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	03/23/2023

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: 03/20/2023-03/23/2023 Census: 40 At this Emergency Preparedness Survey, Sunrise Home Health Care Services Inc., was found to be in 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 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.”	

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 emergency plan was discussed with the patient and/or caregiver and a copy was provided to the patient/caregiver in 1 of 1 assisted living visits. (Patient #2) Findings include: Record review evidenced an agency policy dated 03/2023, titled, "Emergency Management Policy," which stated, "Agency will have an identified plan in	E0017	E0017 Director of Nursing willin-service clinicians on requirement to complete a comprehensive individualizedemergency care plan in the patient's preferred language. 4/21/23 Director of Nursing will havecomprehensive individualized emergency care plan translated into Spanish forpatient #2, cited in survey. It will be explained to patient/family, signatureobtained indicating patient understands the information and a copy left in home.4/14/23 Director of Nursing/designeewill audit all admissions done weekly to ensure an individualized emergencycare plan has been created in patient's preferred language. (On-going) Director of Nursing willin-service clinicians on requirement to document patient/family was instructedon the emergency preparedness information, whether they verbalize understandingand	2023-04-21

	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 will develop and maintain a written emergency management plan describing the process for disaster readiness and emergency management ….” Clinical record review on 03/22/2023, for patient #2, start of care 01/31/2021, evidenced an agency document dated 02/28/2023, titled “Patient Evacuation Planning: Emergency Preparedness,” which indicated patient refused to sign the document. Patient's primary language was Spanish. Observation during a home visit for patient #2 on 03/22/2023, failed to evidence an individualized emergency preparedness plan. During an interview at the home visit for patient #2, on 03/22/2023, at 9:40 AM, the patient’s family member who resided with the patient indicated there had been no emergency preparedness education provided by the		folder. This is to be documented. 4/21/23 Director of Nursing/designeewill audit all admissions done weekly to ensure there is documentationpatient/family was instructed on the emergency preparedness information,whether they verbalize understanding and that a copy was left in the homefolder. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	home health agency. During an interview on 03/22/2023, at 12:50 PM, the administrator indicated emergency preparedness training paperwork should be gone over with patient so the patient understands, then the patient signed to confirm understanding and the emergency preparedness information for the patient should be left in the patient's home.			
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.	E0037	E0037 Administrator/designee willin-service all current employees on agency emergency preparedness training anddocumentation of training is placed in their file. 4/21/23 Administrator will have LPN#1, PTA #1 & #3 and PT #4, cited in survey, sign emergency trainingindicating they received training. 4/21/23	2023-04-21

	(ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with		Administrator willre-instruct PTA #1 and HHA #1, cited in survey, on the training and who theemergency coordinator is. 4/14/23 Administrator will ensure allnew employees receive training on agency emergency preparedness training attime of hire and documentation of training is placed in their file. (On-going) Administrator/designee willensure all staff are trained on emergency preparedness at least every two yearsand documentation is placed in their file. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	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 training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, maintain documentation of all emergency preparedness training and demonstrate staff knowledge of emergency procedures.

Findings include:

During an interview on 3/20/2023, at 3:55 PM, the alternate administrator indicated all staff should have received emergency preparedness training since February.

	During an interview on 3/21/2023, at 2:30 PM, the alternate administrator indicated staff should have read the information attached to the sign-in sheet for their education. Record review of an undated agency policy received on 03/23/2023, titled, "Emergency Disaster Plan Orientation and Training," stated, "All employees will be oriented to the Emergency Disaster Plan (EDP), including their responsibilities in carrying out the plan. This orientation will be provided upon hire-during orientation, and will participate in agency emergency preparedness plan in-service education sessions annually ... Initial Emergency Disaster Preparedness Training will be provided to all new and existing staff, individuals providing services under arrangement and volunteers consistent with their expected roles in the agency ... 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 an agency document on 03/20/2023, identified as the emergency preparedness training log signed by staff on 02/24/2023 and 03/01/2023, failed to evidence LPN (licensed practical nurse) #1, PTA (physical therapy assistant) #1 and #3, and PT (physical therapist) #4 had signed the training log.

During an interview on 03/20/2023, at 3:10PM, the alternate administrator indicated she would need to follow up with the staff to come to office to sign the emergency preparedness training log.

During an interview on 03/21/2023, at 1:42 PM, PTA #1 indicated they had come to home health agency office to sign paperwork but unaware of what training what done. PTA #1 indicated unaware if emergency preparedness training was done. PTA #1 indicated unaware of the name of home health agency's emergency coordinator.

During an interview on 03/22/2023, at 9:40 AM, home

	health aide #1 indicated had training in the office on the computer but unable to recall any details of what training was done on the computer for emergency preparedness. Home health aide #1 indicated was unsure if had in-services in the home health agency office or who provided the in-services. During an interview on 03/22/2023, at 12:50 PM, the administrator indicated the recent home health agency training regarding emergency preparedness was done in the office on an individual basis and the staff were given policies to review. The administrator indicated the emergency preparedness training was not completed on the computer.			
G0000	INITIAL COMMENTS This survey was a Post Condition Revisit survey of a home health agency. Survey Dates: 03/20/2023-03/23/2023 Facility: 012486	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	

	Census: 40 12 month unduplicated census: 88 21 standards were corrected, 10 new standards are cited, 15 standards were recited, one condition of participation was recited and condition of participation 42 CFR §484.102 Emergency Preparedness was corrected. During this Federal Post Condition Revisit Survey, Sunrise Home Health Care Services, Inc., was found to be out of compliance with Condition of Participation §484.60 Care Planning, Coordination of Services, and Quality of Care. This deficiency report reflect State Findings cited in accordance with 410 IAC 17. Quality review completed 03/30/2023		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." 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.	
G0374	Accuracy of encoded OASIS data 484.45(b)	G0374	G0374 Directorof Nursing will in-service all clinicians on	2023-04-20

	Standard: The encoded OASIS data must accurately reflect the patient's status at the time of assessment. Based on record review and interview, the home health agency OASIS (outcome and assessment information set) data failed to accurately reflect the patient's status at the time of assessment in 2 of 3 clinical records reviewed with a recertification date after 03/01/2023. (Patient #1, #6) Findings include: Clinical record review on 3/21/2023, for Patient #6, start of care 3/2/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 3/2/2023-4/30/2023, which indicated the patient's medications included aspirin (a medication used to treat pain and/or fever), Lasix (a medication used to remove excess fluid from the body), Medrol (a steroid medication used to treat inflammation), and metoprolol (a medication used to treat high blood pressure). Review of an agency document titled "Medication Interactions" dated 3/6/2023, indicated there were potential drug interactions between aspirin and lasix		completing the OASIS comprehensiveassessment accurately to reflect the patient's actual status at time ofassessment. This includes all medications prescribed/used. 4/20/23 Directorof Nursing/designee will audit all current patient comprehensive assessments toensure they accurately reflect the patient's status including all medicationsprescribed/used. 4/20/23 Directorof Nursing will instruct clinician who did OASIS on 3/17/23 for patient #1 and#6, cited in survey, to correct OASIS to reflect there were medication issuesfound. 4/20/23 Directorof Nursing/designee will audit all comprehensive assessments submitted weeklyto ensure they accurately reflect the patient's current status. Once 100%compliance is achieved 10% will be audited quarterly to ensure compliance ismaintained. (On-going)	

	potentially causing decreased effects of lasix, aspirin and Medrol potentially causing toxicity, and aspirin and metoprolol potentially impairing effect of metoprolol. Review of the start of care comprehensive assessment dated 3/2/2023, indicated the drug regimen review failed to identify potentially significant medication issues. Review failed to evidence the OASIS data was accurately reflected. During an interview on 3/22/2023, at 11:52 AM, the administrator indicated the OASIS assessment should have been marked to correctly indicate issues were identified during the drug review. Record review of an undated agency policy received on 03/23/2023, titled, "Encoding and Reporting OASIS Data," stated, "… The encoded OASIS must accurately reflect the client's status at the time of assessment …." Clinical record review on 03/21/2023, for patient #1, evidenced an agency document dated 03/17/2023, titled, "OASIS-E Resumption of Care,"		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	in section titled, "(M2001) Drug Regimen Review," indicated during a complete drug regimen review there were no potential clinically significant medications issues found. Review in section titled, "(M2003) Medication Follow-up," indicated no answer was checked regarding the physician being notified of the clinically significant medication issues. Clinical record review of an agency document dated 03/17/2023, titled, "Patient Medication Record," indicated the physician was contacted regarding the medication discrepancies and an interaction list was sent to the physician for review. Review of a web-based source on 03/21/2023, http://drugs.com/interations-check.php?drug_list, evidenced major drug interactions between potassium chloride and dicyclomine (medication for muscle spasms in the stomach) which may increase irritant effects on the stomach and cause bleeding and ulcers,			

	diphenhydramine (medication for allergies) which may increase irritant effects on the stomach and cause bleeding and ulcers, and potassium chloride and lisinopril (blood pressure medication) which may cause elevated potassium levels which can develop into kidney failure, muscle paralysis, and irregular heart rhythm. Review evidenced duplicate medications between Exelon (medication for dementia) and Rivastigmine (generic name for Exelon), and Depakote (seizure medication) and Divalproex (generic name for Depakote). Review failed to evidence the OASIS data sent was accurate regarding no significant medication issues found. During an interview on 03/22/2023, at 12:15 PM, the administrator acknowledged the OASIS data sent was inaccurate and indicated the major drug interactions should have been documented.			
G0412	Written notice of patient's rights	G0412	G0412	2023-04-03

