STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157634	A. BUILDING B. WING	02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Home Health Care Services Inc	2711 W LINCOLN HIGHWAY, MERRILLVILLE, IN, 46410

(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: 01/26/2023-02/02/2023 Census: 43 At this Emergency Preparedness survey, Sunrise 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	E0000 Sunrise Home Health Care Service issubmitting the following Plan of Correction in response to the 2567 issued byISDH and/or CMS as it is required to do by applicable state and federalregulations. The submission of this Plan of Correction is not intended as anadmission, does not constitute an admission by and should not be construed asan admission by Sunrise Home Health Care Service that the findings andallegations contained herein are accurate and true representations of thequality of care and services provided to patients of the Agency. Sunrise HomeHealth Care Service desires this Plan of Correction to be considered ourAllegation of Compliance." Sunrise Home Health Care	2023-03-03

			Serviceretained the services of a nurse consultant February 2, 2023. The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0000	INITIAL COMMENTS This survey was a Recertification and Emergency Preparedness survey for a home health agency. Survey Dates: 01/26/2023-02/02/2023 Facility ID: 012486 Census: 43 During this Federal Recertification Survey, Sunrise Home Health Care Services, Inc., was found to be out of compliance with Conditions of Participation 42 CFR §484.60 Care Planning, Coordination, Quality of Care and 42 CFR §484.102 Emergency Preparedness.	G0000	G0000 Sunrise Home Health Care Service is submitting the followingPlan of Correction in response to the 2567 issued by ISDH and/or CMS as it isrequired to do by applicable state and federal regulations. The submission ofthis Plan of Correction is not intended as an admission, does not constitute anadmission by and should not be construed as an admission by Sunrise Home HealthCare Service that the findings and allegations contained herein are accurateand true representations of the quality of care and services provided topatients of the Agency. Sunrise Home Health Care Service desires this Plan ofCorrection to be considered our Allegation of Compliance.”	2023-03-03

	This deficiency report reflect State Findings cited in accordance with 410 IAC 17. Based on the condition-level deficiencies during the 01/26/2023- 02/02/2023 survey, Sunrise Home Health Care Services, Inc. is precluded from providing its own home health aide training and competency evaluation for a period of two years which began on 02/02/2023-02/02/2025. Quality Review Completed 02/14/2023		Sunrise Home Health Care Service retained the services of anurse consultant February 2, 2023. The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
N0000	Initial Comments This visit was a re-licensure survey of a home health agency. This visit took place from 01/26/2023-02/02/2023 Facility ID: 012486 Census:43	N0000	N0000 Sunrise Home Health Care Service is submitting the followingPlan of Correction in response to the 2567 issued by ISDH and/or CMS as it isrequired to do by applicable state and federal regulations. The submission ofthis Plan of Correction is not intended as an admission, does not constitute anadmission by and should not be construed as an admission by Sunrise Home HealthCare Service that the findings and allegations contained herein are	2023-03-03

			accurateand true representations of the quality of care and services provided topatients of the Agency. Sunrise Home Health Care Service desires this Plan ofCorrection to be considered our Allegation of Compliance." Sunrise Home Health Care Service retained the services of anurse consultant February 2, 2023. The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
E0009	Local, State, Tribal Collaboration Process 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and	E0009	E0009 Administrator will obtain contact information for local, regional, and state officials. Will also obtainlinks to local community organizations that may be needed to assist the agencyin responding to client needs. It will be reviewed quarterly and revised asnecessary. (On-going)	2023-03-02

	collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Based on record review and interview, the home health agency failed to include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. Findings include: Record review of an undated agency policy received on 02/01/2023, titled, "Communication Plan for Emergency Preparedness," stated, "... The Incident Commander will verify contact information for local, State, Federal officials, community partners and resources on a quarterly basis. The agency will keep abreast of current information about emergency management via Methodist		Administrator will contact local, regional, and state officialsto collaborate with them regarding agency's emergency plan. Completed by 3/2/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	designated by local, regional, and state officials ….” Record review of an undated agency policy received on 02/01/2023, titled, “Emergency Preparedness Management Policy,” stated, “… The emergency plan will identify the links to local community organizations that may be needed to assist the agency in responding to clients needs ….” Review of the emergency preparedness binder on 01/27/2023, failed to evidence a process for collaboration with local, tribal, regional, state, and federal emergency preparedness officials. During an interview on 01/27/2023, at 3:30 PM, the administrator indicated he had contacted the local fire department regarding a local emergency plan, but the fire department was not interested in assisting the home health agency. During an interview on 01/31/2023, at 12:43 PM, the administrator indicated he had not collaborated with local, state, or federal emergency management officials regarding			

	the home health agency's emergency plan.			
E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on observation, record review, and interview, the home health agency failed to ensure an individualized plan for each patient during a natural or man-made disaster was included in the patient's comprehensive assessment in 8 of 8 clinical records reviewed. (#1, #2, #3, #4, #5, #6. #7. #8) Findings include: 1. Record review evidenced an	E0017	E0017 Director of Nursing will in-service clinicians onrequirement to complete a comprehensive individualized emergency care plan.Completed by 3/3/23 Director of Nursing/clinicians/designee will createcomprehensive individualized emergency care plan for all current patients andplace copy in home. Completed by 3/3/23 Director of Nursing/designee will audit all admissions doneweekly to ensure an individualized emergency care plan has been created.(On-going)	2023-03-03

	undated agency policy received on 02/01/2023, titled, "Emergency Preparedness Management Policy," which stated, "Agency will have an identified plan in place to ensure the safety and well-being of clients and employees during periods of an emergency or disaster that disrupts agency services … the agency conducts an analysis to identify potential emergencies and the direct and indirect effects these emergencies may have on agency operations and the demand for services. The agency will develop and maintain a written emergency management plan describe the process for disaster readiness and emergency management and implements it as appropriate …Clients dependent on medical equipment that is necessary for maintaining life support will have battery pack backup available …." 2. Clinical record review on 01/27/2023, for patient #1, start of care 12/07/2022, evidenced an agency document titled, "OASIS [outcome assessment and information set] D-1 Start of Care," identified as the		Director of Nursing will in-service clinicians on need tocoordinate care with group home regarding patient's emergency plan of care.Clinician is to request a copy of their plan so agency can place copy in theirchart. There is to be documentation of coordination of care. Completed by3/3/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	comprehensive assessment, and indicated the patient lived alone, an emergency plan was developed, and patient was instructed on disaster/emergency plan. Review of the comprehensive assessment failed to evidence an individualized emergency plan. During an observation of a home visit on 01/27/2023, at 10:00 AM, an agency document titled, "Patient Emergency Preparedness Plan," was evidenced and included blank lines for police, fire, ems, local red cross, local emergency management office, physician, pharmacy, neighbors, and relatives. Review of the document failed to evidence an individualized emergency plan. 3. Clinical record review on 01/27/2023, for patient #2, start of care 06/07/2022, evidenced an agency document dated 12/01/2022, titled, "OASIS-D1 Recertification," and identified as the comprehensive assessment. This document indicated the patient was on dialysis, an emergency plan was developed, and the patient was			

	disaster/emergency plan. Review of the comprehensive assessment failed to evidence an individualized emergency plan. During an observation of a home visit on 01/31/2023, at 9:00 AM, an undated agency document was evidenced titled, "Emergency Contact Information." While reviewing the document the patient indicated she had filled in the emergency contact phone numbers. Review of the agency document failed to evidence an individualized emergency plan.			

	4. Clinical record review on 01/30/2023, for patient #3, start of care 06/20/2022, evidenced an agency document dated 12/13/2022, titled, "OASIS-D1 Recertification," and identified as the comprehensive assessment. This document indicated the patient had a diagnosis of type 2 diabetes mellitus, an emergency plan was developed, and patient was instructed on disaster/emergency plan. Review of the comprehensive assessment failed to evidence an individualized emergency plan. During an observation of a home visit on 01/30/2023, at 7:30 AM, an undated agency emergency plan was evidenced and included blank lines for police, fire, ems, local red cross, local emergency management office, physician, pharmacy, neighbors and relatives. Review of the document failed to evidence an individualized emergency plan. 5. Clinical record review on 01/30/2023, for patient #4, start of care 12/19/2022, evidenced an agency document dated 01/17/2023, titled, "Oasis-E			

	Resumption of Care," and indicated the patient was on oxygen, an emergency plan was developed, and patient was instructed on disaster/emergency plan. Review of the comprehensive assessment failed to evidence an individualized emergency plan. During an observation of a home visit on 01/30/2023, at 9:50 AM, an undated agency emergency plan was evidenced with blank lines to be filled in. Review of the document failed to evidence an individualized emergency plan.			

	6. Clinical record review on 01/30/2023, for patient #5, start of care 06/20/2019, evidenced an agency document dated 11/29/2022, titled, "OASIS D-1 Recertification," and identified as the comprehensive assessment. This document indicated the patient had a diagnosis of traumatic brain injury, had an emergency plan developed and was instructed on disaster/emergency plan. Review of the comprehensive assessment failed to evidence an individualized emergency plan. 7. Clinical record review on 01/30/2023, for patient #6, start of care 01/18/2022, evidenced an agency document dated 01/10/2023, titled, "OASIS-E Recertification," and identified as the comprehensive assessment. This document indicated the patient was on oxygen, an emergency plan was developed, and was instructed on disaster/emergency plan. Review of the comprehensive assessment failed to evidence an individualized emergency plan. 8. Clinical record review on 01/30/2023, for patient #7, start			

	of care 05/11/2022, evidenced an agency document dated 09/07/2022, titled, "OASIS-D1 Recertification," and identified as the comprehensive assessment. This document indicated the patient lived in an assisted living facility, had an emergency plan developed and was instructed on disaster/emergency plan. Review of the comprehensive assessment failed to evidence an individualized emergency plan. 9. Clinical record review on 01/30/2023, for patient #8, start of care 05/17/2022, evidenced an agency document dated 11/11/2022, titled, "OASIS-D1 Recertification," and identified as the comprehensive assessment. This document indicated the patient lived in a group home, had an emergency plan developed and was instructed on disaster/emergency plan. The comprehensive assessment indicated the group home had a disaster/emergency plan in place. Review of the comprehensive assessment failed to evidence an individualized emergency plan.			

	During an interview on 02/01/2023, at 3:00 PM, the director of nursing indicated the group home had an emergency plan and the group home's plan would supersede the home health emergency plan. The director of nursing indicated the home health agency did not document coordination of the group home's emergency plan. 10. During an interview on 01/26/2023, at 3:40 PM, the director of nursing indicated the emergency plan in the patient's home, provided by the agency, was the patient's choice if they wanted to fill out the plan with information. 11. During an interview on 01/30/2023, at 3:40 PM, the administrator indicated the patient's individualized emergency preparedness plan was for the patient to call 911 or 211 for emergencies.			
E0019	Homebound HHA/Hospice Inform EP Officials 418.113(b)(2)	E0019	E0019 Administrator revised emergency preparedness	2023-03-03

	§418.113(b)(2), §460.84(b)(4), §484.102(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the 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:] *[For homebound Hospice at §418.113(b)(2), PACE at §460.84(b)(4), and HHAs at §484.102(b)(2):] The procedures to inform State and local emergency preparedness officials about [homebound Hospice, PACE or HHA] patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment. Based on record review and interview, the home health agency failed to ensure they included the procedures to inform State and local emergency preparedness officials about patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical, psychiatric, and home environment conditions. This had the potential to affect all agency patients. Findings include: Record review of an undated agency policy received on 02/01/2023, titled, "Emergency		procedures toinclude procedure for informing State and local emergency preparednessofficials about patients in need of evacuation from their residences at anytime due to an emergency situation based on the patient's medical, psychiatric,and home environment conditions. Completed by 3/3/23 Administrator will in-service staff on procedure forinforming State and local emergency preparedness officials about patients inneed of evacuation from their residences at any time due to an emergencysituation based on the patient's medical, psychiatric, and home environmentconditions. Completed by 3/3/23 Administrator/designee will review emergency preparednessbinder at least quarterly to ensure it is kept up to date. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	stated, "... The agency will orient agency staff upon hire and provide annual in service for staff on planning for evacuation during an emergent situation which includes: ... Client assessment and evacuation planning ... During the initial assessment, each client will be assessed for care needs and risk during a crisis situation. The assessment will include medical and psychiatric condition, the location of the client, the client's transportation level, special needs, dependency on electricity or oxygen to sustain life, need for shelter, availability of assistance during a crisis and evacuation, and classification level. An individual client emergency plan will be documented as part of the comprehensive assessment to include: ... Facilitate the registration of clients who are dependent upon electricity to sustain life with local fire department and electricity supplier ... Facilitate the registration of those with shelter or evacuation needs with State and local emergency preparedness officials ...." Record review of an undated			

	02/01/2023, titled, "Communication Plan for Emergency Preparedness," stated, "... A current roster with contact information for clients and their emergency contact will be maintained ...." Review of the emergency preparedness binder evidenced an agency document titled, "Master Patient Triage/Disaster Code List," received on 01/27/2023, which failed to evidence the specific location of the patient or patient's/emergency contact phone numbers. The emergency preparedness binder failed to evidence the procedure to inform State and local emergency preparedness officials about patients in need of evacuation from their residences due to an emergency situation. During an interview on 01/31/2023, at 12:43 PM, the alternate administrator indicated the agency's emergency preparedness policy doesn't say specifically about patient's evacuation plan.			

