POC accepted 5-30-2023

Deborah Franco, RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K153	A. BUILDING B. WING	04/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AM - PM HOME HEALTH SERVICES LLC	3906 W 86TH STREET, INDIANAPOLIS, IN, 46268

(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 a Home Health Provider. Survey Dates: 04-20-2023, -4-21-2023, 04-24-2023, and 04-25-2023 Facility # 014070 CCN: 15K153 Census: 27 Unduplicated Skilled Admissions: 6 At this Emergency Preparedness survey, AM PM Home Health Services LLC was found to have been out of compliance with Conditions of Participation 42 CFR 484.102 Emergency Preparedness requirements for Medicaid Participating Providers	E0000	AM-PM Home Health Services, LLC is submitting the following Plan of Correction in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction is not intended as an admission, does not constitute an admission by and should not be construed as an admission by AM-PM Home Health Services, LLC that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. AM-PM Home Health Services, LLC desires this Plan of Correction to be considered our Allegation of Compliance.	

	and Suppliers, including staffing and the implementation of staffing during the Pandemic. QR by Area 3 on 5-3-2023			
E0001	Establishment of the Emergency Program (EP) 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must	E0001	Administrator will ensure agency maintains an Emergency Preparedness Program that is reviewed, and/or revised as needed, with tabletop exercise conducted with an after-action analysis documented. (On-going) Administrator will ensure anytime Emergency Preparedness policies and procedures are reviewed/revised there is documentation of these reviews/revisions. (On-going) Administrator/designee will review and update Emergency Preparedness Program manual/documents. 05/19/2023. Administrator will ensure a tabletop exercise is completed as required by regulation and documentation is maintained for the tabletop exercise. 05/19/2023. Administrator will ensure agency has a full-scale exercise in 2023. Administrator will contact Indiana Public Health Preparedness District Region 5 to see if there are any community based full scale exercises. If there isn't one this will be documented, and agency will conduct their own agency based full-scale exercise. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-05-25

local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:

*[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:

Based on record review and interview, the agency failed to ensure an Emergency Preparedness was maintained, reviewed, and/or revised if needed, with tabletop exercise conducted with an after-action analysis documented since 2020 for 1 of 1 Emergency Preparedness program.

Findings Include:

1. On 04-25-2023 at 10:30 AM, a binder titled "Emergency Management," was reviewed and contained an undated policy titled "Emergency Management Policy", policy number B-400. The policy indicated but was not limited to, " ... The AM-PM Home Health Services will develop and maintain a written emergency management plan describing

	readiness and emergency management and implements it as appropriate ... ” 2. On 04-25-2023 at 09:05 AM, the Scheduler, Administrative Staff #4, provided a binder titled, “Emergency Management.” The binder contained documents that listed potential disasters that may occur that evaluated how prepared the agency was for the disaster and the risk associated with the disaster. The documents evidenced the evaluation was completed monthly. There was no evidence of a tabletop exercise had been completed by the agency. 3. On 04-25-2023 at 09:16 AM, the Administrator provided a binder titled “Governing Body Minutes.” The binder contained Governing Body minutes from June 15, 2022, September 23, 2022, and January 3, 2023. There was no evidence the following elements of an Emergency Preparedness program (policies/procedures, communication plan, training and testing) had been reviewed and updated if needed.			

	4. On 04-25-2023 at 11:51 AM, an interview was conducted with the Administrator and Alternate Administrator. The Administrator indicated the agency had not completed a tabletop exercise since their last survey in the year 2020. The Administrator indicated the Emergency Preparedness plan had not been worked on since their last survey in 2020. The Alternate Administrator stated they reviewed the policies and procedures every 6 months, but indicated they did not document when policies and procedures were reviewed. The Administrator indicated they updated and reviewed the communication plan annually, but was unable to provide any documentation of any agency Emergency Preparedness review and updates if needed.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification of a Home Health Provider. A fully extended survey was announced on 04-24-2023 at 10:36 AM. Survey dates: 04-20-2023, 04-21-2023, 04-24-2023, and	G0000	AM-PM Home Health Services, LLC is submitting the following Plan of Correction in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction is not intended as an admission, does not constitute an admission by and should not be construed as an admission by AM-PM Home Health Services, LLC that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. AM-PM Home Health Services, LLC desires this	

	04-25-2023 Census: 27 Unduplicated Skilled patients: 6 Based on the Condition-level deficiencies during the 4-25-2023 survey, your home health agency was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act in relation to Emergency Preparedness 42 CFR 484.102; Care Planning, Coordination, and Quality of care, 42 CFR 484.60; 42 CFR 484.65 Quality Assessment and Performance Improvement; and 42 CFR 484.70 Infection Control. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being involved with any onsite health aide training and/or competency evaluation program for the two years beginning April 25, 2023, continuing through April 24, 2025. QR by Area 3 on 5-3-2023		Plan of Correction to be considered our Allegation of Compliance.	