	484.50(a)(1)(i) (i) Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities; Based on record review and interview, the home health agency failed to provide written notice of the patient's rights and responsibilities understandable by a person who has limited English proficiency in 1 of 1 clinical records reviewed with an assisted living facility visit. (Patient #2) Findings include: Record review of an agency policy dated 09/2019, titled, "Patient's Bill of Rights," stated, "... All communications must be presented in a language that the client understands ...." Clinical record review of an agency document dated 02/28/2023, titled, "OASIS-E [outcome and assessment information set] indicated the patient's primary language to be Spanish. Review of an agency document		Director of Nursing will have patient rights translated intoSpanish for patient #2, cited in survey, and will provide them to patient. Thiswill be documented in patient chart. 4/30/23 Director of Nursing/designee will review all admissions doneweekly to ensure if patient's primary language is not English the clinicianwill take patient copy of their patient rights translated in their primarylanguage. (On-going) Director of Nursing/designee will ensure patient rights areprovided to patients in their preferred language. Clinician will document inchart patient received their rights in their preferred language. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	01/13/2023, titled, "Consent to Provide Home Health Care Services to Client," indicated the patient had reviewed and read the Patient's Bill of Rights and was written in English. During an assisted living facility visit on 03/20/2023, at 9:00 AM, home health aide #1 interpreted for patient #2, and the patient indicated she was only able to read and write in Spanish. During an interview on 03/23/2023, at 12:07 PM, the administrator indicated the patient's consent form should have been written in Spanish for the patient. 410 IAC 17-12-3(a)1(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. Deficiency corrected by agency on 03/03/2023	G0418	G-0418 This ELEMENT is NOT MET as evidenced by:Deficiency corrected by agency on 03/03/2023Deficiency corrected by agency on 03/03/2023	2023-04-10

	Deficiency corrected by agency on 03/03/2023			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review and interview the home health agency failed to review all medications the patient was currently using in order to identify any potential adverse effects and drug reactions, including significant drug interactions, and duplicate drug therapy in 2 of 7 clinical records reviewed. (Patient #1, #2) Findings include: 1. Record review of an undated agency policy received on 03/23/2023, titled, "Medication Profile," stated, "... At the time of admission, the admission professional shall check all medications a client may be taking to identify possible ineffective drug therapy or adverse reactions, significant	G0536	G0536 Director of Nursing willin-service clinicians on requirement to review all medications patient takes aspart of the comprehensive assessment. That is to include identifying anypotential adverse effects, drug reactions, significant drug interactions, andduplicate drug therapy. If issues are found assessment is to indicate issueswere noted and MD was notified. 4/14/23 Director of Nursing/designeewill audit all current patient charts to ensure medications were reviewed aspart of the comprehensive assessment and include identification of anypotential adverse effects, drug reactions, significant drug interactions, andduplicate drug therapy. If issues are found assessment is to indicate issueswere noted and MD was notified. 4/20/23 Director of Nursing/designeewill audit all comprehensive assessments	2023-04-20

	contraindicated medication. The clinician shall promptly report any identified problems to the physician ... The nurse shall review all medication effectiveness and interactions to ensure appropriateness and identify potential complications. The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication ...." 2. Clinical record review on 03/21/2023, for patient #1, start of care 06/29/2022, evidenced an agency document dated 03/17/2023, titled, "Patient Medication Record," which indicated the physician was sent an interaction medication list. Review of the paper chart failed to evidence the physician was notified of the patient's medication interactions and duplicate medications. Review of an agency document dated 03/17/2023, titled, "Patient Medication Record," indicated the patient's medications were Ondansetron (medication for nausea/vomiting), Flonase		submitted each week to ensure theyinclude a review of medications to identify any potential adverse effects, drugreactions, significant drug interactions, and duplicate drug therapy. If issuesare found assessment is to indicate issues were noted and MD was notified. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained. (On-going) Director of Nursing willensure MD for patient #1, cited in survey, was notified via fax of medicationinteractions and duplicate medications. Pt #3 was transferred 3/23/23. 4/14/23 Director of Nursing willensure medication profile for patient #2, cited in survey, is revised toaccurately reflect medications being taken. Verbal order will be obtained fromMD to reflect the correct dosage of Omeprazole and Sucralfate. 4/21/23 Director of Nursing willin-service clinicians that drug interactions must be run for all meds and faxedto MD.	

	Carbonate Antacid (heartburn medication), Klor-Con (potassium chloride supplement), Triple Antibiotic (antibiotic ointment), Dicyclomine (medication for stomach cramps), Albuterol sulfate inhaler (inhaled medication for lungs), Symbicort (inhaled medication for lungs), Furosemide (diuretic), Cerovite (vitamin), Diclofenac cream (topical pain relieving cream), Senna-Plus (stool softener), Geri-Lanta (medication for indigestion), Hydrocortisone cream (topical itch relief cream), Loperamide (medication for diarrhea), Milk of Magnesia (laxative), FeroSul (iron supplement), Hydrochlorathiazide (diuretic), Lantanoprost (eye medication), Vitamin A & D (ointment for skin), Triple Paste (skin protecting paste), Biofreeze (topical pain reliever), Olanzapine (psychiatric medication), Rivastigmine transdermal (patch for dementia), Aspirin, Atropine opthalmic (eye drops), Chlorhexidine gluconate (reduces inflammation of the gums), Divalproex (seizure medication), Isopto Atropine Opthalmic (eye drops), Janumet		Fax cover sheet must indicate interactions were faxed. 4/14/23 Director of Nursing/designeewill review all faxes sent to MD regarding drug interactions to ensure itindicates 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.	

	(diabetic medication), Pravastatin (cholesterol lowering medication), Prednisolone Opthalmic (eye drops), Timolol (eye drops), Acetaminophen (pain reliever), Diphenhydramine (medication for itching, rash), Guaifenesin-DM (cough syrup), Exelon patch (patch for dementia), Lisinopril (blood pressure medication), Voltaren (topical pain reliever), and Depakote (seizure medication). Review of a web based source on 03/21/2023, http://drugs.com/interactions-check.php?drug-list, evidenced the following 3 major drug to drug interactions between medications on patient #1's medication list: potassium chloride and dicyclomine (medication for muscle spasms in the stomach) may increase irritant effects on the stomach and may cause bleeding and ulcers, potassium chloride and diphenhydramine (medication for allergies) may increase irritant effects on the stomach and may cause bleeding and ulcers, and potassium chloride and olanzapine (medication for mental illness) may cause high level of potassium that can lead to kidney failure, muscle			

paralysis and irregular heart rhythm.

Review evidenced duplicate medication between Exelon patch (medication for dementia) and Rivastigmine patch (generic name for Exelon patch), and Depakote (seizure medication) and Divalproex (generic name for Depakote).

During an interview on 03/17/2023, at 12:10 PM, administration staff #3 indicated the medication interaction/duplication list was not faxed to the physician for review.

During an interview on 03/17/2023, at 12:10 PM, the administrator indicated the physician should have been notified of the medication interactions and duplicated medications.

3. Clinical record review on 03/22/2023, for patient #2, start of care 01/13/2021, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 03/04/2023-05/02/2023, which indicated medications included but not were not limited to Omeprazole (stomach

	medication) 40 milligrams one tablet daily, Sucralfate (stomach medication) 1 gram one tablet daily, and Alendronate (medication to treat weak bones) 70 milligrams one tablet once a week. Observation made during a home visit on 03/22/2023, from 8:50 AM-9:50 AM, of medications reviewed in the home included but were not limited to Lisinopril (blood pressure medication) 10 milligrams one tablet daily, Enalapril (blood pressure medication) 10 milligrams one tablet daily, Omeprazole 40 milligrams one tablet twice a day and Sucralfate 1 gram one tablet 3 times per day. Record review evidenced duplicate medications between Enalapril and Lisinopril. Review failed to evidence the Alendronate on the agency medication list. Review failed to evidence the dosage of Omeprazole, and Sucralfate were correctly indicated on the agency plan of care. Review failed to evidence all patient's medications were reviewed/updated and checked			

	health agency staff. 4. During an interview on 03/23/2023, at 12:14 PM, the administrator indicated the patient's medications should be reviewed at each nursing visit and updated on the plan of care and agency medication list. 410 IAC 17-14-1(a)(1)(B)			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the home health agency failed to provide services as ordered in the plan of care (see tag	G0570	G0570 See G572, G574, G580, G588, G590, G606. The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-04-21

	individualized plan of care the types of services, supplies, equipment required, all medications and treatments, patient-specific interventions, and measurable outcomes and goals identified by the home health agency (see tag G574); failed to ensure all treatments provided by agency staff were ordered by a physician (See tag G580); failed to ensure the plan of care was revised and reviewed by the patients primary care physician to include any changes (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 achieve 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). 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.			

G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to provide services as ordered in the plan of care in 2 of 7 clinical record reviewed. (Patient #6, #7) The findings include: 1. Review of an undated agency policy on 3/23/2023, titled "Plan of Care" stated, "... Home care services are furnished under the supervision and direction of the client's physician/allowed non-physician practitioner ...." 2. Clinical record review on	G0572	G0572 Director of Nursing will in-service staff that if a visit isnot made as scheduled the Director/designee is to be notified and missed visitreport is to be completed at that time if visit cannot be made up that week. 4/20/23 Director of Nursing/designee will audit all scheduled visitseach week against MD orders to ensure frequency is followed and if not there isdocumentation agency attempted to schedule the missed visit during that week.If unable to reschedule visit there is a missed visit report indicating why andMD was notified. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) Director of Nursing will in-service therapists on need toevaluate patient within 48hours of start of care. If	2023-04-20

	3/21/2023, for Patient #6, start of care 3/2/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification 3/2/2023 -4/30/2023, which indicated the patient was to receive 1 HHA [home health aide] visit a week for 8 weeks. Review failed to evidence the agency provided a HHA visit during the week of 3/4/2023. Review of the patient's electronic visit schedule on 3/21/2023, at 3:55 PM, indicated a HHA visit was scheduled for 3/6/2023, and the status of the visit was noted as "not started". Review of the patient's electronic visit schedule on 3/22/2023, at 11:59 AM, indicated a HHA missed visit was submitted for 3/6/2023, and indicated the patient refused the HHA visit. During an interview on 3/22/2023, at 11:59 AM, the administrative assistant indicated the HHA did not complete a visit on 3/6/2023, but entered a missed visit note earlier this morning into the		is to be notified of reason and this documented. 4/20/23 Director of Nursing/designee will audit all starts of caredone weekly to ensure if there are therapies ordered the therapy evaluation isdone within 48hours or there is documentation was notified of reason why notdone in 48hours. 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.	