E0021	HHA- Procedures for Follow up Staff/Pts. 484.102(b)(3) §484.102(b)(3) Condition of Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact. Based on record review and interview, the home health agency failed to ensure the procedures were included to inform the State and local officials of any on-duty staff or patients that the agency were unable to contact. Findings include: Record review of an undated agency document received on 02/01/2023, titled, "Communication Plan for Emergency Preparedness," stated, "... The agency will maintain a Staff Notification	E0021	E0021 Administrator will update emergency preparedness proceduresto include agency procedure to inform the State and local officials of anyon-duty staff or patients that the agency are unable to contact. Completed by3/3/23 Administrator/designee will in-service staff on agency procedure to informthe State and local officials of any on-duty staff or patients that the agencywere unable to contact. Completed by 3/3/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-03-03

	including volunteers and will include: The staff member's telephone number or cell phone number, home address and an alternate means of communication [i.e. emergency contact information] ... The Incident Commander will maintain communication within the agency and also with local officials via the chain of command. The Incident Commander will be responsible for cooperation, collaboration and maintain communication with local officials, [Office of Emergency Management], regional, state, [State Department of Health] and Federal emergency preparedness officials and community health coalitions ...." The policy failed to address what actions would be required due to the inability to make contact with staff or patients and reporting capabilities to the local and State Emergency officials.			

	During an interview on 01/31/2023, at 12:43 PM, the director of nursing indicated the policy doesn't say specifically about notifying local and state authorities if patients or staff can't be reached.			
E0031	Emergency Officials Contact Information 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency.	E0031	E0031 Administrator will maintain contact information for local, regional, and state officials. It will bereviewed quarterly and revised as necessary. (On-going) Administrator will in-service staff on coordination processwith local and/or state officials as part of the emergency preparedness process.Completed by 3/3/23 Administrator/designee will contact the emergencypreparedness coalition for that area to find out when meetings are held. Completed by 3/3/23 Agency will participate in the area emergency preparednesscoalition meetings. (On-going) The Administrator will be responsible for monitoring	2023-03-03

	(iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on record review and interview, the home health agency failed to develop and maintain an emergency preparedness communication plan that included contact information for the Federal, State, tribal, regional, and local emergency preparedness staff. Findings include: Record review of an undated agency policy received on 02/01/2023, titled, "Communication Plan for Emergency Preparedness," stated, "... The Incident Commander will maintain communication within the agency and also with local officials via the chain of command. The Incident Commander will be responsible for cooperation, collaboration and maintaining		thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	officials, [Office of Emergency Management], regional, State, [State Department of Health] and Federal Emergency preparedness officials and community health coalitions ….” Review of the agency emergency preparedness binder on 01/26/2023, failed to evidence an emergency preparedness communication plan that included information for the Federal and State emergency preparedness staff. During an interview on 01/31/2023, at 12:43 PM, the administrator indicated there should be information for Federal and State emergency officials in the emergency binder. The administrator indicated there was no coordination process for the emergency plan with local or state officials and he had not attended any emergency management meetings.			
E0032	Primary/Alternate Means for Communication 483.73(c)(3) §403.748(c)(3), §416.54(c)(3), §418.113(c)(3), §441.184(c)(3), §460.84(c)(3), §482.15(c)(3),	E0032	E0032 Administrator has revised the Emergency Preparednesscommunication plan for alternate means for	2023-02-24

	§483.73(c)(3), §483.475(c)(3), §484.102(c)(3), §485.68(c)(3), §485.542(c)(3), §485.625(c)(3), §485.727(c)(3), §485.920(c)(3), §486.360(c)(3), §491.12(c)(3), §494.62(c)(3). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. Based on record review and interview, the home health agency failed to develop and maintain an emergency preparedness communication plan that included primary and alternate means for communication with the facility, staff, federal, state, tribal, regional, and local emergency management. Findings include: Record review evidenced an undated agency policy received on 02/01/2023, titled, "Communication Plan for Emergency Preparedness," which stated, "... In the event of		communication with the facility,staff, federal, state, tribal, regional, and local emergency management toreflect that WPS /GETS will be added asmeans of communication once agency has received approval. Completed 2/24/23 Administrator will review requirements for the WPS and GETSprogram and submit application for one most appropriate for agency. Completed2/24/23 Administrator will revise policy "Communication Plan forEmergency Preparedness" to add WPS/GETS pending approval. Completed 2/24/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will not recur.	

	down conventional telephone communication, cellular phones will be utilized by administration, nursing personnel and coordination services. If cellular phone systems are not adequately functioning, the agency will utilize backup communication systems that include: organized messenger services, GPS system, Walkie-Talkies, and/or CB/Amateur radio systems, satellite phone, text, email, Website, bulletin boards, fax or radio announcements ...." Review of the emergency preparedness binder on 01/26/2023, failed to evidence an alternate means for communication with the facility, staff, federal, state, tribal, regional, and local emergency management. During an interview on 01/31/2023, at 12:43 PM, the director of nursing indicated there was nothing specific in the policy regarding alternate means of communication. The administrator indicated CB radios are not used anymore for alternate means of communication. The alternate administrator indicated walkie			

	talkies cannot be used due to they only work for short distances.			
E0037	EP Training Program 483.73(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), §485.542(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, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency 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.	E0037	E0037 Administrator/designee will in-service all current employeeson agency emergency preparedness training and documentation of training isplaced in their file. Completed by 3/3/23 Administrator will ensure all new employees receive trainingon agency emergency preparedness training at time of hire and documentation oftraining is placed in their file. (On-going) Administrator/designee will ensure all staff are trained onemergency preparedness at least every two years and documentation is placed intheir file. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-03-03

	*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (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 and failed to maintain documentation of all emergency preparedness training.

Findings include:

Record review of an undated agency policy received on 02/01/2023, titled, " Emergency Disaster Plan Orientation and Training," stated, "... Emergency Disaster Preparedness Training will be provided at least annually ... the agency will maintain documentation of all Emergency Disaster Preparedness Training provided. Attendance and demonstration of staff knowledge of emergency procedures will be notated in the employee's personnel file...."

Review of the emergency preparedness binder on

	01/26/2023, failed to evidence emergency preparedness training at least every 2 years. During an interview on 01/31/2023, at 12:43 PM, the director of nursing indicated there was not any emergency preparedness training with staff in the last 2 years only the tabletop exercise was done with staff.			
E0039	EP Testing Requirements 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an	E0039	E0039 Administrator will revise policy titled “EmergencyPreparedness Management Policy” to say “agency must conduct exercises to testthe emergency plan at least annually. Agency must do the following: (i)Participate in a full-scale exercise that is community-based; or (A) When acommunity-based exercise is not accessible, conduct an annual individual,facility-based functional exercise every 2 years; or. (b) If agency experiencesan actual natural or man-made emergency that requires activation of theemergency plan, the agency is exempt from engaging in its next requiredfull-scale community-based or individual,	2023-03-03

	actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2		facility based functional exercisefollowing the onset of the emergency event. (ii) Conduct an additional exerciseevery 2 years, opposite the year the full-scale or functional exercise, thatmay include, but is not limited to the following: (A) A second full-scaleexercise that is community-based or an individual, facility-based functionalexercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshopthat is led by a facilitator and includes a group discussion, using a narrated,clinically-relevant emergency scenario, and a set of problem statements,directed messages, or prepared questions designed to challenge an emergency plan. Completed by 3/3/23 Administrator will ensure agency follows the requirement toconduct exercises to test the agency emergency plan annually. (On-going)	

	functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed.			

	*[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following:			

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

full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event.

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

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

(B) A mock disaster drill; or

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

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

*[For HHAs at §484.102]

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

least annually. The HHA must do the following:

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

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

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

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

	(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at			

discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed.

Based on record review and interview, the home health agency failed to conduct or participate in a full-scale community drill every 2 years or conduct a facility-based functional exercise every 2 years.

Findings include:

Record review of an undated agency policy received on 02/01/2023, titled, "Emergency Preparedness Management Policy," stated, "... Agency staff members will participate in an annual desktop drill to determine the effectiveness and efficiency of the current plan and any forms developed for use in a disaster...."

Record review of an undated agency policy received on 02/01/2023, titled, "Environmental Safety," which stated, "...Each year the Agency will participate in one community practice drill relevant to emergency preparedness in the community. These drills will evaluate the

	communicate, coordination and attention to "chain of command" structures in the agency and in the community ...." Review failed to evidence a full-scale community drill or facility-based exercise was conducted in the last 2 years. During an interview on 01/31/2023, at 12:43 PM, the director of nursing indicated only a tabletop exercise was completed in 2022. The administrator indicated there had been no full-scale community drill or facility-based exercise.			
G0374	Accuracy of encoded OASIS data 484.45(b) Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment.	G0374	G0374 Director of Nursing will in-service all clinicians oncompleting the OASIS comprehensive assessment accurately to reflect thepatient's actual status at time of assessment. This includes all medicationsprescribed/used. Completed 2/17/23 Director of Nursing/designee will audit all current patientcomprehensive	2023-02-24

	Based on record review and interview, the home health agency failed to transmit accurate OASIS (outcome and assessment information set) with the current status of the patient at the time the OASIS was completed in 3 of 4 clinical records reviewed with skilled nurse visits. (#2, #3, #6) Findings include: 1. Record review of an undated agency policy received 02/01/2023, titled, "Encoding and Reporting Oasis Data," stated, "... the encoded OASIS must accurately reflect the client's status at the time of assessment ...." 2. Clinical record review on 01/27/2023, for patient #2, start of care 06/7/2022, evidenced an agency document dated 06/07/2022, titled, "OASIS-D1 Start of Care," identified as the comprehensive assessment. This document indicated the drug regimen review identified no issues, and failed to evidence documentation in management of injectable medications. Review of an agency document dated 06/09/2022, titled, "Patient Medication Record," indicated the physician was contacted regarding medication		accurately reflect the patient'sstatus including all medications prescribed/used. Completed 2/24/23 Director of Nursing/designee will audit all comprehensiveassessments submitted weekly to ensure they accurately reflect the patient'scurrent status. Once 100% compliance is achieved 10% will be audited quarterlyto ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	discrepancies and the physician was notified of severe medication interactions. 3. Clinical record review on 01/30/2023, for patient #3, start of care 06/20/2022, evidenced an agency document dated 06/20/2022, titled, "OASIS-D1 Start of Care," identified as the comprehensive assessment. This document indicated the drug regimen review identified no issues. Review of an agency document dated 06/21/2022, titled, "Patient Medication Record," indicated physician was notified of severe medication interactions. 4. Clinical record review on 01/30/2023, for patient #6, start of care 01/18/2022, evidenced an agency document dated 01/18/2022, titled, "OASIS-D1 Start of Care," identified as the comprehensive assessment. This document indicated the drug regimen review identified no issues. Review of an agency document dated 01/19/2022, titled, "Patient Medication Record," indicated physician was contacted regarding medication			