G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge;	G0574	Director of Nursing will in-service clinicians on the required elements of the plan of care. (Date completed) (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; (v) Prognosis (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and	2023-05-25

	(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 agency failed to ensure the plan of care contained specific individualized interventions and goals for 5 of 5 (Patients #1, 2, 3, 6, and 8) active clinical records reviewed and include the frequency of skilled nursing visits in 1 of 5 (Patient #3) active clinical records reviewed, as required by agency policy. Findings Include: 4. A review of Patient's #1 plan of care with a recertification period of 02-15-2023, through 04-15-2023, failed to evidence complete and specific goals including, Cardio-Pulm Assessment(heart/lungs), Medication set-up/management of automatic dispensing machine, GU/Renal status(kidney/bladder), Neurological Status, and home health aide. The plan of care failed to contain specific parameters for GU/Renal status, and neurological status. 5. A review of Patient #3's plan		(xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Director of Nursing/designee will audit all plans of care submitted weekly to ensure they contain all required elements. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will audit all current plans of care to ensure they contain all required elements. If a plan of care is missing a required element, a verbal order will be obtained to add missing element(s) by 05/25/2023. Director of Nursing will in-service nurses on requirement to provide patients a current list of meds. Nurses are to check home folder each visit for current medication list and document whether one is present or not. Director of Nursing/designee will audit all visit notes submitted weekly to ensure there is documentation regarding presence of current medication list. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will instruct nurses to check home folders of all current patients to ensure there is a current medication list. If there is not a current medication list one will be provided to patient and placed in folder. Nurse will document in chart if current medication list is present and if not present one will be provided. Director of Nursing will audit all notes submitted weekly until there is documentation all patients have a current medication list in home folder. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

	of care with a recertification period of 03-09-2023, failed to evidence goals for vital signs, medication safety, pulse oximetry (oxygen level), respiratory status, GU/Renal status (kidney/bladder), nutrition and hydration, gastrointestinal (stomach), bowel movements, neurological status (brain function), teaching on the disease process of kidney failure and disease complications, chest pain management, medication compliance, and fall precautions. The POC failed to evidence a specific goal in relation to infection control and for medication safety, the goal for both stated, “Patient will remain safe at home during plan of care." 6. A review of Patient #8’s plan of care with a recertification period of 02-08-2023 to 04-08-2023, failed to evidence complete and specific goals including, medication compliance, disease process, pain level, HHA aide, fall precautions and transfer safety, vital signs (blood pressure, pulse, lung sounds), weight monitoring, anticoagulation therapy(blood thinners), and			

	chest pain management. The plan of care failed to contain specific parameters for blood pressure, weight management, pain level, and call orders to the physician when the parameters are out of range. 410 IAC 17-13-1(a)(1)(D)(iv, xiv) 1. On 04-25-2023 at 09:12 AM, a review of an undated agency policy titled “Plan of Care”, policy number C-580, indicated but was not limited to, “… Type, frequency, and duration of all visits/services… Treatment goals…." 2. A review of the clinical record for Patient #2, with the start of care date of 11-28-2017, contained a plan of care (POC) for the recertification period of 03-02-2023 to 04-30-2023. The POC indicated orders for Skilled Nursing (SN) every 60 days for recertification evaluation and Home Health Aide (HHA) 4 hours a day, 5 days a week for 26 weeks for personal care and Activities of daily living (ADL). The POC contained an "Orders and Goals" section that indicated but was not limited to, "... Order: Skilled nursing to			

	Cardiovascular/Pulmonary Status. Goal: (none listed)... Order: Skilled nursing to assess and evaluate: Fall precautions, Transfer safety. Goal: (none listed)... Order: Skilled nursing to teach and instruct: Signs and symptoms of hypo/hyperglycemia and appropriate actions to take. Goal: (none listed)...." The POC failed to evidence patient-specific measurable goals. 3. A review of the clinical record for Patient #4, with the start of care date of 12-20-2017, contained a POC for the recertification period of 03-24-2023 to 05-22-2023. The POC indicated orders for SN every 60 days for recertification evaluation and HHA 6 hours a day, 7 days a week, for 9 weeks for ADLs and Instrumental Activities of daily living (IADL). The POC contained an "Orders and Goals" section that indicated but was not limited to, "... Order: Skilled nursing to assess and evaluate: Cardiovascular/Pulmonary status. Goal: (none listed)... Order: Skilled nursing to teach and instruct: Disease process and potential complications.			

