STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157626	A. BUILDING B. WING	02/09/2023

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
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR §484.102 for Home Health Providers and Suppliers. Survey Dates: 2/2/2022-2/9/2022 Census: 11 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.	E0000		2023-03-08
E0017	HHA Comprehensive Assessment in Disaster	E0017	To correctthe incomplete/absence of the	2023-03-06

	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 observation, record review and interview, the agency failed to ensure each patient had a complete individualized emergency preparedness plan in the home as well as in the patient's record in 2 of 2 home visits conducted (#1, 3) The findings include: 1. Review of an agency policy titled "Emergency Preparedness Plan", dated 1/10/2023, indicated the agency will develop an individual emergency preparedness plan for each patient which would		Individualized Patient Emergency Plan (IPEP) inthe patients' home/facility, the DON visited ALL current patients of the agencyon March 4, 2023 and checked the Patient Assessment Book of each patient to seeif the IPEPs were properly filled out by the admitting/visiting clinician. The DON observed incomplete fields in theIPEPs of patient #1 and patient #3. Therest of the patients were found to have completed IPEPs. After checking for completeness, the DON hadthe patients/patient caregiver/nurse-on-duty (in facility) sign an "Acknowledgementof Patient's Receipt of Individualized Patient Emergency Plan" (Pls see Attachment-5)which were brought back to the office for filing in the patients' physicalchart. This form was devised by the DONon March 2, 2023 as directed by the Administrator and approved on March 3, 2023(Pls see Attachment-1 for BOD meeting minutes). This form serves as a proofthat the IPEP is complete and in place at the patients' home/facility. Thisprocedure is part of the addendum to the Emergency Preparedness Plan	

	prioritize patients according to their needs, assist patients and families to develop a home emergency plan, and educate patients and families about sources of alternate care in the community and the agency's role during an emergency. 2. During observation of a home visit on 2/6/2023 at 11:00 AM, review of patient #3's individualized emergency plan failed to evidence a completed "priority code" assessment. During an interview on 2/8/2023 at 3:20 PM, the administrator indicated the clinician should create an individualized emergency plan with each patient at the start of care visit which included a "priority code" to alert staff to potential patient needs in case of an emergency. The administrator indicated this was a paper form, which was not maintained in the electronic medical record (Axxess). The administrator indicated the original copy was kept in the patient's home, and no copy was maintained by the agency. 3. An observation of a home visit was conducted on		(Pls see Attachment-6).This will correct any current deficiencies and will be used for monitoringfuture admissions. On March 6, 2023, the DON conducted an in-service to allfield staff regarding the use of the “Acknowledgement of Patient’s Receipt ofIndividualized Patient Emergency Plan” as part of the Admission papers forsignature. (Pls see Attachment-4 for in-service topics and staff attendance.) The monitoring of the form in the patients’physical chart will be added to the agency’s Chart Review Tool (Pls see Attachment-7for the Revised Chart Review Tool) approved by BOD on March 3, 2023. The Director of Nursing is responsible for ensuring that allpatients of the agency have Individualized Patient Emergency Plan. The DON will review 20% of charts monthly for3 months for the presence of the “Acknowledgement of Patient’s Receipt ofIndividualized Patient Emergency Plan” form in the	

	2/3/2023, for patient #1, start of care 12/21/22, with physical therapist (PT) #3. During the observation, the patient's home folder was reviewed for information provided by the agency including an individualized emergency preparedness plan. Review of the emergency preparedness document in the home folder failed to evidence evacuation information in the event of a disaster, such as a fire or flood. Observation evidenced the individualized emergency preparedness plan was incomplete.		threshold is 100%. Once thresholdis met, will continue to audit 20% of charts quarterly to ensure that this deficiencyis corrected and will not recur.	
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	E0037	During the BOD meeting on March 2, 2023 (Pls see Attachment-1for BOD meeting minutes), the BOD directed the Administrator to give in-serviceto staff (including new staff) to on theagency's latest Emergency Preparedness Plan on March 6. Copies of the in-service topics (including programobjectives, content outline, and speaker) were given to the staff, andattendance sheet was provided during in-service to track staff	2023-03-06

	staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[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:		attendance (Plssee Attachment-4). All staff, including PT #1 and PT #3, were present duringthe in-service. To check for knowledge after in-service, the facilitatoremployed one-on-one questions-and-answers with the staff to which the staff demonstratedunderstanding as indicated with a check mark next to the staff's name. The Administrator is responsible for trainingnew & existing staff on Emergency Preparedness at least every 2 years,maintaining documentation of all training, demonstrate staff knowledge, andconducting training on updated policies & procedures to ensure that thisdeficiency is corrected and will not recur. Target threshold is 100%.	

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

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

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

	Plan", dated 1/10/2023, indicated the agency would orient and train all new staff to the Emergency Preparedness Plan upon hire, and provide ongoing education and training to staff annually. Review of an agency policy titled, "TRAINING / INSERVICE EDUCATION", dated April 2012, indicated a written plan will be created for each in-service training session which will include: program objectives, content outline, speaker (and their qualifications), and a list of attendees. Review of an agency document titled "In-Service", dated 1/11/2023, evidenced a list of in-service topics and recipients of the in-services, including emergency preparedness training. Review of the document failed to evidence program objectives, content outline, and speaker. Review of the document failed to evidence staff demonstrated knowledge of emergency procedures. Review of the attendance sheet for the in-service failed to evidence PT (physical therapist) #1 and PT #3.			

	During an interview on 2/8/2023 at 3:20 PM, the administrator indicated the in-service document evidenced all emergency preparedness training the agency provided for the staff since the previous survey. When queried, the administrator indicated she did not have documentation of the program objectives, content outline, and speaker. The administrator indicated the in-service failed to evidence demonstration of staff knowledge of emergency procedures. The administrator indicated PT #1 and PT #3 did not receive emergency preparedness training. The administrator stated, "They couldn't make it" and indicated they will have another in-service for them some time in the future.			
G0000	INITIAL COMMENTS This survey was a Post Condition Revisit of a Recertification survey for a home health agency.	G0000		2023-03-08

	Survey dates: 2/2/2023 to 2/9/2023 Facility ID 012121 Census: 11 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. Quality Review Completed 02/27/2023			
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.	G0536	To correctthe deficiency, the Director of Nursing performed medication reviews on 100% ofall active patients, including patient #2, patient #3, and patient #4. Inaddition to that, the BOD met on March 2, 2023 (Pls see Attachment-1) anddirected the DON to make	2023-03-06

	Based on observation, 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, by a nurse to identify any potential adverse effects, drug reactions, significant side effects, significant drug interactions and duplicate medications in 3 of 4 active clinical records reviewed (patient #2, #3, #6). The findings include: Review of an agency policy titled "Medication Profile", revised 1/10/2023, indicated a drug regimen review should be performed upon admission, when updates to the comprehensive assessment are performed and with the addition of a new medication. The review should identify drug / food interactions, potential adverse effects and drug reactions, drug interactions, ineffective drug therapy, duplicative drug therapy, and noncompliance with drug therapy. Observation of a discharge visit for patient #3 was conducted on 2/6/2022 at 11:00 AM. During the visit, PT (physical		an addendum to the newly-revised Medication Profilepolicy (Pls see Attachment-8) to include procedure for Therapy-only cases. The Addendum was approved by BOD on March 3,2023. An in-service was conducted on March 6, 2023 to all field staff to updatethem on proper documentation procedures of medications in Therapy-only cases. (Plssee Attachment-4 for in-service topics and staff attendance.) The DON is responsible for ensuring that SkilledNurses will perform medication review/reconciliation on Therapy-only cases. TheDON or its designee will review 20% of charts monthly for 3 months using theRevised Chart Review Tool (Pls see Attachment-7). Target threshold is100%. Once threshold is met and aftercompleting 3 months of monthly chart audits, DON or designee will continuemonitoring 20% of patient's charts quarterly to ensure that this deficiency iscorrected and will not recur.	