	3/6/2023. The administrative assistant indicated the agency was not aware of the missed visit until the agency was completing payroll and noticed there was not a visit completed as scheduled that week when the administrative assistant instructed HHA to submit a missed visit note. During an interview on 3/22/2023, at 11:59 AM, the alternate administrator indicated she had no idea if there were any attempts to reschedule the HHA visit during the week of 3/4/2023. During an interview on 3/22/2023, at 11:59 AM, the administrator indicated there was no documentation of any attempts to reschedule the missed HHA visit on 3/6/2023. 3. Clinical record review on 3/21/2023, for Patient #7, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 2/24/2023-4/24/2023, which indicated the agency was to provide physical therapy (PT) services 2 times a week beginning the week of			

	2/25/2023. Review failed to evidence PT services were provided the week of 2/25/2023, and not until 3/4/2023. During an interview on 3/22/2023, at 10:51 AM, the administrator indicated PT should evaluate the patient within 48 hours of the start of care. The administrator indicated he did not know why PT services were not provided until 3/4/2023. 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; (viii) Activities permitted;	G0574	G0574 Directorof Nursing will in-service clinicians on the required elements of theindividualized plan of care. 4/14/23 (i) Allpertinent diagnoses; (ii) Thepatient's mental, psychosocial, and cognitive status; (iii) Thetypes of services, supplies, and equipment required;	2023-04-20

	(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 record review and interview, the home health agency failed to include an individualized plan of care that included the types of services, supplies, and equipment required, patient-specific interventions and measurable outcomes and goals identified by the home health agency in 7 of 7 clinical records reviewed. (Patient#1, #2, #3, #4, #5, #6, #7) Findings include: 8. Clinical record review on 3/21/2023, for Patient #6, start of care 3/2/2023, evidenced the start of care comprehensive assessment dated 3/2/2023, which indicated the patient used a wheelchair and walker. Review indicated the patient		(iv) Thefrequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitationpotential; (vii) Functionallimitations; (viii) Activitiespermitted; (ix) Nutritionalrequirements; (x) Allmedications and treatments; (xi) Safetymeasures to protect against injury; (xii) Adescription of the patient's risk for emergency department visits and hospitalre-admission, and all necessary interventions to address the underlying riskfactors. (xiii) Patientand caregiver education and training to facilitate timely discharge; (xiv) Patient-specificinterventions and education; measurable outcomes and goals identified by theHHA and the patient;	

	shoulder resulting in decreased range of motion, and review indicated the patient had a waffle mattress for pressure relief. Review evidenced an agency document titled "Home Health Certification and Plan of Care" for certification 3/2/2023 -4/30/2023, which indicated the patient's primary diagnosis was sarcoidosis (an inflammatory disease primarily affecting the lungs and lymph nodes). Review failed to evidence the plan of care was individualized to include interventions and goals related to the primary diagnosis. Review evidenced the patient was confined to the home needing the aid of supportive devices to include crutches and cane. Review failed to evidence the plan of care was individualized to include the patient-specific supportive devices required by the patient. Review indicated the patient was on oxygen continuously and had a secondary diagnosis of acute and chronic respiratory failure. Review failed to evidence the plan of care included goals related to the patient's oxygen use and respiratory status. Review failed		(xv) Informationrelated to any advanced directives; and (xvi) Anyadditional items the HHA or physician or allowed practitioner may choose toinclude. Directorof Nursing will ensure MDs for patients cited in survey are contacted andverbal order received to revise plan of care to add the missing elements citedin survey. 4/20/23 Directorof Nursing/designee will review all current patient plans of care by comparingit to the current comprehensive assessment to ensure they contain requiredelements. If a plan is missing an element the clinician will be instructed tocontact MD to obtain verbal order to add missing element(s) to the current planof care. 4/20/23 Directorof Nursing/designee will audit all comprehensive assessments submitted weeklyagainst plan of care submitted to ensure items listed in assessment are on theplan of care. Once 100% compliance is	

	to evidence the plan of care included a patient-specific goal related to the pain and failed to evidence the plan of care included the waffle mattress in the medical equipment. Review indicated the plan of care included 2 different parameters on when to notify the physician for the patient's temperature; one parameter indicated the physician was to be notified of a temperature greater than 100 degrees Fahrenheit and one parameter indicated the physician was to be notified of a temperature greater than 101 degrees Fahrenheit. Review failed to evidence the plan of care was individualized to include a patient-specific parameter for the temperature. During an interview on 3/22/2023, at 11:45 AM, the administrator indicated he did not see a goal in the patient's plan of care related to the primary diagnosis. At 11:47 AM, the administrator indicated the plan of care did not include a goal related to pain. At 11:50 AM, the administrator indicated the plan of care did not include goals related to the patient's oxygen use and respiratory		quarterly toensure compliance is maintained. (On-going) Directorof Nursing will in-service clinicians on making sure vital sign call parametersare specific and there aren't conflicting parameters. 4/20/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	administrator indicated the plan of care did not include the waffle mattress. 9. Clinical record review on 3/21/2023, for Patient #7, evidenced a start of care comprehensive assessment dated 2/24/2023, which indicated the patient used a cane and walker and failed to evidence the use of crutches and wheelchair. Review indicated the patient performed peritoneal dialysis (a treatment for kidney failure that uses the lining of your abdomen to filter the blood) every night at home, which was managed by Entity E. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 2/24/2023-4/24/2023, indicated the patient was confined to the home needing the aid of supportive devices to include crutches and wheelchair. Review failed to evidence the plan of care was individualized to include the patient-specific supportive devices required by the patient. Review indicated the patient's primary diagnosis was chronic lymphocytic			

	blood cells) and secondary diagnoses included, but were not limited to, diabetes (a chronic condition which affects the way the body processes blood sugar). Review indicated the patient was to check blood sugar levels every morning and failed to evidence patient-specific parameters for a normal blood sugar range and when to notify the physician. Review failed to evidence the plan of care included interventions and goals related to the primary diagnosis. Review indicated the physician was to be notified for systolic blood pressure (the pressure against the arteries when the heart contracts) when greater than 190. Review indicated the plan of care included 2 different parameters on when to notify the physician for the patient's temperature; one parameter indicated the physician was to be notified of a temperature greater than 100 degrees Fahrenheit and one parameter indicated the physician was to be notified of a temperature greater than 101 degrees Fahrenheit. Review indicated the plan of care included 2 different parameters on when to notify the physician for the			

	patient's pulse; one parameter indicated the physician was to be notified of a pulse greater than 100 beats per minute and one parameter indicated the physician was to be notified for a pulse greater than 110 beats per minute. Review failed to evidence the plan of care was individualized to include a patient-specific parameter for the temperature and the pulse. During an interview on 3/28/2023, at 11:57 AM, after an attempt was made on 3/23/2023, at 9:20 AM, Person F, nurse at Entity E, dialysis center, indicated the dialysis center and physician should be notified of a systolic blood pressure greater than 160. The plan of care failed to include the individualized blood pressure parameter. During an interview on 3/22/2023, at 10:30 AM, the administrator indicated the plan of care should include blood sugar parameters of 60-250. The administrator indicated the agency's standard blood pressure parameter for systolic blood pressure was 90-190. At 10:37 AM, the administrator indicated the plan of care did			

	not include a goal related to the patient's primary diagnosis. 10. During an interview on 3/22/2023, at 10:42 AM, the administrator indicated the verbiage in the plan of care related to the assistive devices was standard and carried over into the plan of care automatically by the software used for the electronic health record. At 10:52 AM, the administrator indicated the standard pulse parameter and the parameter that should have been included in the plan of care was to call the physician for a pulse greater than 100 beats per minute. At 11:57 AM, the administrator indicated the agency's standard temperature parameter and the parameter that should have been included in the plan of care was to call the physician for a temperature greater than 101 degrees Fahrenheit. 1. Record review evidenced an undated agency policy received on 03/23/2023, titled, "Plan of Care," stated, "... The Plan of Care shall be completed in full to include: ... The types of services, supplies, and equipment required ...			