	Goal: (none listed)...." The POC failed to evidence patient-specific measurable goals.			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to promptly notify the attending physician of a hold in home health aide care visits until the last day of the hold or until after the visits were held for 1 of 2 (Patient #3) active clinical records reviewed with missed care visits. Findings Include: A review of the clinical record for Patient #3 indicated a start of care of 08-02-2018 and a recertification period of 03-09-2023 to -5-07-2023 with orders for a home health aide (HHA) 5 days a week for 4 hours a day to assist with activities of daily living (ADL's) and Instrumental Activities of Daily	G0590	Director of Nursing will in-service nurses that MD is to be notified promptly of change in patient condition or needs that suggest outcomes are not being achieved and/or that the plan of care should be altered. Director of Nursing/designee will audit all documentation submitted weekly to ensure if there is documentation of a change in patient condition or needs that suggest outcomes are not being achieved and/or that the plan of care should be altered, which includes visits being placed on hold, there is documentation MD has been notified. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will in-service nurses on requirement to document how patient will get needs met when an aide visit is not done, notify MD of missed visits timely and to send orders to MD timely by 05/30/2023. Director of Nursing/designee will audit all visit notes submitted weekly to ensure ordered frequency is maintained. If frequency is not met there should be documentation MD was notified promptly. There should be documentation how patient had needs met in the absence of the aide. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-05-25

personal hygiene, safe transfers, light housekeeping, and meal preparation. A review of visit notes evidenced that during the weeks of March 13 through March 24th the home health aide did not make any scheduled visits.

A document received from the administrator on 04-24-2023 at 2:15 PM titled "Verbal Order" indicated the agency placed a request with the physician to approve a hold order for the home health aide for the dates of March 13th-March 24th. The document was dated 04-24-2023. The agency failed to notify the physician of the missed visits at or near the time the missed visits occurred.

410- IAC 17-3-1(a)(2)

1. On 04-25-2023 at 09:12 AM, a review of an undated agency policy titled "Plan of Care", policy number C-580, indicated but was not limited to, "... Professional staff shall promptly alert the physician to any changes that suggest a need to alter the Plan of Care ...."

2. A review of the clinical record for Patient #2, with the start of

	contained a plan of care (POC) for the recertification period of 03-02-2023 to 04-30-2023. The POC indicated orders for Home Health Aide (HHA) 4 hours a day, 5 days a week for 26 weeks for personal care and Activities of daily living (ADL). A review of documents titled "Aide Visit Note – Daily" failed to evidence HHA visits during the weeks of 03-13-2023 through 03-24-2023. On 04-21-2023 at 02:28 PM, the Administrator provided a document titled "Verbal Order", dated and signed by the Administrator on 04-21-2023. The document indicated the agency requested HHA services be placed on hold for Patient #2 for the dates of 03-13-2023 to 03-24-2023. The agency failed to promptly notify the physician of the missed visits at or around the time the missed visits occurred.			

	3. On 04-21-2023 at 02:28 PM, the Administrator indicated the aide was unavailable for the weeks of 03-13-2023 to 03-24-2023, and Patient #2 refused a replacement. The Administrator stated, "I just sent the order to the physician now."			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on observation and record review, the agency failed to provide an updated list of medications, schedules, dosages, and indications in 1 (Patient #4) of 3 home visits. Findings Include: During an observation at Patient #8's residence on 04-21-2023 at 12:00 PM, a folder containing patient information failed to evidence a current list of medications and instructions. 1. On 04-21-2023 at 12:40 PM, the Administrator provided an	G0616	Director of Nursing will in-service nurses on requirement to provide patients with an updated list of medications that includes doses, when to take and indications. Director of Nursing will in-service nurses on requirement to provide patients a current list of meds. Nurses are to check home folder each visit for current medication list and document whether one is present or not. Director of Nursing/designee will audit all visit notes submitted weekly to ensure there is documentation regarding presence of current medication list. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will instruct nurses to check home folders of all current patients to ensure there is a current medication list. If there is not a current medication list one will be provided to patient and placed in folder. Nurse will document in chart if current medication list is present and if not, present one will be provided. Director of Nursing will audit all notes submitted weekly until there is documentation all patients have a current medication list in home folder. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-05-25

	"Medication Management", the policy indicated but was not limited to, "... Program Specific... Specific instructions for how and when to take the medications will be reviewed and documented... Medication Orders... b. Dose and time drug is to be given and any time limitations. c. Indication for the drug...." 2. On 04-21-2023 at 12:40 PM, the Administrator provided an undated policy titled "Medication Profile", the policy indicated but was not limited to, "... The profile will be reviewed and updated as needed to reflect current medications the client is taking... To provide a complete list of ALL medications the client is taking and an evaluation of the client's knowledge of the effects of these medications...." 3. On 04-21-2023 at 8:00 AM, an interview was conducted at Patient #4's residence. The Patient indicated they were unable to locate their admission folder since they moved to their new residence.			
G0640	Quality assessment/performance improvement	G0640	Administrator will ensure agency maintains a Quality Assessment and Performance	2023-05-25

	484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the agency failed to provide documentation they had maintained a Quality Assessment and Performance Improvement program for 2023. The cumulative effects of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.65, Quality Assessment and Performance Improvement. Findings Include: 1. On 04-25-2023 at 09:40 AM,		Improvement (QAPI) program yearly. (On-going) Administrator will implement the Quality Assessment and Performance Improvement program for 2023 by 05/25/2023. Administrator will ensure Governing Body Minutes reflect QAPI policies and procedures were reviewed and/or discussed. Minutes will also reflect the concerns identified and discussed. (On-going) Governing Body will meet to review QAPI policies and procedures for 2023. The implementation of the QAPI plan will be discussed. This will be reflected in the meeting minutes by 05/25/2023. Administrator will in-service staff on what areas/issues are being monitored for the QAPI program and what documentation is to be completed regarding those areas/issues by 05/25/2023. Administrator/Director of Nursing will review documentation regarding areas/issues being monitored for QAPI monthly. (On-going) Administrator/Director of Nursing will ensure the staff is in-serviced quarterly on any issues found with the areas being monitored for QAPI. There will be documentation of what education was provided, who will be monitoring issues for improvement. (On-going) Administrator/Director of Nursing will implement a performance improvement plan for falls and ensure staff are in-serviced on the components of the plan by 05/25/2023. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

