2022, at 11:33 AM, the administrator indicated the agency should complete a comprehensive assessment after a patient had a fall.			
G0548	Within 48 hours of the patient's return 484.55(d)(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner - ordered resumption date; Based on record review and interview, the comprehensive assessment failed to be completed to include the assessment of the wounds within 48 hours of the patient's return home from a hospital admission in 1 of 1 active clinical record reviewed with a hospitalization. (#5) The findings include:	G0548	The DON reviewed 100% of all clinical records of patients with wound on January 6 - 8, 2023 as part of the post-survey chart audit to check for proper documentation of wound assessment in the Comprehensive Assessment and Skilled Nursing (SN) notes. (Please see Attachment-20 for the tool that was and will be used for the first 3 monthly post-survey chart audits.) The BOD met on January 9, 2023	2023-01-11

	Review of an agency policy obtained 12/14/2022, and dated April 2012, titled "Reassessment/Recertification" stated, "... Each patient will be reassessed using a comprehensive OASIS [Outcome and Assessment Information Set] assessment tool for the review and revision of the plan of care when: ... The patient returns home after an inpatient admission lasting 24 hours or longer ...." Review of an undated agency policy obtained 12/14/2022, titled "Wound Care Management" stated, "... Documentation of wounds must include type of wound, measurements including length, depth, and width, description of the wound bed, surrounding area, undermining, staging, color, odor and estimated amount of drainage...." Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 10/18/2022-12/16/2022, which indicated the patient was to receive skilled nursing services,		(Pls see Attachment-1) and directed the DON to revise the Wound Care Management policy to include assessment of pressure ulcers and staging of pressure ulcer. The DON revised the Wound Care Management policy on January 10, 2023. (Pls see Attachment-11). The DON conducted an in-service to all nurses on January 11, 2023 about the revised Wound Care Management policy, with emphasis on proper assessment and documentation of the wounds which includes measurements and appearance of the wound. The DON is responsible for monitoring the proper documentation of wound assessment in the Comprehensive Assessment and SN notes. The DON or its designee will audit 20% of charts monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3 months of monthly chart audits, the contents of this post-survey	

	to include but not limited to, wound care. Review indicated the patient's goals included, but were not limited to, maintaining skin integrity. Review of an agency document titled "OASIS-D1 [Outcome and Assessment Information Set] Resumption of Care" completed by the clinical manager and dated 12/2/2022, indicated the patient was hospitalized from 11/25/2022 – 12/1/2022, for a urinary tract infection. Review indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage I (a type of pressure ulcer with reddened, nonblanching, intact skin) to the sacrum (lower back, above the buttocks). Review failed to evidence comprehensive assessment included the measurements and appearance of the wound. During an interview on 12/12/2022, at 10:52 AM, the clinical manager indicated the assessment of the wound base should be included in the comprehensive assessment. The clinical manager indicated she		chart audit tool will be incorporated into the quarterly clinical record review tool (Pls see Attachment-15). This tool will be used to continue monitoring 20% of patient's charts quarterly to ensure that this deficiency is corrected and will not recur.	

	ulcer did not need to be measured.			
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 to the receiving facility or health care practitioner of a discharged or transferred patient to ensure the safe and effective transition of care in 3 of 3 discharged or transferred patients. (#3, #5, #7) Findings include: 1. Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "Transfer Summary" dated 11/25/2022, which indicated the	G0564	On January 6 – 8, 2023, the DON reviewed 100% of all clinical records of patients who were discharged or transferred from December 15 – 31, 2022 as part of the post-survey chart audit to check for proper documentation of wound assessment in the Comprehensive Assessment and Skilled Nursing (SN) notes. (Please see Attachment-20 for the tool that was and will be used for the first 3 monthly post-survey chart audits.) The BOD met on January 9, 2023 (Pls see Attachment-1) and directed the DON to revise the policies on Discharge Summary and Transfer Summary including (1) sending a copy of the Transfer Summary & medication list to the	2023-01-11

	patient was transferred to the hospital. Review failed to evidence the agency provided the receiving hospital with the transfer summary. During an interview on 12/12/2022, at 11:18 AM, the administrator indicated the agency did not send the transfer summary to the hospital. 2. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document titled "Transfer Summary" dated 7/22/2022. Review failed to evidence to which facility the patient was transferred, the patient's condition, significant health history, and transfer orders and instructions. During an interview on 12/9/2022, at 10:49 AM, the administrator indicated the patient transferred to Hospital A for seizures and to rule out a stroke. The administrator indicated the transfer summary was not sent because it was not completed to include the facility to which the patient transferred and transfer orders/instructions. Review of an agency document		receiving facility or health care practitioner of a transferred patient within 2 days of transfer, (2) sending a copy of the Discharge Summary & medication list to the receiving facility or health care practitioner of a discharged patient within 5 days of discharge. The DON revised the policies on Discharge Summary (Pls see Attachment-13) and Transfer Summary (Pls see Attachment-14) on January 10, 2023. The DON conducted an in-service on January 11, 2023 to all field staff about (1) timely completion of Discharge and Transfer Summaries, and (2) documenting the receiving facility or health care practitioner to ensure safe and effective transition of care. The DON gave an in-service on January 11, 2023 to the secretary about (1) faxing Discharge Summary to the primary care practitioner or	

	titled "Physician Order" dated 8/5/2022, indicated the patient was discharged from the agency and being admitted to hospice. Review of an agency document titled "PT [physical therapy] Discharge Summary" dated 8/5/2022, failed to evidence discharge instructions and failed to evidence to which hospice agency the patient was discharged to. Review failed to evidence the discharge summary was provided to the hospice agency and the physician responsible for the plan of care. During an interview on 12/9/2022, at 10:49 AM, the administrator indicated the agency should include in the discharge summary the summary of the patient's care to include the diet, activities, upcoming physician appointments, safety precautions, and necessary equipment/supplies. 1. Record review evidenced an agency policy dated April 2012, received 12/13/2022 titled, "Discharge Planning," which stated "... clinicians will assist		other health care professional who will be responsible for providing care and services to the patient after discharge from the Agency within 5 days of the patient's discharge, and (2) faxing Transfer Summary to the receiving facility within 2 days of patient's transfer. The DON is responsible for monitoring proper documentation of Transfer and Discharge Summaries and timely transmission through fax to the receiving health care professional or facility. The DON or its designee will audit 20% of charts monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3 months of monthly chart audits, the contents of this post-survey chart audit tool will be incorporated into the quarterly clinical record review tool (Pls see Attachment-15). This tool will be used to continue monitoring 20% of patient's charts quarterly to ensure that this deficiency is	

	patients regarding their discharge by … sending a post discharge letter to the patient's physician ….” 2. Record review evidenced an agency policy dated April 2012, received 12/13/2022 titled, “Discharge Summary,” which stated “… a complete discharge summary … is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA [home health agency] within 5 business days of the patient's discharge ….” 3. Clinical record review of patient #3 on 12/08/2022, start of care 04/28/2022, evidenced an agency document titled, “PT [physical therapy] Discharge Summary” for discharge date 08/25/2022. This document failed to reveal the discharge summary was sent to the patient's physician or the receiving facility. During an interview on 12/12/2022, at 3:03 PM, the clinical manager indicated the discharge plan was not sent to the physician or facility upon		corrected and will not recur.	

	patient's discharge.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review, and interview, the home health agency failed to ensure the patient's services that are written in an individualized plan of care identifies patient specific measurable outcomes and goals (see tag G572); the plan of care included all required information for the treatment of the patient (see tag G574); the patient care orders including verbal orders in the plan of care (see tag G576); a revised plan of care by physician every 60 days (see tag G588); physician	G0570	The DON reviewed 100% of all active patient charts on January 6 - 8, 2023 as part of the post-survey chart audit. (Please see Attachment-20 for the tool that was and will be used for the first 3 monthly postsurvey chart audit.) The chart audit done for tags G-572, G-574, G-576, G-588, G-590, G-596, G-606, G-610, G-612, and G-616 were part of the audit for tag G-570. The DON conducted an in-service on January 11, 2023 to all field staff about (1) ensuring patient services that are written in the individualized plan of care addresses patient's specific measurable outcomes & goals, (2) inclusion of all required information for the treatment of the patient in the plan of care, (3) inclusion of verbal orders in the plan of care, (4) a revised plan of care	2023-01-11

	G590); revisions to the plan of care due to a change in patient's health status must be communicated to the patient and all physicians (see tag 596); integrate services that could affect patient safety and treatment (see tag G606); each patient receive ongoing education and training identified in the plan of care (see tag G610); failed to include written instructions to the patient to include a visit schedule (see tag G612); and failed to include patient medication instructions written in plan language (see tag 616). The cumulative effect of these systemic problems has results 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 Care and Quality of Care. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the home health agency failed to ensure the patient's medical and social needs were met in (3 of 7) clinical records reviewed. (#3, #5, #7)		(5) physician notification of changes, (6) revisions to the plan of care due to a change in patient's health status must be communicated to the patient and all physicians, (7) integrated services that could affect patient's safety and treatment, (8) providing each patient with on-going education and training identified in the plan of care, (9) providing written instructions to the patient including a visit schedule, and (10) providing patient medication instruction written in plain language. The DON is responsible for ensuring that the field staff understands and follows items #1-10 of the previous paragraph. The DON or its designee will audit 20% of charts monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3 months of monthly chart audits, the contents of this post-survey chart audit tool will be incorporated into the quarterly clinical record	

	Findings include: 1. Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "OASIS-D1 [Outcome and Assessment Information Set] Start of Care" completed by the clinical manager and dated 8/19/2022. Review indicated the patient was at risk for falls, required assistance for dressing, bathing, toileting, and ambulation. Review indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (a type of open pressure ulcer with partial thickness loss of skin) to the right buttocks and a pressure ulcer stage I (a type of pressure ulcer with reddened, nonblanching, intact skin) to the right buttock. Review indicated the patient was at risk for skin breakdown and indicated the patient required 24 hour supervision. Review evidenced the patient lived with her daughter, who was the primary caregiver. Review failed to evidence the agency offered home health aide services to assist the patient with personal care and		Attachment-15). This tool will be used to continue monitoring 20% of patient's charts quarterly to ensure that this deficiency is corrected and will not recur.	

	activities of daily living. During an interview on 10/14/2022, at 9:02 AM, the patient's caregiver indicated she has had to quit her job to care for her mother and indicated the patient is bedridden. The caregiver indicated she could use assistance from a home health aide to help with the patient's bathing and personal care and indicated she was not offered home health aide services from the agency. During an interview on 12/12/2022, at 11:51 AM, the administrator indicated home health aide services were not offered to the patient because the agency did not provide home health aide services. 2. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document titled "OASIS-D1 Start of Care (PT) [Physical Therapy]" dated 5/3/2022. Review indicated the patient was at risk for falls; was dependent for grooming and dressing; required assistance with toileting, bathing, transferring; and was chairfast. Review indicated the patient			

	required a 2 person moderate to maximum assistance due to severe neurological and cognitive dysfunction. Review indicated the patient lived in an assisted living facility. Review failed to evidence the patient was offered home health aide services to assist with patient care. Review failed to evidence if the assisted living provided dependent care to meet the patient's needs. Review of agency documents titled "Communication Note" indicated the patient had falls on 5/15/2022, 5/29/2022, 6/11/2022, 6/20/2022, 6/28/2022, 7/14/2022, 7/19/2022, and 7/21/2022. Review failed to evidence the agency offered home health aide services to assist with patient transfers and activities of daily living. Review of an agency document titled "Recertification (PT)" dated 6/30/2022, indicated the patient was dependent for grooming and dressing and needed assistance for bathing, toileting, and transfers. Review indicated occupational therapy was recommended. Review failed to evidence occupational			

	therapy was offered to the patient. During an interview at the entrance conference on 12/7/2022, at 10:44 AM, the administrator indicated the agency did not offer home health aide services and did not contract with another agency for home health aide services. The administrator indicated if the patient was assessed to need home health aide services, the agency would inform the physician so the patient could go to another agency that offered home health aide services.			