	discrepancies and severe medication interactions. 5. During an interview on 01/31/2023, at 2:54 PM, the director of nursing indicated the OASIS should be entirely completed unless a section was not applicable or marked N/A.			
G0418	Patient's or legal representative's signature 484.50(a)(2) Obtain the patient's or legal representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities. Based on record review and interview, the home health agency failed to obtain the legal representative's signature confirming that he or she had received a copy of the notice of rights and responsibilities in 2 of 2 discharged clinical records reviewed. (#7, #8) Findings include: 1. Record review of an agency policy dated 09/2019, titled, "Patient's Bill of Rights," stated, "... in the event that the client is unable to make decisions, the Patient's Bill of Rights shall be	G0418	G0418 Director of Nursing will in-service clinicians onrequirement that if patient has a legal representative clinician must obtainsignature of legal representative indicating they received a copy of the noticeof rights and responsibilities. If patient has a legal representative patientmay not sign their own documentation. Completed 2/10/23 Director of Nursing/designee will audit all current patientcharts to ensure if they have a legal representative there is documentationwith representative's signature showing they received copy of notice of rightsand	2023-03-03

	given to the client's legal guardian. The reason the client is unable to acknowledge receipt of the Patient's Bill of Rights shall be documented …." 2. Clinical record review on 01/30/2023, for patient #7, start of care 05/11/2022, evidenced an agency document dated 05/11/2022, titled, "Consent to Provide Home Health Care Services to Client," which stated, "…I acknowledge that I have reviewed and read the Patient's Bill of Rights …." The consent was initialed by the patient. Record review of document dated 05/19/2017, titled, "Health Care Power of Attorney," indicated 2 patient's family members as the attorney-in-fact (the person granted power of attorney). Review failed to evidence the health care power of attorney signed the consent. Record review of an agency document dated 05/11/2022, titled, "OASIS [outcome and assessment information set]-D1 Start of Care," identified as the comprehensive assessment, indicated a diagnosis of		legal representative patient may notsign their own documentation. Completed 3/03/23 Director of Nursing/designee will audit all admissions doneweekly to ensure if patient has a legal representative clinician there issignature of legal representative indicating they received a copy of the noticeof rights and responsibilities. If patient has a legal representative patientdid not sign their own documents. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	cognitive function) without behavioral disturbance. 3. Clinical record review on 01/30/2023, for patient #8, start of care 05/17/2022, evidenced an agency document dated 05/17/2022, titled, "Consent to Provide Home Health Care Services to Client," which stated, "... I acknowledge that I have reviewed and read the Patient's Bill of Rights ...." The consent was signed by the patient. Record review of a document dated 12/15/2005, titled, Appointment of Health Care Representative," indicated an appointment of a health care representative. Record review of an agency document dated 05/17/2022, titled, "OASIS-D1 Start of Care," identified as the comprehensive assessment, indicated a diagnosis of moderate intellectual disabilities, down syndrome (condition associated with intellectual disabilities), and conduct disorder. Review failed to evidence the health care representative signed the consent. 4. During an interview on			

	02/01/2023, at 2:20 PM, the director of nursing indicated the patients should not have signed for themselves that they had received the Patient's Bill of Rights. 410 IAC 17-12-3(a)(2)			
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 home health agency failed to ensure lines of authority for the delegation of responsibility down to the patient care level shall be clearly set forth in writing and readily identifiable. Findings include: Record review of an undated agency document received on 02/01/2023, titled, "Governing	N0440	N0440 Administrator revised the organizational chart to removeoccupational therapy, add physical therapy assistant and show that theregistered nurse, licensed practical nurse and home health aide report to theDirector of Nursing. Completed 2/23/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-02-23

	Body," stated, "... The Governing Body shall assume full legal authority and responsibility for the overall management and operation of Agency ... Purpose ... To ensure lines of authority are established ...." Record review of an undated agency document received on 01/26/2023, titled, "Organization Chart," indicated Agency staff: PT (physical therapy), OT (occupational therapy), ST (speech therapy) and MSW (medical social worker). Review included OT that failed to be offered through the home health agency. Review failed to include PTA (physical therapist assistant) on the organization chart. Review indicated the RN (registered nurse), LPN (licensed practical nurse) and HHA (home health aide) reported to QAPI (quality assessment performance improvement). During an interview on 01/26/2023, at 2:00 PM, the administrator indicated the OT should not be on organizational chart and indicated the PTA should be included on the organizational chart. The			

	administrator also indicated the RN, LPN, and HHA does not report to QAPI.			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the home health agency failed to ensure documentation of orientation to the job, receipt of job description and annual performance evaluations in 4 of 4 therapy and social worker records reviewed. (PT (physical therapist #1, PTA (physical therapy assistant	N0458	N0458 Administrator will in-service staff responsible forobtaining documentation required for employee files on what is to be in anemployee file. Completed by 3/1/23 Administrator/Director of Nursing/designee will audit allnew employee files to ensure all required documentation is present. (On-going) Administrator/Director of Nursing will audit files ofcontract personnel before they are assigned to patients to ensure all requireddocumentation is present. (On-going) Administrator/Director of Nursing/designee will audit allcurrent active employee files to ensure all required documentation is present.Any documentation missing will be obtained. Completed by 3/1/23 Administrator/Director of	2023-03-01

	#2, speech therapist #1, and social worker #2) Findings include: 1. Record review evidenced an undated agency policy received on 02/01/2023, titled, "Performance Evaluations," which stated, "... A competency-based performance evaluation will be conducted for all employees after one year of employment and at least annually thereafter ... Job performance will be documented on the appropriate form by the evaluator and will become a permanent part of the employee personnel file. Contracted organizations/personnel are expected to adhere to these requirements as part of the contractual agreement and to submit completed documentation of competency and performance evaluations to the agency ...." 2. Record review evidenced an undated agency policy received on 02/01/2023, titled, "Personnel Records," which indicated, "... Personnel files will be established and maintained for all personnel ... Employment Information:		allemployee files at yearly to ensure annual performance evaluations are done.(On-going) Administrator revised all the Contracts for our contractorsthat reflect no performance evaluations will be done annually. Completed 2/24/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	Signed job description … Orientation checklist-completed and signed ….” 3. Record review evidenced an undated agency policy received on 02/01/2023, titled, “Contract Personnel,” which stated, “… Prior to rendering services to agency clients, all contract personnel shall receive an orientation to the agency’s client care policies and procedures and applicable personnel requirements … Contract personnel utilized by the agency shall be periodically evaluated by a qualified supervisor … proof of an annual performance evaluation from the practicing supervisor shall be submitted to the agency ….” 4. Personnel record review on 01/30/2023, failed to evidence a job description for PTA (physical therapy assistant) #2. 5. Personnel record review on 01/30/2023, failed to evidence a job orientation for PTA #2, PT (physical therapist) #1, and social worker #2. 6. Personnel record review on 01/30/2023, failed to evidence an annual performance			

	evaluation for contracted employees PTA #2, PT #1, social worker #2, and speech therapist #1. There failed to be any evidence of a performance evaluation conducted by the home health agency or the contracted agency in the personnel file. During an interview on 01/31/2023, at 3:40 PM, the alternate administrator indicated annual evaluations are not done for contracted staff.			
N0462	Home health agency administration/management 410 IAC 17-12-1(h) Rule 12 Sec. 1(h) Each employee who will have direct patient contact shall have a physical examination by a physician or nurse practitioner no more than one hundred eighty (180) days before the date that the employee has direct patient contact. The physical examination shall be of sufficient scope to ensure that the employee will not spread infectious or communicable diseases to patients. Based on record review and interview, the home health agency failed to ensure a physical exam was received for each employee who had direct patient contact before the date the employee had	N0462	N0462 Administrator will in-service agency staff involved inhiring of employees/human resource functions that If an employee is contractedthru another agency a copy of their physical will be obtained and placed intheir file that is kept by the home health care agency. Date completed 2/23/23 Administrator/Director of Nursing will audit files ofcontract personnel before they are permitted to see patients to ensure copy oftheir physical is in file. (On-going) The Administrator will be	2023-02-23

	direct patient contact in 2 of 3 therapist records reviewed. (physical therapist #1, speech therapist #2) Findings include: 1. Record review of an undated agency policy received on 02/01/2023, titled, "Personnel Records," stated, "... Personnel files will be established and maintained for all personnel ... physical, if required ... Staff members contracted to the agency through another organization will have the following information available to review in the contracting agency's personnel record ... health status screening ...." 2. Personnel record review on 01/30/2023, evidenced physical therapist #1's physical examination record dated 09/04/2018. Review evidenced first patient contact date of 02/24/2014. Review failed to evidence a physical examination prior to first patient contact. 3. Personnel record review on 01/30/2023, evidenced speech therapist #1's physical examination record dated 01/21/2013. Review indicated first patient contact date of		responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	05/12/2012. Review failed to evidence a physical examination prior to first patient contact. During an interview on 01/31/2023, at 3:40 PM, the alternate administrator indicated they were unsure of physical examination records for contracted staff.			
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or	N0464	N0464 Administrator will in-service agency staff involved inhiring of employees/human resource functions that clinicians must have anannual tuberculosis screening. Date completed 2/23/23 Administrator/Director of Nursing will audit all currentemployee files to ensure there is evidence of an annual tuberculosis screening.Any employee who doesn't have a current tuberculosis screening will completeone. Date completed 2/23/23 Administrator/Director of Nursing/designee will auditemployee files monthly to ensure tuberculosis screenings are up to date.(On-going)	2023-02-23

	(iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on record review and interview, the home health agency failed to ensure tuberculosis screening was completed annually in 1 of 1 registered nurse personnel records reviewed. (registered nurse #1) Findings include: Record review evidenced an		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	on 02/01/2023, titled, "Occupational Exposure to Tuberculosis Prevention Plan," which stated, "... Agency will establish a program to identify individuals at risk for or with a diagnosis of active tuberculosis ... The agency will perform annual and ongoing risk assessment surveillance for the agency ...." Record review on 01/30/2023, evidenced an agency document titled, "Annual TB [tuberculosis] Symptoms Evaluation," which indicated the last annual TB Symptoms Evaluation for Registered Nurse #1 was 11/29/2021. The agency failed to perform an annual risk assessment for Registered Nurse #1. During an interview on 01/31/2023, at 3:40 PM, the director of nursing indicated tuberculosis evaluation should be done annually.			
N0478	Q A and performance improvement 410 IAC 17-12-2(d) Rule 12 Sec. 2(d) If personnel under contracts are used by the home health agency, there	N0478	N0478 Administrator will review all current contracts to ensurethey indicate the services to be provided. Any contract that	2023-02-23

	shall be a written contract between those personnel and the home health agency that specifies the following: (1) That patients are accepted for care only by the primary home health agency. (2) The services to be furnished. (3) The necessity to conform to all applicable home health agency policies including personnel qualifications. (4) The responsibility for participating in developing plans of care. (5) The manner in which services will be controlled, coordinated, and evaluated by the primary home health agency. (6) The procedures for submitting clinical notes, scheduling of visits, and conducting periodic patient evaluation. (7) The procedures for payment for services furnished under the contract. Based on record review and interview, the home health agency failed to ensure a written contract between the contracted personnel and the home health agency specified the services to be furnished. Findings include: Record review of an undated agency policy received on 02/01/2023, titled, "Contract Personnel," stated, "... Contracts will delineate the scope of services and responsibilities of each part ... to assure there is a		doesn't indicateservice(s) to be provided will be revised and resigned. Date completed 2/23/23 Administrator will review all contracts before being signedto ensure they indicate the services to be provided. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	the scope of services provided between the Agency and other organization or individuals providing home care services ...." Record review of an agency document dated 06/06/2022, titled, "Independent Contractor Agreement," indicated the therapy service was to provide therapy services. The contract agreement failed to specify the services to be furnished. During an interview on 01/31/2023, at 3:30 PM, the alternate administrator indicated the service contract should include physical therapy and physical therapist assistant services.			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview, the home health agency failed to provide a comprehensive assessment that accurately reflected the patient's status in 2 of 6 active clinical records reviewed	G0528	G0528 Director of Nursing will in-serviceall clinicians on completing the OASIS comprehensive assessment accurately toreflect the patient's actual status at time of assessment. This includes allmedications prescribed/used. Completed 2/10/23	2023-03-01