	looking at the patient's medications and stated, "I should have brought in my computer to review the meds". Observation of the home visit failed to evidence PT #3 reconciling the patient's medications with the written medication list. During the home visit, patient #3 showed the surveyor and PT #3 a tube of Voltaren cream (a topical NSAID--non-steroidal anti-inflammatory) they had been using for knee pain. Observation of the home visit evidenced a prescription bottle of Tramadol (a pain medication) which indicated the patient was to take the medication twice a day as needed for pain. Review of the plan of care for certification period 12/17/2022 to 2/14/2023 evidenced the patient was allergic to NSAIDs. Review of the plan of care evidenced the patient was taking Tramadol one tab daily as needed for pain. During an interview on 2/8/2023 at 1:50 PM, the administrator indicated a medication reconciliation should be performed at each			

	administrator indicated a medication review should be performed if a new medication is found in the home in order to assess for potential interactions or duplicative therapy. When queried, the administrator indicated if a clinician does not have their computer, they should reconcile the medications in the home with the written list of patient medications, which should be kept up-to-date . When informed of the findings, the administrator offered no further information. *. Clinical record review on 2/9/2023, for patient #2, start of care 1/20/2023, evidenced an agency document titled "... RESUMPTION OF CARE" from 2/3/2023, and electronically signed by PT (physical therapist) #3. This document had an area subtitled "Medications" which had a checked box to indicate medications have been reconciled. Another area stated "(M2010) Patient/Caregiver High Risk Drug Education: Has			

	instruction on special precautions for all high-risk medications ... and how and when to report problems that may occur? ...." Which had a box checked next to the statement "Yes" to indicate PT #3 completed the task. Record review failed to evidence a registered nurse performed a review of all current medications. *. Clinical record review on 2/9/2023, for patient #6, start of care 9/28/2022, evidenced an agency document titled "... Recertification (PT)" from 1/25/2023, and electronically signed by alternate administrator #2. This document had an area subtitled "Visit Interventions" which stated "Reviewed and/or instructed on the following information: ... Medication Review ..." This section had a box checked next to the statement "Performed complete medication review and assessed drug interactions ...." to indicate alternate administrator #2, a physical therapist, performed the task. Record review failed to evidence a registered nurse			

	performed a review of all current medications. During an interview on 2/9/2023, at 2:04 PM, administrator #1 indicated the patient's medication list was received from a facility or doctor at start of care. Administrator #1 indicated if medications were discovered during a visit, the physical therapist would check the bottles with the medication list. Administrator #1 and quality assurance #4 were informed that a physical therapist may perform a start of care but not a medication reconciliation.			
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.	G0564	The DON conducted an in-service on March 6, 2023 to all fieldstaff to re-educate on transmission of Discharge or Transfer Summary to thereceiving facility or to the physician to ensure safe and effective transitionof care, including all necessary medical information pertaining to the patient'scourse of illness and treatment, post-discharge goals of care, and	2023-03-06

	Deficiency corrected 01/11/2023 Corrected 1/11/2023		treatmentpreferences. (Pls see Attachment-4 for in-service topics and staff attendance.) The DON is responsible for monitoring proper documentation ofTransfer and Discharge Summaries and timely transmission through fax to thereceiving health care professional or facility. The DON or its designee willreview 20% of charts monthly for 3 months using the Revised Chart Review Tool(Pls see Attachment-7). Target threshold is 100%. Once threshold is met and after completing 3months of monthly chart audits, DON or designee will continue monitoring 20% ofpatient's charts quarterly to ensure that this deficiency is corrected and willnot recur.	
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	G0570	Our agency did not receive a deficiency under this tag.	2023-03-08

	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. Review of an undated agency policy titled "PHYSICIAN'S PLAN OF CARE", received 2/9/2023, indicated home health services should be provided in accordance with a plan of care based on the patient's diagnosis and assessment of the patient's immediate and long-term needs. Review of an agency policy titled "DISCHARGE PLANNING", dated April 2012, indicated the clinician should assist patients with their discharge by assessing what resources were available and serving as a referral source for obtaining follow-up support services. Review of an agency policy titled "PHYSICIAN PARTICIPATION IN PLAN OF CARE", revised 2/11/2020, indicated orders for the plan of care shall be reviewed and			

	revised by the physician based on changes in the patient's physical condition. Review of an agency policy titled "PATIENT BILL OF RIGHTS", revised 9/9/2019, indicated the patient has the right to participate in, be informed about, and consent or refuse care with respect to establishing and revising the plan of care or treatment, any factors that could impact treatment effectiveness and any changes in care or treatment to be furnished. Review of an agency policy titled, "THERAPY SERVICES", revised 1/10/2023, indicated the therapist will inform the physician of changes in the patient's condition and may recommend changes as telephone orders. Clinical record review for patient #3, start of care 12/17/2022, evidenced a document titled, "PHYSICIAN VERIFICATION OF FACE-TO-FACE ENCOUNTER", dated 1/27/2023, signed by cardiologist #4. The document stated, " ... I certify that, based on my findings, the following			

	home health services ... Skilled Nursing ... My Clinical findings support the need for the above services because: New onset or exacerbation of diagnosis...." Review of the plan of care for certification period 12/17/2022 to 2/14/2023 evidenced the patient's principal diagnosis was Hypertensive heart disease with heart failure. The plan of care indicated the patient required education about the signs and symptoms of hypertension, how to prevent venous stasis, medication management and pain management. Review of the plan of care failed to evidence skilled nursing services. The plan of care indicated the patient shall be discharged when goals are met. Review of the plan of care evidenced a list of discharge goals which included (but was not limited to): Patient will demonstrate becoming independent with home exercise plan by discharge, Pain level stabilizes and patient demonstrates ability to self-manage pain, and Patient will attain optimal effectiveness of pain management regimen. Review of physical therapy visit			

	notes dated 1/16/2023, 1/23/2023, and 1/30/2023 evidenced the patient was homebound due to leaving the home requiring a considerable and taxing effort, severe shortness of breath upon exertion, assistance needed with ambulation, unable to be up for a long period, and unsafe to go out of home alone. On the subsequent visit, 2/6/2023, the patient was discharged. During observation of a discharge visit on 2/9/2023 at 11:00 AM, the patient complained of new right leg pain and swelling. During a conversation observed at 11:46 AM, PT (physical therapist) #3 indicated to person #3 (family member of patient #3) would need continued (outpatient) physical therapy to improve their walking. Person #3 indicated neither they nor the patient drove. Observation of the discharge visit failed to evidence patient demonstration of the home exercise program. PT #3 failed to ensure the patient's goals were met prior to discharging the patient. Observation of the home visit failed to evidence PT #3 addressing the patient's new			

	complaint of pain and swelling to the right leg prior to discharge. Observation of the home visit failed to evidence PT #3 addressing the patient's need for continued therapy and lack of transportation for outpatient therapy prior to discharge. During an interview on 2/8/2023 at 1:42 PM, the administrator indicated the agency ensured a patient's needs were met by creating an individualized plan of care and following it. The administrator indicated all patient goals needed to be met prior to the agency discharging the patient. The administrator indicated if a change is noted in a patient's condition, even at a discharge visit, the clinician should notify the physician and tell them their recommendation. The administrator indicated it was not within a physical therapist's scope of practice to teach about hypertension and heart failure, but they could give some simple instructions. When queried, the administrator indicated the patient did not receive skilled nursing services because the patient's family member did not want them.			

	The administrator indicated the clinical record failed to evidence documentation of refusal of nursing services for the patient. When queried why a patient who has not met all goals, has new assessment findings / pain, and needs continued therapy was discharged, the administrator indicated she would have to talk to PT #3. By end of survey, no further information was received. *. Record review of an undated agency policy titled "Admission Criteria and Process" retrieved on 2/9/2023, stated "Policy ... 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 ... A patient will be referred to other resources if the organization cannot meet his/her needs ... Once a patient is admitted to services within its financial and service capabilities, mission, and applicable law and regulations			

	...." *. Observation of a home visit was conducted on 2/3/2023, for patient #1 and with physical therapist (PT) #3. Observation evidenced the patient was dependent and required assistance with activities of daily living (ADLs) including but not limited to ambulation, toileting, and feeding. Clinical record review on 2/9/2023, for patient #1, start of care 12/21/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 12/21/2022 – 2/18/2023. This document evidenced the patient lived at entity #6. This document failed to evidence what treatments and services that were provided by entity #6's nursing staff. Record review failed to evidence the agency could ensure all patient needs were met. During an interview on 2/3/2023, at 10:17 AM, person #7 indicated the family of patient #1 had to choose a home health agency that could			

recommended Amore.

During an interview on 2/8/2023, at 8:40 AM, person #8 indicated that home health aides and private duty caregivers were not allowed at entity #6.

During an interview on 2/9/2023, at 11:52 AM, when queried if the patient/caregivers were offered home health aide services for assistance with ADL's, the administrator indicated the patient's family was always there to help and did not remember if they refused services.