	During an interview on 12/9/2022, at 11:04 AM, the administrator indicated the agency did not offer home health aide services to assist with personal care because the agency did not provide home health aide services. The administrator indicated she was unsure if the assisted living facility provided dependent care. The administrator indicated if another discipline was recommended, the physician should be contacted for the order for that discipline to evaluate. The cumulative effect of these systemic problems has results 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 Care and Quality of Care. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the home health agency failed to ensure the			

needs were meet in (# of #) clinical records reviewed. (#3)

1. Record review evidenced an agency policy revised 02/09/2020, received 12/13/2022 titled, "Coordination of Services," which stated, "... the following are essential components of professional coordination and supervision of services to assigned patients for the ongoing evaluation of the patient's needs: ... maintaining efficient communication with patient, family, physician, and all care providers to ensure prompt transmission of significant information which may require immediate action or decision-making. Coordinating with patient, family, caregivers, and all involved services to unify and maximize their contributions to ensure patient safety, comfort, and benefits of services ...."

2. Record review evidenced an agency policy dated April 2012, received 12/13/2022, titled, "Admission Criteria and Process," which stated,"... A patient will be accepted for care based on consideration. Consideration will be given to

	the adequacy and suitability of organization personnel, resources to provide the required services, and the reasonable expectation that the patient's medical, nursing, rehabilitative, and social needs can be adequately met in the patient's place of residence ...." 3. Clinical record review on 12/08/2022 for patient #3, start of care 04/28/2022, evidenced an agency document titled, "Oasis [outcome and assessment information set]-D1, Recertification (PT) [physical therapy]" for certification period 06/27/2022-08/25/2022. This comprehensive assessment identified needs for self-care deficits related to dressing and to consider need for OT (occupation therapy) and HHA (home health aide), and for cognition consider need for OT, ST (speech therapy), MSW (social worker). This comprehensive assessment indicated OT for other disciplines recommended. This document failed to evidence OT, HHA, ST, or MSW was recommended to physician. During an interview on			

	administrator indicated their agency does not currently employ home health aides. During an interview on 12/12/2022, at 2:54 PM, the clinical manager indicated the care coordination regarding recommendations on the comprehensive assessment would require contacting the physician's office to get approval and then notifying the assisted living facility nurse. The clinical manager indicated she would have to check with the physical therapist to see what happened with the OT and HHA considerations/recommendations. During an interview on 12/14/2022, at 11:15 AM, the clinical manager indicated she had contacted PT #2 and PT #2 indicated he had spoken to the occupational therapist and the occupational therapist indicated the patient had reach the max potential during occupational therapy prior. The clinical manager indicated there was no documentation of PT discussion with the OT. The clinical manager indicated she doesn't remember if she was notified			

	regarding recommendations provided by the PT or OT. 410 IAC 17-13-1(a)			
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 record review and interview, the agency failed to provide the services as directed in the plan of care in 1 of 2 clinical records reviewed with wounds. (#5) The findings include: Review of an undated agency policy on 12/14/2022, titled "Physician's Plan of Care" stated, "... Skilled nursing and other home health services	G0572	The DON reviewed 100% of all clinical records of patients on January 6 - 8, 2023 as part of the post-survey chart audit to check for staff's compliance to the patient's Plan of Care. (Please see Attachment-20 for the tool that was and will be used for the first 3 monthly post-survey chart audits.) The DON conducted an in-service on January 11, 2023 to all field staff to follow the Plan of Care, including, but not limited to, (1) medication reconciliation, (2) patient education on risks (e.g., bleeding) when taking certain medications. The DON is responsible for ensuring that the field staff follow the patient's Plan of	2023-01-11

	should be provided in accordance with a plan of care based on the patient's diagnosis and assessment ...." Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 10/18/2022-12/16/2022, which indicated the skilled nurse was to reconcile the patient's medications at every visit and educate on the risk of anticoagulant (a type of medication that thins the blood to prevent blood clots and increasing the risk of bleeding) use. Review of agency documents titled "Skilled Nurse Visit" completed by the clinical manager and dated 11/3/2022, 11/9/2022, 11/16/20221, and 11/21/2022 failed to evidence the nurse reconciled the patient's medications as directed in the plan of care. Review failed to evidence the patient was educated on the risk of bleeding as directed in the plan of care. During an interview on		goals and properly document all services provided during visit in the visit notes. The DON or its designee will audit 20% of charts monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3 months of monthly chart audits, the contents of this post-survey chart audit tool will be incorporated into the quarterly clinical record review tool (Pls see Attachment-15). This tool will be used to continue monitoring 20% of patient's charts quarterly to ensure that this deficiency is corrected and will not recur.	

	12/12/2022, at 11:40 AM, the clinical manager indicated the medications should have been reconciled at every visit. At 11:43 AM, the clinical manager indicated she did not see education on the risk of bleeding was provided to the patient.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and	G0574	The DON reviewed 100% of all clinical records of patients on January 6 - 8, 2023 as part of the post-survey chart audit to check for therapists' compliance to the Therapy Services policy, including proper coordination with other disciplines and complete documentation. (Please see Attachment-20 for the tool that was and will be used for the first 3 monthly post-survey chart audits.) The BOD met on January 9, 2023 (Pls see Attachment-1) and directed the DON to revise the Therapy Services policy, which includes therapist coordination with Nurse on Duty in assisted living facilities regarding new or changed medications. The	2023-01-11

	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 mental, psychosocial, cognitive status, types of services, supplies, equipment required, frequency and duration of visits, all medications, treatments and safety measures to protect again injury were in the patients individualized plan of care in 6 of 7 clinical records reviewed. (#1,#2, #3, #5, #6, #7) Findings include: 1. Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 10/18/2022-12/16/2022, which indicated the patient's medications included, but were not limited to, Nystatin (a medication used to treat fungal infections) to affected areas and Lidocaine patches (a medication used to relieve pain) to affected areas. Review failed to evidence the plan of care included to		BOD also directed the DON to revise the Medication Profile policy to include the specific "site of administration" of the medications. The DON revised the Therapy Services policy on January 10, 2023. (Pls see Attachment-16). The DON conducted an in-service on January 11, 2023 to all field staff on (1) coordination with nurse on duty in assisted living facilities regarding new or changed medications, (2) inclusion of DME (e.g., gait belt, compression stockings) in the Plan of Care, (3) inclusion of "site of administration" in the medication profile, and (4) inclusion of safety measures [e.g., seizure precautions, bleeding precautions] in the Plan of Care. The DON is responsible for ensuring that the field staff will (1) coordinate with Nurse on Duty of assisted living facilities regarding new or changed medications, (2) include DMEs and Safety measures in the Plan of Care, and (3) include the "site of	

	what areas of the body were the affected areas for the application of Nystatin and Lidocaine. Review indicated a blank for what emphasis the skilled nurse was to focus the physical assessment on and what comorbidities the skilled nurse was to assess. During an interview on 12/12/2022, the administrator indicated the Nystatin was to be applied to the groin and the Lidocaine patches were to be applied to the knees and back. The administrator indicated she leaves the blanks on the plan of care to double-check what goes in the blanks. 2. Clinical record review on 12/12/2022, for Patient #6, start of care 11/30/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/30/2022-1/28/2023. Review indicated the patient's diagnoses included, but were not limited to, epilepsy (a brain disorder that causes seizures), and indicated the patient's medications included, but were not limited to, Keppra (a medication used to		administration" of medications in the Medication Profile. The DON or its designee will audit 20% of charts monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3 months of monthly chart audits, the contents of this post-survey chart audit tool will be incorporated into the quarterly clinical record review tool (Pls see Attachment-15). This tool will be used to continue monitoring 20% of patient's charts quarterly to ensure that this deficiency is corrected and will not recur.	

	failed to evidence the plan of care included safety measures of seizure precautions. During an interview on 12/12/2022, at 3:35 PM, the clinical manager indicated seizure precautions should be included in the plan of care. 3. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/3/2022-7/1/2022, which indicated the patient's medications included, but were not limited to, aspirin (a medication used to treat pain/fever and/or to thin the blood to prevent blood clots) and Lexapro (a medication used to treat depression). Review indicated an increased risk in bleeding with the use of both aspirin and Lexapro and failed to evidence the plan of care included bleeding precautions as a safety measure. During an interview on 12/9/2022, at 11:42 AM, the administrator indicated bleeding risk should have been included in the plan of care.			

	1. Record review evidenced an undated agency policy received 12/13/2022 titled "Physician's Plan of Care," which stated, "... the plan of care should include: medications ... treatments ... mental status ... types of services, frequency of visits, equipment/supplies required, and safety measures to protection against injury ...." 2. Clinical record review of patient #1 on 12/08/2022, start of care 09/28/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period 11/27/2022-01/25/2023, which stated, "... medications glucose (for low blood sugar), oxygen, atorvastatin (cholesterol lowering medication), carvedilol (heart medication), furosemide (diuretic), metolazone (diuretic), Norco (pain medication), and NovoLog (insulin) ...." Record review on 12/08/2022 evidenced assisted living facility B document, received 12/08/2022, titled, "Physician's Orders for 12/08/2022 which indicated medication Glimepiride (blood sugar			

daily for order date 11/08/2022.

The plan of care failed to evidence the medication Glimepiride.

During an interview on 12/12/2022, at 12:16 PM, the clinical manager indicated the physical therapist should get a medication list from the assisted living facility and give to the nurse to check and verify medications are current and clarify with physician if any new medications noted. The clinical manager was notified of glimepiride medication was not on the plan of care but on assisted living facility's medication list. The clinical manager did not respond.