	Patient-specific interventions and education; measurable outcomes and goals identified ...." 2. Clinical record review on 03/21/2023, for patient #1, start of care 06/29/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 02/24/2023-04/24/2023. Review indicated the plan of care included 2 different parameters on when to notify the physician for the patient's temperature; one parameter indicated the physician was to be notified of a temperature greater than 100 degrees Fahrenheit and one parameter indicated the physician was to be notified of a temperature greater that 101 degrees Fahrenheit. Review failed to evidence the plan of care was individualized to include a patient-specific parameter for temperature. 3. Clinical record review on 03/22/2023, for patient #2, start of care 01/13/2021, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification			

	period 03/04/2023-05/02/2023. Review indicated the plan of care included 2 different parameters on when to notify the physician for the patient's temperature; one parameter indicated the physician was to be notified of a temperature greater than 100 degrees Fahrenheit and one parameter indicated the physician was to be notified of a temperature greater that 101 degrees Fahrenheit. Review failed to evidence the plan of care was individualized to include a patient-specific parameter for temperature. 4. Clinical record review on 03/21/2023, for patient #3, start of care 12/23/2020, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 02/11/2023-04/11/2023. Review indicated the plan of care included 2 different parameters on when to notify the physician for the patient's temperature; one parameter indicated the physician was to be notified of a temperature greater than 100 degrees Fahrenheit and one parameter			

	indicated the physician was to be notified of a temperature greater that 101 degrees Fahrenheit. Review failed to evidence the plan of care was individualized to include a patient-specific parameter for temperature. 5. Clinical record review on 03/20/2023, for patient #4, start of care 11/28/2022, evidenced an agency document dated 03/07/2023, titled, "RN [registered nurse] Skilled Nurse Visit," which indicated the patient had on ted hose (stockings that help prevent swelling in the legs). Review of an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/27/2023-03/27/2023 failed to evidence the use of ted hose. Review evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/27/2023-03/27/2023. Review indicated the plan of care included 2 different parameters on when to notify the physician for the patient's			

	indicated the physician was to be notified of a temperature greater than 100 degrees Fahrenheit and one parameter indicated the physician was to be notified of a temperature greater that 101 degrees Fahrenheit. Review failed to evidence the plan of care was individualized to include a patient-specific parameter for temperature. Clinical record review on 03/21/2023, for patient #5, start of care 09/13/2022, evidenced an agency document dated 03/09/2023, titled, "OASIS-E [outcome and assessment information set] Recertification," which indicated the patient was wearing compression stockings to improve his circulation. Review of an agency document titled, "Home Health Certification and Plan of Care," for certification period 03/12/2023-05/10/2023, failed to evidence the use of the compression stockings. 6. During an interview on 03/22/2023, at 12:34 PM, the administrator indicated the compression stockings/ted hose			

	of care. 7. During an interview on 03/22/2023, at 10:50 AM, the administrator indicated the vital sign parameters on the patient's plan of care are standardized. 410 IAC 17-13-1(a)(1)(D)(ii)			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the agency failed to ensure services and treatments were administered only as ordered by a physician in 1 of 4 clinical record reviews with physical therapy assistant (PTA) services. (Patient #7) The findings include: Review of an undated agency policy on 3/23/2023, titled "Plan of Care" stated, "... Home care services are furnished under the supervision and direction of the client's physician ... Orders for therapy services shall include	G0580	G0580 Director of Nursing will in-service clinicians onrequirement to have an order for all services/treatments provided to patient.Therapists will be in-serviced on requirement for therapy orders to includespecific procedures and modalities to be used and the amount, frequency, andduration. 4/20/23 Director of Nursing/designee will audit all visit notessubmitted weekly to ensure services/treatments documented follow MD orders.Once 100% compliance is achieved, 10% will be audited quarterly to ensurecompliance is maintained. (On-going) Director of Nursing will ensure MD is contacted for patient#1, cited in survey, to obtain verbal	2023-04-20

	modalities to be used and the amount, frequency, and duration…." Clinical record review on 3/21/2023, for Patient #7, evidenced agency documents titled "PTA Visit" dated 3/7/2023, 3/14/2023, and 3/16/2023 and completed by the PTA, which indicated the PTA performed massage to the patient's neck and lower back for 15-20 minutes. Review failed to evidence an order for the massage treatment provided to the patient. During an interview on 3/22/2023, at 11:00 AM, the administrator asked why did there have to be an order for the PTA to provide massage? 410 IAC 17-13-1(a)		order for massage to the patient's neckand lower back. 3/23/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
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.	G0588	G0588 Director of Nursing willin-service clinicians on requirement to update/revise plan of care as needed toensure patient needs are met. 4/20/23 Director of Nursing willreview all current patient plans of care to ensure there are orders for	2023-04-20

	Based on record review and interview, the agency failed to ensure the plan of care was reviewed and revised by the physician and the agency based on the patient's needs in 1 of 4 clinical record reviewed with physical therapy assistant (PTA) services. (#6) The findings include: Review of an undated agency policy on 3/23/2023, titled "Plan of Care" stated, "... The plan will be consistently reviewed to ensure that client needs are met, and will be updated as necessary ...." Clinical record review on 3/21/2023, for Patient #6, start of care 3/2/2023, evidenced agency documents titled "PTA Visit" dated 3/14/2023 and 3/16/2023, which indicated the PTA assisted the patient in applying an immobilizer to the right shoulder. Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 3/2/2023-4/30/2023, failed to evidence the application of an immobilizer. Review failed to		the services/tasksbeing provided. If there is no order for a service/task clinician will call MDto obtain verbal order and revise plan of care to reflect new order. 4/20/23 Director of Nursing/designeewill audit all visit notes submitted weekly by comparing notes to plan ofcare/verbal orders to ensure services/tasks being provided have been ordered byMD. 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.	

	evidence the plan of care was revised and reviewed by the physician to include the use of an immobilizer to the right shoulder. During an interview on 3/22/2023, at 11:55 AM, the administrator indicated there was not a physician order nor was the plan of care revised to include the immobilizer and reviewed by the physician. 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 record review and interview, the home health agency failed to promptly alert the physician of changes in the patient's condition in 5 of 7 clinical records reviewed. (Patient #1, #3, #4, #6, #7) Findings include: 1. Clinical record review on 3/21/2023, for Patient #6, start	G0590	G0590 Director of Nursing willin-service clinicians on requirement to notify MD promptly of any changes inthe patient's condition or needs that suggest the outcomes were not beingachieved and/or the plan of care should be altered. If clinician has to leave amessage the clinician must document follow up with MD. If MD office doesn'tcall back within a reasonable time clinician must call MD office again forfollow up and document. Clinician is also to notify the Director of Nursing andappropriate agency case manager and document.	2023-04-20

	of care 3/2/2023, evidenced a physician order dated 3/1/2023, which indicated the patient was to receive home health services to include occupational therapy (OT) services. Review of an agency document titled "Patient Communication" dated 3/2/2023, indicated the patient was notified the agency does not provide OT services and the patient refused a referral to another agency to receive OT services. Review failed to evidence the physician was notified of the agency's inability to provide OT services as ordered and of the patient's refusal of a referral to another agency for OT services as ordered. During an interview on 3/22/2023, at 3:13 PM, the administrator indicated the agency did not provide OT services and indicated he did not see where the agency notified the physician of the inability to provide OT services and the patient's refusal to go to another agency to receive OT services. Review of agency documents titled "PTA [physical therapy		04/20/23 Director of Nursing/designeewill audit 100% of visit notes submitted weekly to ensure if there isdocumentation of change in patient condition or needs that suggest the outcomeswere not being achieved and/or the plan of care should be altered there isdocumentation MD was notified promptly. If clinician had to leave a messagethere must documentation of follow up with MD. If MD office doesn't call backwithin a reasonable time clinician must call MD office again for follow up anddocument. Clinician is also to notify the Director of Nursing and appropriateagency case manager and document. Once 100% compliance is achieved 10% will beaudited quarterly to ensure compliance is maintained. (On-going) Administrator has obtained acontract with a therapy company that will be able to provide occupationaltherapy. 4/4/23 Director of Nursing willin-service clinicians on need to notify MD if agency is unable	

	assistant] Visit" dated 3/7/2023 and 3/9/2023, evidenced the patient had pain to the right shoulder with an intensity of 3/10 on a scale of 0-10. Review of documents dated 3/14/2023 and 3/16/2023 indicated the patient had pain to the right shoulder with an intensity of 7/10. Review failed to evidence the agency contacted the physician with the increase in pain intensity to the right shoulder. During an interview on 3/22/2023, at 11:55 AM, the administrator indicated the physician should have been notified about the persistent increased pain level. 2. Clinical record review on 3/21/2023, for Patient #7, evidenced an agency document titled "PTA Visit" dated 3/7/2023, and completed by the PTA, which indicated the PTA documented the patient had a new location of pain to the left side and into the lower back due to a possible pulled muscle in the abdomen due to being sick and coughing. Review failed to evidence the agency notified the physician of the patient's new location of pain,		to provide aservice or patient refuses a service. 4/20/23 Director of Nursing willin-service clinicians on need to notify, as appropriate, agency RN casemanager/physical therapist/Director of Nursing of any change in patientcondition. This is to be documented. 4/20/23 Director of Nursing/designeewill audit all visit notes submitted weekly to ensure if there is a change inpatient condition there is documentation, as appropriate, agency RN casemanager/physical therapist/Director of Nursing was notified of any change inpatient condition. 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.	

	potential pulled abdominal muscle, and patient's report of being sick and coughing. During an interview on 3/22/2023, at 10:54 AM, the administrator indicated he did not see that the agency notified the physician of the changes in patient's condition. Review of an agency document titled "PTA Visit" dated 3/14/2023, and completed by the PTA, indicated the patient reported nausea and diarrhea since the day prior. Review of the agency document titled "Patient Medication Profile" indicated the patient's medications included, but were not limited to, docusate (laxative) daily. Review failed to evidence the agency notified the physician of the patient's report of nausea and diarrhea. During an interview on 3/22/2023, at 11:34 AM, the administrator indicated there was no record the agency notified the physician about the patient's report of nausea and diarrhea. At 11:38 AM, the administrator indicated the patient possibly needed to hold			

	diarrhea. Review of an agency document titled "PTA Visit" dated 3/16/2023, and completed by the PTA, indicated the patient had a fall 2 days prior with patient complaint of pain to the low back and neck. Review failed to evidence the agency notified the physician of the patient's fall. During an interview on 3/22/2023, at 11:38 AM, the alternate administrator indicated the administrative staff was not aware of the fall and had not notified the physician. Record review evidenced an undated agency policy received on 03/23/2023, titled, "Medical Supervision," stated, "... Physician will be contacted when any of the following occurs: Condition Changes, Expected response to treatment or medication changes ... Any change in client condition ... Agency responsibilities include: Prompt reporting of a change in client condition ... Periodic updates on client/condition/progress ...." 1. Clinical record review on			

	03/21/2023, for patient #1, start of care 06/29/2022, evidenced an agency document dated 03/13/2023, titled, "PTA [physical therapy assistant] Maintenance," which indicated the patient encountered 3 falls from Friday thru Sunday due to knee buckling and increased confusion and had a heartrate of 51. Review of an agency document dated 03/17/2023, titled, "OASIS-E [outcome and assessment information set] Resumption of Care," which indicated the patient was hospitalized from 03/14/2023-03/16/2023 due to weakness and low heartrate. Review failed to evidence the physician was notified of the change in patient condition on 03/13/2023 prior to the hospitalization on 03/14/2023. Review of an agency document dated 03/10/2023, titled, "Patient Fall Log," indicated the agency was notified of a patient's fall by Entity D. Review failed to indicate the physician was notified of the fall on 03/10/2023.			