*. Clinical record review on 2/9/2023, for patient #6, start of care 9/28/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/26/2023 – 3/26/2023. This document had an area subtitled "Orders For Discipline and Treatment" which stated "PT Frequency: 2wk3 [2 times a week, for 3 weeks] … Physical Therapy to instruct patient on energy conservation techniques to provide optimal function to

	Therapy to assess gait and instruct patient on methods to improve gait stability and promote safety ... Physical Therapy to perform balance training to decrease risk for injury ... Physical Therapy to perform therapeutic exercises and provide patient with home exercise program to restore functional strength and mobility ...." Record review evidenced the patient lived at entity #6. Record review failed to evidence which treatments and services were provided by entity #6 nursing staff. Record review failed to evidence the agency could ensure all patient needs were met. During an interview on 2/9/2023, at 1:35 PM, administrator #1 indicated they did not know specifically which tasks were provided by the nursing staff at entity #6. Record review of an agency document titled "Communication Note" which was electronically signed by administrator #1 on 1/19/2023, stated "... Received a call from [alternate administrator #2] PT, informing the office that the patient tested positive for covid			

	yesterday 1/18/2023. According to [entity #6 floor nurse], patient has no symptoms at this time ….” Record review of an agency document titled “Missed Visit” which was electronically signed by alternate administrator #2 on 1/19/2023, stated “… Therapy is on hold due to the patient testing positive for COVID ….” Record review evidenced skilled serviced were withheld due to the patient testing positive for covid -19. Record review failed to evidence the patient was exhibiting negative symptoms of the covid-19 virus that would have impacted a physical therapy visit. Record review failed to evidence the patient’s needs were met. During an interview on 2/9/2023, at 1:48 PM, administrator #1 indicated the patient was put in an isolation room and alternate administrator #2 was told to hold therapy for 1 week by the physician. Alternate administrator #1 indicated they did not know why the physician would say that. *. Clinical record review on			

	2/9/2023, for patient #2, start of care 1/20/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 12/21/2022 – 2/18/2023. This document evidenced the patient lived at entity #6. This document failed to evidence what treatments and services that were provided by entity #6's nursing staff. Record review failed to evidence the agency could ensure all patient needs were met. During an interview on 2/9/2023, at 1:24 PM, when queried what level of care the nursing staff at entity #6 provided to the patient, administrator #1 indicated the patient was located on the memory care unit which mostly had bed alarms and nurse aides to assist.			
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	G0572	The DON reviewed the clinical records of 100% of all active patientson March 6-7, 2023 as part of the post-survey chart audit to check for staff'scompliance to the patient's Plan of Care.	2023-03-08

	podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on observation, record review and interview, the agency failed to ensure the services were provided as directed in the plan of care, in 3 of 4 active clinical records reviewed (patient #2, #3, #6) The findings include: 1. Review of an undated agency policy titled "PHYSICIAN'S PLAN OF CARE", received 2/9/2023, indicated services should be provided in accordance with a plan of care based on the patient's diagnosis and assessment of the patient's needs, which has been approved and signed by the physician. 2. Review of the plan of care for 12/17/2022 to 2/14/2023 for patient #3 evidenced the patient was on bleeding precautions. The plan of care indicated the patient shall demonstrate progression of the home exercise program each visit. Observation of a discharge visit		Regarding patient#6, the DON informed the doctor via fax onMarch 7, 2023 of the polypharmacy and asked for a verification of the dosage ofthe medication in question. On March 8, 2023, an order was received todiscontinue the medication in question (Pls see Attachment-9 for coordinationof care). The DON also conducted an in-service on March 6, 2023 to all fieldstaff to re-educate on following the Plan of Care to meet established goals(e.g. progression of patient's demonstration of home exercise program,prevention of hospitalization due to polypharmacy), and properly document allservices provided during visit in the visit notes. (Pls see Attachment-4 for in-servicetopics and staff attendance.) The DON is responsible for ensuring the Plan of Care isfollowed. The DON or its designee will review 20% of charts monthly for 3months using the Revised Chart Review	

	on 2/9/2023 failed to evidence patient demonstration of the home exercise program. Review of all visit notes from 1/11/2023 to 1/30/2023 failed to evidence bleeding precautions. During an interview on 2/8/2023 at 2:07 PM, the administrator indicated the physical therapist should document in the visit notes what safety precautions were maintained and progress toward goals. When informed of the findings, the administrator indicated she did not know why PT#3 did not assess the patient's demonstration of the home exercise program at the discharge visit. *. Record review of the website https://www.mayoclinichealthsystem.org on 2/7/2023, evidenced an article titled "Tylenol Dosing (Acetaminophen) ... Adults and teenagers—325 or 500 milligrams (mg) every 3 or 4 hours, 650 mg every 4 to 6 hours, or 1000 mg every 6 hours as needed. The total dose		Tool (Pls see Attachment-7). Targetthreshold is 100%. Once threshold is metand after completing 3 months of monthly chart audits, DON or designee willcontinue monitoring 20% of patient's charts quarterly to ensure that thisdeficiency is corrected and will not recur.	

	mg (for example, eight 500–mg tablets) a day ….” *. On 2/8/2023, an entity #6 document was retrieved from person #8, titled “Service & Wellness Programs” which outlined three different level of care packages subtitled “Independent Wellness Program … Assisted Wellness Program … Hands-On Wellness Program ….” This document also included information on but not limited to incontinent management services, a la carte services, memory care services and additional community fees. This document stated “… With A La Carte Services, residents can customize the services needed, such as personal laundry, shower assistance or just an extra set of hands when they need it the most ….” An interview was conducted on 2/8/2023, from 8:33 AM – 8:48 AM, at entity #6 with person #8 and person #9 to discuss the levels of care provided by the nursing staff in their facility. Person #8 indicated the nursing staff at entity #6 does not provide any skilled care. Person #8 indicated nursing staff provided medication			

	management, but some residents required only reminders and some need administration. Person #8 indicated their nursing staff could assist with toileting, laundry, or bathing but would be different for each patient. *. Clinical record review on 2/9/2023, for patient #6, start of care 9/28/2022, diagnoses included but not limited to hypertensive heart disease (result of unmanaged high blood pressure which lead to poor pumping of the heart), muscle weakness, and diabetes, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/26/2023 – 3/26/2023. An area of this document subtitled "Medications" stated, "Norco 5 mg [milligram] – 325 mg [combination of hydrocodone (5 mg) and acetaminophen (325 mg) medication used to relieve moderate to severe pain] … 1 tab [tablet] 3 times a day … Acetaminophen [mild pain reliever] 500 mg oral tablet 2 tabs (1000 mg) every 6 hours as needed for pain …" Another area subtitled "Orders for Discipline and Treatment"			

	stated, "PT [physical therapist] to minimize risk for hospitalization due to polypharmacy [simultaneous use of multiple drugs by a single patient, for one or more conditions] requiring help with managing medications ... PT to minimize risk for hospitalization due to high risk principal diagnosis - hypertensive heart disease with heart failure, weakness, diabetes, history of falls ... Physical therapy to provide skilled assessment, teaching/ training and reinforcement of teaching to properly assess, manage and mitigate pain ...." Record review evidenced the patient was prescribed to take Norco, a medication which contained 325 mg of acetaminophen, three times a day (a total of 975 mg of acetaminophen per day). Review evidenced the patient was prescribed to take 1000 mg of acetaminophen every 6 hours as needed for pain (possibility of 4000 mg of acetaminophen per day). Record review evidenced the maximum daily allowance of acetaminophen was 4000 mg per day. Record			

	could have potentially exceeded the daily allowance by 975mg of acetaminophen. Record review failed to evidence the physical therapist assisted to manage the patient's medications as ordered on the plan of care. Record review failed to evidence the physical therapist provided teaching and reinforcement to properly assess and manage pain. During an interview on 2/9/2023, at 1:35 PM, administrator #1 indicated they didn't know which package for level of care this patient received from entity #6. During an interview on 2/9/2023, at 2:04 PM, administrator #1 indicated the patient received medication from the nursing staff at entity #6, and they know the daily allowance. Administrator #1 indicated documentation of the teaching provided by physical therapist would be located within the visit note, usually under the narrative section. *. Clinical record review on 2/9/2023, for patient #2, start of care 1/20/2023, primary			

	diagnosis of hypertensive heart disease with heart failure, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 12/21/2022 – 2/18/2023. This document had an area subtitled "Orders for Discipline and Treatment" which stated "…PT to minimize risk for hospitalization due to high risk principal diagnosis - hypertensive heart disease with heart failure, weakness, difficulty in walking, atrial fibrillation [irregular and often very rapid heart rhythm that can lead to blood clots in the heart], pvd [peripheral vascular disease], dementia and repeated falls … therapist to observe for symptoms of heart failure such as worsening shortness of breath, dry hacking cough, fatigue, confusion, heart palpitations, swelling of the extremities, in lowered ability to exercise and report to the physician or nurse on duty at [entity #6] …." Record review failed to evidence teaching about medications and pertinent diagnoses. Record review failed to evidence documentation of the physical therapist's attempt to minimize			

	hospitalizations due the patient's high risk pertinent diagnoses. Record review failed to evidence the plan of care was followed as ordered. During an interview on 2/9/2023, at 1:24 PM, administrator #1 indicated they agency did not expect the therapists to educate the patient in detail, but should report signs and symptoms to the nurse on duty at entity #6 and the patient's physician.			
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;	G0574	To correct the deficiency, the Plan of Care of patient #3 wasupdated during recertification on February 13, 2023 to document the patient'sDME. The DON in-serviced all field staffon March 6, 2023 on ensuring that the Plan of Care included all necessary components,including but not limited to equipment, supplies and DME. (Pls see Attachment-4 for in-service topicsand staff attendance.) The DON also reviewed the clinical records of 100% ofall active patients on March 6-7, 2023 as part of the post-survey chart	2023-03-06