Observation on 12/08/2022, at 11:05 AM, evidenced physical therapy use of a gait belt on patient for sitting to standing from wheelchair.

The plan of care failed to evidence the gait belt under DME (durable medical equipment) and supplies.

3. Clinical record review of patient #3, start of care 04/28/2022, evidenced an

	Health Certification and Plan of Care," for certification period 06/27/2022-08/25/2022 which stated, "DME [durable medical equipment] and Supplies... tub/shower bench, grab bars, wheelchair ...." Record review on 12/08/2022, evidenced an agency document dated 08/13/2022, titled, "PT [physical therapy] Visit," which stated, "...continue walking the patient using a gait belt for safety ...." The plan of care failed to evidence the gait belt under DME and supplies. During an interview on 12/12/2022, at 12:22 PM, the clinical manager indicated the gait belt should be on the plan of care. 4. Clinical record review on 12/08/2022, for patient #2, start of care 11/10/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period 11/10/2022-01/08/2023, which stated, "...DME [durable medical equipment] walker, wheelchair, cane, oxygen, nebulizer, tub/shower bench ...."			

	Observation on 12/08/2022, at 9:00 AM, evidenced use of bilateral lower extremity compression stockings. The plan of care failed to include compression stockings under DME and supplies. During an interview on 12/12/2022, at 3:10 PM, the clinical manager indicated the compression stockings should be included on the plan of care. 410 IAC 17-13-1(a)(1)(c)			
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Based on observation, record review, and interview, the home health agency failed to include all patient care orders, including verbal orders in the plan of care in 1 of 3 patients receiving skilled nursing care. (#4) Findings include: Record review evidenced an agency policy dated April 2012, received 12/13/2022, titled,	G0576	As part of the post-survey audit, the DON called 100% of active patients in the homes and in assisted living facilities on January 6 - 8, 2023 to check if there were over-the-counter medications and/or new or changed medications that were not included in the Medication Profile. (Please see Attachment-20 for the tool that was and will be used for the first 3 monthly post-survey chart audits.) The	2023-01-11

	"Verification of Physician Orders," which stated "... orders will be documented on a form provided by Amore Home Health Care Services, Inc., dated and signed by the professional receiving the order. A copy of the physician's order will be kept in the clinical record ...." Record review evidenced an undated agency policy received on 12/13/2022, titled, "Physician's Plan of Care," which stated, "... the plan of care should include ... medications, and treatments ...." Clinical record review of patient #4 on 12/08/2022, evidenced an assisted living facility B document dated 12/13/2022, titled, "Physician's Orders for 12/13/2022," which stated, "... treatment: Eucerin cream apply to bilateral lower extremities every day ...." Review evidenced an agency document titled, "Home Health Certification and Plan of Care" for certification period 11/10/2022-01/08/2023, which stated, "... wound care to open wounds on left lower extremity every skilled nurse visit. Cleanse wound with NS [normal saline],		DON conducted an in-service on January 11, 2023 to field staff about including over-the-counter medications in the Medication Profile and coordinating with nurse on duty in assisted living facilities regarding new or changed medications. The DON is responsible for ensuring that the field staff will (1) include over-the-counter medications in the Medication Profile, and (2) coordinate with nurse on duty of assisted living facilities regarding new or changed medications. The DON or its designee will call 20% of patients monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3 months of monthly chart audits, the contents of this post-survey chart audit tool will be incorporated into the quarterly clinical record review tool (Pls see Attachment-15). This tool will be used to continue monitoring 20% of patient's charts quarterly to ensure that this deficiency is	

	pat dry, apply silver alginate dressing and wrap with kerlix ...." The home health agency plan of care failed to evidence Eucerin cream to lower extremities. Observation of a home visit on 12/13/2022, at 10:30 AM, evidenced the clinical manager applied Eucerin cream to bilateral lower extremities. During an interview on 12/13/2022, at 1:08 PM, the clinical manager indicated the Eucerin cream was ordered by the nurse practitioner at assisted living facility B based on the clinical manager's discussion with the nurse practitioner, and the order was on the assisted living facility's B treatment order. The clinical manager indicated the Eucerin cream was not a prescription medication so an order does not need to be written.		corrected and will not recur.	
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the	G0588	The DON reviewed 100% of all clinical records of patients on January 6 - 8, 2023 as part	2023-01-11

	home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the agency failed to revise the plan of care as frequently as the patient's care required in 2 of 2 clinical records reviewed with hospitalizations. (#5, 7) The findings include: 1. Review of an undated agency policy obtained 12/14/2022, titled "Physician's Plan of Care" stated, "... The plan should be reviewed and updated as necessary by the home health services team every sixty (60) days or more often should the patient's condition warrant...." 2. Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced agency documents titled "Home Health Certification and Plan of Care" for certification period 8/19/2022-10/17/2022 and 10/18/2022-12/16/2022, which indicated the patient's goals included, but were not limited to, the patient would remain free from falls/injury and would remain free of signs and symptoms of urinary tract infection.		of the post-survey chart audit to check the Plan of Care upon Reassessment if the goals were updated based on any changes in patient's condition. (Please see Attachment-20 for the tool that was and will be used for the first 3 monthly post-survey chart audits.) The DON conducted an in-service on January 11, 2023 to field staff about revising the goals in the Plan of Care upon reassessment to suit the current status of the patient (such as falls, UTI, pressure ulcer). The DON is responsible for ensuring that the field staff will revise goals in the Plan of Care upon reassessment to suite the current status of the patient. The DON or its designee will audit 20% of charts monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3 months of monthly chart audits, the contents of this post-survey chart audit tool will be incorporated into the quarterly clinical record	

	Review of an agency document titled "60-Day Summary/Case Conference" dated 10/14/2022, indicated the patient had a fall and a urinary tract infection during the certification period. Review failed to evidence the plan of care was revised to reflect a change in the patient's goals related to the falls and urinary tract infection. Review of an agency document titled "OASIS-D1 [Outcome and Assessment Information Set] Resumption of Care" completed by the clinical manager and dated 12/2/2022, indicated the patient was hospitalized from 11/25/2022 – 12/1/2022 for a urinary tract infection. Review failed to evidence the plan of care was revised to reflect a change in the patient's goals related to urinary tract infections. During an interview on 12/12/2022, at 11:07 AM, the administrator indicated the agency did not change the goals but should have made them something different since the patient did have a fall and a urinary tract infection. Review of an agency document		review tool (Pls see Attachment-15). This tool will be used to continue monitoring 20% of patient's charts quarterly to ensure that this deficiency is corrected and will not recur.	

	titled "Home Health Certification and Plan of Care" for certification period 10/18/2022-12/16/2022, indicated the patient's primary diagnosis was a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (a type of open pressure ulcer with partial thickness loss of skin) to the left buttock. Review of an agency document titled "Skilled Nurse Visit", dated 11/21/2022, indicated the wound to the patient's left buttock was healed. Review failed to evidence the plan of care was revised to reflect the change in the patient's primary diagnosis before 12/2/2022. During an interview on 12/12/2022, at 11:21 AM, the administrator indicated the plan of care was not revised until 12/2/2022. 3. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 7/2/2022-8/20/2022, which			

	services were to be provided 1 time a week for 8 weeks. Review indicated the PT goals included, but were not limited to, the patient would remain free from falls/injury. Review of agency documents titled "Communication Note" indicated the patient had falls on 7/14/2022, 7/19/2022, and 7/21/2022. Review failed to evidence the plan of care was revised to reflect a change in the PT goals related to the patient's falls. Review of an agency document titled "Physician Order" dated 7/28/2022, indicated the PT services were changed to 1 time a week for 3 weeks for range of motion exercise to decrease the risk of contractures. Review failed to evidence the plan of care was revised to reflect a goal related to the risk of contractures. During an interview on 12/9/2022, at 11:31 AM, the administrator indicated the plan of care should have been revised to reflect the risk of contractures and the patient's repeated falls.			

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 record review and interview, the agency failed to notify the physician of changes in the patient's condition in 3 of 7 clinical records reviewed. (#5, 6, 7) The findings include: 1. Review of an agency policy obtained 12/14/2022, and revised 2/9/2020, titled "Coordination of Services" stated, "... The following are essential components of professional coordination ... maintaining efficient communication with patient, family, physician ... to ensure prompt transmission of significant information which may require immediate action or decision-making...." 2. Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "SN	G0590	The DON reviewed 100% of all clinical records of patients on January 6 - 8, 2023 as part of the post-survey chart audit to check if physicians were notified about significant patient findings that may require immediate action or decision-making. (Please see Attachment-20 for the tool that was and will be used for the first 3 monthly post-survey chart audits.) The DON conducted an in-service on January 11, 2023 to field staff about coordination of services, including prompt transmission of significant information to the physician which may require immediate action or decision-making (e.g., change in wound status, diarrhea, falls). The DON is responsible for ensuring that the field staff will notify the physician of significant patient findings which may require immediate action or decision-making. The DON or its designee will	2023-01-11

	Visit" completed by the registered nurse (RN) and dated 11/3/2022. Review indicated the patient's wound to the left buttock had purulent drainage and failed to evidence the physician was notified of the change in wound care status. During an interview on 12/12/2022, at 11:13 AM, the clinical manager indicated the physician should be notified with any deterioration of the wound. 3. Clinical record review on 12/12/2022, for Patient #6, start of care 11/30/2022, evidenced an agency document titled "Occupational Therapy Assessment/Evaluation" completed by the occupational therapist and dated 12/1/2022. Review indicated the patient complained of having diarrhea throughout the night before due to the nurse from the assisted living giving her a laxative that was not a normal medication for the patient. Review failed to evidence the occupational therapist notified the physician of the patient's diarrhea. During an interview on		audit 20% of charts monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3 months of monthly chart audits, the contents of this post-survey chart audit tool will be incorporated into the quarterly clinical record review tool (Pls see Attachment-15). This tool will be used to continue monitoring 20% of patient's charts quarterly to ensure that this deficiency is corrected and will not recur.	