	(#2, #5) Findings include: 1. Record review evidenced an undated agency policy received on 02/01/2023, titled, "Comprehensive Client Assessment," which stated, "... the initial assessment bridges the gap between the first client encounter until a plan of care can be implemented. These may include items such as ... skilled treatments ... nutritional needs ... the comprehensive assessment must accurately reflect the client's status ...." 2. Clinical record review on 01/27/2023, for patient #2, start of care 06/07/2022, evidenced an agency document dated 06/07/2022, titled, "OASIS [observation and assessment information set] D1 Start of Care," identified as the comprehensive assessment. This document indicated the patient had an AV graft (access for dialysis) to the right upper arm. The comprehensive assessment failed to evidence assessment of the AV graft site. During an interview on 01/31/2023, at 2:25 PM, the director of nursing indicated the		Administrator/Director ofNursing/designee will audit all current patient comprehensive assessments toensure they accurately reflect the patient's status including all medicationsprescribed/used. Completed by 3/1/23 Director of Nursing/designee willaudit all comprehensive assessments submitted weekly to ensure they accuratelyreflect the patient's current status. Once 100% compliance is achieved 10% willbe audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	comprehensive assessment should include assessment for thrill and bruit to the AV graft site. 3. Clinical record review on 01/30/23, for patient #5, start of care 06/20/2019, evidenced an agency document dated 11/29/2022, titled, OASIS-D1 Recertification," which was identified as the comprehensive assessment. This document indicated the patient had a peg tube (plastic feeding tube that goes into the stomach). The comprehensive assessment failed to evidence assessment of the peg tube site. During an interview on 02/01/2023, at 12:00 PM, the director of nursing indicated the peg tube site assessment should be included on the comprehensive assessment. 410 IAC 17-14-1(a)(1)(B)			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant	G0536	G0536 Director of Nursing will in-service clinicians onrequirement to review all medications patient takes as part of thecomprehensive assessment. That is to include	2023-03-02

	side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the home health agency failed to ensure all current patient medications were reviewed as part of the comprehensive assessment, to identify any potential adverse effects, drug reactions, significant drug interactions, and duplicate drug therapy in 2 of 4 clinical records reviewed with skilled nurse visits. (#2, #6) Findings include: 1. Record review evidenced an undated agency policy received 02/01/2023, titled, "Comprehensive Client Assessment," which indicated the comprehensive assessment will include a review of all medications the patient was currently using in order to identify significant drug interactions and duplicate drug therapy. 2. Record review evidenced an undated agency policy received 02/01/2023, titled, "Medication Management," which stated, "... Comprehensive client assessment performed at start of care and other defined points in time include review of all medications the client is taking		identifying any potential adverseeffects, drug reactions, significant drug interactions, and duplicate drugtherapy. If issues are found assessment is to indicate issues were noted. Completed2/10/23 Administrator/Director of Nursing/designee will audit allcurrent patient charts to ensure medications were reviewed as part of the comprehensiveassessment and include identification of any potential adverse effects, drugreactions, significant drug interactions, and duplicate drug therapy. If issuesare found assessment is to indicate issues were noted. Completed by 3/2/23 Administrator/Director of Nursing/designee will audit allcomprehensive assessments submitted each week to ensure they include a reviewof medications to identify any potential adverse effects, drug reactions,significant drug interactions, and duplicate drug therapy. If issues are foundassessment is to indicate issues were noted. Once 100% compliance is achieved10% will	

	[prescribed, samples, over the counter, herbal remedies, PRN medications] and records this in the client record ...." 3. Clinical record review on 01/27/2023, for patient #2, start of care 06/07/2022, evidenced an agency document titled, "OASIS [outcome and assessment information set] D1 Start of Care," identified as the comprehensive assessment, which indicated no issues found during drug regimen review. Review of an agency document dated 06/09/2022, titled, "Patient Medication Record," indicated the physician was faxed a record of medication discrepancies and severe medication interactions. Review of the paper chart faxed to the physician evidenced the medication list was faxed to the physician but failed to evidence the medication interaction list was faxed. Review of a web based source on 01/27/2023, https://drugs/com/interactions-check.php, evidenced the following 14 major drug to drug interactions between medications on patient		compliance is maintained. (On-going) Director of Nursing will in-service clinicians that druginteractions must be run for all meds and faxed to MD. Fax cover sheet mustindicate interactions were faxed. Designee will review all faxes sent to MD regarding druginteractions to ensure it indicates drug interactions were sent. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	cyclobenzaprine (muscle relaxer) and tramadol (pain reliever) -may cause central nervous system depression, respiratory distress, coma and death; cinacalcet (thyroid medication) and Rexulti (antipsychotic) may cause respiratory distress, coma and death; tramadol and Rexulti may cause respiratory distress, coma and death; hydrocodone (pain reliever) and Rexulti may cause respiratory distress, coma and death; sertraline (antidepressant) and Rexulti may cause abnormal muscle movements and low blood pressure (circulating blood against blood vessel walls), gabapentin (pain reliever) and tramadol may cause respiratory distress, coma and death; hydrocodone and tramadol may cause seizures, respiratory distress, coma and death; sertraline and tramadol may cause confusion, hallucination, seizures, tremor, nausea and vomiting; trazadone (depression medication) and tramadol may cause confusion, hallucination, seizures, change in blood pressure, elevated heart rate, nausea and vomiting; hydrocodone and gabapentin may cause respiratory distress,			

	coma, and death; cyclobenzaprine and hydrocodone may cause respiratory distress, coma and death; trazadone and cyclobenzaprine may cause confusion, hallucinations, seizure, elevated heart rate, tremor, nausea and vomiting; trazadone and sertraline may cause confusion, hallucinations, seizure, elevated heart rate, fever, tremor, nausea and vomiting; and sertraline and cyclobenzaprine may cause confusion, hallucination, seizure, tremor, nausea and vomiting. During an interview on 01/31/2023, at 2:00 PM, the director of nursing indicated the medication interaction list should have been sent to the physician for review. 4. Clinical record review on 01/30/2023, for patient #3, start of care 06/20/2022, evidenced an agency document titled, "OASIS-D1 Start of Care," identified as the comprehensive assessment. This document indicated no issues were found during drug regimen review. Record review of an agency			

	titled, "Patient Medication Record," evidenced duplicate therapy of medication Diclofenac (pain relieving gel) 1% 4 grams apply 4 grams three times a day to the skin and Diclofenac 2 grams apply four times a day; and duplicate medications of hydrochlorathiazide (medication for fluid retention) 25 milligrams one tablet every day, 2nd note hydrochlorathiazide 25 milligrams one tablet every day and losartan hydrochlorathiazide (blood pressure medication) 100/25 milligrams one tablet daily. During an interview on 01/31/2023, at 2:40 PM, the director of nursing indicated she doesn't know why diclofenac and hydrochlorathiazide are duplicated on the medication list she would need to check. The director of nursing indicated the medications should be reconciled at each nursing visit. 5. Clinical record review on 01/31/2023, for patient #6, start of care 01/18/22, evidenced an agency document titled, "OASIS-D1 Start of Care,"			

	identified as the comprehensive assessment. This document indicated no issues found during drug regimen review. Review of an agency document dated, 01/19/2022, titled, "Patient Medication Record," indicated a fax was sent to the physician regarding medication discrepancies and severe medication interactions. Review of the paper chart faxed to the physician evidenced the medication list was faxed but failed to evidence the medication interaction list was sent to the physician. Review of a web based source on 01/30/2023, http://www.drugs.com/interactions-check.php," evidenced the following 4 major drug to drug interactions between medications on patient #6 medication list: sotalol (treat abnormal heart rhythm) and sertraline (antidepressant) may increase risk of irregular heart rhythm; sotalol and albuterol (inhaler used to treat narrowing of airways) may cause narrowing of airways; oxybutynin (medication for overactive bladder) and			

	effects on the stomach causing ulcers and bleeding; and hydrocodone (pain reliever) and gabapentin (pain reliever) may cause respiratory distress, coma and death. During an interview on 02/01/2023, at 12:23 PM, the administrator indicated the medication interactions were not sent to the physician because of a computer glitch due to software issue that was corrected. 410 IAC 17-14-1(a)(1)(B)			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the home health agency failed to ensure they sent all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and	G0564	G0564 Agency unable to correct two patients cited in survey asthey had already been discharged.	2023-03-01

	treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care in 2 of 2 clinical records reviewed of transferred patients. (#4, #8) Findings include: 1. Record review evidenced an agency policy dated 12/26/2019, titled, "Patient Transfer," which stated, "... A transfer summary shall be completed ... The original Transfer Summary form shall be sent to the new provider or facility ... if a client transfers to another health facility or home health agency, a copy of the summary shall be sent with the client ...." 2. Clinical record review on 01/30/2023, for patient #4, start of care 12/19/2022, evidenced an agency document dated 01/11/2023, titled, "OASIS-E Transfer," which indicated the patient was transferred to an inpatient facility. Review failed to evidence a transfer summary was sent to the inpatient facility.		Director of Nursing will in-service clinicians onrequirement for all necessary medical information pertaining to the patient'scurrent course of illness and treatment, post-discharge goals of care, andtreatment preferences to be sent to the receiving facility or health carepractitioner for a transfer or discharge to ensure the safe and effectivetransition of care. Completed by 3/1/23 Director of Nursing/designee will audit alltransfers/discharges submitted each week to ensure all necessary medical informationpertaining to the patient's current course of illness and treatment, currentstatus of goals, and treatment preferences were sent to the receiving facilityor health care practitioner for a transfer or discharge to ensure the safe andeffective transition of care. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going)	

	During an interview on 02/01/2023, at 11:40 AM, the director of nursing indicated a transfer summary was not sent to the inpatient facility. 3. Clinical record review on 01/30/2023, for patient #8, start of care 05/17/2022, evidenced an agency document dated 12/31/2022, titled, "Memo to Physician," which indicated the patient had been hospitalized on 12/27/2022. Review failed to evidence a transfer summary was sent to the hospital. During an interview on 02/01/2023, at 3:00 PM, the director of nursing indicated a transfer summary was not sent to the hospital. The director of nursing indicated transfer and discharge summaries are not sent if patient was sent to the hospital.		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
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	G0570	G0570 Please see G0574, G0588, G0590, G0606, G0614, G0616. The Administrator will be responsible for monitoring thesecorrective actions to	2023-03-03

	reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review and interview, the home health agency failed to include in the individualized plan of care the types of services, supplies, equipment required, nutritional requirements, all medications and treatments, and patient specific interventions and safety measures (see tag G574); failed to have the physician review and revise the plan of care as frequently as the patient's condition requires (see tag G588); failed to promptly alert the physician to any changes in the patient's condition or needs that suggest the outcomes are not being achieved and/or the plan of care should be altered (see tag G590); failed to integrate services to assure the identification of patients needs that could affect patient safety and treatment effectiveness (see tag G606); failed to provide a written visit schedule consistent with the patient's most current plan of care (see tag G614); and failed to provide the patient written		ensure that this deficiency is corrected and will notrecur. Completed by 3/3/23	

	information regarding the patient's medication regimen in plan language (see tag G616). Findings: The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safety environment for the Condition of Participation 42 CFR §484.60: Care Planning, Coordination of Services, and Quality of Care. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (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;	G0574	G0574 Director of Nursing will in-service clinicians on therequired elements of the individualized plan of care. Completed 2/10/23 (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, andcognitive status; (iii) The types of services, supplies, and equipmentrequired;	2023-02-10