	(x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to ensure the plan of care included all necessary components in 1 of 4 active clinical records reviewed. (#3) The findings include: Review of an undated agency policy titled "PHYSICIAN'S PLAN OF CARE", received 2/9/2023 indicated the plan of care should include (but not be limited to) all medications, treatments, equipment / supplies required, and instruction for timely discharge. Observation of a home visit for patient #3 was conducted on 2/8/2023 at 11:00 AM. Upon arrival to the address on the patient's current plan of care,		auditto check for completeness of the Plan of Care. The DON is responsible for ensuring that the Plan of Careincluded all necessary components. TheDON or its designee will review 20% of charts monthly for 3 months using theRevised Chart Review Tool (Pls see Attachment-7). Target threshold is 100%. Once threshold is met and after completing 3months of monthly chart audits, DON or designee will continue monitoring 20% ofpatient’s charts quarterly to ensure that this deficiency is corrected and willnot recur.	

	the surveyor and PT (physical therapist) #3 were at the wrong address. Person #5 indicated the patient never lived at the address on the plan of care, but gets mail sent there. After going to the correct address, observation of the home visit was conducted and evidenced patient #3 had a shower chair. Observation of both patient's bathrooms failed to evidence grab bars. Review of the plan of care for certification period 12/17/2022 to 2/14/2023 indicated grab bars were present in the patient's home. The plan of care failed to evidence the patient had a shower chair. During an interview on 2/8/2023 at 2:28 PM, the administrator indicated the plan of care should include all equipment / supplies in the home for the patient. *. Clinical record review on 2/9/2023, for patient #1, start of care 12/21/2022, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 12/21/2022 – 2/18/2023. This document had an area subtitled			

	"Patient Name, Address, and Phone Number" which had the address to entity #6 and failed to evidence the patient's room number. Record review failed to evidence the exact location of the patient within entity #6. Review failed to evidence the patient's individualized address on the plan of care. During an interview on 2/9/2023, at 11:52 AM, when queried about the room number for patient #1, administrator #1 indicated they did not remember the exact location, and it was not listed on the plan of care. *. Clinical record review on 2/9/2023, for patient #2, start of care 1/20/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/20/2023 – 3/20/2023. This document had an area subtitled "Patient Name, Address, and Phone Number" which had the address to entity #6 and failed to evidence the patient's room number. Record review failed to evidence the exact location of the patient within entity #6. Review failed to evidence the patient's individualized address			

	on the plan of care. During an interview on 2/9/2023, at 1:29 PM, when queried about the room number for patient #2, administrator #1 indicated the patient was on the memory care unit and would have to pass by the information desk to see them. Administrator #1 indicated the room number should have been on the plan of care. *. Clinical record review on 2/9/2023, for patient #6, start of care 9/28/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 1/26/2023 – 3/26/2023. This document had an area subtitled "Patient Name, Address, and Phone Number" which had the address to entity #6 and failed to evidence the patient's room number. Record review failed to evidence the exact location of the patient within entity #6. Review failed to evidence the patient's individualized address on the plan of care. During an interview on			

	queried about the room number for patient #6, administrator #1 indicated the patient was on the 3rd floor.			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on observation, record review and interview, the agency failed to notify the physician of changes in the patient's condition in 1 of 2 clinical records reviewed with a home visit. (#3) The findings include: Review of an agency policy titled "MONITORING PATIENT'S RESPONSE / REPORTING TO PHYSICIAN", dated April 2012, indicated the clinician will contact the physician on the same day when any of the following occur: significant change in the patient's condition, significant change in the home environment, inability	G0590	To correct the deficiency, the DON reviewed 100% of allclinical records of patients on March 6 - 7, 2023 as part of the post-surveychart audit to check if physicians were notified about significant patientfindings that may require decision-making. The DON also conducted an in-serviceon March 6, 2023 to field staff about reporting significant information to thephysician which may require decision-making (e.g., pain, swelling). (Pls see Attachment-4for in-service topics and staff attendance.) The DON is responsible for ensuring that thefield staff will notify the physician of significant patient findings which mayrequire decision-making. The DON or its designee will review 20% of chartsmonthly for 3 months using the Revised Chart Review Tool (Pls see Attachment-7).Target threshold is 100%. Once thresholdis met and after completing 3 months of monthly chart audits, DON or designeewill continue monitoring 20% of patient's charts quarterly to ensure that thisdeficiency is corrected and will not recur.	2023-03-07

	specified time frame, changes in the expected response to treatment, changes that have occurred regarding diagnosis, prognosis or treatment, any problem implementing the plan of care, results are received for laboratory tests, and patient is to be discharged from the agency or a service. The policy indicated all conferences or attempts to communicate with the physician will be documented in the clinical record. Review of an agency policy titled, "THERAPY SERVICES", revised 1/10/2023, indicated the therapist will inform the physician of changes in the patient's condition and may recommend changes as telephone orders. Review of an agency policy titled "PHYSICIAN PARTICIPATION IN PLAN OF CARE", revised 2/11/2020, indicated orders for the plan of care shall be reviewed and revised by the physician based on changes in the patient's physical condition. During observation of a home			

	patient #3 complained of pain and swelling to the right leg. At 12:10 PM PT (physical therapist) #3 was observed calling the physician's office and leaving a message indicated the patient was being discharged from home health and he recommended outpatient therapy. PT #3 failed to inform the physician about the pain and swelling to the patient's right leg. Review of all assessments for certification period 12/17/2022 to 2/14/2023 failed to evidence patient complaint of pain or swelling to the right leg. During an interview on 2/8/2023 at 1:48 PM, the administrator indicated the clinician should notify the physician whenever there is a change in a patient's condition. The administrator indicated the physician needed to be made aware so they could determine the need for a change in the comprehensive assessment or the plan of care. The administrator indicated the clinician should also inform her if there were a change in the patient's condition. When queried, the administrator			

	indicated PT #3 did not inform her of the patient's new complaint of leg pain and swelling. 410 IAC 17-13-1(a)(2)			
G0608	Coordinate care delivery 484.60(d)(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on observation, record review and interview, the home health agency failed to ensure care was coordinated with outside healthcare entities who services agency patients for 2 of 2 active clinical records reviewed of patients living in an assisted living facility. (patient #1, #2). The findings include: 1. An agency policy dated April 2012, titled "Coordination Of Services With Other Providers:", stated "... Purpose To ensure the coordination of services provided by the organization and by other service providers. Policy A Case Manager will be	G0608	To correct this deficiency, the DON talked to the DON ofentity #6 and queried on the different levels of care of the patients under theagency's care. Due to the entity'sprivacy policy, the level of care cannot be divulged. As an alternative, it was suggested by theentity's DON that during start of care, the admitting clinician should ask thenurse-on-duty about what treatments or services are provided by the entity(e.g., administration of medications). The DON conducted an in-service on March 6, 2023 to field staff aboutcoordination of care with other providers and the inclusion in the Plan of Careof treatments and services received by patients in facilities. (Pls see Attachment-4for in-service topics and staff attendance.)	2023-03-06

	coordinating services provided to the patient by the organization, including services provided directly and through contract. The Case Manager will act as liaison with other organizations or individuals also providing care to the patient to assure effective coordination of related services. … The Case Manager will be responsible for the coordination between service providers, which will include, but not be limited to: A. Organization personnel's understanding of each organization's/individual's responsibility in providing care. … Ongoing communication regarding issues and concerns with the organizations or individuals providing care will be the responsibility of Amore Home Health Care Services, Inc. management team." 2. Observation of a home visit was conducted on 2/3/2023, for patient #1 and with physical therapist (PT) #3. Observation evidenced the patient was dependent and required assistance with activities of daily living (ADLs) including but not limited to ambulation, toileting,		The DON is responsible for ensuring that the field staff willdocument the treatments and services received by patients in facilities in thePlan of Care as part of the coordination of care with other providers. The DON or its designee will review 20% ofcharts monthly for 3 months using the Revised Chart Review Tool (Pls see Attachment-7).Target threshold is 100%. Once thresholdis met and after completing 3 months of monthly chart audits, DON or designeewill continue monitoring 20% of patient's charts quarterly to ensure that thisdeficiency is corrected and will not recur.	