	12/12/2022, at 3:45 PM, the clinical manager indicated the occupational therapist should have called the physician. 4. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document titled "Communication Note" dated 6/30/2022, which indicated the patient had falls on 6/20/2022 and 6/28/2022. Review failed to evidence the physician was notified of the patient's falls. During an interview on 12/9/2022, at 11:33 AM, the administrator indicated the agency should have notified the physician of the falls.			
G0596	Revisions communicated to patient and MDs 484.60(c)(3)(i) (i) Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, and all physicians or allowed practitioner's issuing orders for the HHA plan of care. Based on record review and interview, the agency failed to communicate change in discharge plans to the physician in 1 of 2	G0596	On January 6 - 8, 2023, the DON reviewed 100% of all clinicalrecords of patients discharged from December 15 to 31, 2023 as part of the post-surveychart audit to check if physicians were notified about patient's discharge. (Pleasesee Attachment-20 for the tool that was and will be used for the first 3 monthlypost-survey chart	2023-01-11

	closed records reviewed. (#7) The findings include: Review of an agency policy dated April 2012, and obtained 12/14/2022, titled "Discharge Planning" stated, "... Provide information regarding the patient discharge potential at case conferences with other team members ... All communication and information regarding discharge planning will be documented in the clinical record...." Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced agency documents titled "Physician Order", which indicated the PT was to provide services 1 time a week for 3 weeks per the order signed by the PT and dated 7/29/2022. Review of document dated 8/5/2022, and with a fax date to the physician of 8/25/2022, indicated the patient was discharged from the agency and was to be admitted to hospice. Review failed to evidence the physician was notified of the change in discharge plans prior to the order being faxed to the		audits.) The DON conducted an in-service on January 11, 2023to field staff about providing information regarding patient discharge to thephysician. The DON is responsible for ensuring that the field staff willnotify the physician of the patient's discharge. The DON or its designee willaudit 20% of charts monthly for 3 months. Target threshold is 100%. Oncethreshold is met and after completing 3 months of monthly chart audits, thecontents of this post-survey chart audit tool will be incorporated into thequarterly clinical record review tool (Pls see Attachment-15). This tool will be used to continue monitoring20% of patient's charts quarterly to ensure that this deficiency is correctedand will not recur.	

	physician for signature on 8/25/2022. During an interview on 12/9/2022, at 12:16 PM, the administrator indicated there was no documentation of communication to the physician regarding the change in discharge plans.			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on observation record review and interview, the home health agency failed to integrate services to assure the identification of patient needs that could affect patient safety and treatment effectiveness and failed to ensure the coordination of care was provided by all disciplines, in 4 of 7 clinical records reviewed. (#1, #5, #6, #7) Findings include: 1. Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an	G0606	The DON reviewed 100% of all clinical records of patients on January6 - 8, 2023 as part of the post-survey chart audit to check if patient findingswere coordinated with other health care provider. (Please see Attachment-20 forthe tool that was and will be used for the first 3 monthly post-survey chartaudits.) The DON conducted an in-service on January 11, 2023 to field staffabout coordination of care with other providers to integrate services to assurethat patient needs, patient safety and treatment effectiveness are met (e.g.,more rest periods during therapy session due to shortness of breath &fatigue reported to a different care provider prior to the visit, coordinationwith clinical	2023-01-11

	[Physical Therapy] Discharge" completed by the PT and dated 10/12/2022, indicated the patient refused the PT visit due to the patient complaining of being in a lot of pain. Review failed to evidence the PT reported to the case manager to patient's refusal of the PT visit and the patient's complaint of pain. During an interview on 12/12/2022, at 11:36 AM, the clinical manager indicated she did not see any documentation that the patient's report of pain and refusal of the PT was visit was communicated to the case manager. The clinical manager indicated the PT should have called her to coordinate care.		manager about patient's refusal of therapy due to pain, coordinationwith facility nurse on duty regarding new medication, and coordination withfacility nurse on duty regarding giving discharge instructions to patient withmemory deficits & confusion). The DON is responsible for ensuring that the field staff willcoordinate patient's care with other providers. The DON or its designee willaudit 20% of charts monthly for 3 months. Target threshold is 100%. Oncethreshold is met and after completing 3 months of monthly chart audits, thecontents of this post-survey chart audit tool will be incorporated into thequarterly clinical record review tool (Pls see Attachment-15). This tool will be used to continue monitoring20% of patient's charts quarterly to ensure that this deficiency is correctedand will not recur.	

	2. Clinical record review on 12/12/2022, for Patient #6, start of care 11/30/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/30/2022-1/28/2022, which indicated the agency was providing physical therapy and occupational therapy services. Review failed to evidence the patient's medications included a laxative (a type of medication used to treat constipation). Review of an agency document titled "Occupational Therapy Assessment/Evaluation" completed by the occupational therapist and dated 12/1/2022, indicated the patient complained of having diarrhea throughout the night before due to the nurse from the assisted living giving her a laxative that was not a normal medication for the patient. Review failed to evidence the occupational therapist notified the physical therapist and failed to evidenced coordination of care with the assisted living to determine what laxative was administered to the patient. During an interview on 12/12/2022, at 3:45 PM, the			

clinical manager indicated she did not see any coordination of care with the assisted living facility and the physical therapist. The clinical manager indicated she was not sure what laxative was administered to the patient and indicated the patient did not have an order for a laxative. The clinical manager indicated the occupational therapist should have reported the patient's complaint of diarrhea to the clinical manager.

3. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document titled "OASIS-D1 [Outcome and Assessment Information Set] Start of Care (PT)" dated 5/3/2022. Review indicated the patient lived in an assisted living facility and indicated the patient was assessed to have a memory deficit with constant confusion.

Review of an agency document titled "OT [occupational therapy] Discharge" dated 6/10/2022, indicated the patient had severely impaired short and long term memory and indicated the patient was

with toilet transfer, feeding, and transfers. Review indicated the occupational therapist provided discharge instructions to the patient and failed to evidence the coordination of care was provided to the assisted living to include discharge instructions.

During an interview on 12/9/2022, at 11:13 AM, the administrator indicated the agency should coordinate care with the assisted living regarding the OT discharge instructions.

1. Record review evidenced an agency policy revised 02/09/2020, received 12/13/2022 titled, "Coordination of Services," which stated, "... the following are essential components of professional coordination and supervision of services to assigned patients for the ongoing evaluation of the patient's needs: ... maintaining efficient communication with patient, family, physician, and all care providers to ensure prompt transmission of significant information which may require immediate action or decision-making. Coordinating

	with patient, family, caregivers, and all involved services to unify and maximize their contributions to ensure patient safety, comfort, and benefits of services ...." 2. Observation of patient #1, start of care 09/28/2022, on 12/08/2022, at 10:55 AM, evidenced patient requiring frequent rest periods due to shortness of breath and fatigue. On 12/08/2022, at 11:10 AM, the patient indicated she felt nervous. Interview regarding patient #1 on 12/08/2022 at 11:30 AM, start of care 09/28/2022, with assisted living facility B, nurse C. This interview was conducted after the patient physical therapy visit. Nurse C indicated the patient had an incident that morning of being anxious and short of breath, nurse C indicated wheezing was noted, nurse C stated she contacted the physician and ordered a chest xray that would be done on 12/08/2022. During an interview with PT (physical therapist) #1 on 12/08/2022, at 10:45 AM the PT			

	with assisted living facility B by giving update to nurse after PT care visit completed. During an interview on 12/12/2022, at 12:18 PM, the clinical manager indicated the PT should have talked to the nurse prior to the start of physical therapy and should have contacted the physician to see if should continue the physical therapy. 410 IAC 17-12-2(h)			
G0610	Patients receive education and training 484.60(d)(5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge. Based on record review and interview, the agency failed to provide patient/caregiver education in 1 of 2 clinical records reviewed with an infection. (#5) The findings include: Review of an agency document on 12/14/2022, and dated April	G0610	On January 6 - 8, 2023, the DON reviewed 100% of all clinicalrecords of patients discharged from December 15 to 31, 2023 as part of the post-surveychart audit to check if patients were given education on medications prior todischarge. (Please see Attachment-20 forthe tool that was and will be used for the first 3 monthly post-survey chartaudits.) The DON conducted an in-service on January 11, 2023 to fieldstaff about providing education to patient/patient caregiver prior to	2023-01-11

	2012, titled "Medication Profile" stated, "... Each patient will receive appropriate written material for specific medications he/she is receiving. The material will contain information on actions of the medication, potential side effects, contraindications the patient should be aware of, and any special instructions when taking the specific medication...." Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "SN [skilled nurse] Wound Care Visit" completed by the registered nurse (RN) and dated 10/27/2022. Review indicated the patient received new medications for a urinary tract infection, nitrofurantoin (an antibiotic) and fluconazole (a medication used to treat fungal infections). Review failed to evidence the RN provided education related to the new medications to the patient and/or caregiver. During an interview on 12/12/2022, at 11:11 AM, the clinical manager indicated the agency should have printed out a drug information sheet to give		dischargerelated to new medications by giving written materials on actions of themedication, potential side effects, contraindications the patient should beaware of, and any special instructions when taking the specific medication. The DON is responsible for ensuring that the field staff willprovide education to the patient/patient caregiver on new medications prior todischarge. The DON or its designee will audit 20% of charts monthly for 3months. Target threshold is 100%. Once threshold is met and after completing 3months of monthly chart audits, the contents of this post-survey chart audittool will be incorporated into the quarterly clinical record review tool (Plssee Attachment-15). This tool will beused to continue monitoring 20% of patient's charts quarterly to ensure thatthis deficiency is corrected and will not recur.	

	to the patient and reviewed medication side effects and indications for use. The clinical manager indicated she did not see that education was provided to the patient on the new medication.			
G0612	Written instructions to patient include: 484.60(e) Standard: Written information to the patient. The HHA must provide the patient and caregiver with a copy of written instructions outlining: Based on observation, record review, and interview the home health agency failed to include written instructions to the patient regarding visit schedule in 1 of 2 skilled nurse assisted living facility visits. (#4) Findings include: Record review evidenced an agency policy dated April 2012, received on 12/13/2022, titled, "Admission Criteria and Process," stated, "... upon acceptance into service, the patient will be provided with an organization brochure and various educational materials providing the patient and family/caregiver with sufficient	G0612	As part of the post-survey audit, the DON called 100% ofactive patients in the homes and in assisted living facilities on January 6 -8, 2023 to check if their nurse/therapist provided a visit schedule in theirhomes. (Please see Attachment-20 for the tool that was and will be used for thefirst 3 monthly post-survey chart audits.) The DON conducted an in-service on January11, 2023 to field staff about providing the patient/patient caregiver withvisit schedule during which care and service will be given. The clinician will use the calendar providedin the Patient Assessment Book. The DON is responsible for ensuring that the field staff willprovide a visit schedule to	2023-01-11

	information on: ... hours during which care and service is available ...." Observation during a home visit for patient #4, on 12/13/2022, at 10:30 AM, evidenced a home health patient folder in which the visit schedule calendar was blank. During an interview on 12/13/2022, at 10:40 AM, the clinical manager indicated the patient visit schedule was verbalized with the nurse at the assisted living facility.		The DON or itsdesignee will call 20% of patients monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3months of monthly audits, the contents of this post-survey chart audit toolwill be incorporated into the quarterly clinical record review tool (Pls seeAttachment-15). This tool will be usedto continue monitoring 20% of patients quarterly to ensure that this deficiencyis corrected and will not recur.	
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview, the home health agency failed to provide the patient with written medication instructions written in plain language in 1 of 1 physical therapy home health visits observed. (#1) Findings include: Record review evidenced an	G0616		2023-01-11