	(viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview the home health agency failed to ensure the individualized plan of care included the types of services, supplies, and equipment required; nutritional requirements, all medications and treatments, patient specific interventions and safety measures in 8 of 8 clinical records reviewed. (#1, #2, #3, #4, #5, #6, #7, #8) Findings include: 1. Record review of an undated agency policy received on 02/01/2023, titled, "Plan of Care," stated, "... The Plan of Care shall be completed in full to include ... diagnostic tests, including laboratory ... specific		(iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk foremergency department visits and hospital re-admission, and all necessaryinterventions to address the underlying risk factors. (xiii) Patient and caregiver education and training tofacilitate timely discharge;	

	requirements … medications, treatments, and procedures … medical supplies and equipment required, and any safety measures to protect against injury ….” 2. Record review of an undated agency policy received on 02/01/2023, titled, “Care Plans,” stated, “… a Care Plan shall be developed with the client and/or caregiver. The interventions shall correspond to the problems identified, services needed and the client goals for the episode of care … The Care Plan shall include, but not limited to … a list of specific interventions with plans for implementations ….” 3. Record review of an undated agency policy received on 02/01/2023, titled, “Medication Orders,” stated, “… Orders for PRN [as needed] Medications must include name, dose, reason for use ….” 4. Clinical record review on 01/27/2023, for patient #1, start of care 12/07/2022, evidenced an agency document titled, “Home Health Certification and Plan of Care,” for certification period 12/07/2022-02/04/2023,		(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 orallowed practitioner may choose to include. Director of Nursing will in-service clinicians on need toindicate what other providers are involved and what they are providing (i.e. –other agencies, group homes, assisted living, etc), meds to be taken “asneeded” need to have the reason/frequency, tube feeding patients need to havefrequency/amount and interval of formula/and the flushing frequency, if it wasbefore the formula after the formula or in between feedings, the flush. Completed2/10/23 Administrator/Director of Nursing/designee will review allcurrent patient plans of care to ensure they contain required elements. If aplan is missing an element the clinician will be instructed to contact MD	

	which indicated the patient was taking Digoxin (medication for abnormal heart rhythms), and the patient was home bound. Review failed to evidence monitoring/intervals of a digoxin level blood test. During an interview on 01/31/2023, at 2:00 PM, the administrator indicated monitoring of the digoxin level should be included on the plan of care and the administrator would check with the physician. Record review indicated the patient was on Aspirin (medication to reduce pain and to reduce formation of blood clots) 325 mg [milligram] 2 tablets daily. Review failed to evidence safety instructions regarding bleeding precautions. During an interview on 01/31/2023, at 1:10 PM, the director of nursing indicated bleeding precautions are included on the plan of care for patients taking regular aspirin dose of 325 milligrams, but was not included on the plan of care if the patient was on aspirin dose of 81 milligrams. 5. Clinical record review on		toobtain verbal order to add missing element(s) to the current plan of care.Completed 2/10/23 Administrator/Director of Nursing/designee will audit allplans of care submitted weekly to ensure they contain required elements. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	of care 06/07/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care, "for certification period 12/04/2022-02/01/2023, which indicated the patient received dialysis. Review of an agency document dated 01/10/2023, titled, "LPN (licensed practical nurse) Skilled Nursing Visit," indicated the patient had a right arm AV Graft (access for dialysis) with an audible bruit (assessment by sound of AV graft site) and palpable thrill (assessment by palpation of AV graft site). Review failed to evidence the plan of care included the AV Graft site assessment and evaluation needs. Review failed to evidence the plan of care included safety measures related to the AV Graft site. During an interview on 01/31/2023, at 2:25 PM, the director of nursing indicated the plan of care should include assessment need of the AV Graft site to include assessing for thrill and bruit. The director of nursing indicated safety measures should be on plan of			

	care to include bleeding precautions, lifting precautions, and no blood pressure assessment with cuff on the AV Graft arm. Review of an agency document dated 12/29/2022, titled, "LPN Skilled Nursing Visit," indicated the patient utilized a medical alert device PRN (as needed). Review failed to evidence the plan of care safety measures included the medical alert device. During an interview on 01/31/2023, at 2:30 PM, the director of nursing indicated the medical alert device should be included in the patient's safety measures and would only be included in the orders if the physician ordered the medical alert device. Review of the plan of care evidenced medications which stated, "... Nystatin external 10000 unit/GM [gram] apply to affected area as needed ... Cyclobenzaprine HCL [hydrochloride] oral 10 mg 1 tab 3 times per day as needed ...." Review failed to evidence			

indications for as needed medication.

During an interview on 01/31/2023, at 1:55 PM, the director of nursing indicated the reason for the as needed medication should be included on the plan of care medication list.

6. Clinical record review on 01/30/2023, for patient #3, start of care 06/20/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/17/2022-02/14/2023 which indicated skilled nurse to report fasting blood sugar of < 60 or > 250.

Review evidenced an agency document dated 12/13/2022, titled, "OASIS (outcome and assessment information set)-D1 Recertification," which indicated the patient wore a continuous glucose monitor and the sensor was due to be changed in 12 days.

Review of the plan of care failed to evidence the continuous glucose monitor or the sensor change frequency.

During an interview on

	01/31/2023, at 2:45 PM, the director of nursing indicated the plan of care should include the continuous glucose monitor and sensor change frequency. The director of nursing indicated the husband just knows when to change the sensor. Observation of a home visit for patient #3 on 01/30/2023, at 7:30 AM, evidenced the patient wore ted hose (stockings that help prevent swelling in the legs) to the legs for swelling. Review of the plan of care failed to evidence the use of ted hose. During an interview on 01/31/2023, at 3:30 PM, the director of nursing indicated the ted hose should be on the plan of care and should be included on the education narrative. 7. Clinical record review on 01/30/2023, for patient #4, start of care 12/19/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/19/2022-02/16/2023, which evidenced the medication Norco (pain medication). The plan of care stated, "... Norco oral 5-325 milligrams 1 tab by			

	mouth as needed for pain ….” Review failed to evidence the frequency of the Norco medication. During an interview on 02/01/2023, at 11:42 AM, the director of nursing indicated the physician did not give a frequency to the Norco, but the patient only takes one per day. The director of nursing indicated she understood what the concern was regarding the frequency of the Norco but that she can’t make up the frequency if the physician did not indicate the frequency. 8. Clinical record review on 01/30/2023, for patient #5, start of care 06/20/2019, evidenced an agency document titled, “Home Health Certification and Plan of Care,” for certification period 01/30/2023-03/30/2023 which stated, “…Nutritional Requirements Other: Flush with 60 milliliters. Enteral Nutrition Kate Farms [formula] Amount 1300 cc [cubic centimeters] /day via Gravity Peg [feeding tube that goes into the stomach] Bolus [tube feeding given like a meal, a larger amount is given in a short period of time] ….”			

	Review failed to evidence the plan of care included the frequency and amount of the peg tube formula. Review failed to evidence the plan of care included the frequency and schedule of the flush. During an interview on 02/01/2023, at 12:00 PM, the director of nursing indicated the peg tube formula should be on the medication list of the plan of care. The director of nursing indicated the peg tube frequency, amount and interval of formula; and the flushing frequency, if it was before the formula after the formula or in between feedings, the flush should be included on the plan of care. 9. Clinical record review on 01/30/2023, for patient #6, start of care 01/18/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/13/2023-03/13/2023, which indicated the orders were for the skilled nurse to notify the physician if the patient's weight was greater than 5 pounds or less than 5 pounds.			

	Review of agency documents dated 12/27/2022, 01/05/2023, 01/19/2023, titled, "LPN [licensed practical nurse] Skilled Nursing Visit" failed to evidence the weight of the patient. During an interview on 02/01/2023, at 12:23 PM, the administrator indicated the patient was unable to be weighed and was unable to get on the scale. The administrator indicated he would need to remove the weight assessment from the plan of care. Review failed to evidence the plan of care was individualized. 10. Clinical record review on 01/30/2023, for patient #7, start of care 05/11/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 09/08/2022-11/06/2022, which indicated the patient had type 2 diabetes mellitus, and dementia (loss of cognitive functioning).			

	Review failed to evidence the plan of care included the frequency of blood sugar testing or the caregiver responsible for testing the blood sugar. During an interview on 02/01/2023, at 2:30 PM, the director of nursing indicated the blood sugars were being checked at the patient's assisted living facility and the plan of care should include the blood sugar testing and frequency. 11. Clinical record review on 01/30/2023, for patient #8, start of care 05/17/2022, evidenced an agency document titled "Home Health Certification and Plan of Care," for certification period 11/13/2022-01/11/2023, which indicated the patient primary diagnosis of type 2 diabetes mellitus and moderate intellectual disabilities and lived in a 24 hour supportive living services facility. Review failed to evidence the plan of care included the frequency of the blood sugar testing or the caregiver responsible for testing the blood sugar. During an interview on			

	02/01/2023, at 3:10 PM, the director of nursing indicated the group home was testing her blood sugars and should be included on the plan of care. Review of an agency document titled, "Home Health Certification and Plan of Care," for certification period 11/13/2022-01/11/2023, evidenced medications which stated, "… A&D External Dime size use daily as needed … Triple Antibiotic External Dime Size use daily as needed to affected area …." The review failed to evidence an indication for as needed medication. During an interview on 02/1/2023, at 3:00 PM, the director of nursing indicated the reason for the as needed medication should be included on the plan of care medication list. 410 IAC 17-13-1(a)(1)(D)(ii, viii, ix, x, xiii)			
N0586	Scope of Services 410 IAC 17-14-1(h)	N0586	N0586 Director of Nursing will ensure aides #1 and #2, cited inthe	2023-03-01

	Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas: (1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff. (2) Observing, reporting, and documenting patient status and the care or service furnished. (3) Reading and recording temperature, pulse, and respiration. (4) Basic infection control procedures and universal precautions. (5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (6) Maintaining a clean, safe, and healthy environment. (7) Recognizing emergencies and knowledge of emergency procedures. (8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination.		survey, are trained in the categories that were not completed. Completed by 3/1/23 Director of Nursing will in-service nurses doing aide skillcompetency training on all areas aides are to be competency tested in. Completed by 3/1/23 Director of Nursing/designee will review competencyevaluations for newly hired aided to ensure they have met competencyrequirements before being placed on visit schedule. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

(10) Safe transfer techniques and ambulation.

(11) Normal range of motion and positioning.

(12) Adequate nutrition and fluid intake.

(13) Medication assistance.

(14) Any other task that the home health agency may choose to have the home health aide perform.

Based on record review and interview, the home health agency failed to ensure the home health aide's continuing education hours included a minimum of 8 hours in any of 8 subject areas from January 1st through December 31st.

Findings include:

Record review of an undated agency policy received on 02/01/2023, titled, "Competency Evaluation of Home Care Staff," stated, "... The Home Health Aide will have successfully completed the competency evaluation program if he/she demonstrates competency in a minimum of eleven of the twelve areas required in federal guidelines ...."

Record review of home health aide #1, and #2, on 01/31/2023, failed to evidence training was provided in the following areas:

	documenting patient status and the care or service furnished, reading and recording temperature, pulse, and respiration, basic elements of body functioning and changes in body function that must be reported to an aide's supervisor, recognizing emergencies, appropriate and safe techniques in personal hygiene, safe transfer techniques, normal range of motion, adequate nutrition and fluid intake, and medication assistance. During an interview on 01/31/2023, at 12:30 PM, administrative staff #4, indicated they did not know home health aide training had to be in specific subject areas.			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the home health agency failed to ensure the physician	G0588	G0588 Director of Nursing will in-service clinicians onrequirement to notify MD of a change in patient's condition and document. Completed 2/24/23 Adminstrator/Designee will audit all visit documentationsubmitted weekly to ensure if there is	2023-02-24

	reviewed and revised the plan of care as frequently as the patient's conditions required in 1 of 3 transferred/discharged clinical charts reviewed. (#4) Findings include: Record review evidenced an undated agency policy received on 02/01/2023, titled, "Care Plans," which stated, "... The Care Plan shall be reviewed, evaluated, and revised (minimally every 60 days and as needed) based upon the client's health status and/or environment, ongoing client assessments ...." Clinical record review on 01/30/2023, for patient #4, start of care 12/19/2022, evidenced an agency document titled, "OASIS [outcome assessment and information set]-E Resumption of Care," which indicated the patient was admitted to the hospital from 01/11/2023-01/16/2023 and was discharged with a urinary catheter (a flexible tube that collects urine from the bladder and leads to a drainage bag). Review of an agency document titled, "Home Health Certification and Plan of Care,"		documentation indicating a change inpatient condition there is documentation MD has been notified and plan of carerevised as appropriate. Once 100% compliance is achieved 10% will be auditedquarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	for certification period 12/19/2022-02/16/2023, failed to evidence instructions for the urinary catheter. During an interview on 02/01/2023, at 11:45 AM, the director of nursing indicated there were no new orders for the urinary catheter so did not update the plan of care. The director of nursing indicated the urinary catheter was removed by the urologist on 01/26/2023. 410 IAC 17-13-1(a)(2)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on observation, record review, and interview the home health agency failed to ensure they promptly alerted the physician to any changes in the patient's condition or needs that suggest the outcomes were not being achieved and/or the plan of care should be altered in 4 of 6 active clinical records reviewed. (#1, #2, #3, #4)	G0590	G0590 Director of Nursing will in-service clinicians onrequirement to notify MD promptly of any changes in the patient's condition orneeds that suggest the outcomes were not being achieved and/or the plan of careshould be altered. If clinician has to leave a message the clinician mustdocument follow up with MD. If MD office doesn't call back within a reasonabletime clinician must call MD office again for follow up and document. Clinician is also to notify theDirector of Nursing and appropriate agency	2023-03-01

	Findings include: 1. Record review of an undated agency policy received on 02/01/2023, titled, "Plan of Care," stated, "Home care services are furnished under the supervision and direction of the client's physician. The plan of care is based on a comprehensive assessment and information provided by the client/family and health team members … The plan will be consistently reviewed to ensure the client needs are met, and will be updated as necessary … Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care …" 2. Clinical record review on 01/27/2023, for patient #1, start of care 12/07/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/07/2022-02/04/2023, which indicated the patient had diagnoses of hypertension (elevated blood pressure), heart murmur, heart valve replacement and was on Digoxin (a medication to treat irregular heartbeat). Record review of an agency		case manager and document. Completed by 3/01/23 Director of Nursing/designee will audit 100% of visit notessubmitted weekly to ensure if there is documentation of change in patientcondition or needs that suggest the outcomes were not being achieved and/or theplan of care should be altered there is documentation MD was notified promptly.If clinician had to leave a message there must documentation of follow up withMD. If MD office doesn't call back within a reasonable time clinician must callMD office again for follow up and document. Clinician is also to notify theDirector of Nursing and appropriate agency case manager and document. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

document dated 01/09/2023, titled, “PTA [physical therapy assistant] Visit,” indicated the patient had an episode of rapid heart rate on 01/08/2023, with feeling of fatigue which lasted a few hours.