	and feeding. Clinical record review on 2/9/2023, for patient #1, start of care 12/21/2022, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 12/21/2022 – 2/18/2023. This document indicated the patient lived at entity #6. This document failed to indicate what treatments and services were provided by entity #6's nursing staff. During an interview on 2/3/2023, at 10:17 AM, person #7 indicated the family of patient #1 had to choose a home health agency that could come to entity #6, who also recommended Amore. During an interview on 2/8/2023, at 8:40 AM, person #8 indicated that home health aides and private duty caregivers were not allowed at entity #6. During an interview on 2/9/2023, at 11:52 AM, when queried if the patient/caregivers were offered home health aide services for assistance with ADL's, the administrator indicated the patient's family			

	was always there to help and did not remember if they refused services. 3. Clinical record review on 2/9/2023, for patient #2, start of care 1/20/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 12/21/2022 – 2/18/2023. This document indicated the patient lived at entity #6. This document failed to evidence what treatments and services were provided by entity #6's nursing staff. During an interview on 2/9/2023, at 1:24 PM, when queried what level of care the nursing staff at entity #6 provided to the patient, administrator #1 indicated the patient was located on the memory care unit which mostly had bed alarms and nurse aides to assist.			
G0610	Patients receive education and training 484.60(d)(5) Ensure that each patient, and his or her	G0610	The DON conducted an in-service on March 6, 2023 to fieldstaff about providing education and training to the	2023-03-06

	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 a home visit (#3). The findings include: Review of an agency policy titled "THERAPY SERVICES", revised 1/10/2023 indicated the physical therapist will provide treatment in accordance with physician orders. Review of the plan of care for 12/17/2022 to 2/14/2023 for patient #3 indicated the physical therapist was to instruct the patient / caregiver on how to prevent venous stasis (blood pooling in the extremities). Review of the plan of care evidenced the patient was on bleeding precautions		patient/patient caregiver regardingthe care and services identified in the Plan of Care (e.g., disease prevention,bleeding precautions). (Pls see Attachment-4for in-service topics and staff attendance.) The DON also reviewed the clinicalrecords of 100% of all active patients on March 6-7, 2023 as part of thepost-survey chart audit to check for patient/patient caregiver education. The DON is responsible for ensuring that thefield staff will provide patient education and training. The DON or itsdesignee will review 20% of charts monthly for 3 months using the Revised ChartReview Tool (Pls see Attachment-7). Target threshold is 100%. Once threshold is met and after completing 3months of monthly chart audits, DON or designee will continue monitoring 20% ofpatient's charts quarterly to ensure that this deficiency is corrected and willnot recur.	

	Review of all visit notes from 1/11/2023 to 1/30/2023 failed to evidence bleeding precautions and patient / caregiver instruction on how to prevent venous stasis. During an interview on 2/8/2023 at 2:07 PM, the administrator indicated the physical therapist should document the education provided in each visit note. The administrator indicated if a patient is on bleeding precautions, the clinician should instruct them on what to do for bleeding that won't stop, to watch for blood in urine, to use a soft toothbrush, and to let the agency or the physician know if they notice any bleeding. When informed of the findings, the administrator reviewed the patient's medical record and offered no further information. 410 IAC 17-14-1(a)(1)(G)			
G0612	Written instructions to patient include: 484.60(e)	G0612	To correct the deficiency, the DON checked the PatientAssessment Book of 100% of ALL active patients of the agency, including patient#1 & patient #3, on March 4, 2023	2023-03-06

	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 and plan of treatment in 2 of 2 clinical records where a home visit was conducted. (patient #1, #3) The findings include Review of an agency policy titled "PATIENT BILL OF RIGHTS", revised 9/9/2019, indicated the patient has the right to be informed about the frequency of visits and disciplines that will furnish the care or treatment. Observation of a home visit for patient #3 on 2/6/2023 at 11:00 AM failed to evidence a completed calendar of visits. During an interview on 2/6/2023 at 12:00 PM, person #3 (family member of patient #3) indicated they did not get a written schedule of visits from the agency. During an interview on 2/8/2023 at 2:29 PM, the administrator indicated the patient was informed about the		to see if the Plan of Care were attachedand if the Calendar of Visits were completed by the visiting clinician. The DONalso conducted an in-service on March 6, 2023 to field staff about providingthe patient/patient caregiver with (1) a copy of the Plan of Care, and (2) visitschedule during which care and service will be given. This visit schedule will be completed in theCalendar of Visits found in the Patient Assessment book. (Pls see Attachment-4 for in-service topicsand staff attendance.) The DON is responsible for ensuring that the field staff willprovide a visit schedule to the patient/patient caregiver/facility. The DON orits designee will call 20% of patients monthly for 3 months and recorded in theRevised Chart Review Tool (Pls see Attachment-7). Target threshold is 100%. Once threshold ismet and after completing 3 months of monthly audits, DON or designee willcontinue monitoring 20% of patients quarterly to ensure that this	

	schedule of visits by the clinician filling out the calendar maintained in the patient's home. When informed of the findings, the administrator indicated the clinician should have filled out the calendar in the patient's home. *. An observation of a home visit was conducted on 2/3/2023, for patient #1, start of care 12/21/22, with physical therapist (PT) #3. At 10:10 AM, the patient's home folder was reviewed for information provided by the agency to include a current plan of treatment. Observation failed to evidence a plan of treatment in the patient home folder.		deficiency iscorrected 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 agency failed to ensure each patient had a current and complete medication list in 1 of	G0616	To correct this deficiency, the DON conducted an in-serviceon March 6, 2023 to field staff about periodically checking for new,discontinued or changed medications in patient's home or facility, and updatethe Medication Profile accordingly. (Plssee Attachment-4 for in-service topics and staff attendance.) The DON also called100% of active patients on March 8, 2023 to check for any	2023-03-06

	1 home visits conducted in an assisted living facility (#1). The findings include: An observation of a home visit was conducted on 2/3/2023, for patient #1, start of care 12/21/22, with physical therapist (PT) #3. At 10:10 AM, the patient's home folder was reviewed for information provided by the agency to include a current medication list and instructions. Review of a document titled "Medication Profile" evidenced the topical non-steroidal anti-inflammatory drug, Voltaren gel was to be applied 3 times a day to the right hip. At 10:19 AM, a list of orders was retrieved from the floor nurse at entity #1, where the patient lived. The orders failed to evidence Voltaren was administered to the patient by the staff at entity #1. Observation failed to evidence the medication list provided by the agency was current and consistent with entity #1's orders. During an interview on 2/9/2023, at 11:49 AM, administrator #1 indicated the		new, discontinued orchanged medication and if properly documented in the patient's MedicationProfile. The DON is responsible for ensuring that the field staff willdocument any new, discontinued or changed medication in the patient's home orfacility. The DON or its designee willcall 20% of patients monthly for 3 months and recorded in the Revised ChartReview Tool (Pls see Attachment-7). Target threshold is 100%. Once threshold ismet and after completing 3 months of monthly audits, DON or designee willcontinue monitoring 20% of patients quarterly to ensure that this deficiency iscorrected and will not recur.	

	be consistent with the orders at entity #6.			
G0652	Activities lead to an immediate correction 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 ensure the quality assessment performance improvement (QAPI) data collected led to an immediate correction of the identified problems that could directly or potentially threaten the health and safety of patients. The findings include: Record review evidenced an agency policy 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 on 02/09/2023,	G0652	On February 10, 2023, the Performance Improvement Council (PIC)met and discussed the following: (1) collected data (iQIES) on potentiallyavoidable events, (2) identified problems that needed to be focused on (3) improvementmeasures to identified problems, (4) a tool to be developed to monitorimprovement after implementing improvement measures. (Pls see Attachment-10 for PIC meeting minutes.) On March 2, 2023, the PIC submitted the PerformanceImprovement Projects on improving ambulation/locomotion and urinary tractinfection to the Administrator. The PIC included the (1) identified problems, (2)root cause analysis, and (3) recommended solutions for the improvement of theproblems. (Pls see Attachment-11 for the	2023-03-06

	QAPI binder evidenced the home health agency aggregated data of improvements needed with decline in 3 or more activities of daily living, development of UTI's (urinary tract infections) and ambulation/locomotion. During an interview on 02/09/2023 at 10:21 AM, the administrator indicated their current focus was improvement of ambulation/locomotion and they have not implemented any actions at this point. 410 IAC 17-12-2(a)		details of the Performance ImprovementProjects.) The PIC included the tool tobe used for monitoring improvement which was approved by BOD on March 3, 2023(Pls see Attachment-12). The BOD also approved the improvement measuresrecommended by the PIC (Pls see Attachment-1) for immediateimplementation. An in-service wasconducted on March 6, 2023 to all field staff as part of the improvementmeasures. (Pls see Attachment-4 for in-service topics and staff attendance.) The Administrator is responsible for ensuring immediatecorrection of any problems identified by PIC that directly or potentiallythreaten the health and safety of patients. The Administrator will report tothe BOD about the outcome and recommend changes to the polices/procedures ortrain the staff to improve the incidence of the event every quarter to ensurethat the deficiency is corrected and will not recur.	