	Quality Assessment and Performance Improvement,)" was reviewed and contained a policy titled "Performance Improvement". The policy indicated but was not limited to, "... AM-PM Home Health Services shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes... Special Instructions ... 7. The Board of Directors will receive information about findings and activities that is needed to fulfill their responsibility for the quality of client care and safety and security of clients, staff, and others ... 13. The Performance Improvement Plan is evaluated at least annually ...." 2. On 04-25-2023 at 09:16 AM, the Administrator provided a binder titled "Governing Body Minutes". The binder contained Governing Body minutes from June 15, 2022, September 23, 2022, and January 3, 2023. There was no evidence QAPI and policies and procedures were reviewed or discussed. 3. On 04-25-2023 at 09:40 AM,			

	Assurance/Performance Improvement" were reviewed. The years were noted on the documents, 3 of the 4 documents had the year 2022 and 1 of the 4 documents had the year 2023. The documents evidenced a review of issues that indicated but was not limited to, "Infection control ... Incidents... QAPI/Quarterly chart audits ... compliance issue s...." There was no documentation/evidence of performance improvement plans initiated. 4. On 04-25-2023 at 11:26 AM, an interview with the Administrator and Alternate Administrator was conducted. When queried regarding the involvement of the governing body, the Administrator indicated the governing body was aware of the incidents and they communicated with the governing body the concerns. There was no evidence in the Governing Body notes of QAPI or incidents being discussed. 5. On 04-25-2023 at 11:03, a document titled "Aide Meeting Notes", dated January 21, 2023, was reviewed. The document indicated but was not limited to,			

	"... Nurses ... went over ... Incident reports (Falls, hospital, and missed visits). Aides were advised again how important it is to call the online phone after hrs (sic hours) or office during hours to let them know if there is an issue with any of the clients ...." There was no documentation/evidence of any further in-service training or performance improvement plans initiated. On 04-25-2023 at 11:26 AM, an interview with the Administrator and Alternate Administrator was conducted. The Alternate Administrator indicated they saw a trend of falls increasing in the past few months. The Administrator indicated they would educate the Home Health Aides (HHA). There was no evidence of performance improvement plans initiated. 410 IAC 17-12-2(a)			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard	G0682	G0682 Administrator has created a COVID-19 Vaccination Policy per CMS requirement by 05/11/2023 Governing Body met and approved COVID-19 Vaccination Policy by 05/10/2023 Administrator will in-service staff on the COVID-19 Vaccination policy and the requirement to provide proof of COVID	2023-05-25

precautions, to prevent the transmission of infections and communicable diseases.

Based on record and interview, the agency failed to implement standard precautions to include the CMS COVID-19 vaccination mandate and failed to implement mitigation precautions for unvaccinated healthcare professionals providing direct patient care during the entire COVID-19 public health emergency pandemic.

The findings include:

1. During an interview with Administrator 1 on 04-21-2023 at 10:24 AM, she indicated the agency did not require eligible staff to receive the COVID-19 vaccination as she did not think it was required. Staff were not required to be/become fully vaccinated and/or submit documentation of a medical or religious exemption.

2. A review of a 3-4-2020 document issued by the Center for Medicaid and Medicare Services (CMS) titled "Attachment G: Home Health Agencies" indicated, but was not limited to; HHAs [Home Health Agencies] must have a

vaccination or complete an exemption request by 05/25/2023.

Administrator/designee will audit all current employee files daily until all current employees have either proof of COVID-19 vaccination or an approved exemption. (On-going)

Administrator/designee will audit all new employee files to ensure there is proof of either COVID vaccination or anexemption. Employees will not be allowed to work until proof has been provided. (On-going)

Administrator will in-service staff they are to notify Director of Nursing if they test positive for COVID. Nurses are to notify Director of Nursing if a patient tests positive for COVID by 05/25/2023.

Administrator will in-service staff who have a medical/religious exemption that is highly recommended they wear a mask when providing patient care. If they are coughing, they must wear a mask. They are to notify supervisor immediately if they are running a fever. They are to contact Administrator/Director of Nursing for any questions or concerns.

The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.

have received at least a single-dose, or the first dose of a multi-dose COVID-19 vaccine series prior to providing any care, treatment, or other services for the facility and/or its patients. The policy must also ensure those staff who are not yet fully vaccinated, who have been granted an exemption or accommodation as authorized by law, or who have a temporary delay, adhere to additional precautions that are intended to mitigate the spread of COVID-19 ..."