Record review of an agency document dated 01/11/2023, titled, “PTA Visit,” indicated the patient had a squeezing feeling in her chest and that it lasted less than 30 minutes on 01/10/2023.

Record review of an agency document dated 01/27/2023, titled, “PTA Visit,” stated, "... Patient said that on Wednesday she had another heart episode ...."

Record review failed to evidence physician notification of patient’s symptoms documented on 01/09/2023, 01/11/2023, and 01/27/2023.

Observation during a home visit on 01/27/2023, at 10:00 AM, the patient indicated she had what was described as a "heart episode" on Wednesday.

During an interview on 01/31/2023, at 1:10 PM, the

PTA should notify the agency case manager and physician. The director of nursing indicated the physician should be notified of any patient concerns.

During an interview on 01/31/2023, at 1:15 PM, the administrator indicated the patient should be evaluated and vitals signs done prior to continuing physical therapy.

3. Clinical record review on 01/27/2023, for patient #2, start of care 06/07/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/04/2022-02/01/2023, which indicated the patient had peripheral vascular disease (narrowed arteries reduce flow to legs).

Review evidenced an agency document dated 12/29/2022, titled, "LPN [licensed practical nurse] Skilled Nursing Visit," which indicated the patient had an excoriated area 2 cm [centimeter] x 2 cm to abdominal fold.

During an observation of a home visit on 01/31/2023, at 9:00 AM, the patient was

observed to have 2 scabbed areas on right front anterior leg surrounded by pink skin. The patient indicated the area was opened and was being covered with a bandage and she had left it open to air now that it had closed.

Review failed to evidence documentation of physician notification of the abdominal excoriation or the leg skin change in condition.

During an interview on 01/31/2023, at 2:00 PM, the director of nursing indicated the physician should be notified if there was new skin breakdown.

4. Clinical record review on 01/30/2023, for patient #3, start of care 06/20/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/17/2022-02/14/2023, which indicated the skilled nurse should report a fasting blood sugar of less than 60 or greater than 250. Review evidenced the plan of care updated on 12/13/2022, by the director of nursing, stated, "... her waking AM glucose today

	then 135 after meal ...." Review failed to evidence the physician was notified of the fasting blood sugar of 59. During an interview on 01/31/2023, at 2:48 PM, the director of nursing indicated she left a message with the physician's office regarding the blood sugar but doesn't remember if the office called back, and should have been documented in the communication notes. Record review evidenced an agency document dated, 01/02/2023, titled, "LPN Skilled Nursing Visit," which indicated the patient had a blister on the left ankle of 2 centimeters by 2 centimeters. The patient was instructed on skin care, avoid bursting blister, signs and symptoms of infection, keep skin clean, dry and moisturized and when to notify the skilled nurse/medical doctor. Review failed to evidence the physician was notified of the blister. During an interview on 01/31/2023, at 2:50 PM, the director of nursing indicated a nurse practitioner visit was scheduled to see the patient			

	regarding the left ankle blister and should have been documented in the chart of the physician notification. 5. Clinical record review on 01/30/2023, for patient #4, start of care 12/19/2022, evidenced an agency document dated 01/10/2023, titled, "PTA Visit," which indicated the patient was received by the PTA sitting in the recliner with knees up due to stomachache. The PTA indicated poor endurance and complaints of stomach pain limited therapy activity. The PTA noted the patient did not feel well and stomach hurt. Record review evidenced an agency document titled, "OASIS [outcome and assessment information set] E Transfer," dated, 01/11/2023, which indicated the patient was very weak and taken to emergency room via ambulance for concern of possible gastrointestinal bleed Review failed to evidence the PTA promptly notified the home health agency's clinical manager or the physician of the patient's complaints on 01/10/2023.			

	During an interview on 02/1/2023, at 11:50 AM, the director of nursing indicated the PTA notified the agency of the patient's complaints on 01/11/2023, and the agency nurse saw patient for an evaluation the day of notification. 410 IAC 17-13-1(a)(2)			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the home health agency failed to ensure integrated services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines in 2 of 6 active clinical records reviewed. (#2, #5) Findings include: 1. Record review of an undated	G0606	G0606 Director of Nursing will in-service clinicians on need tocoordinate care with all entities involved in patient's care. That includesother disciplines within agency and outside agencies – i.e. dialysis. Clinicianneeds to update other entities on issues that they need to be aware of andfollow up with other entities when there is an issue with other entity.Completed 2/10/23 Administrator/designee will audit all clinical documentationsubmitted weekly to ensure there is coordination of care documented if otherhealth care entities involved and it is something they should be	2023-02-10

	02/01/2023, titled, "Coordination of Client Services," stated, "... The agency will integrate services, whether they are provided directly or under contract, to assure the identification of client needs and factors that could affect client safety and the effectiveness of treatment. The coordination of care is provided by all disciplines and included communication with physicians ... Coordination of care means assuring that the client needs are continually assessed, addressed in the Plan of Care, that care is delivered in a timely and effective manner, and that goals are achieved. The agency will coordinate the nursing, therapy, aide and social work services ...." 2. Record review of an undated agency policy received on 02/01/2023, titled, "Plan of Care," stated, "... The Plan of Care is based on a comprehensive assessment and information provided by the client/family and health team members. The plan will be consistently reviewed to ensure that client needs are met ... 3. Clinical record review on		aware of. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained. (On-going) Adminstrator/designee will review all clinical documentationsubmitted weekly to ensure if another discipline is needed there isdocumentation agency is able to provide that discipline or notifies MD ofinability to provide and assists patient/caregiver with finding an agency whocan provide needed discipline. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	01/27/2023, for patient #2, start of care 06/07/22, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/04/2022-02/01/2023, indicated patient's skilled nursing goals was to keep all scheduled dialysis days with a target date of 02/01/2023. Review of an agency document dated 12/01/2022, titled, "OASIS [outcome and assessment information set]-D1 Recertification," indicated patient was unable to get to dialysis due to medical transportation was not available due to holiday schedule. Review failed to evidence coordination with the patient's dialysis center to ensure transportation to dialysis. During an interview on 01/31/2023, at 10:00 AM, the patient indicated she scheduled the medical transportation to dialysis herself and was picked up at the corner of her street. The patient indicated there was always difficulty around the holidays scheduling transportation to dialysis due to the dialysis change in schedule.			

	During an interview on 01/31/2023, at 2:54 PM, the director of nursing indicated care had not been coordinated with dialysis center to address transportation. The director of nursing indicated if the patient missed dialysis the physician should be notified, and the agency should call the dialysis center to see why the patient missed the visit. During an interview on 01/31/2023, at 2:54 PM, the alternate administrator indicated the home health agency's social worker also worked for a dialysis center and the dialysis social worker should work to ensure patient transportation. 4. Clinical record review on 01/30/2023, for patient #5, start of care 06/20/2019, evidenced an agency document titled, "Home Health and Plan of Care," for certification period 01/30/2023-03/30/2023 indicated the patient required 24-hour dependent care due to traumatic brain injury and indicated the patient had a home health aide from another agency that just started that			

	indicated the caregiver had a difficult time finding an agency and caregiver had been providing all care and was grateful for the assistance. Review evidenced agency documents titled, "Coordination of Care," which indicated patient had several different home health agencies providing skilled nursing or home health aide services on 06/03/022, 08/01/2022, 09/28/2022, and 01/28/2023. Review evidenced an agency document dated 12/21/2022, titled, "ST [speech therapy] Re-Evaluation," which indicated other discipline recommended: occupational therapy but there were none available for traumatic brain injury in the area. During an interview on 02/01/2023, at 12:07 PM, the alternate administrator indicated their agency did not offer a home health aide because the caregiver didn't need help bathing the patient. The alternate administrator indicated the caregiver had problems getting help during the pandemic.			

	Review failed to evidence the home health agency coordinated services to assist caregiver with finding a home health aide or staff to assist the patient's primary caregiver. 410 IAC 17-12-2(h)			
N0610	Clinical Records 410 IAC 17-15-1(a)(7) Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on observation, record review, and interview, the home health agency failed to ensure clinical records were completed in 1 of 2 home visit observations of a home health aide. (#2) Findings include: Record review of an undated agency policy received on 02/01/2023, titled, " Home Health Aide: Documentation," stated, "... Home Health Aides will document care/services provided on the home health aide charting form.	N0610	N0610 Director of Nursing will in-service aides on requirement tofollow the aide plan of care and document tasks actually performed. If patientrefuses to let aide do an ordered task the aide is to mark that task as refusedand notify the Director of Nursing/designee. Completed2/24/23 Director of Nursing/designee will instruct clinicians whendoing visits to ask patient about tasks on the aide care plan and if aide isproviding them. Completed 2/24/23 Director of Nursing/designee will audit all aide visit notessubmitted weekly to ensure tasks are either marked as done or refused. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained.	2023-02-24

	Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan ... Purpose to provide documentation of the care performed by the Home Health Aide on each visit ... The Home Health Aide shall utilize the appropriate Home Health Aide flow sheet or charting to document services rendered to the client ...." Review of an agency document dated 01/31/2023, titled, "HHA [home health aide] Visit," indicated the home health aide had provided linen change, bed made, and oral hygiene was performed. During an observation of a home health aide home visit on 01/31/2023, at 9:00 AM, observation failed to evidence the home health aide provided linen change, the bed was made, or the patient had oral hygiene performed. During an interview on 01/31/2023, at 10:04 AM, patient #2 indicated the home health aide does not ever change linen or make the bed. During an interview on		(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	director of nursing indicated the home health aide should document care as not completed on the home health aide visit form if care/services was not performed. The director of nursing indicated the home health agency should be notified by the home health aide if care/services were not completed.			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on observation, record review, and interview, the home health agency failed to provide a written visit schedule to the patient consistent with the patient's most current plan of care in 2 of 4 home visits. (#1, #4) Findings include: 1. Record review evidenced an undated agency policy received 02/01/2023, titled, "Plan of Care," which stated, "... The Plan of Care shall be completed in full to include: ... Type,	G0614	G0614 Director of Nursing will in-service clinicians onrequirement for patient to be provided a written visit schedule consistent withthe current discipline(s) and frequency as listed on plan of care or mostrecent verbal order. Clinicians are to review visit schedule each visit foraccuracy and revise as needed. Completed by 3/2/23 Director of Nursing will instruct clinicians to review visitschedules in patient homes when making their next visit to ensure the schedulereflects current disciplines and frequencies. If schedule is not	2023-03-02

	frequency, and duration of all visits/services ..." 2. Clinical record review on 1/27/2023, for patient #1, start of care 12/07/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/07/2022-02/04/2023, which indicated the physical therapy was ordered for 2 times a week for 8 weeks. During an observation of a home visit on 01/27/2023, at 10:00 AM, there was not a therapy home visit schedule in the patient's binder or home. During an interview on 01/27/2023, at 10:40 AM, PTA (physical therapy assistant) #2 indicated the visit schedule was done verbally with the patient. During an interview on 01/31/2023, at 1:45 PM, the director of nursing indicated the physical therapist should put a visit schedule in the patient's home agency binder. 2. Clinical record review on 01/30/2023, for patient #4, start of care 12/19/2022, evidenced an agency document titled, "Home Health Certification and		accurateclinician is to make appropriate changes. Completed by 3/2/23 Designee will randomly audit 10% of home visit schedulesquarterly to ensure they reflect the current disciplines and frequencies.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	Plan of Care," for certification period 12/19/2022-02/16/2023, which indicated physical therapy visits twice a week for 9 weeks and home health aide twice a week for 7 weeks. During an observation of a home visit on 01/30/2023, at 9:30 AM, two home health agency binders were reviewed with no evidence of agency visit schedule available. During an interview on 01/30/2023, at 10:04 AM, home health aide #1 was unable to locate the visit schedule. During an interview on 02/01/2023, at 11:44 AM, the alternate administrator indicated the staff was supposed to write out visit schedule for patient.			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation and interview, the home health agency	G0616	G0616 Director of Nursing will in-service clinicians onrequirement to complete medication profiles using plain language and notmedical abbreviations. Completed by 3/3/23 Director of Nursing/designee	2023-03-03