	Review of an agency document titled, "Home Health Certification and Plan of Care," for certification period 02/24/2023-04/24/2023 indicated the physician should be notified of a heartrate less than 50. Review of an agency document dated 03/18/2023, titled, "PT [physical therapy] Re-Evaluation," indicated the patient's heart rate prior to therapy was 47 and Entity D's nurse was notified. Review failed to evidence the physician and home health agency was notified of the heart rate below parameters. During an interview on 03/22/2023, at 12:05 PM, the administrator indicated the physician, home health agency's registered nurse case manager, and physical therapist should have been notified regarding the patient's change in condition noted by the PTA on 03/13/2023. During an interview on 03/23/2023, at 11:50 AM, the administrator indicated the physician and home health agency's registered nurse case			

	manager should have been notified of the patient's heartrate outside of parameters noted by the PT on 03/18/2023. 2. Clinical record review on 03/21/2023, for patient #3, start of care 12/23/2020, evidenced an agency document dated 03/10/2023, titled, "Patient Fall Log," indicated the agency was notified of a patient's fall by Entity D. Review failed to evidence the plan of care physician was notified of the patient's fall. During an interview on 03/22/2023, at 12:47 PM, the administrator indicated the plan of care physician should have been notified of the patient's fall. 3. During an interview on 03/22/2023, at 12:10 PM, administrative staff #3 indicated she was notified by text message by Entity D that the patient #1, and patient #3 had fallen on 03/10/2023. Administrative staff #3 indicated she notified the administrator and administrative assistant of the fall and did not notify the physician. Administrative staff #3 indicated she filled out the			

	patient fall log documentation. 4. Clinical record review on 03/20/2023, for patient #4, start of care 11/28/2022, evidenced an agency document dated 03/01/2023, titled, "PTA Visit," which indicated the patient had an incident the other day that caused the patient to slide down to the ground because of loss of balance. Review failed to evidence the plan of care physician was notified of the patient's fall that was noted on the 03/01/2023 PTA note. During an interview on 03/22/2023, at 12:50 PM, the administration indicated the plan of care physician, physical therapist, and the home health agency's registered nurse case manager should have been notified of the patient's fall. 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 agency failed to ensure coordination of services in 4 of 4 clinical records reviewed with physical therapy assistant services. (Patient #1, #4, #6, #7) The findings include: 1. Review of an undated agency policy received 3/23/2023, titled "Coordination of Client Services" stated, "... The agency will integrate services ... 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 ... The agency will coordinate the nursing, therapy, aide and social work services. ... Documentation must address the coordination activities ... Involvement of the care team must be apparent in	G0606	G0606 Director of Nursing willin-service clinicians on need to coordinate care with all entities involved inpatient's care. That includes other disciplines within agency and outsideagencies – i.e. dialysis. Clinician needs to update other entities on issuesthat they need to be aware of and follow up with other entities when there isan issue with other entity. 4/20/23 Director of Nursing/designeewill audit all clinical documentation submitted weekly to ensure there iscoordination of care documented if other health care entities involved and itis something they should be aware of. Once 100% compliance is achieved 10% willbe audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing/designeewill review all clinical documentation submitted weekly to ensure if anotherdiscipline is needed there is documentation agency is able to provide thatdiscipline	2023-04-20

	electronic health record or a paper document. How and when communication happens must be documented. ... Coordination will include providers of care who are not part of the agency ... Each staff Registered Nurse shall meet with the Clinical Manager or designee as necessary to review all areas of client needs...." 2. Clinical record review on 3/21/2023, for Patient #6, start of care 3/2/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 3/2/2023-4/30/2023, which indicated the patient received assistance with companion care and activities of daily living 2 days a week. Review of an agency document titled "Patient Evacuation Planning: Emergency Preparedness" dated 3/2/2023, indicated Entity C provided companion care. Review failed to evidence the agency coordinated care with Entity C on the type and frequency of services provided to the patient. During an interview on		or notifies MD of inability to provide and assists patient/caregiverwith finding an agency who can provide needed discipline. Once 100% complianceis achieved 10% will be 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.	

	administrator indicated there was no coordination of care with Entity C and indicated the agency should have coordinated care with Entity C even if the patient paid for services privately. Review of agency documents titled "PTA [physical therapy assistant] Visit" dated 3/7/2023 and 3/9/2023, evidenced the patient had pain to the right shoulder with an intensity of 3/10 on a scale of 0-10. Review of documents dated 3/14/2023 and 3/16/2023 indicated the patient had pain to the right shoulder with an intensity of 7/10. Review failed to evidence the PTA coordinated care with the nurse case manager regarding the increase in pain intensity to the right shoulder. 3. Clinical record review on 3/21/2023, for Patient #7, evidenced a start of care comprehensive assessment dated 2/24/2023, which indicated the patient performed peritoneal dialysis (a treatment for kidney failure that uses the lining of your abdomen to filter the blood) every night at home, which was managed by Entity E			

	indicated the patient had no edema (fluid retention resulting in swelling). Review of an agency document titled "Home Health Certification and Plan of Care" for certification period 2/24/2023-4/24/2023, indicated the patient's medications included, but were not limited to bumetanide (a medication used to treat fluid retention) twice daily. Review indicated the patient was on a 32 ounce fluid restriction. Review indicated the agency was to call the physician for a pulse greater than 110 beats per minute. Review of an agency document titled "Skilled Nursing Visit" dated 3/8/2023, indicated the nurse assessed the patient to have edema to both ankles. Review failed to evidence the nurse coordinated care with the dialysis center to inform them of the change in fluid retention. During an interview on 3/22/2023, at 10:46 AM, the clinical manager indicated he was not sure if and when the dialysis center wanted to know about the patient's fluid retention.			

	Review failed to evidence coordination of care with Entity E to include the patient's dry weight and how often the patient was to monitor weight and vital signs. During an interview on 3/28/2023, at 11:57 AM, after an attempt was made on 3/23/2023, at 9:20 AM, Person F, nurse at Entity E indicated the patient was to monitor vital signs and weight daily. Person F indicated the patient's dry weight was 122 pounds and dialysis should be notified with weight changes of 5 pounds or more. Person F indicated the patient did come into the dialysis center twice a month and indicated if there was another nurse making home visits, it would be beneficial if that nurse could help monitor if the patient was checking vital signs and weights daily and notify the dialysis center of changes in the patient's status. Review of an agency document titled "PTA Visit" dated 3/7/2023, and completed by the PTA, indicated the patient's pulse was 111 beats per minute. Review failed to evidence the PTA coordinated care with the			

	PT or the nurse case manager to inform him of the pulse greater than the ordered parameters. Review indicated the PTA documented the patient had a new location of pain to the left side and into the lower back due to a possible pulled muscle in the abdomen due to being sick and coughing. Review failed to evidence the PTA coordinated care with the PT or the nurse case manager to inform them of the pulse greater than the ordered parameters, the patient's new location of pain, potential pulled abdominal muscle, and patient's report of being sick and coughing. During an interview on 3/22/2023, at 10:54 AM, the administrator indicated he did not see that the PTA had notified the PT and nurse case manager of the changes in patient's condition. Review of an agency document titled "PTA Visit" dated 3/14/2023, and completed by the PTA, indicated the patient reported nausea and diarrhea since the day prior. Review indicated the PTA documented			

	sleeping the night prior due to a change in dialysis. Review of the agency document titled "Patient Medication Profile" indicated the patient's medications included, but were not limited to, docusate (laxative) daily. Review failed to evidence the PTA notified the PT or the nurse case manager regarding the patient's report of nausea and diarrhea and the change in dialysis. Review failed to evidence the agency coordinated care with the dialysis center regarding the patient's report of a change in dialysis causing difficulty sleeping and the report of the patient's nausea and diarrhea. During an interview on 3/22/2023, at 11:34 AM, the administrator indicated there was no record the PTA notified either the PT or the nurse case manager about the patient's report of nausea and diarrhea. At 11:36 AM, the administrator indicated he did not know what the change was in dialysis and indicated the agency should have informed the dialysis center about the patient's report of a change with dialysis and report of nausea and			

	diarrhea. Review of an agency document titled "PTA Visit" dated 3/16/2023, and completed by the PTA, indicated the patient had a fall 2 days prior with patient complaint of pain to the low back and neck. Review failed to evidence the PTA coordinated care with the PT and nurse case manager. During an interview on 3/22/2023, at 11:38 AM, the alternate administrator indicated the administrative staff was not aware of the fall. 4. During an interview on 3/22/2023, at 10:57 AM, the administrator indicated the PTA should notify the nurse case manager of any updates or changes in the patient's current status. 1. Clinical record review on 03/21/2023, for patient #1, start of care 06/29/2022, evidenced an agency document dated 03/13/2023, titled, "PTA [physical therapy assistant] Maintenance," which indicated entity D had informed the PTA of patient having 3 falls from Friday to Sunday due to knees buckling and increased			

	confusion. Review failed to evidence the PTA notified the physical therapist, the plan of care physician or the home health agency's registered nurse case manager. Review failed to evidence the coordination of services between the PTA and the home health agency. Review of an agency document titled, "Home Health Certification and plan of Care," for certification period 02/24/2023-04/24/2023, indicated parameters to notify the physician include a heart rate less than 50. Review of an agency document dated 03/18/2023, titled, "PT [physical therapy] Re-Evaluation," indicated the patient's heartrate was 47. Review evidenced the PT notified Entity D's nurse. Review failed to evidence the PT notified the plan of care physician or the home health agency's registered nurse case manager.			