3. During an interview with the Administrator on 04-2-2023 at 10:36 AM, she indicated the agency had completed incident reports for COVID-19 positive patients that were hospitalized and was unsure if any patients had been hospitalized in 2022 with the infection. She indicated the agency required staff to notify them if they were COVID-19 positive. No tracking information of positive COVID-19 employees or patients was provided.

4. A review of the Agency's policies and procedures received from Administrator

	titled, "AM-PM HOME HEALTH SERVICES LLC'S COVID 19 (sic Covid-19) PLAN," evidenced the absence of policies and procedures addressing allowable vaccination exemptions and additional precautions for unvaccinated staff to mitigate the risk of spread of COVID-19. The administrator indicated the Agency followed OSHA (Occupational Health and Safety Administration) when developing their COVID-19 policies and procedures, not CMS. 410 IAC 17-17-12-1(m)			
G0684	Infection control 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and	G0684	Administrator will in-service nurses on need to track and investigate infectious and communicable diseases for patients as part of the Quality Assurance and Process Improvement Program (QAPI) by 05/22/2023. Director of Nursing will in-service nurses on completing infection control reports for patients who are diagnosed with an infectious or communicable disease and/or are started on antibiotics. This is part of the Quality Assurance and Process Improvement (QAPI) program. 05/15/2023. Director of Nursing will in-service staff on COVID-19 policy and steps to protect themselves and patients by 05/25/2023. Director of Nursing/designee will enter these reports on a log. They will implement a process improvement plan based on the analysis and investigation of the report. Staff and patients, as appropriate, will be provided	2023-05-25

	(2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview, the agency failed to maintain a quality assurance performance improvement program (QAPI) that provided surveillance, tracking, and investigation of infectious and communicable diseases including COVID-19 from 3-4-2020 until current (the duration of the public health emergency for COVID-19) for 1 of 1 home health agency. A document received on 04-24-2023 at 11 AM from the Alternate Administrator, RN, titled, “Monthly Event Record” contained but not limited to, “ Infectious Disease Reporting-EMPLOYEE ILLNESS…2020." For each month of 2020 the following information was documented related to employees with Covid-19 initials, date agency notified, diagnosis, treatment, and resolution including when they would return to work. No other documents were provided for tracking Covid-19 infection occurrences.		education as needed based on analysis and trends. (On-going) Director of Nursing/designee will review these reports monthly to ensure they are complete. (On-going) Director of Nursing/designee will implement training as needed quarterly based on analysis of these reports. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

Findings Include:

1. On 04-25-2023 at 09:40 AM, a binder titled, "QAPI (sic Quality Assessment and Performance Improvement)" was reviewed and contained a policy titled "Performance Improvement". The policy indicated but was not limited to, "... AM-PM Home Health Services shall establish a performance improvement plan to continuously measure, assess, and improve the performance of clinical and other processes... Special Instructions... 7. The Board of Directors will receive information about findings and activities that is needed to fulfill their responsibility for the quality of client care and safety and security of clients, staff, and others... 13. The Performance Improvement Plan is evaluated at least annually...."

2. On 04-25-2023 at 09:16 AM, the Administrator provided a binder titled "Governing Body Minutes". The binder contained Governing Body minutes from June 15, 2022, September 23, 2022, and January 3, 2023.

	There was no evidence QAPI and policies and procedures were reviewed or discussed. 3. On 04-25-2023 at 09:40 AM, documents titled "Quality Assurance/Performance Improvement" were reviewed. The years were noted on the documents, 3 of the 4 documents had the year 2022 and 1 of the 4 documents had the year 2023. The documents evidenced a review of issues that indicated but was not limited to, "Infection control... Incidents... QAPI/Quarterly chart audits... compliance issues...." There was no evidence of performance improvement plans initiated. 4. On 04-25-2023 at 11:26 AM, an interview with the Administrator and Alternate Administrator was conducted. When queried regarding the involvement of the governing body, the Administrator indicated the governing body was aware of the incidents and they communicated with the governing body the concerns. There was no evidence in the Governing Body notes of QAPI or incidents being discussed.			

G0687	COVID-19 Vaccination of Home Health Agency staff 484.70 (d)-(d)(3)(i-x) § 484.70 Condition of Participation: Infection Prevention and Control. (d) Standard: COVID-19 Vaccination of Home Health Agency staff. The home health agency (HHA) must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine. (1) Regardless of clinical responsibility or patient contact, the policies and procedures must apply to the following HHA staff, who provide any care, treatment, or other services for the HHA and/or its patients: (i) HHA employees; (ii) Licensed practitioners; (iii) Students, trainees, and volunteers; and (iv) Individuals who provide care, treatment, or other services for the HHA and/or its patients, under contract or by other arrangement. (2) The policies and procedures of this section do not apply to the following HHA staff: (i) Staff who exclusively provide telehealth or telemedicine services outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section; and	G0687	Administrator has created a COVID-19 Vaccination Policy per CMS requirement by 05/11/2023 Governing Body met and approved COVID-19 Vaccination Policy by 05/10/2023 Administrator will in-service staff on the COVID-19 Vaccination policy and the requirement to provide proof of COVID vaccination or complete an exemption request by 05/25/2023. Administrator/designee will audit all current employee files daily until all current employees have either proof of COVID-19 vaccination or an approved exemption. (On-going) Administrator/designee will audit all new employee files to ensure there is proof of either COVID vaccination or an exemption. Employees will not be allowed to work until proof has been provided. (On-going) Administrator will in-service staff they are to notify Director of Nursing if they test positive for COVID. Nurses are to notify Director of Nursing if a patient tests positive for COVID by 05/25/2023. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-05-25