	agency policy dated April 2012 received 12/13/2022, titled, "Medication Profile," which stated "...the medication profile will be used as a care planning and teaching guide to ensure that the patient and family/caregiver as well as other clinicians understand the medication regimen. This includes ... using the medication profile to evaluate the use of medications in the home setting ... using the medication profile to teach purpose of medication, dosages, routes, administration times, side effects, and contraindications ...." 2. Observation of a home visit on 12/08/2022, at 10:50 AM, of patient #1, evidenced a patient's home health folder with a medication list which stated, "... glucose [blood sugar] prn [as needed], acetaminophen [pain reliever] 500mg [milligrams] q [every] 6 hours prn, choleciferol [vitamin D] 2 caps one PO [by mouth], fluoxetine [depression] 20mg one cap, Remeron [depression] 15mg 1x, senna [for constipation] 8.6mg 2 tabs 1x, thera-fe plus [vitamin], miralax		As part of the post-survey audit, the DON called 100% ofactive patients in the homes and in assisted living facilities on January 6 -8, 2023 to check if their nurse/therapist provided a medication list in theirhomes in plain language. (Please see Attachment-20 for the tool that was andwill be used for the first 3 monthly post-survey chart audits.) The DONconducted an in-service on January 11, 2023 to field staff about providing thepatient with medication list in plain language (e.g., twice a day instead ofBID). The DON is responsible for ensuring that the field staff willprovide the patient with medication list in plain language. The DON or itsdesignee will call 20% of patients monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3months of monthly audits, the contents of this post-survey chart audit toolwill be incorporated into the quarterly clinical record review tool (Pls seeAttachment-15). This tool will be usedto continue monitoring 20% of	

	[acid reflux] 20mg 1x, zofran [treat nausea and vomiting] 4mg q8 hours prn, potassium chloride [vitamin supplement] 10meq 1x, unker salve [muscle pain] 1 4 hours prn, novolog insulin bid [twice per day] ss [sliding scale], norco [pain reliever] 5 1x, atorvastatin [cholesterol medication] 20 1x, carvedilol [heart medication] 6.25mg 2x, furosemide [diuretic] 20mg 2x, metolazone [diuretic] 2.5mg M [Monday]/Wednesday ...." This document failed to evidence medication list for a patient in plain language. During an interview on 12/12/2022, at 12:00 PM, the clinical manager indicated the medications for the patient should be in a language the patient can understand.		patients quarterly to ensure that this deficiencyis corrected and will not recur.	
G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI).	G0640	The Governing Body including the Administrator reviewed (1) the measurable improvement indicators, (2) utilize quality indicator data to identify opportunities for improvement, (3) the QAPI data focused on high-risk, high-volume, or problem-prone areas, (4) the QAPI date considered incidence, prevalence, and severity of problems in the high-risk or high-volume areas, (5) the QAPI data led to an immediate correction of any identified problems that directly or potentially	2023-01-11

	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's QAPI (quality assessment performance improvement) program failed to evidence measurable improvement in indicators (see tag G642); utilize quality indicator data to identify opportunities for improvement (see tag G644); the QAPI data focused on high risk, high volume or problem prone areas (see tag G648); the QAPI data considered incidence, prevalence, and severity of problems in the high risk or high volume areas (see tag G650); the QAPI data led to an immediate correction of any identified problems that directly or potentially threaten the health and safety of patients (see tag G652); performance improvement activities tracked adverse patient events, analyzed their causes, and implemented preventive actions (see tag G654); the agency took action aimed at performance improvement and measured its		threaten the health and safety of patients, (6) performance improvement activities tracked adverse patient events, analyze their causes, and implemented preventive actions, (7) the agency took action aimed at performance improvement and measured its success and tracked performance to ensure that improvements are sustained, (8) conducted a performance project annually, and (9) ensure that the governing body was responsible for the implementation and maintenance of the QAPI program. For continued compliance, the Performance Improvement Council will meet every quarter to ensure that the deficiency is corrected and will not recur.	

	success and tracked performance to ensure that improvements are sustained (see tag G656); conducted a performance improvement project annually (see tag G658); and failed to ensure the governing body was responsible for the implementation and maintenance of the QAPI program (see tag 660). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR §484.65 Condition: Quality Assessment/Performance Improvement.			
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	G0642	The Administrator conducted an in-service to the Performance Improvement Council (PIC) on January 11, 2023 about measurable improvement indicators to improve health outcomes and quality of care of patients of the Agency. After the in-service, the PIC discussed the previous QAPI program and evaluated what's applicable to current agency status. The PIC also discussed ways to improve the QAPI program. The PIC meeting included planning for the first quarter of 2023. For continued compliance, the Performance Improvement Council team will meet every quarter to ensure that the deficiency is corrected and will not recur.	2023-01-11

	enable the HHA to assess processes of care, HHA services, and operations. Based on record review and interview, the home health agency failed to ensure measurable improvements indicators were implemented to improve health outcomes and quality of care for the agency's QAPI (quality assessment performance improvement) program. Findings include: Record review evidenced an agency policy received 12/14/2022, dated April 2012, titled, "Improving Organizational Performance," which stated, "...senior management will ... identify and set specific outcomes for measurable improvement and acceptable limits for findings ...." Review of the agency's QAPI program on 12/09/2022, failed to evidence data showing the measurable improvements in indicators related to the patient health outcomes and quality of care. During an interview on 12/09/2022, at 10:40 AM, the administrator indicated there was no QAPI information, and that there wasn't enough staff			

	to maintain QAPI. 410 IAC 17-12-2(a)			
G0644	Program data 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and interview, the home health agency failed to ensure the QAPI (quality assessment performance improvement) program utilized data from the measures derived from OASIS (outcome and assessment information set) to identify opportunities for improvement and monitor the quality of care. The findings include:	G0644	The Administrator conducted an in-service on January 11, 2023 to the PIC to use the data collected by the Administrator from iQies for the QAPI program on a quarterly basis, including, but not limited to, potentially avoidable event, such as development of UTI. The Administrator will in-service field and office staff on identifying events that require reporting and recording incidences of events. Incident and infection logs are collected months and will be analyzed by the PIC every 3 months to determine the cause of the incidence. The PIC will report to the Administrator. The Administrator will report to the BOD about the outcome and recommend changes to the policy or train the staff to improve the incidence of the event every quarter to ensure that the deficiency is corrected and will not recur.	2023-01-11

	Record review evidenced an agency policy received 12/14/2022, dated April 2012, titled, "Improving Organizational Performance," which stated, "... at least one important aspect related to care must be monitored through use of OASIS [outcome and assessment information set]data ...." Record review evidenced an agency document received 12/13/2022, revised 01/28/2020, titled, "Performance Improvement Study Infection," which stated, "... indicators patients who develop an infection ... studies will be performed monthly ...." Review of the agency's QAPI program on 12/09/2022, failed to evidence OASIS data was utilized to identify opportunities for improvement. Review of agency's documents titled, "Infections," for January, March, April, May, June, September, October and November 2022, received on 12/09/2022, evidenced 21 patients' names with physician, treatment, type of infection, and			

	documents failed to evidence OASIS data was utilized by the home health agency to identify opportunities for improvement. Review on 12/08/2022 of patient #2, start of care 11/10/2022, evidenced an agency document titled, "OASIS-D1 Start of Care," for certification period 11/10/2022-01/08/2023, which indicated the patient was treated for a urinary tract infection in the past 14 days. During an interview on 12/09/2022, at 10:40 AM, the administrator indicated there was no QAPI information, and that there wasn't enough staff to maintain QAPI. 410 IAC 17-12-2(a)			
G0648	High risk, high volume, or problem-prone area 484.65(c)(1)(i) (i) Focus on high risk, high volume, or problem-prone areas; Based on record review and interview, the home health agency failed to ensure performance improvement activities focused on	G0648	The Administrator conducted in-service on January 11, 2023 to PIC to include performance improvement activities focused on areas of high risk and high volume. PIC will collect data monthly and analyzed every 3 months to determine the cause of the incidence. The PIC will create a plan of improvement related to the data provided. The PIC will report to the Administrator. The Administrator will report to the BOD about the outcome and recommend changes to the policy or train the staff to improve the incidence of the event every quarter to ensure that the deficiency is corrected and will not	2023-01-11

	areas of high risk and high volume. The findings include: 1. record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "SN [skilled nurse] Wound Care Visit" dated 10/27/2022, which indicated the physician ordered antibiotics for a urinary tract infection. Review of an agency document titled "SN Foley [a type of catheter, a tube inserted into the bladder to drain urine from the body] Change Visit" dated 11/9/2022, indicated the patient complained of burning and pain at the catheter insertion site and was assessed to have cloudy, found smelling urine with sediment. The patient indicated the symptoms had been persistent for the pasts few days. Review indicated the physician prescribed antibiotics for a urinary tract infection. Review of an agency document titled "OASIS-D1 [Outcome and Assessment Information Set] Resumption of Care" completed by the clinical manager and dated 12/2/2022, indicated the patient was hospitalized from		recur.	