	Review failed to evidence the coordination of services between the PT and the home health agency. 2. Clinical record review on 03/20/2023, for patient #4, start of care 11/28/2022, evidenced an agency document dated 03/01/2023, titled, "PTA Visit," which indicated the patient had reported they had slid down to the ground after loss of balance. Review failed to evidence the PTA notified the physical therapist, the plan of care physician or the home health agency's registered nurse case manager. Review failed to evidence the coordination of services between the PTA and the home health agency. 3. During an interview on 03/22/2023, at 12:05 PM, the administrator indicated the PTA and PT should have coordinated with the home health agency's registered nurse case manager, and the plan of care physician to notify of the patients' change in condition. 410 IAC 17-12-2(g)			

G0652	Activities lead to an immediate correction 484.65(c)(1)(iii) (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview, the home health agency failed to ensure the 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 evidenced an undated agency policy received on 03/23/2023, titled, "Quality Assessment and Performance Improvement (QAPI)," which stated, "... QAPI ... Purpose ... To use performance improvement activities to track adverse client events, analyze their causes and implement preventive actions ...." Review of the agency's QAPI binder on 03/20/2023, failed to evidence the QAPI activities led to an immediate corrective action of any identified problems that directly or potentially threaten the health and safety of patients.	G0652	G0652 Administrator will ensure the QAPI activities conducted byagency lead to immediate corrective action of any identified problems thatdirectly or potentially threaten the health and safety of patients. (On-going) Administrator and Director of Nursing will review QAPIactivities and implement a corrective action plan for identified problems foundthat directly or potentially threaten the health and safety of patients. 4/20/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-04-20

	During an interview on 03/20/2023, at 10:50 AM, the alternate administrator indicated the agency had done nothing this year with the QAPI program to implement corrective action of identified problems. 410 IAC 17-12-2(a)			
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the home health agency failed to conduct at least one performance improvement project yearly.	G0658	G0658 Administrator instructedDirector of Nursing in need to conduct at least one perform improvement projectyearly. 4/20/23 Administrator/Director ofNursing will determine what the performance improvement project for 2023 willbe. 04/20/23 Administrator/Director ofNursing will determine each January what the performance improvement projectwill 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.	2023-04-20

	Findings include: Record review evidenced an undated agency policy received on 03/23/2023, titled, "Quality Assessment and Performance Improvement (QAPI), which 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's QAPI binder on 03/20/2023, failed to evidence a performance improvement project. During an interview on 03/20/2023, at 2:00 PM, the alternate administrator indicated the agency did not have a performance improvement project and had not done anything this year with the QAPI program.			
G0684	Infection control 484.70(b)(1)(2)	G0684	G0684 Director of Nursing will in-service clinicians that	2023-04-20

	Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview the home health agency failed to maintain a coordinated agency-wide program for the surveillance, identification prevention, control, and investigation of infections in 1 of 1 clinical records reviewed with an infection. (Patient #1) Findings include: Record review of an undated agency policy received on 03/23/2023, titled, "Infection Control Surveillance," stated, "Agency will establish a continuous data monitoring and collecting system to detect infections or identify changes in infection trends ... Data regarding infection may be		anypatient with an infection/on an antibiotic must be reported to Director ofNursing so an infection report can be completed. 4/20/23 Director of Nursing/designee will audit all visit notes,comprehensive assessments and verbal orders submitted weekly to ensure if thereis documentation of an infection or an antibiotic there is an infection reportform completed. 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.	

	sources including home visits, verbal orders for antibiotics ... interviews with staff ... An infection control log will be maintained. The agency will identify follow-up actions taken as a result of identified infections ...." Clinical record review on 03/21/2023, for patient #1, start of care 06/29/2022, evidenced an agency document dated 02/23/2023, titled, "PT [physical therapy] Re-Evaluation," which indicated the patient was admitted to the hospital from 02/09/2023-02/12/2023, for pneumonia. Review of an agency document titled, "Home Health Certification and Plan of Care," for certification period 02/24/2023-04/24/2023, indicated the patient had a diagnosis of bronchopneumonia. Review of an agency document dated 02/16/2023, titled, "Patient Medication Record," indicated the patient was taking Azithromycin (antibiotic) from 02/16/2023-02/20/2023. Review failed to evidence the home health agency			

	surveillance of the patient's pneumonia identified. During an interview on 03/22/2023, 12:15 PM, the alternate administrator indicated there were no patient infections documented for January, February or March of 2023. During an interview on 03/22/2023, 12:20 PM, the administrator indicated an infection report should have been completed for the patient's pneumonia.			
G0686	Infection control education 484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s). Based on record review and interview, the agency failed to provide infection control education to staff in 3 of 4 active physical therapy personnel training records reviewed. (PT #1, PT #2, PT #3) The findings include: Review of an agency document dated 9/12/2019, titled "Infection Control Plan" stated,	G0686	G0686 Director of Nursing/designeewill provide infection control education to all current employees includingPT#1 cited in survey. 4/21/23 Director of Nursing willensure all employees receive infection control training annually. (On-going)	2023-04-21

	"… Ongoing education will also be provided to employees …." A review of an agency document titled "Inservice on G0686" and identified as the infection control education indicated infection control training was provided between 2/17/2023 – 2/24/2023. Review failed to evidence infection control training was provided to PT #1, PT #2, and PT #3. During an interview on 3/20/2023, at 3:55 PM, the alternate administrator indicated all staff should have received infection control training since February. During an interview on 3/21/2023, at 1:46 PM, PT #1 indicated she had not had any training since her time of hire 7 years ago. PT #1 indicated she was told to come into the office to sign some paperwork but was just told to sign it and did not receive any inservice or education. During an interview on 3/21/2023, at 2:30 PM, the alternate administrator indicated staff should have read the information attached to the		The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	education.			
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 skilled professional failed to provide the services as directed in the plan of care in 3 of 7 clinical records reviewed. (Patient #1, #6, #7) The findings include: 1. Review of an undated agency policy on 3/23/2023, titled "Skilled Professional Services" stated, "... Skilled professionals must assume responsibility for ... Providing services that are ordered by the physician as indicated in the plan of care...." 2. Clinical record review on 03/21/2023, for patient #1, start of care 06/29/2022, evidenced an agency document dated 03/13/2023, titled "Home Health Certification and Plan of	G0710	G0710 Directorof Nursing will in-service clinicians on requirement to provide services asordered by MD on the plan of care. 04/21/23 Directorof Nursing/designee will audit all visit notes submitted weekly to ensure theyreflect the services ordered on the plan of care. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) Directorof Nursing will in-service clinicians on documenting whether patient verbalizedunderstanding of teaching provided. 4/21/23 Directorof Nursing/designee will audit visit notes submitted weekly to ensure there isdocumentation patient verbalized understanding of any teaching provided. Once100% compliance is achieved 10% will be audited quarterly to ensure complianceis maintained.	2023-04-21

	02/24/2023-04/24/2023, which indicated parameters to notify the physician of a heart rate less than 50 beats per minute. Review of an agency document dated 03/18/2023, titled, "PT [physical therapy] Re-Evaluation," indicated the patient's heart rate was 47 beats per minute. Review failed to evidence the PT notified the physician as directed in the plan of care. During an interview on 03/22/2023, at 12:05 PM, the administrator indicated the PT should have notified the physician of the patients' change in condition. 3. Clinical record review on 3/21/2023, for Patient #6, evidenced an agency document titled "Home Health Certification and Plan of Care" which evidenced the patient received oxygen at 2 liters per minute (LPM) continuously. Review of an agency document titled "Physician Order" dated 3/3/2023 indicated the physical therapy orders included home exercise program instruction. Review of agency documents		(On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	titled "PTA Visit" dated 3/7/2023, 3/9/2023, 3/14/2023, 3/16/2023, and completed by the PTA, indicated the patient was receiving oxygen at 3 LPM. Review failed to evidence the PTA provided services according to the plan of care. Review failed to evidence the PTA followed the plan of care and provided home exercise program instruction on 3/7/2023, 3/9/2023, 3/14/2023, and 3/16/2023. During an interview on 3/22/2023, at 11:54 AM, the administrator indicated the PTA should follow the plan of care. 4. Clinical record review on 3/21/2023, for Patient #7, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification period 2/24/2023-4/24/2023, which indicated the patient was on a 32 ounce fluid restriction. Review indicated the agency was to provide skilled nursing services to include the assessment of all body systems and knowledge of disease process and its associated care and treatment. Review indicated the agency was to call the			

	physician for a pulse greater than 110 beats per minute. Review of an agency document titled "PTA [physical therapy assistant] Visit" dated 3/7/2023, and completed by the PTA, indicated the patient's pulse was 111 beats per minute. Review failed to evidence the agency notified the physician of the pulse greater than the parameters as directed in the plan of care. During an interview on 3/22/2023, at 10:52 AM, when queried when was the physician notified of the pulse greater than the ordered parameters, the administrator stated, "You're telling me the order has to be followed in black and white?" The administrator indicated it was up to the PTA if the physician should be notified or not. Review of an agency document titled "Skilled Nursing Visit" completed by the clinical manager and dated 3/8/2023, failed to indicate the nurse assessed the patient's knowledge of and compliance with the fluid restriction. During an interview on			