(ii) Staff who provide support services for the HHA that are performed exclusively outside of the settings where home health services are directly provided to patients and who do not have any direct contact with patients, families, and caregivers, and other staff specified in paragraph (d)(1) of this section.

(3) The policies and procedures must include, at a minimum, the following components:

(i) A process for ensuring all staff specified in paragraph (d)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the HHA and/or its patients;

(ii) A process for ensuring that all staff specified in paragraph (d)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations;

(iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19;

(iv) A process for tracking and securely

	of all staff specified in paragraph (d)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the HHA has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the HHA's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;			

(ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and

(x) Contingency plans for staff who are not fully vaccinated for COVID-19.

Based on observation, record review, and interview, the agency failed to ensure their COVID-19 Vaccine Mandate policy and procedures were implemented and failed to ensure that the agency met the COVID-19 Vaccine Mandate at 100% compliance for 21 of 21 employees that provide the agency's direct care and the with the potential of adverse outcomes for the agency's current 27 patients.

The findings include:

1. A review of a document received from Administrator 1 on 04-21-2023 at 11:04 AM, titled, "AM-PM HOME HEALTH SERVICES LLC'S COVID 19 PLAN," with no date of implementation indicated, contained but was not limited to, " AM-PM HOME HEALTH SERVICES LLC is committed to

	providing a safe and healthy workplace for all employees ... has developed the following COVID 19 plan, which includes policies and procedures to minimize the risk of transmission of COVID-19, by OSHA's (sic Occupational and Safety Health Administration) Covid ... encourages employees to receive the COVID-19 vaccination ... " The agency failed to implement a policy regarding the COVID-19 guidelines according to the Centers for Medicaid and Medicare (CMS) COVID-19 vaccination mandate for CMS participants. 2. A review of a document received from Administrator 1 on 04-21-2023 at 11:04 AM titled, "AM PM COVID-19 EMERGENCY PLAN, Caring for Clients in their home," dated November 11th, 2020, contained but not limited to, "When making a home visit ... Complete (name of electronic medical record) questionnaire for client and self weekly ... Prevention measures (Mask procedure and Hand Washing) ... Monitor your client's symptoms ... a) If the client has			

	cough, or shortness of breath, both the client and the caregiver should wear face masks. B. If you suspect a possible Covid-19 case assist the client in contacting their health care (sic healthcare) provider ... WHAT TO DO IF YOU ARE ILL OR TEST POSITIVE FOR COVID ... Inform Agency Staff ... your client will be re-assigned (sic reassigned) ... stay home when you're sick ... Return to work when the following conditions have been met per CDC (Center for Disease Control) ... AM PM highly recommends all staff to receive the COVID vaccine to help ensure protection for yourself and your clients." The agency failed to implement and update policies and procedures to address additional precautions for unvaccinated staff by not monitoring vaccination status or implementing additional precautions for unvaccinated staff to mitigate the spread of Covid-19, in accordance with CMS's vaccination for COVID-19 (or evidence of a medical or religious exemption) mandate of . 3. A review of a document			

	issued by the Center for Medicaid and Medicare Services (CMS) titled "Attachment G: Home Health Agencies" indicated, but was not limited to; HHAs [Home Health Agencies] must have a process for ensuring all staff ... have received at least a single-dose, or the first dose of a multi-dose COVID-19 vaccine series prior to providing any care, treatment, or other services for the facility and/or its patients. The policy must also ensure those staff who are not yet fully vaccinated, who have been granted an exemption or accommodation as authorized by law, or who have a temporary delay, adhere to additional precautions that are intended to mitigate the spread of COVID-19 ... From 90 days on, the expected minimum threshold will be 100%. 4. During an interview with Administrator #1 on 04-21-2023 at 10:24 AM, she indicated the agency did not require staff to receive the Covid -19 vaccination as she did not think it was required. When queried regarding the implementation date of the Agency's document			