G0654	Track adverse patient events 484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions. Based on record review and interview, the home health agency failed to ensure they implemented preventative actions for their performance improvement activities identified. The findings include: Record review evidenced an agency policy 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 on 02/09/2023 evidenced the home health agency's QAPI binder. The home health agency identified areas in need of improvement as decline in 3 or more activities of daily living, development of UTI's (urinary tract infection) and improvement in ambulation/locomotion.	G0654	On March 2, 2023, the PIC submitted the PerformanceImprovement Projects on improving ambulation/locomotion and urinary tractinfection to the Administrator. The PIC included root cause analysis, and recommendedsolutions to the identified problems including preventive measures. (Pls see Attachment-11for the details of the Performance Improvement Projects.) On March 3, 2023, the BOD approved the implementationof improvement measures recommended by the PIC including preventive measures. An in-service was conducted on March 6, 2023to all field staff as part of the improvement measures. (Pls see Attachment-4for in-service topics and staff attendance.) The Administrator is responsible for tracking adverse patientevents, analyzing their causes, and implement preventive actions. The Administrator will recommend to the BOD changesto the policies/procedures or train the staff to improve the incidence	2023-03-06

	During an interview on 02/09/2023 at 10:15 AM, the administrator indicated the agency was communicating with the therapist and would increase frequency of treatments if needed and analyze what the root of the problem was to increase an improvement in ambulation/locomotion. During an interview on 02/09/2023 at 10:23 AM, the administrator indicated they have not implemented any of the performance improvement activities at this time. 410 IAC 17-12-2(a)		of theevent every quarter to ensure that the deficiency is corrected and will notrecur.	
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 they implemented their performance improvement measures to ensure its success and that improvements were sustained.	G0656	On March 2, 2023, the PIC submitted the PerformanceImprovement Projects on improving ambulation/locomotion and urinary tractinfection to the Administrator. (Pls see Attachment-11 for the details of the PerformanceImprovement Projects.) The PIC includedthe tool to be used for monitoring improvement which was approved by BOD onMarch 3, 2023 (Pls see Attachment-12).	2023-03-06

	The findings include: Record review evidenced an agency policy 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 of the agency's QAPI [quality assessment performance improvement] binder on 02/09/2023 failed to evidence the home health agency implemented their performance improvement measures to ensure its success and that improvements were sustained. During an interview on 02/09/2023 at 10:24 AM, the administrator indicated the agency was going to develop a tool on how they could monitor to see if their focused improvements were sustained. The administrator indicated nothing had been implemented yet and hopefully by tomorrow they could create something. 410 IAC 17-12-2(a)		This tool will be used for monitoringduring the 2nd quarter of 2023 to determine effect of theimprovement measures implemented, including the In-service that was conductedon March 6, 2023 to all field staff. (Pls see Attachment-4 for in-servicetopics and staff attendance.) The Administrator is responsible for implementingperformance improvement activities, measuring/tracking their success, and ensuringthat improvements are sustained. The Administrator will report to the BOD quarterlyabout the performance improvement outcome to ensure that the deficiency is correctedand will not recur.	

G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the home health agency failed to ensure they documented quality improvement projects, the reasons for conducting the project and the measurable progress achieved. The findings include: Record review evidenced an agency policy dated April 2012, titled, "Improving Organizational Performance," which stated, "... the governing body is responsible for ensuring that the performance improvement program is	G0658	On March 6, 2023, the Administrator gave an in-service to allstaff including members of the Performance Improvement Council regarding theirduties and responsibilities, including but not limited to documenting allimprovement projects to note any measurable progress or decline. (Pls see Attachment-4for in-service topics and staff attendance.) The Administrator is responsible for ensuring that allPerformance Improvement Projects will be documented. The Administrator will check PIC projectsquarterly to ensure that the deficiency is corrected and will not recur.	2023-03-06

	maintained, and is evaluated annually ...." Review of the agency's QAPI [quality assessment performance improvement] binder failed to evidenced the agency documented their quality improvement projects, the reasons for conducting the project and the measurable progress achieved. During an interview on 02/09/2023 at 10:27 AM, the administrator indicated nothing had been implemented yet and the agency would have a meeting tomorrow to discuss and finalize their quality improvement projects.			
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	On March 2, 2023, the PIC submitted the PerformanceImprovement Projects on improving ambulation/locomotion and urinary tractinfection to the Administrator. The PIC included the (1) identified problems,(2) root cause analysis, and (3) recommended solutions for the improvement ofthe problems.	2023-03-06

	(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 their governing body implemented, maintained and evaluated effectiveness for focused problems identified in their quality assessment performance improvement (QAPI) program to ensure quality improvement and patient safety. The findings include: Record reviewed evidenced an agency policy 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 on 02/09/2023, of the agency's QAPI binder		(Pls see Attachment-11 for the details of the PerformanceImprovement Projects.) The PIC includedthe tool to be used for monitoring improvement which was approved by BOD onMarch 3, 2023 (Pls see Attachment-12). This tool will be used for monitoring during the 2nd quarterof 2023 to determine effect of the improvement measures implemented, includingthe In-service that was conducted on March 6, 2023 to all field staff. (Pls seeAttachment-4 for in-service topics and staff attendance.) The Governing Body is responsible for ensuring that theperformance improvement program is defined, implemented, and maintained, and isevaluated annually to ensure that the deficiency is corrected and will not recur.	

	aggregated and the agency had chosen to focus on decline in 3 or more activities of daily living, development of UTI's [urinary tract infection] and ambulation/locomotion. There failed to be any evidence in the QAPI binder of improvements that had been implemented, maintained or evaluated for effectiveness. During an interview on 02/09/2023 at 10:12 AM, the administrator indicated the agency was gathering data to keep track of incidences, formulate answers and report these to the board of directors (governing body). During an interview on 02/09/2023 at 10:23 AM, the administrator indicated nothing had been implemented at this point. The administrator indicated the governing body had discussed the iQIES report and at the end of the month they would do an incident and infection log.			
G0716	Preparing clinical notes	G0716	To correct this deficiency, the	2023-03-07

	484.75(b)(6) Preparing clinical notes; Based on record review and interview, the home health agency failed to ensure all clinicians prepared clinical records to be complete, accurate and current for 4 of 4 active clinical records reviewed. (Patient #1, #2, #3, #6) The findings include: 5. Review of the plan of care for 12/17/2022 to 2/14/2023 for patient #3 evidenced the patient was on bleeding precautions. The plan of care indicated the patient shall demonstrate progression of the home exercise program each visit. Review of all visit notes from 1/11/2023 to 1/30/2023 failed to evidence bleeding precautions. During an interview on 2/8/2023 at 2:07 PM, the administrator indicated the physical therapist should document in the visit notes what safety precautions were maintained at each visit.		DON reviewed 100% of allclinical records of patients on March 6 - 7, 2023 to check for accurate andtimely completion of clinical notes. The DON also conducted an in-service on March6, 2023, to all field staff about accurate documentation of patient'smedications (e.g., intermittent vs continuous oxygen), safety precautions(e.g., bleeding precaution), and timely completion of visit notes. (Pls see Attachment-4for in-service topics and staff attendance.) The DON is responsible for monitoring accurate and timely completionof clinical notes. The DON or itsdesignee will review 20% of charts monthly for 3 months using the Revised ChartReview Tool (Pls see Attachment-6). Target threshold is 100%. Once threshold is met and after completing 3months of monthly chart audits, DON or designee will continue monitoring 20% ofpatient's charts quarterly to ensure that this deficiency is corrected and willnot recur.	