	failed to ensure they provided the patient written information regarding the patient's medication regimen in plain language that does not include medical abbreviations in 4 of 4 home visits. (#1, #2, #3, #4) Findings include: 1. Observation of patient #1, start of care 12/07/2022, during a home visit on 01//27/2023, at 10:00 AM, failed to evidence a medication list provided by the home health agency. During an interview on 1/27/2023, at 10:37 AM, patient #1 indicated no medication list was available. Patient #1 indicated when the nurse came out one time may have reviewed the medications, but no medication list was left by the agency. During an interview on 1/31/2023, at 1:50 PM, the director of nursing indicated the therapist should have put a medication list in the patient's home binder. The director of nursing indicated the home health agency provides the medication list to the therapist to bring to the patient's home.		will review all current patientmedication profiles to ensure they are written using plain language and notmedical abbreviations. Any profile that has medical language will be revisedand clinician will be instructed to make the revisions on the profile in thehome. Completed by 3/3/23 Administrator/designee will review all clinicaldocumentation submitted weekly for mention of new/changed meds and will thenreview medication profile to ensure it does not contain medical abbreviations.Med profiles will be reviewed for admissions, recertification and resumptionsto ensure they use plain language. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will in-service clinicians onrequirement to leave medication profile in home at time of admission. Clinicianis to check home binder each visit to ensure there is a medication profilepresent. If one is not present Director of Nursing/Case Manager is to be	

	2. Observation of patient #2 during a home visit on 1/31/2023, at 9:00 AM, evidenced a medication list, identified by the patient as the medication list provided by the home health agency. The medication list stated, "... Tramadol [pain medication] 50mg [milligrams] every 6 hours PRN [as needed] ...." Review failed to evidence a medication list written in plain language without medical abbreviations. During an interview on 2/01/2023, at 11:58 AM, the director of nursing indicated the patient's medication provided by the agency for the patient's home was the same medication list that was sent to the physician. The director of nursing indicated the prescription "lingo" on the medication list for PRN medication should be changed to as needed for the patient. 3. Observation of patient #3 during a home visit on 1/30/2023, at 7:30 AM, failed to evidence a medication list provided by the home health agency.		notifiedso a copy can be sent to home. Completedby 3/1/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	During an interview on 1/31/2023, at 3:35 PM, the director of nursing indicated a medication list provided by the home health agency should be put into the patient's home health binder. During an interview on 1/31/2023, at 7:40 AM, patient #3 indicated she does not have a written medication list. 4. Observation of patient #4 during a home visit on 1/30/2023, at 9:30 AM, failed to evidence a medication list in the patient's 2 home health binders provided by the agency. During an interview on 2/01/2023, at 11:44 AM, the alternate administrator indicated the patient's medication list should be in the patient's home health binder agency provided to patient.			
G0644	Program data 484.65(b)(1),(2),(3) Standard: Program data.	G0644	G0644 Governing Body met to discuss and approve the data to becollected and the frequency of collection for the QAPI program. Governing Bodymeeting minutes state data to be collected and	2023-02-24

	(1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and interview, the home health agency's governing body failed to approve the frequency and detail of the data collection for Quality Assessment Performance Improvement (QAPI) program. Findings include: Record review of an undated agency policy received on 02/01/2023, titled, "Quality Assessment and Performance Improvement," stated, "... The governing body is responsible for ensuring the following: An ongoing program for quality improvement and patient safety is defined, implemented, and maintained ...." Record review of an undated agency policy received on 02/01/2023, titled, "Governing		frequency. Completed 2/24/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	Governing Body shall assume full legal authority and responsibility for the overall management and operation of Agency. This includes the provision of home health services ... the Quality Assessment and Performance Improvement Program ...." Review of the agency's QAPI binder on 02/01/2023, failed to evidence the governing body had approved the frequency and detail of the data collection. During an interview on 02/02/2023, at 10:45 AM, the director of nursing indicated the governing body should approve the frequency and detail of the data collection for the QAPI program, and there was no governing body meeting minutes regarding QAPI. 410 IAC 17-12-2(a)			
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	G0652	G0652 Administrator/Director of Nursing will ensure theperformance improvement activities lead to an immediate correction of anyidentified problems that directly or potentially threaten the health	2023-02-21

	interview, the home health agency failed to ensure the performance improvement activities led to an immediate correction of any identified problems that directly or potentially threaten the health and safety of patients. Findings include: Record review of an undated agency policy received on 02/01/2023, titled, "Quality Assessment and Performance Improvement (QAPI)," stated, "... QAPI ... Purpose to use performance improvement activities to track adverse client events, analyze their causes and implement preventive actions ...." Review of the agency QAPI binder on 02/01/2023, failed to evidence the QAPI activities led to immediate corrective action of any identified problems that directly or potentially threaten the health and safety of patients.		and safetyof patients. (On-going) Administrator instructed Director of Nursing on need toprovide staff education/training on problems that are identified in the QAPIprogram. Completed2/21/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	During an interview on 02/02/2023, at 10:50 AM, the director of nursing indicated education and staff training should be implemented when problems are identified on the performance improvement activities.			
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the home health agency failed to conduct at least one performance improvement project yearly. Findings include: Record review evidenced an undated agency policy received	G0658	G0658 Administrator instructed Director of Nursing in need toconduct at least one perform improvement project yearly. Completed 3/1/23 Administrator/Director of Nursing will determine what theperformance improvement project for 2023 will be. Completed by 3/1/23 Administrator/Director of Nursing will determine eachJanuary what the performance improvement project will be for the year.(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-03-01

	on 02/01/2023, titled, "Quality Assessment and Performance Improvement," stated, "... Performance Improvement Projects ... must conduct performance improvement projects. The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the agency services and operations ...." Record review of the agency QAPI (quality assessment performance improvement) binder on 02/01/2023, failed to evidence a performance improvement project. During an interview on 02/02/2023, at 10:36 AM, the director of nursing indicated there was not a performance improvement project and didn't realize the agency needed to have a performance improvement project.			
G0686	Infection control education 484.70(c) Standard: Education. The HHA must provide infection control	G0686	G0686 Director of Nursing/designee will provide infection controleducation to all current employees. Completed by	2023-03-01

	education to staff, patients, and caregiver(s). Based on record review and interview, the home health agency failed to ensure they provided infection control education to all staff annually. Findings include: Record review evidenced an undated agency policy received on 02/01/2023, titled, "Infection Control Education/Training," which stated, "For each 12 months of employment, all employees and contractors who have contact with the clients in the clients' resident shall complete in-service training about infection control practices to be used in the home ... Employee education shall occur at the time of employment ... and annually ... Training records will include dates, contents of the training sessions, names and qualifications of instructors, and the names and job titles of attendees...." Record review evidenced an undated agency policy received on 02/01/2023, titled, "In-Service Education/Staff Development," which stated, "... All staff members must attend ... mandatory in-service		3/1/23 Administrator will ensure all employees receive infectioncontrol training annually. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	programs. The mandatory in-service training programs include: OSHA [occupational safety and health administration]/Bloodborne Pathogens and infection control ...." Record review on 02/01/2023, failed to evidence the administrative staff #2, #3, #4, and Registered Nurse #1 received annual infection control training. During an interview on 02/01/2023, at 11:50 AM, the director of nursing indicated she didn't know infection control training had to be done annually.			
G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here	G0687	G0687 Director of Nursing will in-service staff on the additionalprecautions needed to mitigate the transmission and spread of COVID-19, for allstaff who are not fully vaccinated. These precautions may include requiringunvaccinated staff to follow additional CDC (center for disease control)recommended	2023-03-03

	as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and (ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section. (3) The policies and procedures must include, at a minimum, the following components: (i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination		precautions, such as adhering to universal source control andphysical distancing measures in areas that are restricted from patient access,reassigning unvaccinated staff to non-patient areas, or to duties which limitexposure to those most at risk, or requiring unvaccinated staff to use a NIOSH(National Institute for Occupational Safety and Health) N95 (filteringfacepiece respirator) or equivalent or higher-level respirator for sourcecontrol, when they are providing direct care to or otherwise interacting withpatients. Any unvaccinated employees inthe office will wear a well-fitting mask. These additional precautions have been putinto COVID policy. Completed by 3/3/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients; (ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (d)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law;			

	(vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Based on observation, record			

review and interview, the home health agency failed to implement policies and procedures to ensure the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who were not fully vaccinated.

Findings include:

Record review of an agency policy dated 11/09/2021, titled, "Mandatory COVID-19 Vaccine Policy and Procedure," stated, "... Covered Staff Members who are granted exemptions ... will be required to take the following steps as a reasonable accommodation in place of becoming Fully Vaccinated. If Staff members, clinical or clerical, have been in direct contact with a person that is actively symptomatic and/or tested positive for COVID-19 they are to monitor for any signs and symptoms for 72 hours, using proper general precautions around patients ... If a staff member, clinical or clerical, is symptomatic [fever chills, body aches, etc.] they are not to see patients in the field or be present in the office without testing ...."

Review failed to evidence a

	contingency plan developed to mitigate the spread of COVID-19 infections that may include: requiring unvaccinated staff to follow additional CDC (center for disease control) recommended precautions, such as adhering to universal source control and physical distancing measures in areas that are restricted from patient access, reassigning unvaccinated staff to non-patient areas, or to duties which limit exposure to those most at risk, requiring at least weekly testing for unvaccinated staff, or requiring unvaccinated staff to use a NIOSH (National Institute for Occupational Safety and Health) N95 (filtering facepiece respirator) or equivalent or higher-level respirator for source control, regardless of whether they are providing direct care to or otherwise interacting with patients. Review of an untitled agency document, dated 01/21/2022, identified as the COVID-19 vaccination exemption stated, "... Employees understand that they may be required to take additional steps to protect themselves and other from			

	contracting and spreading COVID-19 when in the field or office … Employee has been given a copy of the Additional Precautions that all unvaccinated staff members are required to follow ….” During an observation on 01/26/2023, at 10:38 AM, unvaccinated administrative staff #2, #3, and governing body member A were observed without a face mask. During an observation on 01/26/2023, at 1:00 PM, unvaccinated administrative staff #1 was observed without a face mask after arriving to the agency office. During an observation on 01/30/2023, at 9:42 AM, unvaccinated home health aide #1 entered the patient’s home without a mask. Home health aide #1 put on a surgical mask at 9:50 AM. During an interview on 01/26/2023, at 3:30 PM, the administrator indicated the home health agency doesn’t have a COVID-19 policy related to unvaccinated staff. The administrator indicated there			

	mitigate transmission of COVID-19 for staff not fully vaccinated. The administrator indicated the agency used standard precautions. During an interview on 01/26/2023, at 3:45 PM, the administrator indicated governing body member A was the owner of the home where the home health agency was located in and provided maintenance for the home. The administrator indicated governing body member A doesn't believe in the vaccine. During an interview on 01/26/2023, at 3:45 PM, the alternate administrator indicated governing body member A was not a direct employee, and the home health agency does not have documentation of governing body member A vaccine status. During an interview on 02/01/2023, at 11:48 AM, the director of nursing indicated no masking in the patient's home was required for the staff that was vaccinated or unvaccinated for COVID-19. The director of nursing indicated she thought the additional precautions			

	related to COVID-19 were up to the individual agency. The director of nursing indicated the agency was not tracking the status of governing body member A, and indicated it was an oversight and they would begin tracking governing body member A vaccination status. During an observation on 02/02/2023, at 10:25 AM, administrative staff #1, #2, #3, and #4 were observed not wearing masks.			
G0710	Provide services in the plan of care 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; Based on record review and interview, the home health agency failed to ensure they provided services ordered by the physician as indicated in the plan of care in 4 of 5 clinical records reviewed with physical therapy services. (#1, #4, #7, #8) Findings include: 1. Record review of an undated agency policy received on 02/01/2023, titled, "Care Plans,"	G0710	G0710 Director of Nursing will in-service clinicians onrequirement to provide services as ordered by MD on the plan of care. Completed by 3/1/23 Administrator/Director of Nursing/designee will audit allvisit notes submitted weekly to ensure they reflect the services ordered on theplan of care. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) Director of Nursing will	2023-03-01

	stated, "... Each client will have a care plan on file that address their identified needs and the agency's plan to respond to those needs. This plan is developed with the client and family, as indicated, and is based on services needed to achieve specific measurable goals ... The interventions shall correspond to the problems identified, services needed and the client goals for the episode of care ... The Care plan shall include ... Reasonable, measurable, and realistic goals as determined by the assessment and client expectations. A list of specific interventions with plans for implementation ...." 2. Record review of an undated agency policy received on 02/01/2023, titled, "Skilled Professional Services," stated, "... Skilled professional services include skilled nursing services, physical therapy ... Skilled professionals who provide services to home health agency clients ... must participate in the coordination of care ... Skilled professionals must assume responsibility for ... ongoing interdisciplinary assessment of the client.		patienthas a pain goal pain level before visit and after visit is documented. Evaluations/re-evaluations/discharges must have documentation of pain assessment. If pain goal is not being met MD isto be notified. Completed by 3/1/23 Director of Nursing/designee will audit all therapydocumentation submitted weekly to ensure there is documentation of pre/postpain level and a pain assessment. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these correctiveactions to ensure that this deficiency is corrected and will not recur.	