	11/25/2022 – 12/1/2022 for a urinary tract infection. 2. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced agency documents titled "Communication Note", which indicated the patient had falls on 5/15/2022, 5/29/2022, 6/11/2022, 6/20/2022, 6/28/2022, 7/14/2022, 7/19/2022, and 7/21/2022. 1. Record review evidenced an agency policy received 12/14/2022, dated April 2012, titled, "Improving Organizational Performance," which stated, "... the problem solving approach will stress the interrelationship of quality services provided, management activities, and sound business practices as applicable to the organization's ...activities related to patient care and patient safety focusing on high risk, high volume, and problem prone areas ... at least one important aspect related to care must be monitored .... 2. Record review evidenced an agency document received 12/13/2022, revised			

	"Performance Improvement Study Infection," which stated, "...indicators patients who develop an infection ... studies will be performed monthly ... the director of nursing shall be responsible for evaluating all infection log data monthly ...." 3. Review on 12/08/2022 of patient #1, start of care 09/28/2022, evidenced an agency document dated 12/08/2022, titled, "Communication Note," which stated, "... the patient was lowered to the floor ...while trying to transfer her to the bathroom ...." 4. Review on 12/08/2022 of patient #2, start of care 11/10/2022, evidenced an agency document titled, "OASIS [outcome and assessment information set]-D1 Start of Care," for certification period 11/10/2022-01/09/2023, indicated the patient was treated for a urinary tract infection in the past 14 days. 5. Review on 12/08/2022 of patient #3, start of care 04/28/2022, evidenced an agency document dated 05/31/2022, titled, "Incident			

	Log," which stated, "...fall with injury ...." 6. Review of agency's documents titled, "Infections," for January, March, April, May, June, September, October and November 2022, received on 12/09/2022, evidenced 21 patients' names with physician, treatment, type of infection, and infection date. These documents failed to evidence performance improvement activities focused on areas of high risk and high volume. 7. Review of agency's documents titled, "Incidents," for January, February, March, April May, June, September, October and November evidenced 24 patient incidents. These documents failed to evidence performance improvement activities focused on areas of high risk and high volume. 8. Review of the QAPI program on 12/08/2022, failed to evidence a focus on infections or incidents. 9. During an interview on 12/09/2022, at 10:40 AM, the administrator indicated there is			

	performance improvement) information, and that there isn't enough staff to maintain QAPI.			
G0650	Incidence, prevalence, severity of problems 484.65(c)(1)(ii) (ii) Consider incidence, prevalence, and severity of problems in those areas; and Based on record review and interview, the home health agency failed to ensure the QAPI (quality assessment performance improvement) data considered incidence, prevalence, and severity of problems in the high risk or high volume areas. Findings include: Record review evidenced an agency policy received 12/14/2022, dated April 2012, titled, "Improving Organizational Performance," which stated, "... identify and set specific outcomes for measurable improvement and acceptable limits for findings ...." Review of agency's documents titled, "Incidents," for January, February, March, April May, June, September, October and November evidenced 24 patient	G0650	The Administrator conducted in-service on January 11, 2023 to PIC to include performance improvement activities focused on areas of high risk and high volume. PIC will collect data monthly and analyzed every 3 months to determine the cause of the incidence. If the incidence is severe enough to cause patient hospitalization, more frequent monitoring of the Performance Improvement study should be done. The PIC will create a plan of improvement related to the date provided. The PIC will report to the Administrator. The Administrator will report to the BOD about the outcome and recommend changes to the policy or train the staff to improve the incidence of the event every quarter to ensure that the deficiency is corrected and will not recur.	2023-01-11

	failed to evidence data considered in high risk or high volume areas was included in the agency's QAPI program. Review of agency's documents titled, "Infections," for January, March, April, May, June, September, October and November 2022, received on 12/09/2022, evidenced 21 patients' names with physician, treatment, type of infection, and infection date. These documents failed to evidence agency data was considered in high risk or high volume areas and was included in the agency's QAPI program. Review of the agency's QAPI program on 12/09/2022, failed to evidence home health agency data was considered regarding incidence, prevalence, and severity of problems in the high risk or high volume areas. During an interview on 12/09/2022, at 10:40 AM, the administrator indicated there was no QAPI information, and there wasn't enough staff to maintain QAPI.			
G0652	Activities lead to an immediate correction	G0652	The Administrator conducted in-service on January 11, 2023 to field staff to report	2023-01-11

	484.65(c)(1)(iii) (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview the home health agency failed to evidence the QAPI (quality assessment performance improvement) data led to an immediate correction of any identified problems that directly or potentially threaten the health and safety of patients. Findings include: 1. Record review evidenced an agency policy received 12/14/2022, dated April 2012, titled, "Improving Organizational Performance," which stated, "... that each performance improvement activity contains ... follow-up plans if findings fail to meet acceptable limits including plan of correction ...." 2. Review of agency's documents titled, "Incidents," for January, February, March, April May, June, September, October and November evidenced 24 patient incidents. These documents failed to evidence the data led to a correction of any identified		incidence of events. The Administrator also gave in-service to PIC to conduct Performance Improvement Study regularly to correct identified problems. PIC will collect data monthly and analyzed every 3 months to determine the cause of the incidence. The PIC will create a plan of improvement related to the data provided. The PIC will report to the Administrator. The Administrator will report to the BOD about the outcome and recommend changes to the policy or train the staff to improve the incidence of the event every quarter to ensure that the deficiency is corrected and will not recur.	

	problems. 3. Review of agency's documents titled, "Infections," for January, March, April, May, June, September, October and November 2022, received on 12/09/2022, evidenced 21 patients' names with physician, treatment, type of infection, and infection date. These documents failed to evidence the data led to a correction of any identified problems. 4. Review of the agency's QAPI (quality assessment performance improvement) program on 12/09/2022, failed to evidence data led to an immediate correction of any identified problems that directly or potentially threaten the health and safety of patients. 5. During an interview on 12/09/2022, at 10:40 AM, the administrator indicated there is not any QAPI information, and that there isn't enough staff to maintain QAPI.			
G0654	Track adverse patient events 484.65(c)(2)	G0654	The Administrator conducted in-service on January 11, 2023 to PIC to utilize performance improvement activities to track adverse patient events, analyze their causes and implement preventative actions. PIC will collect data monthly from iQies to utilize outcome reports on a quarterly basis and analyzed data to	2023-01-11

	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 were utilized to track adverse patient events, analyze their causes, and implement preventative actions. The findings include: Record review evidenced an agency policy received 12/14/2022, dated April 2012, titled, "Improving Organizational Performance," which stated, "... that each performance improvement activity contains ... follow-up plans if findings fail to meet acceptable limits including plan of correction ...." Record review evidenced an agency document received 12/14/2022, revised 01/28/2020, titled, "Performance Improvement Study Infection," which stated, "... indicators patient who develop an infection ... studies will be performed monthly ...."		determine the cause of the incidence. The PIC will identify issues for improvement. The PIC will report to the Administrator. The Administrator will report to the BOD about the outcome and recommend changes to the policy or train the staff to improve the incidence of the event every quarter to ensure that the deficiency is corrected and will not recur.	

	Review of the agency's QAPI (quality assessment performance improvement) program on 12/09/2022, failed to evidence performance improvement activities that tracked adverse patient events, analyzed their causes, and implemented preventative actions. During an interview on 12/09/2022, at 10:40 AM, the administrator indicated there was no QAPI information, and that there wasn't enough staff to maintain QAPI. 410 IAC 17-12-2(a)			
G0656	Improvements are sustained 484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained. Based on record review and interview, the home health agency failed to ensure the agency took measures aimed at performance improvement, to measure its success and track performance to ensure that improvements were	G0656	The Administrator conducted in-service on January 11, 2023 to PIC to (1) take measures aimed at performance improvement, (2) to measure its success and track performance, (3) to ensure that improvements were sustained, and (4) follow-up plans if findings fail to meet acceptable limits. The PIC will continue to do performance Improvement study quarterly and address opportunities for improvement to ensure that the deficiency is corrected and will not recur.	2023-01-11

	sustained. Findings include: Record review evidenced an agency policy received 12/14/2022, dated April 2012, titled, "Improving Organizational Performance," which stated, "... assure that each performance improvement activity contains ... follow-up plans if findings fail to meet acceptable limits including plan of correction ...." Review on 12/09/2022, of the QAPI (quality assessment performance improvement) program failed to evidence the agency had taken action to measure and track the performance of the performance improvement activities. During an interview on 12/09/2022, at 10:40 AM, the administrator indicated there was no QAPI information, and there wasn't enough staff to maintain QAPI. 410 IAC 17-12-2(a)			
G0658	Performance improvement projects	G0658	The Administrator conducted in-service on January 11, 2023 to PIC to create at least one performance improvement project either in	2023-01-11

	484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the home health agency failed to ensure there was at least one performance improvement project either in development, ongoing or completed each calendar year. The findings include: Record review evidenced an agency policy received 12/14/2022, dated April 2012, titled, "Improving Organizational Performance," which stated, "... the governing body is responsible for ensuring that the performance improvement program is defined, implemented and maintained, and is evaluated annually ...."		development, ongoing or complete each calendar year to ensure that the deficiency is corrected and will not recur.	

	Review of an agency document revised 01/28/2020, received on 12/13/2022, titled, "Performance Improvement Study Infection," failed to evidence a performance improvement study was maintained and evaluated annually. Review of the agency's QAPI (quality assessment performance improvement) program on 12/09/2022, failed to evidence a performance improvement project. During an interview on 12/09/2022, at 10:40 AM, the administrator indicated there was no QAPI information, and there wasn't enough staff to maintain QAPI.			
G0660	Executive responsibilities for QAPI 484.65(e)(1)(2)(3)(4) Standard: Executive responsibilities. The HHA's governing body is responsible for ensuring the following: (1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained;	G0660	The Governing Body will review its responsibility for ensuring that the performance improvement program is defined, implemented, and maintained, and evaluated annually to ensure that the deficiency is corrected and will not recur.	2023-01-11

(2) That the HHA-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness;

(3) That clear expectations for patient safety are established, implemented, and maintained; and

(4) That any findings of fraud or waste are appropriately addressed.

Based on record review and interview, the home health agency failed to ensure the governing body was responsible for implementing and maintaining an ongoing program for quality improvement and patient safety.

The findings include:

Record reviewed evidenced an agency policy received 12/14/2022, dated April 2012, titled, "Improving Organizational Performance," which stated, "... the governing body is responsible for ensuring that the performance improvement program is defined, implemented, and maintained, and is evaluated annually ...."

Record review of a revised agency document dated 01/28/2020, received on

	"Performance Improvement Study Infection," indicated the director of nursing would be responsible for evaluating all infection log data monthly, and the QAPI (quality assessment performance improvement) team would summarize monthly findings into a quarterly report, including trends and recommendations which would then be submitted to the administrator. The administrator would report QAPI findings to the board of directors. This document failed to evidence the governing body maintained and evaluated a performance improvement program annually. Review of the agency's QAPI program on 12/09/2022, failed to evidence performance improvement activities by the governing body. Review of an agency document titled "Board of Directors Meeting," dated 01/17/2022, failed to evidence QAPI was discussed in the meeting minutes. During an interview on 12/09/2022, at 10:40 AM, the administrator indicated there			

	was no QAPI information, and there wasn't enough staff to maintain QAPI.			
G0680	Infection prevention and control 484.70 Condition of Participation: Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. Based on record review and interview the home health agency failed to maintain an infection control program (see tag G684); and provide infection control education to staff (see tag G686). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality healthcare in a safe environment for Condition of Participation 42 GFR §484.70: Infection Prevention and Control.	G0680	The BOD met on January 9, 2023 (Pls see Attachment-1) and reviewed the Agency's Infection Control Plan and directed the DON to restart the infection control program. The DON conducted an in-service on January 11, 2023 to all field and office staff about prevention and control of infection and communicable diseases. The DON is responsible for educating the staff on infection control no less than annually. The infection control in-services will be part of the Annual Checklist Form (Pls see Attachment-2) to ensure that this deficiency is corrected and will not recur.	2023-01-11
G0684	Infection control	G0684	The BOD met on January 9, 2023 (Pls see Attachment-1) and reviewed the Agency's	2023-01-11

	484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview the home health agency failed to maintain a coordinated agency-wide program for the surveillance, identification, prevention, and investigation of infectious and communicable diseases that is an integral part of the agency's quality assessment and performance improvement program. Findings include: Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "SN [skilled nurse] Wound Care Visit" dated 10/27/2022, which indicated the physician ordered		Infection Control Plan and directed the DON to restart the program for the surveillance, identification, prevention, control and investigation of infectious and communicable diseases. The DON conducted an in-service on January 11, 2023 to all field and office staff about identification and reporting of infections, as well as track the occurrence and transmission of infections. The DON is responsible for evaluating all infection log data monthly which the PIC will use for its quarterly reporting to identify trends, which will then be submitted to the administrator. This is done to ensure that this deficiency is corrected and will not recur.	

infection.