	not able to provide a date.			
G0942	Governing body 484.105(a) Standard: Governing body. A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its quality assessment and performance improvement program. Based on record review and interview, the agency failed to demonstrate members of the governing body were responsible and completed a review of the agency's budget and Quality Assurance Performance Improvement Plan (QAPI) for 2022 and 2023. Findings Include: 1. On 04-20-2023 at 12:05 PM, a review of the agency's Admission packet was conducted. The Admission packet evidenced a document titled "Code of Conduct" indicated but was not limited to, "... the Governing Body, will comply with all applicable federal and state laws, applicable professional	G0942	G0942 Governing Body met to review the agency budget and to approve the areas to be monitored for the Quality Assurance and Process Improvement Program (QAPI) for 2023. This will be reflected in the Governing Body meeting minutes by 05/17/2023. Administrator will ensure Governing Body meeting minutes reflect was discussed/reviewed at the meetings. (On-going) Administrator will ensure Governing Body meeting minutes reflect yearly the review of the agency budget and what areas are to be monitored for the Quality Assurance and Process Improvement Program. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-05-17

	agency policy and procedures ...." 2. On 04-25-2023 at 09:16 AM, the Administrator provided a binder titled "Governing Body Minutes." The binder contained Governing Body minutes from June 15, 2022, September 23, 2022, and January 3, 2023. There was no documentation/evidence of Quality Assurance Performance Improvement (QAPI), policies and procedures, or that the agency's budget was reviewed or discussed among the governing body. 3. On 04-25-2023 at 11:21 AM, an interview was conducted with the Administrator. When queried regarding the discussions between the Governing Body members, the Administrator indicated they discuss what is going on with the patients, new hires, new patients, hospital visits, incidents, aide meetings, and possibly QAPI, Emergency Preparedness (EP), and the agency budget. The Administrator indicated the policies were reviewed but stated, "not necessarily documented in the minutes."			

	The administrator indicated there was no evidence in the Governing Body Meeting documents of QAPI, EP, policies and procedures, and the agency's budget having been discussed. 410 IAC 17-12-1(b)			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interviews, the agency failed to answer their 24-hours per day number 3 of 3 different days the number was called with the potential to affect all 27 agency patients. Findings Include: 3. On 04-23-23 at 4:10 PM the On-Call number was called and went to voicemail identifying the number as the On-Call number of AM-PM Home Health, a voice message was left requesting a call back to verify the On-Call number was active.	G0948	Administrator will in-service staff that calls placed to the on-call number are to be returned within 60 minutes by 05/12/2023. Administrator will randomly call the on-call number weekly to ensure if call is not answered immediately that a return call is received within 60 minutes. This will be documented on an "On-Call Tracking Log." (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-05-12

	No return phone call was received. 4. On 04-24-2023 at 06:38 AM the On-Call number was called and went to voicemail identifying the number as the On-Call number of AM-PM Home Health, a voice message was left requesting a call back to verify the On-Call number was active. 5. On 04-24-2023 at 8:35 AM received a phone call from the Agency's Owner from the office, reporting the voicemail should have been forwarded to the On-Call nurse. She was contacting the phone service provider for answers. 410 IAC 17-12-1(C)(1) 1. On 04-25-2023 at 09:12 AM, a review of an undated policy titled "Provision for 24-Hour RN (sic Registered Nurse) Availability" indicated but was not limited to, "... A Registered Nurse shall be accessible at all times, 24 hours per day, by telephone to meet client needs... The on-call Nurse shall respond to all messages in a timely manner...." 2. On 04-20-2023 at 09:10 PM,			

	the on-call (a nurse designated to respond to patient emergencies after office hours) number was called with a voicemail left that requested a return call. On 04-21-2023 at 08:43 AM, the Owner of the agency returned the call.			
N0000	Initial Comments This visit was for a State Re-licensure survey of a Home Health Agency Survey dates: 04-20-2023, 04-21-2023, 04-24-2023, and 04-25-2023 Census: 27 Unduplicated Skilled patients: 6 QR by Area 3 on 5-3-2023	N0000	AM-PM Home Health Services, LLC is submitting the following Plan of Correction in response to the 2567 issued by ISDH and/or CMS as it is required to do by applicable state and federal regulations. The submission of this Plan of Correction is not intended as an admission, does not constitute an admission by and should not be construed as an admission by AM-PM Home Health Services, LLC that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to patients of the Agency. AM-PM Home Health Services, LLC desires this Plan of Correction to be considered our Allegation of Compliance.	
N0442	Home health agency	N0442	Administrator will in-service Governing Body	2023-05-12

	administration/management 410 IAC 17-12-1(b) Rule 12 Sec. 1(b) A governing body, or designated person(s) so functioning, shall assume full legal authority and responsibility for the operation of the home health agency. The governing body shall do the following: (1) Appoint a qualified administrator. (2) Adopt and periodically review written bylaws or an acceptable equivalent. (3) Oversee the management and fiscal affairs of the home health agency. Based on record review and interview, the agency failed to document it had periodically reviewed the agency's bylaws since 2022, for 1 of 1 home health agency governing body. Findings Include: 1. On 04-20-2023 at 12:05 PM, a review of the agency's Admission packet was conducted. The Admission packet evidenced a document titled "Code of Conduct" indicated but was not limited to, " ... the Governing Body, will		on the need to review and/or update the agency bylaws yearly and indicate this in the meeting minutes by 05/12/2023. Administrator will review Governing Body meeting minutes to ensure there is documentation the bylaws were reviewed and/or updated at least yearly. (On-going) Governing Body met to review the agency bylaws and the meeting minutes reflect this by 05/12/2023. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