	Development and evaluation of the plan of care in partnership with the client ... Providing services that are ordered by the physician as indicated in the plan of care ...." 3. Record review of an undated agency policy received on 02/01/2023, titled, "Pain Assessment/Management," stated, "... The Agency will work with the client ... to establish a goal for pain relief and develop and implement a plan to achieve that goal ... Pain is assessed on every home visit and documented on a pain or symptom flow sheets. Documentation will include the effectiveness of all pain interventions ... The documentation will include what interventions were used and describe response/effectiveness of care ... The nurse/therapist will use a standardized agency accepted pain assessment tool that evaluates the location, duration, severity (rating scale), alleviating factors, exacerbating factors, current treatments (medication and non-medication) and response to treatment ...." 4. Clinical record review on			

	01/27/2023, for patient #1, start of care 12/07/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/07/2022-02/04/2023, which indicated the patient was oriented and lived alone. The plan of care indicated physical therapist to determine the patient's condition, plans and rehab. Review evidenced an agency document dated 12/07/2022, titled, "OASIS [outcome and assessment information set]-D1 Start of Care," identified as the comprehensive assessment, which indicated intensity of pain at level 5 [on a scale of 0 - 10 with 0 being no pain and 10 the most severe], pain level at 3 after medication. The comprehensive assessment indicated the patient's pain goal was to lessen pain through physical therapy. Review evidenced agency documents titled, "PTA [physical therapist assistant] Visit," for 12/16/2022, 01/09/2023, 01/11/2023, 01/18/2023, 01/23/2023, and 01/27/2023 which failed to evidence pre			

	scale documentation. The PTA Visits indicated pain to the knees increased by movement, relieved by rest and medication, and interferes with walking. 5. Clinical record review on 01/30/2023, for patient #4, start of care 12/19/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/19/2022-02/16/2023, which indicated the physical therapist was to determine the patient's condition, plans and rehab. Review of agency documents titled, "PTA Visit," dated 12/28/2022, indicated pain level at intensity 6 pre and post therapy; dated 12/28/2022, indicated pain level at intensity 7 pre and post therapy; dated 01/03/2023, indicated pain level at intensity 6 pre and post therapy; dated 01/05/2023, indicated pain level at intensity 7 pre and post therapy; dated 01/10/2023, indicated pain level at intensity 6 pre and post therapy; and 1/26/2023, indicated pain level at intensity 5 pre and post therapy. 6. Clinical record review on			

	01/30/2022, for patient #7, start of care 05/11/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 09/08/2022-11/06/2022, which stated, "... Maintenance physical therapy to determine the patient's condition, plans and rehab ...." Review of an agency document dated 09/07/2022, titled, "OASIS-D1 Recertification," identified as the comprehensive assessment, indicated the patient's pain intensity at 4 through the day and night indicating movement and sitting up makes pain worse. The patient's pain goal was the patient will have comfort while in bed. Review of an agency document dated 10/03/2022, titled, "PT [physical therapy] Re-Evaluation," failed to evidence pain assessment. Review of an agency document dated 10/31/2022, titled, "PT Discharge," failed to evidence pain assessment.			

	Review failed to evidence services were provided as indicated in the plan of care. 7. Clinical record review on 01/30/2023, for patient #8, start of care 05/17/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 11/13/2022-01/11/2023, which indicated physical therapy to determine the patient's condition, plans and rehab. Review of an agency document dated 11/11/2022, titled, "OASIS-D1 Recertification," identified as the comprehensive assessment, indicated the patient's pain intensity to be at 8, and the patient's pain goal was to be 1-2. Review of an agency document dated 11/14/2022, titled, "PTA Maintenance," indicated the patient's pain intensity to be at 4 to the knee, the document failed to indicate the post therapy intensity. Review of an agency document dated 11/23/2022, titled, "PTA Maintenance," indicated pre-therapy pain			

	document failed to indicate the post therapy intensity. 8. During an interview on 01/31/2023, at 1:10 PM, the director of nursing indicated pain level should be documented at each physical therapy visit. 9. During an interview on 01/31/2023, at 1:48 PM, the administrator indicated clinicians should utilize pain scale to document frequency, duration, medication, and pain relief at each visit. 10. During an interview on 02/01/2023, at 11:40 AM, the director of nursing indicated patient's pain level should be reported to the skilled nurse if not meeting the patient's pain goals. 410 IAC 17-14-1(a)(1)(H)			
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and	G0718	G0718 Director of Nursing will in-service clinicians onrequirement to communicate with all physicians involved in the current plan ofcare. Completed 2/17/23	2023-02-17

	interview, the home health agency failed to ensure communication with all physicians involved in the current plan of care for 1 of 1 clinical records reviewed of patients receiving warfarin (blood thinning medication). (#6) Findings include: Record review of an undated agency policy received on 02/01/2023, titled, "Coordination of Client Services," stated, "... Agency will communicate with ALL physicians who are writing orders regarding the plan of care ...." Clinical record review on 01/30/2023, for patient #6, start of care 01/18/2022, evidenced an agency document titled," Home Health Certification and Plan of Care," for certification period 01/13/2023-03/13/2023, which indicated the patient was receiving warfarin. The plan of care indicated the skilled nurse will check the INR (blood level to monitor bleeding time) and call results to the physician. Review of an agency document dated 01/19/2023, titled, "LPN [licensed practical nurse] Skilled Nursing Visit," indicated doctor B was notified of INR results.		Administrator/Director of Nursing/designee will audit allvisit notes submitted weekly to ensure if there are issues documented there isdocumentation all physicians involved in the current plan of care are notified.Once 100% compliance is achieved 10% will be audited quarterly to ensurecompliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	The plan of care was signed by doctor C. Review failed to evidence the home health agency coordinated doctor C's warfarin orders for patient #6 with doctor B. During an interview on 02/01/2023, at 12:15 PM, the administrator indicated doctor C monitors the INR level. The administrator indicated doctor B and doctor C are aware of each other. 410 IAC 17-14-1(a)(1)(G)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on observation, record review and interview, the home health agency failed to ensure the home health aide provides services that were included in the plan of	G0800	G0800 Director of Nursing will in-service aides on requirement toprovide all services and only services included on the aide plan of care. If atask isn't done aide needs to indicate why and is to notify case manager. Completed2/17/23 Director of Nursing/designee will audit all aide notessubmitted weekly by comparing them to aide plan of care to ensure plan is beingfollowed. If a task isn't	2023-02-17

	care in 1 of 2 home visits with a home health aide. (#2) Findings include: Record review evidenced an undated agency policy received on 02/01/2023, titled, "Home Health Aide Care Plan," which stated, "... All home health aide staff will follow the identified plan. The Care Plan will be available to all persons involved in the client care ...." Record review evidenced an undated agency policy received on 02/01/2023, titled, "Home Health Aide: Documentation," which stated, "... Home Health Aides will document care/services provided on the home health aide chart form. Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan ...." Clinical record review on 01/27/2023, for patient #2, start of care 06/07/2022, evidenced an agency document titled, "Aide Care Plan," for dates 12/04/2022-02/01/2023, which indicated home health aide duties to perform included, but not limited to, change linens every visit, make bed every visit,		ordered task wasn'tprovided and notify case manager. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	and oral hygiene every visit. Observation of a home health aide visit on 01/31/2023, at 9:00 AM, evidenced the bed linens were not changed, the bed was not made, and oral hygiene was not performed. During an interview on 01/31/2022, at 10:04 AM, patient #2 indicated the home health aide does not ever change the bed linens or make the bed. During an interview on 02/02/2023, at 10:29 AM, the director of nursing indicated the home health aide knows what care was to be provided based on the aide care plan. The director of nursing indicated if care or tasks were not performed by the home health aide it should be documented what was not performed and the home health agency should be notified.			
G0808	Onsite supervisory visit every 14 days 484.80(h)(1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or	G0808	G0808 Director of Nursing will in-service clinicians onrequirement to supervise home health aide at least every 14 days in cases wherepatient is	2023-03-03

	speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit. Based on record review and interview, the home health agency failed to ensure they provided a supervisory aide visit no less frequently than every 14 days for patients receiving home health aide services in 1 of 3 active patients who received home health aide services. (#4) Findings include: Record review evidenced an undated agency policy received on 02/01/2023, titled, "Home Health Aide Supervision," which stated, "... Supervisory visits of Home Health Aides shall be according to the following frequency: When skilled services are being provided to a client, a Registered Nurse/Therapist must make a supervisory visit to the client's resident no later than every 14 days [either when the Home Health Aide is present to observe and assess care delivery, or when the Home Health Aide is absent] to assess relationships and determine whether goals are being met ...		also receiving therapy or nursing. Completed 3/3/23 Director of Nursing/designee will audit all supervisory notessubmitted weekly to ensure they are being done at least every 14 days. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	Supervisory visits are to be documented in the client's chart on the Home Health Aide Supervision Form ... The aide visit record is reviewed by the supervising nurse/therapist to assure services are being provided according to the care plan...." Clinical record review on 01/30/2023, for patient #4, start of care 12/19/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 12/19/2022-02/16/2023, which indicated an order for home health aide services 2 times per week for 7 weeks. Review indicated patient had visits by the home health aide 12/26/2022, 12/30/2022, 01/02/2023, 01/06/2023, 01/09/2023, 01/20/2023, 01/23/2023, 01/27/2023, and 01/30/2023. Record review failed to evidence any supervisory visits. During an interview on 02/01/2023, at 11:30 AM, the director of nursing indicated there were no supervisory aide visits documented and she			

	supervisory visits were not in the chart.			
G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on observation, record review and interview, the home health agency failed to ensure services were provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Findings include: Record review evidenced an undated agency policy received on 02/01/2023, titled, "Equipment and Supplies Management," which stated, "...Equipment and/or supplies will be properly stored, cleaned, and maintained by Agency staff before client usage ... All agency staff is required to read packaging labels for directions regarding temperature effect on items. Manufacturer's direction will be adhered to ...." During an observation on	G0984	G0984 Director of Nursing will in-service any clinicians who givePPD's that when they open a vial of TB serum they must date the vial whenopened. Vial is only good for 30 days once opened and must be discarded after30 days. Completed 2/3/23 Director of Nursing will check opened TB serum vials weeklyto ensure opened vial has not been opened more than 30 days. (On-going) We are no longer going to be giving TB tests. Our staff will have to go to either ourMedical Directors office or the Department of Health. The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-02-03

	01/27/2023, at 12:30 PM, an agency refrigerator was evidenced with Sanofi Tuberculin Purified Protein (a skin test to check for an infectious lung disease) . The Tuberculin Purified Protein vial was opened and in the manufacturer's box. The manufacturer's box indicated discard open product after 30 days. There was no date documented when vial was opened on the manufacturer box or the vial. During an interview on 01/27/2023, at 12:30 PM, the administrator indicated he did not know the Tuberculin Purified Protein had to be discarded 30 days after opening of the vial.			

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael R Dodson	Adminstrator	2/24/2023 3:29:17 PM