Review of an agency document titled "SN Foley [a type of catheter, a tube inserted into the bladder to drain urine from the body] Change Visit" dated 11/9/2022, indicated the patient complained of burning and pain at the catheter insertion site and was assessed to have cloudy, found smelling urine with sediment. The patient indicated the symptoms had been persistent for the pasts few days. Review indicated the physician prescribed antibiotics for a urinary tract infection.

Review of an agency document titled "OASIS-D1 [Outcome and Assessment Information Set] Resumption of Care" completed by the clinical manager and dated 12/2/2022, indicated the patient was hospitalized from 11/25/2022 – 12/1/2022 for a urinary tract infection.

Review failed to evidence the agency provided infection surveillance to include data on the tracking and trending of the infections.

1. Record review evidenced an agency policy dated April 2012,

	"Infection Control Plan," which stated, "... establish the mechanism by which the organization will address surveillance, prevention, identification, control, and reporting of infections ... educate organization personnel ... in the prevention and control of infections ... provide for surveillance system to track the occurrence and transmission of infections ...."			

	2. Record review evidenced a revised agency document dated 01/28/2020, received 12/13/2022, titled, "Performance Improvement Study Infection," which stated, "... indicators patients who develop an infection while receiving ... services ... studies will be performed monthly; summaries will be conducted quarterly and annually ... the director of nursing shall be responsible for evaluating all infection log data monthly, the QAPI [quality assessment performance improvement] team shall summarize monthly findings into a quarterly reporting, including trends identified ... which will then be submitted to the administrator ...." 3. Record review evidenced an agency policy dated April 2012, received 12/13/2022, titled, "Risk Management: Infection and Safety Control." Which stated, "... the organization will utilize its safety and performance improvement process to identify risks for the acquisition and transmission of infectious agents on an ongoing basis. The infection control plan will be monitored and evaluated			

	in the annual program evaluation …with the review of the organization's safety and performance improvement activities … success or failure of interventions for preventing and controlling infection will be addressed … the performance improvement coordinator will be responsible for managing and coordinating infection control activities and reporting of infection control activities to the Performance Improvement Committee ….” 4. Record review on 12/08/2022, for patient #2, start of care 11/10/2022, evidenced an agency document dated 11/10/2022, titled, “Infection Log,” which stated, “… patient went to the hospital on 11/01/2022 … urine culture showed enterococcus faecalis, patient was started on antibiotics ….” This document failed to evidence the infection log data was coordinated with an agency wide surveillance program.			

	5. Review of the agency's incident/infection control log on 12/09/2022 evidenced the last date patient specific data was entered is 12/21/2021. 6. Review of agency's document titled, "Infections," for January, March, April, May, June, September, October and November 2022, received on 12/09/2022, evidenced patients' names with physician, treatment, type of infection, and infection date. This document failed to evidence surveillance, identified sources of infection, tracking of patterns and trends of infections or establishment of a corrective plan for infection control and monitoring of the corrective plan. During an interview on 12/07/2022, at 2:45 PM, the clinical manager indicated the infection control plan log is not finished and is still being put together.			
G0686	Infection control education 484.70(c)	G0686	The DON conducted an in-service on January 11, 2023, to all field and office staff about infection control policies and	2023-01-11

	Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). Based on record review and interview the home health agency failed to provide infection control education to staff. Findings include: 1. Record review evidenced an agency policy dated April 2012, received 12/13/2022, titled, "Risk Management: Infection and Safety Control," which stated, "... Amore Home Health Care Services will educate all personnel on infection control policies, procedures ... personnel will be provided training on the basics of transmission of pathogens to patients and personnel ... infection control inservices will be scheduled no less than annually ... attendance will be mandatory and will be documented ... records of inservice attendance will be maintained in the personnel file ...." Review of the infection control log on 12/07/2022, evidenced the last documented agency infection control training as 03/2020.		procedures, including, but not limited to, basics of transmission of pathogens to patients and personnel. The DON is responsible for educating all personnel on infection control policies and procedures no less than annually to ensure that this deficiency is corrected and will not recur.	

	During an interview on 12/07/2022, at 2:45 PM, the clinical manager indicated the infection control plan log is not finished, still putting together. At 5:10 PM, the clinical manager indicated there is no further information regarding the infection control plan.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review, interview, and observation the home health agency failed to prepare clinical notes in 4 of 7 clinical records reviewed. (#2, #5, #6, #7) Findings include:	G0716	The DON reviewed 100% of all clinical records of patients on January6 - 8, 2023 as part of the post-survey chart audit to check accurate and completedocumentation in clinical notes. (Please see Attachment-20 for the tool thatwas and will be used for the first 3 monthly post-survey chart audits.) The DONconducted an in-service on January 11, 2023, to all field staff about accuratedocumentation of patient assessment (e.g., weight), patient's medications(e.g., Eliquis, Keppra, Aspirin, Lexapro), safety precautions (e.g., bleedingprecaution), proper disposal of sharps used on the patient, and timelycompletion of visit notes.	2023-01-11

	1. Clinical record review on 12/9/2022, for Patient #5, start of care 8/19/2022, evidenced an agency document titled "Medication Profile", which was signed by the clinical manager on 8/19/2022. Review indicated the patient's medications included, but were not limited to, Eliquis (a type of anticoagulant medication used to thin the blood to treat and/or prevent blood clots). Review of an agency document titled "OASIS-D1 [Outcome and Assessment Information Set] Start of Care" completed by the clinical manager and dated 8/19/2022, failed to evidence the patient was on anticoagulant medication. During an interview 12/12/2022, at 10:40 AM, the clinical manager indicated the box for anticoagulant medication should have been checked. Review of an agency document titled "SN [skilled nurse] Wound Care Visit" dated 11/3/2022, and signed by the registered nurse, indicated the nurse administered the flu vaccination to the patient in the right arm		The DON is responsible for monitoring accurate and completedocumentation in clinical notes. The DONor its designee will audit 20% of charts monthly for 3 months. Target threshold is 100%. Once threshold is met and after completing 3months of monthly chart audits, the contents of this post-survey chart audittool will be incorporated into the quarterly clinical record review tool (Plssee Attachment-15). This tool will beused to continue monitoring 20% of patient's charts quarterly to ensure thatthis deficiency is corrected and will not recur.	

	evidence the box indicating the sharps were disposed of per biohazard policy was checked. During an interview on 12/12/2022, at 10:40 AM, the administrator indicated she gave the patient the injection and did dispose of the sharp in the biohazard container but forgot to mark the box. Review of an agency document titled "Skilled Nurse Visit", completed by the clinical manager and dated 10/19/2022, 10/27/2022, 11/3/2022, 11/9/2022, 11/16/2022, and 11/21/2022 failed to evidence the patient was using an anticoagulant. During an interview on 12/12/2022, at 11:41 AM, the clinical manager indicated she should have marked the box indicating the patient used an anticoagulant because she assessed the patient for bruising during visits. 2. Clinical record review on 12/12/2022, for Patient #6, start of care 11/30/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 11/30/2022-1/28/2023,			

	which indicated the agency was to provide physical therapy (PT) services 2 times a week for 3 weeks and then 1 time a week for 6 weeks. Review failed to evidence a PT visit since 12/2/2022. Review indicated the patient's diagnoses included, but were not limited to, epilepsy (a brain disorder that causes seizures), and indicated the patient's medications included, but were not limited to, Keppra (a medication used to treat/prevent seizures). During an interview on 12/12/2022, at 3:37 PM, the administrator indicated the PT provided services to the patient on 12/6/2022 and 12/8/2022 and indicated the PT had not yet started the visit notes. The administrator indicated the agency encouraged staff to complete their notes the same day as the visit. Review of an agency document titled "OASIS-D1 Start of Care (PT)" completed by the PT and dated 11/30/2022, failed to evidence seizure precautions were included in the patient's safety measures. During an interview on			

	12/12/2022, at 3:39 PM, the administrator indicated the PT should have documented seizure precautions in the safety measures in the comprehensive assessment. 3. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 5/3/2022-7/1/2022, which indicated the patient's medications included, but were not limited to, aspirin (a medication used to treat pain/fever and/or to thin the blood to prevent blood clots) and Lexapro (a medication used to treat depression). Review indicated an increased risk in bleeding with the use of both aspirin and Lexapro. Review of an agency document titled "OASIS-D1 [Outcome and Assessment Information Set] Start of Care (PT) [Physical Therapy]" completed by the PT and dated 5/3/2022. Review failed to evidence the patient's safety measures included bleeding precautions. During an interview on			

12/9/2022, at 11:42 AM, the administrator indicated the PT should have included bleeding precautions in the safety measures.

1. Record review evidenced an undated agency policy received on 12/13/2022 titled, "Nursing Services," which stated, "...the nursing care will include ... assessing, noting and reporting the patient's physical condition ...."

2. Record review evidenced an undated agency policy received on 12/13/2022 titled, "Clinical Records," which stated, "... all entries recorded in the record must be ... accurate ...."

3. Record review evidenced an agency policy dated April 2012 received 12/13/2022 titled, "Ongoing Assessments," which stated, "... during each home visit the appropriate clinician will re-evaluate the patient according to the problems identified during the initial visit ... the clinician will reassess the patient for weight [once each week, if indicated by disease process] ...."