	3/22/2023, at 10:46 AM, the clinical manager indicated he did not feel the need to assess the patient's knowledge of and compliance with the patient's fluid restriction based on his assessment. 410 IAC 17-14-1(a)(1)(H)			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the licensed practical nurse (LPN) failed to prepare clinical notes in 1 of 3 clinical record reviewed with a LPN. (Patient #6) The findings include: Review of an undated agency policy on 3/23/2023, titled "Skilled Professional Services" stated, "... Skilled professionals must assume responsibility for ... Preparing clinical notes ...." Review of an undated agency policy on 3/23/2023, titled "Clinical Documentation" stated,	G0716	G0716 Director of Nursing will in-service clinicians onrequirement to complete documentation within 48 hours of the visit. 4/20/23 Director of Nursing will audit all visit notes submittedweekly to ensure there is a visit note or documentation for the frequencyordered for the week or a note why a visit wasn't made. Once 100% compliance isachieved 10% will be 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.	2023-04-20

	ordered on the plan of care will be completed the day service is rendered ….” Review of an untitled agency document identified as the visit schedule on 3/20/2023, indicated LPN #1 was scheduled to provide a skilled nurse visit to Patient #6 on 3/20/2023. Review of the clinical record on 3/22/2023, for Patient #6, failed to evidence a skilled nursing visit note for the week of 3/18/2023. During an interview on 3/22/2023, 11:54 AM, the administrative assistant indicated LPN #1 performs her visits to the patient on Mondays and would contact her to have her complete her visit note. During an interview on 3/23/2023, at 12:06 PM, the administrator indicated staff should document the same day as the visit and explained things could get missed, get documented inaccurately, and the agency isn’t aware of things timely if visits aren’t documented on the same day. 410 IAC 17-14-1(a)(2)(B			

G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the home health agency failed to provide the home health aide with patient specific written care instructions for 2 of 4 clinical records reviewed with home health aide services. (Patient #4, #6) Findings include: 5. Clinical record review on 3/21/2023, for Patient #6, start of care 3/2/2023, evidenced an agency document titled "Home Health Certification and Plan of Care" for certification 3/2/2023 -4/30/2023, which indicated the patient was to receive 1 HHA visit a week for 8 weeks. Review indicated the plan of care included 2 different parameters on when to notify the physician for the patient's temperature;	G0798	G0798 Director of Nursing will in-service clinicians onrequirement to include patient specific written care instructions on aide careplan to include any precautions, temperature call parameters and frequency oftasks to be performed. 4/14/23 Director of Nursing/designee will audit all aide care planssubmitted weekly to ensure they contain specific care instructions includingany precautions, temperature call parameters and frequency of tasks to beperformed. Once 100% compliance is achieved 10% will be audited quarterly toensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-04-14

	physician was to be notified of a temperature greater than 100 degrees Fahrenheit and one parameter indicated the physician was to be notified of a temperature greater than 101 degrees Fahrenheit. During an interview on 3/22/2023, at 11:57 AM, the administrator indicated the agency's standard temperature parameter and the parameter that should have been included in the plan of care was to call the physician for a temperature greater than 101 degrees Fahrenheit. Review of an agency document titled "Aide Care Plan" dated 3/2/2023, indicated the home health aide was to take the patient's temperature at every visit and report a temperature greater than 100 degrees Fahrenheit. Review failed to evidence the home health was provided correct instructions related to the temperature reporting parameter. Review indicated the home health aide was to provide foot and nail care as needed and failed to evidence the patient-specific instructions for when to provide			

	home health aide. During an interview on 3/22/2023, at 11:58 AM, the administrator indicated the home health aide should be directed to report a temperature greater than 101 degrees Fahrenheit. At 3:18 PM, the administrator indicated the home health should provide nail and foot care if the patient needs it. 1. Record review of an agency policy dated 08/23/2019, titled, "Home Health Aide Care Plan," stated, "... A complete and appropriate Care Plan, identifying duties to be performed by the Home Health Aide, shall be developed by a Registered Nurse or Therapist. All home health aide staff will follow the identified plan ... To provide documentation that the supervising Nurse oriented the assigned Aide to the client's care initiating the care. To provide documentation that the client's care is individualized to his/her specific needs ... Prior to initiating care, the Home Health Aide shall be oriented by a Registered Nurse/Therapist ... to the client's care needs and shall be updated on			

	modifications or changes in the client's care. The orientation will include any specific observations the home health aide is expected to report and document with parameters for reporting ...." 2. Clinical record review on 03/20/2023, for patient #4, start of care 11/28/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 01/27/2023-03/27/2023, indicated the patient's safety measures included but not limited to anticoagulant (bleeding) precautions. Review of an agency document titled, "Aide Care Plan," for period 01/27/2023-03/27/2023, failed to evidenced bleeding precautions for the patient. 3. Clinical record review on 03/21/2023, for patient #5, start of care 09/13/2022, evidenced an agency document titled, "Home Health Certification and Plan of Care," for certification period 03/12/2023-05/10/2023, indicated the patient's safety measures included but not limited to anticoagulant bleeding precautions.			

	Review of an agency document titled, "Aide Care Plan," for period 01/11/2023-03/11/2023, failed to evidence anticoagulant bleeding precautions for the patient. 4. During an interview on 03/23/2023, at 12:03 PM, the administrator indicated if a patient was on bleeding precautions it should be included on the aide plan of care.			
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 provided services that were included in the plan of care in 1 of 1 assisted living facility visits. (Patient #2)	G0800	G0800 Director of Nursing willin-service aides on requirement to provide all services and only servicesincluded on the aide plan of care. If a task isn't done aide needs to indicatewhy and is to notify case manager. 4/14/23 Director of Nursing/designeewill audit all aide notes submitted weekly by comparing them to aide plan ofcare to ensure plan is being followed. If a task isn't done aide needs toindicate ordered task wasn't provided and notify	2023-04-14

	Findings include: Record review evidenced an undated agency policy received on 03/23/2023, titled, "Home Health Aide Care Plan," which stated, "... All home health aide staff will follow the identified plan ...." Record review evidenced an undated agency policy received on 03/23/2023, titled, "Home Health Aide Services," which stated, "... The Aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising Nurse/therapist ... All services provided by the Home Health Aide shall be documented in the clinical record...." Clinical record review on 03/22/2023, for patient #2, start of care 01/13/2021, evidenced an agency document titled, "Aide Care Plan," for dates 03/04/2023-05/02/2023, which indicated the home health aide was to provide oral care every visit and pressure areas checks every visit. Review of an agency document dated 03/22/2023, titled, "HHA		case manager. Once 100% complianceis achieved 10% will be 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.	

	[home health aide] Visit," evidenced oral care and pressure area checks every visit were not completed. During an observation of an home visit on 03/22/2023, from 8:50 AM-9:50 AM, oral care was failed to be performed by the home health aide. During an interview on 03/23/2023, at 12:39 PM, the administrator indicated the home health aide should be following the plan of care and completing care as indicated on the plan of care.			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the administrator failed to ensure they provide oversight of the day-to-day operations, and ensured staff followed agency policy on completing incident reports in 1 of 4 clinical records reviewed with falls. (Patient #7)	G0948	G0948 Administrator will in-service clinicians they are to notifyDirector of Nursing of any falls so an incident report can be completed. 4/20/23 Administrator will in-service Director of Nursing they areto notify Administrator of any reported falls so Administrator can reviewincident report. 4/20/23 Director of Nursing/designee	2023-04-20

	The findings include: Review of an undated agency policy received 3/23/2023, titled "Governing Body" stated, "… Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the day to day operations of the agency …." Review of an undated agency policy received on 3/23/2023, titled "Incident Reporting" stated, "… Agency will document and report all incidents that deviate from routine agency operations and will or could result in injury or potential harm to a client/caregiver … An Incident Report form shall be completed in its entirety by the person involved or the first person to become aware of the incident…." Clinical record review on 3/21/2023, for Patient #7, evidenced an agency document titled "PTA [physical therapy assistant] Visit" dated 3/16/2023, which indicated the patient fell 2 days prior with complaints of pain to her neck		will audit all visit notessubmitted weekly to ensure if there is documentation of a fall there isdocumentation Director of Nursing was notified so an incident report could becompleted. Once 100% compliance is achieved, 10% will be audited quarterly toensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	evidence an incident report was completed for the patient's fall. During an interview on 3/22/2023, at 11:38 AM, the alternate administrator indicated there were no incident reports related to falls for the patient. During an interview on 3/22/2023, at 12:08 PM, the administrator indicated an incident report should be completed in the electronic health record after notification of a patient fall. 1. Clinical record review on 03/21/2023, for patient #1, start of care 06/29/2022, evidenced an agency document dated 03/10/2023, titled, "Patient Fall Log," indicated entity D reported a fall to the home health agency and failed to evidence the physician, or registered nurse case manager was notified. Review of an agency document dated 03/13/2023, evidenced the patient had 3 falls from Friday-Sunday (03/10/2023-03/13/2023). Review failed to evidence a fall log report was completed and failed to evidence the physician			