	1. Record review of a contract between Amore Home Health Care Services and entity #1, effective 1/3/2023, stated "... 6. Provider will provide the recording of clinical daily notes (all of which clinical and daily notes are to be written on the day that the service is provided) for their incorporation into the medical records of the Agency within two (2) days of the visit date for the purpose of planning and evaluating patient care ... Initial evaluation will be called in by the therapist on the same day of the evaluation or will be encoded in the system software within forty-eight (48) hours or so ...." This document was signed by administrator #1 and person #2, on 1/3/2023.			

	2. Clinical record review on 2/9/2023, for patient #1, start of care 12/21/2022, on the agency's electronic health record (EHR), evidenced an entry for a visit for 2/1/2023, with PT (physical therapist) #3's name next to it, which had not been started yet. Record review evidenced documentation for the visit had not been started 8 days after the visit occurred. During an interview on 2/3/2023, at 10:39 AM, PT #3 indicated they have access to the agency's EHR and communicated with administrator #1 almost daily. During an interview on 2/9/2023, at 11:54 AM, administrator #1 indicated it would be better if the clinicians documented on their visits the same day and all PT clinicians have access to the agency's web based EHR. During an interview on 2/9/2023, at 11:58 AM, quality assurance (QA) #4 indicated when documentation was not completed, administrator #1 would be notified to reinforce timely submission. Administrator #1 indicated they			

would notify alternate administrator #2 because they are the administrator at entity #1, which is where the physical therapists are contracted from.

3. Clinical record review on 2/8/2023, for patient #2, start of care 1/20/2023, on the agency's EHR, evidenced an entry for a Resumption of Care (ROC) visit for 2/3/2023, with PT #3's name next to it and remained 90% incomplete. Record review evidenced the ROC remained incomplete for 5 days after the visit occurred.

On 2/8/2023, at 3:13 PM, a copy of the ROC visit from 2/3/2023, was requested and administrator #1 indicated the visit was not completed.

During an interview on 2/9/2023, at 1:30 PM, administrator #1 indicated the ROC was completed the previous night after a copy of visit was requested.

4. Clinical record review on 2/9/2023, for patient #6, start of care 9/28/2022, pertinent diagnosis of dependence on supplemental oxygen,

	evidenced an agency document titled "Recertification (PT)" from 1/25/2023, and electronically signed by alternate administrator #2. This document had an area subtitled "Risk Assessment" which had a box next to the statement "Emergency Preparedness Performed" that remained un-checked. An area subtitled "Respiratory Status" which had boxes checked next to the statements "Oxygen use, intermittent: LPM [liters per minute] 2 ..." and "No safety risks noted ...." Record review evidenced the patient was dependent on continuous oxygen use. Record review failed to evidence emergency preparedness was completed and reviewed at the comprehensive assessment. Record review failed to evidence the skilled professional prepared complete and accurate clinical records. During an interview on 2/9/2023, at 1:35 PM, administrator #1 indicated the patient was on continuous oxygen and the documentation of "intermittent" was in error.			

	410 IAC 17-14-1(c)(5) THERAPIST			
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 they were responsible for all day-to-day operations including but not limited to reinforcement of contracts with other agencies. The findings include: Record review of a contract between Amore Home Health Care Services and entity #1, effective 1/3/2023, stated "... 6. Provider will provide the recording of clinical daily notes (all of which clinical and daily notes are to be written on the day that the service is provided) for their incorporation into the medical records of the Agency within two (2) days of the visit date for the purpose of planning and evaluating patient care ... Initial evaluation will be	G0948	On March 6, 2023, the Administrator/DON conducted an in-serviceto staff about (1) timely transmission of discharge summary to the physician,(2) coordination of care with other providers, (3) timely submission of visitnotes from contractors, and (4) the availability of a list of other home healthagencies with home health aide services and in-home care & assistance (Plssee Attachment-13). (Pls see Attachment-4 for in-service topics and staffattendance.) 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. TheGoverning Body will evaluate the Administrator every 3 months	2023-03-06

	called in by the therapist on the same day of the evaluation or will be encoded in the system software within forty-eight (48) hours or so ….” This document was signed by administrator #1 and person #2, on 1/3/2023. Review of an agency policy titled “Discharge Summary”, revised 1/10/2023, indicated the clinician who provided care to a patient who was discharged will complete and submit a discharge summary within 5 days of discharge from service. Clinical record review for patient #5 evidenced an agency document titled, “PT (physical therapy) DISCHARGE SUMMARY”, dated 1/11/2023, and signed by PT #4. This summary indicated the patient was discharged from all agency services on 1/11/2023. Review of an agency document titled, “TRANSMISSION VERIFICATION REPORT” and an agency fax cover sheet evidenced the discharge summary was faxed to the physician on 1/20/2023, 9 days after the patient was discharged. Record review		for the firstyear. (Please see Attachment-21 for Performance Evaluation Form forAdministrator.) Target threshold is100%. Once threshold is met and after completing quarterly evaluations for the1st year, the Governing Body will continue to evaluate theAdministrator yearly thereafter.	

	administrator implemented policies and procedures. During an interview on 2/9/2023, at 2:43 PM, administrator #1 indicated the discharge summary should be sent within 5 days. Administrator #1 indicated the patient was discharged on 1/11/2023, but discharge summary was not faxed until 1/20/2023. Record review of an agency document titled "Patient Survey Census" retrieved on 2/2/2023, evidenced 11 of 11 patients received contracted therapy services and 10 of 11 patient were residents at entity #6. Clinical record review on 2/9/2023, failed to evidence administrator #1 could decipher the level of care provided by the nursing staff at entity #6 for 3 of 3 active patients who lived there. During an interview on 2/9/2023, at 11:16 AM, administrator #1 indicated 3rd floor residents are more mobile, sometimes there was an aide depending on staffing. Administrator #1 indicated on the memory care unit residents			

need more care to help with activities of daily living (ADLs). Administrator #1 indicated entity #6 was responsible in full for the shared patients who were residents there.

An interview was conducted on 2/8/2023, from 8:33 AM – 8:48 AM, at entity #6 with person #8 and person #9 to discuss the levels of care provided by the nursing staff in their facility. Person #8 indicated the nursing staff at entity #6 does not provide any skilled care, the home health agency would assume responsibility for any skilled care provided. Person #8 indicated nursing staff provided medication management, but was not the same for every resident. Person #8 explained some residents required only reminders and some need administration. Person #9 indicated their nursing staff could assist with toileting, laundry, or bathing but would be different for each patient.

Clinical record review on 2/9/2023, failed to evidence documentation of visits submitted within 48 hours as stated on the signed contract for 3 of 4 active clinical records

	reviewed who received contracted therapy services from entity #1. During an interview on 2/9/2023, at 11:25 AM, administrator #1 indicated that all contracted clinicians have access to the agency's electronic medical record (Axxess) and could document in real time. Administrator #1 indicated the contracted therapist have their own patients to see in addition to Amore's patients, so they were expected to have their visit notes within 14 days. When queried how the contract with entity #1 was reinforced, quality assurance (QA) #4 indicated the administrator would contact the contracted clinicians. Administrator #1 indicated they would contact alternate administrator #2 because he was the administrator of entity #1 and would enforce timely submission of visit notes. During the entrance conference on 2/2/2023, from 10:44 AM – 11:10 AM, administrator #1 identified the agency did not provide home health aide (HHA)			

	services. When queried on the process to follow when a patient is referred with/ a need was identified for a HHA, administrator #1 indicated the agency would make the patient and physician aware they did not provide HHA services prior to start of care when possible. During an interview on 2/9/2023, at 11:01 AM, administrator #1 indicated if a patient required HHA services, they would verbally list names of other agencies with HHA services and provide a phone number if requested. At 11:09 AM, the administrator failed to provide a list of agencies that would give the patient/caregiver an opportunity to select another agency that could provide HHA services. During an interview on 2/8/2023, from 8:33 AM – 8:48 AM, person #8 indicated HHA's and private caregivers were not allowed at entity #6. Review evidenced 10 of 11 active patients were located at entity #6 and would not have access to HHA services if required.			