4. Clinical record review for patient #2 on 12/08/2022, start

	of care 11/10/2022, evidenced an agency document dated 12/08/2022 titled, "Skilled Nurse Visit," which stated, "... Weight 202 pounds ...." Review evidenced an agency document dated 12/08/2022 titled, "Skilled Nurse Visit," which stated, "... Skilled nurse to instruct the patient to log weight daily and inform skilled nurse/medical doctor if weight is >2 lbs. [pounds]/day or >5 lbs./week ...." Review evidenced an agency document dated 11/22/2022 titled, "Skilled Nurse Visit," which evidenced the weight was not recorded on that day. Review evidenced an agency document dated 12/01/2022 titled, "Skilled Nurse Visit," which stated, "... weight at 202 lbs. ...." During an observation on 12/08/2022, at 9:00 AM, patient's spouse indicated patient was weighed on 12/08/2022 and his weight was at 220 pounds. Observation on 12/08/2022, at 9:55 AM, evidenced upon exit from the home visit the patient			

	was not weighed during skilled nurse home visit. The skilled nurse visits failed to evidence patient's weight was accurately documented on the nurse visit note. During an interview on 12/12/2022, at 3:05 PM, the clinical manager indicated the patient's weight is done daily by the patient and the patient's weight is not 220lbs because he doesn't have edema to his lower extremities and stated weight is 202 lbs. The clinical manager indicated education to the patient was to call if weight >2 lbs. in one day or >5lbs in one week. 410 IAC 14-1(a)(1)(E)-RN			
G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to	G0940	On January 9, 2023, the Governing Body reviewed its responsibility to determine the agency's (1) budget, (2) quality assessment and performance improvement program, (3) day-to-day operations, coordination of referrals, and (4) guidelines regarding medication storage. The governing body is responsible for organization and management of the agency annually as monitored by the Annual Checklist Form (Pls see Attachment-2) and will ensure that deficiencies are corrected and will not recur.	2023-01-09

	another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on record review, interview, and observation the home health agency failed to ensure the organization and management of the home health agency as follows: the governing body failed to assume responsibility of the agency's budget and quality assessment and performance improvement program (see tag G942); the administrator failed to maintain the day to day operations of the agency (see tag G948); the clinical manager failed to coordinate referrals (see tag 964); and the clinical manager failed to ensure the home health agency services are provided in accordance with current clinical practice guidelines regarding medication storage (see tag G984). The cumulative effect of these systemic problems has resulted in the home health agency's inability to ensure provision of quality health care in a safe environment for the condition of participation 42 CFR §484.105 Organization and Administration of Services. A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview the home health agency			

	organizational structure, including lines of authority. Findings include: 1. Record review on 12/13/2022, of an undated agency policy titled, "Use of Organizational Chart," which stated, "... organizational charts will be used to define relationships and lines of authority within the organization ... organizational charts will be reviewed, revised and dated as changes occur...." Record review on 12/12/2022, evidenced an agency document revised 05/04/2020, titled, "Organizational Chart," which included PTA (physical therapy assistant) and COTA(certified occupational therapy assistant). During an interview on 12/12/2022, at 4:30 PM, the clinical manager indicated the agency does not use PTA and COTA in its facility. 410 IAC 17-12-1(a)(2)			
G0942	Governing body 484.105(a)	G0942	On January 9, 2023, the BOD reviewed the full legal authority and responsibility for the Agency's overall management	2023-01-10

	Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview the agency's governing body failed to assume responsibility for the agency's review of the agency's budget and the quality assessment and performance improvement program. Findings include: 1. Clinical record review of an agency policy revised 05/03/2020, received on 12/13/2022, titled, "Organizational Plan," which stated, "... the agency's operating and capital expense budget is prepared ... and approved by the Board of Directors annually...." During an interview on 12/09/2022, at 2:45 PM, administration staff #4 indicated the only budget she has is from 2021 doesn't have the budget from 2022. 2. Clinical record review of an agency policy dated April 2012, received on 12/14/2022, titled,		and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment, and performance improvement program. The BOD then in-serviced and directed the Finance Director to create a 3-yr operational and capital expense budget starting year 2023. The Finance Director created the 3-yr operational and capital expense budget starting year 2023 on January 10, 2023. The BOD will monitor the creation of 3-year budget yearly using the Annual Checklist Form. (Pls see Attachment-2) The BOD is responsible for reviewing the Agency's overall management and operation. The BOD will monitor the completion of 3-year operational and capital budget to ensure that this deficiency is corrected and will not recur.	

	"Improving Organizational Performance" which stated, "... senior management will have the responsibility ... define expectations of the performance improvement activities ... performance improvement results will be utilized to address problem issues ... the governing body is responsible for ensuring the performance improvement program is defined, implemented and maintained, and is evaluated annually ...." During an interview on 12/09/2022, at 10:40 AM, the clinical manager indicated there is no QAPI (quality assessment performance improvement) information, there is not enough staff to maintain QAPI. 410 IAC 17-12-1(b)			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview the administrator failed to ensure responsibility for all day-to-day operations of the home	G0948	On January 11, 2023, the Administrator/DON conducted anin-service to staff about (1) review of medications, (2) proper documentationof individualized plan of care, (3) coordination of care with all disciplines,(4) infection control program documentation, (4)	2023-01-11

	health agency. Findings include: 1. Record review evidenced a revised agency policy dated 05/04/2020, received on 12/14/2022, titled, "Organizational Plan," which stated, "... responsibilities of the administrator ... maintains current organizational charts ... ensures the completion, maintenance and submission of reports and records required ... maintains ... administrative records and all policies and procedures of the agency ...." 2. Record review evidenced an agency policy dated April 2012, received 1213/2022, titled, Improving Organizational Performance," which stated, "... senior management will have the responsibility: to guide the organization's efforts in improving organizational performance; to define expectations of the performance improvement activities ... performance improvement results will be utilized to address problem issues ...." 3. Record review evidenced a revised agency policy dated		QAPI program, (5) EmergencyPreparedness Program, and (6) Individualized plan of care specified care andservices necessary to meet patient specific needs identified in comprehensiveassessment. The Governing Body is responsible for ensuring that theAdministrator is monitoring the Agency's day-to-day operations, including theareas stated above to ensure that the deficiencies are corrected and will notrecur. The Administrator will report to the Governing Body quarterly. The GoverningBody will evaluate the Administrator every 3 months for the first year. (Pleasesee Attachment-21 for Performance Evaluation Form for Administrator.) Target threshold is 100%. Once threshold ismet and after completing quarterly evaluations for the 1st year, theGoverning Body will continue to evaluate the Administrator yearly thereafter.	

	01/28/2022, received on 12/13/2022, titled, "Performance Improvement Study Infection," which stated "... the QAPI [quality assessment performance improvement] team shall summarize monthly findings ... which will then be submitted to the administrator ... the administrator shall report to BOD [board of directors] all QAPI findings ...." 4. The administrator failed to ensure the agency policy was followed for the review of medications. Please see tag G536. 5. The administrator failed to ensure the plan of care was individualized and included all required documentation. Please see tag G574. 6. The administrator failed to ensure there was coordination of care with all disciplines servicing the patients. Please see tag G606. 7. The administrator failed to ensure there was an infection control program documented and maintained. Please see tag G684.			

8. The administrator failed to ensure there was a Quality Assessment and Performance Improvement program maintained at the home health agency. Please see tag G942.

9. The administrator failed to maintain the emergency preparedness program. Please see tag E0004.

10. The administrator failed to ensure the individualized plan of care specified the care and services necessary to meet the patient-specific needs identified in the comprehensive assessment. Please see tag G570.

During an interview on 12/07/2022, at 2:45 PM, the administrator indicated the infection log is not finished.

During an interview on 12/08/2022, at 12:35 PM, administration staff #5 indicated they thought the agency was going to close, so did not update the emergency preparedness program.

During an interview on 12/09/2022, at 10:40 AM, the administrator indicated there is

	she doesn't have the staff to maintain. 410 IAC 17-12-1(b)(3) 410 IAC 17-12-1(c)(1)			
G0964	Coordinate referrals; 484.105(c)(3) Coordinating referrals, Based on record review and interview, the clinical manager failed to provide clinical oversight of referrals for therapy in 2 of 4 clinical records reviewed with physical therapy services. (#3, 7) The findings include: 1. Review of an agency policy on 12/14/2022, titled "Organizational Plan" revised 5/4/2020, stated, "… Responsibilities of the Director of Nursing: … Responsible for the quality and coordination of home health services …." 2. Clinical record review on 12/08/2022 for patient #3, start of care 04/28/2022, evidenced an agency document titled,	G0964	On January 11, 2023, the DON conducted an in-service to fieldstaff about proper coordination of care between disciplines and notification ofphysician of any recommended additional services The DON is responsible for monitoring the proper coordinationof care between disciplines and physician notification of recommendedservices. The DON will report to theAdministrator quarterly. TheAdministrator is responsible for ensuring that the DON provides clinicaloversight. The Administrator will evaluate the DON every 3 months for the firstyear. (Please see Attachment-21 for Performance Evaluation Form for Director ofNursing.) Target threshold is	2023-01-11

	Assessment Information Set]-D1 Recertification (PT) [physical therapy]" for certification period 06/27/2022-08/25/2022. Review indicated the PT recommended occupational therapy (OT) for the patient based on assessment. Review failed to evidence OT services were provided. During an interview on 12/14/2022, at 11:15 AM, the clinical manager indicated she does not remember if she was notified regarding recommendation for OT services. 3. Clinical record review on 12/7/2022, for Patient #7, start of care 5/3/2022, evidenced an agency document "Recertification (PT)" dated 6/30/2022. Review indicated PT recommended OT services for the patient. Review failed to evidence occupational therapy was provided to the patient. 4. During an interview on 12/9/2022, at 11:04 AM, the clinical manager indicated if another discipline was recommended, the physician should be contacted for the order for that discipline to		100%. Once threshold is met and after completingthe quarterly evaluations for the 1st year, the Administrator willcontinue to evaluate the DON yearly thereafter.	

	evaluate.			
G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on observation, record review, and interview, the administrator failed to ensure medications were stored properly. The findings include: Review of an undated agency policy obtained 12/14/2022, titled "Vaccinations" stated, "... A working thermometer should be placed centrally in the unit...." During an interview on 12/9/2022, at 10:45 AM, the administrator indicated the agency provided patients with flu vaccines if requested and stored the vaccines on site. During an observation on 12/9/2022, at 10:45 AM, an unlabeled refrigerator was observed in the office. Inside of	G0984	On January 9, 2023, the BOD met and reviewed the Vaccine Storage policy. The BOD instructed the Administrator to revise the Vaccine Storage policy. The Administrator revised the Vaccine Storage policy (Pls see Attachment-17) on January 10, 2023and created a log sheet for checking the temperature (Pls see Attachment-18) in the refrigerator daily to ensure that this deficiency is corrected and will not recur.	2023-01-10

	labeled "Flucelvax Quadrivalent" (a medication used to administer the influenza vaccine) was observed on the shelf with 6 single dose, pre-filled syringes observed inside of the box. Observed on the box were storage guidelines from the manufacturer which indicated the medication should be stored between 36-46 degrees Fahrenheit. There was not a thermometer observed inside of the refrigerator. During an interview on 12/9/2022, at 10:45 AM, the administrator indicated the agency does not check the temperature of the refrigerator containing the vaccines. 410 IAC 17-12-1(d)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dorothy Brinas	Administrator	1/31/2023 2:49:19 PM