	or registered nurse case manager was notified. 2. Clinical record review on 03/21/2023, for patient #3, start of care 12/23/2020 evidenced an agency document dated 03/10/2023, titled, "Patient Fall Log," indicated entity D reported a fall to the home health agency and failed to evidence the physician or registered nurse case manager was notified. 3. During an interview on 03/22/2023 at 12:10 PM, administrative staff #3 indicated she was notified by text from entity D that patient #1, and patient #3 had falls on 03/10/2023. Administrative staff indicated she completed the patient fall log and did not notify the physician. 4. Clinical record review on 03/20/2023, for patient #4, start of care 11/28/2022, evidenced an agency document dated 03/01/2023, titled, PTA [physical therapy assistant] Visit," indicated the patient had an incident that caused the patient to slide down to the ground after loss of balance. Review failed to evidence a fall			

	log report was completed and failed to evidence the physician or registered nurse case manager was notified. 5. During an interview on 03/22/2023, at 12:05 PM, the administrator indicated fall logs should be completed when there was a patient fall. The administrator indicated the agency's registered nurse case manager and physician should be notified when a fall occurs.			
G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, Based on record review and interview, the clinical manager failed to provide clinical oversight of client visit assignments in 1 of 3 clinical records reviewed with home health aide services. (Patient #6) The findings include: Review of an undated agency policy obtained 3/23/2023, titled "Clinical Manager" stated, "... The oversight provided by the clinical manager(s) includes:	G0960	G0960 Directorof Nursing will in-service staff that if a visit is not made as scheduled theDirector/designee is to be notified and missed visit report is to be completedat that time if visit cannot be made up that week. 4/20/23 Directorof Nursing/designee will audit all scheduled visits each week against MD ordersto ensure frequency is followed and if not there is documentation agencyattempted to schedule the missed visit during that week. If unable toreschedule visit there is a missed visit	2023-04-20

	… Making client and personnel assignments ….” Clinical record review on 3/21/2023, at 4:00 PM, for Patient #6, evidenced an agency document titled “Home Health Certification and Plan of Care” for certification period 3/2/2023-4/30/2023, which indicated the agency was to provide home health aide (HHA) services 1 time a week. Review of the electronic medical record indicated a home health aide visit was scheduled on 3/6/2023, with a status of “not started”. Review failed to evidence the agency provided a HHA visit during the week of 3/4/2023. Review evidenced the last HHA visit was 3/13/2023. Review of an undated agency document identified as the visit schedule on 3/20/2023, indicated HHA #2 was scheduled to provide a home health aide visit to the patient on 3/20/2023. During an interview on 3/22/2023, at 11:59 AM, the administrative assistant indicated the home health aide did not complete a visit but entered a missed visit note		report indicating why and MD wasnotified. Once 100% compliance isachieved 10% will be audited quarterly to ensure compliance is maintained.(On-going) Directorof Nursing will in-service therapists on need to evaluate patient within 48hoursof start of care. If unable to do within 48hours MD is to be notified of reasonand this documented. 4/20/23 Directorof Nursing/designee will audit all starts of care done weekly to ensure ifthere are therapies ordered the therapy evaluation is done within 48hours orthere is documentation was notified of reason why not done in 48hours. 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.	

	earlier this morning into the electronic health record dated 3/6/2023. The administrative assistant indicated the agency was not aware of the missed visit until the agency was completing payroll and noticed there was not a visit completed as scheduled that week. The administrative assistant indicated HHA #2 would be making a visit to the patient today. During an interview on 3/22/2023, at 11:59 AM, the clinical manager indicated the home health aide did not notify the agency of the missed visit during the week of 3/4/2023. The clinical manager indicated he was not aware that HHA #2 had not provided a visit as scheduled on 3/20/2023. 410 IAC 17-14-1(a)(1)(K)			
G0968	Assure implementation of plan of care 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. Based on record review and interview, the clinical manager failed to provide clinical oversight	G0968	G0968 Director of Nursing will in-service clinicians they are tofollow the plan of care and notify MD of any change in patient condition or toobtain orders for a service/task patient needs before providing	2023-04-20

	assuring the development and implementation of the individualized plan of care in 1 of 4 clinical record reviewed with physical therapy assistant (PTA) services provided. (Patient #7) The findings include: Review of an undated agency policy obtained 3/23/2023, titled "Clinical Manager" stated, "... The oversight provided by the clinical manager(s) includes: ... Assuring the development, implementation, and updates to the individual plans of care...." Clinical record review on 3/21/2023, for Patient #7, evidenced agency documents indicating the PTA was not following the plan of care as directed. See tags G0580 and G0710. During an interview on 3/22/2023, the clinical manager indicated it is up to the PTA if they feel it is necessary to notify the physician of the heart rate outside of the normal parameters as directed per the plan of care. At 11:00 AM, the clinical manager stated, "The		thatservice/task. 4/20/23 Director of Nursing/designee will audit all visit notessubmitted weekly and compare to the plan of care to ensure services/tasksprovided are ordered and if there is a change in patient condition there isdocumentation MD was notified. 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.	

	therapist can't massage?" When queried where was the therapy order in the patient's plan of care for massage, the clinical manager stated, "Why does it need to be? I'm not a therapist. Why am I answering for PT [physical therapy]?" When queried how the clinical manager provided clinical oversight for the development and implementation of the plan of care, the clinical manager stated, "Not for therapy. That's up to the therapist." 410 IAC 17-14-1(a)(1)(C)			
N0000	Initial Comments This visit was a re-licensure survey of a home health agency. This visit took place from 03/20/2023-03/23/2023 Facility ID: 012486 Census: 40	N0000	N000 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."	
N0447	Home health agency administration/management 410 IAC 17-12-1(c)(4) Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on observation, record review, and interview, the administrator failed to ensure the accuracy of public information. The findings include: Review of an undated agency	N0447	N0447 Administrator has signed a contract with a therapy companythat will provide therapies including Occupational Services (OT) as needed byagency. 4/4/23 Administrator will ensure that if agency is not able toprovide a specific therapy the information posted at agency and on agencywebsite accurately reflects services agency can provide. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	2023-04-04

	policy received 3/23/2023, titled "Governing Body" stated, "... Appoint a qualified Administrator. Delegate to that individual the authority and responsibility for the day to day operations of the agency to include provision of home care services in accordance with the state and federal regulations ...." During an observation on 3/22/2023, at 3:00 PM, a sign on the window to the agency next to the entrance indicated the agency offered occupational therapy (OT) services. During an observation of the agency's website, sunrisehh.net, on 3/22/2023, at 3:04 PM, the website was observed to include the agency offered OT services. During an interview on 3/22/2023, at 3:13 PM, the administrator indicated the agency did not offer OT services, and indicated he was unaware the sign in the window indicated OT services were provided by the agency. The administrator indicated he was not aware the website indicated the agency provided OT services and indicated he had			

	not looked at the agency's website in a long time.			
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 agency failed to ensure personnel records contained annual performance evaluations in 1 of 1 personnel record reviewed for a speech therapist. (Other Staff #1)	N0458	N0458 Administrator will in-service staff responsible forobtaining documentation required for employee files on what is to be in anemployee file. 4/20/23 Administrator/Director of Nursing/designee will audit allcurrent active employee files to ensure all required documentation is present.Any documentation missing will be obtained. 4/20/23 Administrator/Director of Nursing/designee will audit all employeefiles yearly to ensure annual performance evaluations are done. (On-going)	2023-04-20

	The findings include: Review of an undated agency document revised 2/2023, titled "Performance Evaluations" stated, "... A competency-based performance evaluation will be conducted for all employees after one (1) year of employment and at least annually thereafter...." Personnel record review on 3/20/2023, for Other Staff #1, failed to evidence a performance evaluation since 2013. During an interview on 3/20/2023, at 3:54 PM, the alternate administrator indicated there was not a performance evaluation for Other Staff #1 because she is a contracted employee.		Administrator revised policy "Contract Personnel" to stateagency that contract personnel is hired thru will be responsible for theirannual performance evaluation unless they are the only employee of thecontractor and the home health agency will do performance evals. 4/20/23 The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
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	N0464	N0464 Administrator will in-serviceagency staff involved in hiring of employees/human resource functions thatclinicians must have an annual tuberculosis screening. 4/20/23	2023-04-20

	documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (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		Administrator/Director ofNursing will audit all current employee files to ensure there is evidence of anannual tuberculosis screening. Any employee who doesn't have a currenttuberculosis screening will complete one. 4/20/23 Administrator/Director ofNursing/designee will audit employee files monthly to ensure tuberculosisscreenings are up to date. (On-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

(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 agency failed to ensure personnel were screened annually for tuberculosis (a contagious disease primarily affecting the lungs) in 1 of 1 personnel record reviewed for a physical therapist (PT). (PT #2)

The findings include:

Review of an undated agency policy on 3/23/2023, titled "Occupational Exposure to Tuberculosis Prevention Plan" stated, "... The agency will perform an annual risk assessment survey of the agency staff ...."

Personnel record review on 3/20/2023, for PT #2, first patient contact date 2/24/2021, failed to evidence an annual TB screening since time of hire.

During an interview on 3/20/2023, at 3:37 PM, the alternate administrator indicated she thought the chest

	employee had to do.			
N0586	Scope of Services 410 IAC 17-14-1(h) Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas: (1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff. (2) Observing, reporting, and documenting patient status and the care or service furnished. (3) Reading and recording temperature, pulse, and respiration. (4) Basic infection control procedures and universal precautions. (5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (6) Maintaining a clean, safe, and healthy environment. (7) Recognizing emergencies and knowledge of emergency procedures. (8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following:	N0586	N0586 Deficiency corrected by agency on 2/23/23	2023-04-10

	(A) Bed bath. (B) Bath; sponge, tub or shower. (C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Any other task that the home health agency may choose to have the home health aide perform. Deficiency corrected by agency on 02/23/2023 Deficiency corrected by agency on 02/23/2023			

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 Dodson	Administrator	4/10/2023 4:15:58 PM