	410 IAC 17-12-1(b)(3)			
N0000	Initial Comments This visit was a re-licensure survey of a home health agency This visit took place from 2/2/2023 to 2/9/2023 Facility ID: 012121 Census: 11	N0000		2023-03-08
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the administrator failed to ensure lines of	N0440		2023-03-03

	authority were clearly defined in the agency's organizational chart. The findings include: Record review of an agency document retrieved on 2/9/2023, titled "Employee Handbook" stated "VI. Delegation and Lines of Authority … 2. The Administrator has the ability to delegate that authority. In the absence of the Administrator, the Director of Nursing has the complete authority to act on behalf of the Administrator. In the absence of the Director of Nursing, the Backup Director of Nursing has complete authority to act on behalf of the Director of Nursing …." Review of an undated agency policy titled "Use of Organizational Chart" retrieved on 2/9/2023, stated "Policy … There will be defined lines of authority, which clearly establishes responsibility and accountability for all organization personnel …." Review of an agency document titled "Organizational Chart" retrieved on 2/2/2023,		On March 2,2023, the Board of Directors (BOD) discussed and clearly defined the agency'sLines of Authority and the Organizational Chart (Pls see Attachment-1 for BODmeeting minutes). The BOD directed theAdministrator to make the revisions in the agency's Administrative book and inthe Employee Handbook. On March 3, 2023, the BOD approved the revisions. Pleasesee Attachment-2 for the corrected Lines of Authority and Organizational Chart. The BOD is responsible for defining the agency'sLines of Authority as part of the annual review of policies & procedures.The BOD will continue to do the annual review of policies to ensure that thisdeficiency is corrected and will not recur. Target threshold is 100%.	

	chart was labeled "Board of Directors" with an arrow down to a box with administrator #1 and alternate administrator #2's names inside, followed by an arrow down to a box with administrator/clinical manager #1 and alternate clinical manager #3's names inside. Review of this document evidenced the lines of authority had administrator #1 and alternate administrator #2 at the same level just below the board of directors. Review evidenced the same lines of authority for administrator/clinical manager #1 and alternate clinical manager #3. Review failed to evidence the lines of authority were defined per agency policy. Record review failed to evidence clearly defined lines of authority as indicated in the employee handbook. During an interview on 2/9/2023, at 10:59 AM, administrator #1 indicated that in the absence of the administrator's presence, the order of command would be the clinical manager, then alternate administrator, and finally alternate clinical			

	administrator and alternate administrator have the same lines of authority, administrator #1 stated "Administrator is higher." When queried if the clinical manager and alternate clinical manager have the same lines of authority, administrator #1 indicated the clinical manager is much higher than the alternate clinical manager. Administrator #1 acknowledged they are also the clinical manager and indicated in their absence, the chain of command would be split; Clinical concerns would be directed to alternate clinical manager #3 and all other concerns would go to alternate administrator #2.			
N0520	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence. Based on observation, record review and interview, the home health agency failed to ensure the patient's needs were met in 1 of 1 active clinical record	N0520	<u>Update onpatient #3</u>: On February 8, 2023, 2 days after the PTvisit, PT#3 was able to talk to the patient's doctor with regards to the newsymptoms and recommendation for continued therapy for continued training. Plssee Attachment-3 for (a) PT#3's communication note with patient's doctor, (b) DON'scommunication note with PT#3 as she was informed that the doctor agreed tocontinue	2023-03-06

	reviewed for a patient that did not live at an assisted living facility (patient #3). The findings include: Record review of an undated agency policy titled "Admission Criteria and Process" retrieved on 2/9/2023, stated "Policy ... 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 ... A patient will be referred to other resources if the organization cannot meet his/her needs ... Once a patient is admitted to services within its financial and service capabilities, mission, and applicable law and regulations ...." Review of an undated agency policy titled "PHYSICIAN'S PLAN OF CARE", received 2/9/2023, indicated home health services should be provided in accordance with a plan of care		home therapy, and (c) signed Physician Order. Thus, because of the new symptoms of thepatient, the patient's new needs were met by continuing care as coordinatedbetween the PT, MD and DON. To further correctthe deficiencies on patient #3, an in-service was conducted by the DON on March6, 2023 to re-educate the field staff on: 1. proper documentation including butnot limited to refusal of service/s 2. demonstrating Home Exercise Programto patients prior to discharge 3. ensuring that patients' goals are metprior to discharge 4. addressing patients' new complaintseven during day of planned discharge and reassessing the patient for possiblecontinuation of care (Reassessment or Recertification) 5. addressing patients' needs by takinginto consideration the ability to drive or lack of transportation prior todischarge to an outpatient	

	based on the patient's diagnosis and assessment of the patient's immediate and long-term needs. Review of an agency policy titled "DISCHARGE PLANNING", dated April 2012, indicated the clinician should assist patients with their discharge by assessing what resources were available and serving as a referral source for obtaining follow-up support services. Review of an agency policy titled "PHYSICIAN PARTICIPATION IN PLAN OF CARE", revised 2/11/2020, indicated orders for the plan of care shall be reviewed and revised by the physician based on changes in the patient's physical condition. Review of an agency policy titled "PATIENT BILL OF RIGHTS", revised 9/9/2019, indicated the patient has the right to participate in, be informed about, and consent or refuse care with respect to establishing and revising the plan of care or treatment, any factors that could impact treatment effectiveness and any		center (Pls see Attachment-4for in-service topics and staff attendance) The Director of Nursing is responsible for ensuringthat the patient's health needs can be adequately met by the home health agencyin the patient's place of residence and proper documentation in theComprehensive Assessment and Visit notes. The DON will review 20% of charts monthly for 3 months. Target thresholdis 100%. Once threshold is met, willcontinue to audit 20% of charts quarterly to ensure that this deficiency iscorrected and will not recur.	

be furnished.

Review of an agency policy titled, "THERAPY SERVICES", revised 1/10/2023, indicated the therapist will inform the physician of changes in the patient's condition and may recommend changes as telephone orders.

Clinical record review for patient #3, start of care 12/17/2022, evidenced a document titled, "PHYSICIAN VERIFICATION OF FACE-TO-FACE ENCOUNTER", dated 1/27/2023, signed by cardiologist #4. The document stated, " ... I certify that, based on my findings, the following services are medically necessary home health services ... Skilled Nursing ... My Clinical findings support the need for the above services because: New onset or exacerbation of diagnosis...."

Review of the plan of care for certification period 12/17/2022 to 2/14/2023, evidenced the patient's principal diagnosis was Hypertensive heart disease with heart failure. The plan of care indicated the patient required education about the signs and symptoms of hypertension, how

pooling in the legs), medication management and pain management. Review of the plan of care failed to evidence skilled nursing services. The plan of care indicated the patient shall be discharged when goals are met. Review of the plan of care evidenced a list of discharge goals which included (but was not limited to): Patient will demonstrate becoming independent with home exercise plan by discharge, Pain level stabilizes and patient demonstrates ability to self-manage pain, and Patient will attain optimal effectiveness of pain management regimen.

Review of physical therapy visit notes dated 1/16/2023, 1/23/2023, and 1/30/2023 evidenced the patient was homebound due to leaving the home requiring a considerable and taxing effort, had severe shortness of breath upon exertion, assistance was needed with ambulation, unable to be up for a long period, and unsafe to go out of home alone. On the subsequent visit, 2/6/2023, the patient was discharged.

During observation of a

discharge visit on 2/9/2023 at 11:00 AM, the patient complained of new right leg pain and swelling. During a conversation observed at 11:46 AM, PT #3 indicated to person #3 (family member) would need continued (outpatient) physical therapy to improve their walking. Person #3 indicated neither they nor the patient drove. Observation of the discharge visit failed to evidence patient demonstration of the home exercise program. PT #3 failed to ensure the patient's goals were met prior to discharging the patient. Observation of the home visit failed to evidence PT #3 addressing the patient's new complaint of pain and swelling to the right leg prior to discharge. Observation of the home visit failed to evidence PT #3 addressing the patient's need for continued therapy and lack of transportation for outpatient therapy prior to discharge.

During an interview on 2/8/2023 at 1:42 PM, the administrator indicated the agency ensured a patient's needs were met by creating an

following it. The administrator indicated all patient goals needed to be met prior to the agency discharging the patient. The administrator indicated if a change was noted in a patient's condition, even at a discharge visit, the clinician should notify the physician and tell them their recommendation. The administrator indicated it was not within a physical therapist's scope of practice to teach about hypertension and heart failure, but they could give some simple instructions. The administrator indicated the patient did not receive skilled nursing services because the patient's family member did not want them. The administrator indicated the clinical record failed to evidence documentation of refusal of nursing services for the patient. When queried why a patient who has not met all goals, had new assessment findings / pain, and needs continued therapy was discharged, the administrator indicated she would have to talk to PT #3. By end of survey, no further information was received.

that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dorothy Brinas	Administrator	3/8/2023 3:56:21 PM