	federal and state laws, applicable professional standards of practice and agency policy and procedures ….” 2. On 04-25-2023 at 09:16 AM, the Administrator provided a binder titled “Governing Body Minutes.” The binder contained Governing Body minutes from June 15, 2022, September 23, 2022, and January 3, 2023. There was no documentation/evidence of the agency bylaws having been discussed/reviewed/or updated if needed by the Governing Body. 3. On 04-25-2023 at 11:21 AM, an interview was conducted with the Administrator. When queried regarding the discussions between the Governing Body members, the Administrator indicated they discuss what is going on with the patients, new hires, new patients, hospital visits, incidents, aide meetings, and possibly QAPI, Emergency Preparedness (EP), and the agency budget. The Administrator indicated the meeting minutes failed to indicate the agency’s bylaws			

	had been discussed in the 3 meetings above. There was no documentation/evidence in the Governing Body Meeting documents of the bylaws having been discussed by the Governing Body members.			
N0518	Patient Rights 410 IAC 17-12-3(e) Rule 12 Sec. 3(e) (e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided. Based on record review and interview, the agency failed to ensure their admission packets contained written information for their patients about Advance Directives information for 1 of 1 agency. Findings Include: 1. On 04-20-2023 at 12:05 PM, a review of the agency's Admission packet was conducted. The Admission packet evidenced a document	N0518	N0518 Administrator will in-service nurses on requirement for patients to receive information on Advanced Directives both written and verbally. Nurses are to document in chart information was given both verbally and written by 05/25/2023. Director of Nursing will review all admissions done weekly to ensure there is documentation information on Advanced Directives was given both verbal and written. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will instruct nurses to look at each current patient's home folder for written information on Advanced Directives. If there is no written information, then nurse is to take copy of the information and place in home folder. Nurse is to document if written information was present and if not then document a written copy was provided by 05/25/2023. Director of Nursing/designee will review all visit notes submitted weekly for documentation all patients have written information on Advanced Directives. Once all patients have written information audit for that can stop. Administrator/designee will make sure all new patient admission packets have written information on Advanced Directives. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure	2023-05-25

	titled "Admission Services Agreement Home health", that indicated, but was not limited to, " ... Acknowledgement of Information: I have received verbal and written information on the following: Advance Directives ...." 2. During a home visit at Patient #1's residence on 04-24-2023 at 02:00 PM, the agency's admission packet for the patient failed to evidence Advance Directive information. 3. During a home visit at Patient #4's residence on 04-21-2023, at 08:01 AM, Patient #4 indicated when they moved to this residence, they lost their admission packet and had been unable to locate the packet. 4. During a home visit at Patient #8's residence on 04-21-2023 at 12:00 PM, the agency admission packet was unable to be found in Patient #8's residence. 5. During an interview on 04-24-2023 at 10:35 AM with the Administrator, the Administrator indicated they would verbally inform the patients at their admission, of their options for Advance		recur.	

	written materials. 6. During an interview on 04-24-2023 at 11:16 AM with the Administrator, the Administrator provided a document titled "Advance Health Care Directives Your Right To Decide," which was prepared by Entity #1 with a revision date of November 1, 2018. The Administrator indicated they removed it from the admission packets, and the advance directive document was not in their patients' packets.			
N9999	Final Observations A review of Indiana Code 16-27-2.5, evidenced ... **(a)** A home health agency must:**(1)** have a written drug testing policy that is distributed to all employees; and **(2)** require each employee to acknowledge receipt of the policy. **(b)** A home health agency shall randomly test: **(1)** at least fifty	N9999	Administrator/designee will ensure 50% of aides are randomly selected for and drug tested annually. (On-going) Administrator will create a process for determining how the 50% are randomly selected by 05/25/2023 The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-05-25

percent (50%) of the home health agency's employees who: **(A)** have direct contact with patients, and **(B)** are not licensed by a board or commission under IC 25;... Sample Size Determination: The agency shall establish the number of affected employees as of July 1 of each year. From July 1 through June 30 of the following year, the agency must have test results for *at least* fifty (50) percent of the total number of affected employees established on July 1 of the prior year.

Based on record review and interview the agency failed to randomly drug test 50% of employees per state guidelines for 19 of 19 eligible employees from 2021 through 2022.

The findings include:

1. A review of a document titled, “Drug Testing Policy for all Employees," no date of implementation, received from Administrator 1, on 04-25-2023 at 10:15 AM, contained, but not limited to, “Sec. 2 (sic Section) (b) ...a home health agency shall randomly test: (1) at least fifty

	percent (50%) of the home health agency's employees who (A) have direct contact with patients; and (B) are not licensed by a board of commission under IC 25;..." 2. During an interview on 04-25-2023 at 9:58 AM with the administrator, she reported the agency had not done the 50% drug screening annually for the required unlicensed direct care providers (home health aides) employees since 2020.			

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
Tonisha Harrington	RN Administrator	5/18/2023 12:06:20 PM