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	09/08/2023

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
G0000	INITIAL COMMENTS This visit was for a 3rd revisit of a Home Health Provider, to conduct a Post Condition Revisit (PCR) survey. The 1st revisit occurred on 06-08-23, with the 2nd revisit occurred on 07-18-2023. Survey Dates: 09/06/2023, 09/07/2023, 09/08/2023 Census: 22 Unduplicated Skilled Patients: 3 The agency removed the Conditions of Participation: Care Planning, Coordination of Services, and Quality of Care, 484.60 and 5 citations were corrected. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Condition-level deficiencies	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 Plan of Correction to be considered our Allegation of Compliance."	

	were first identified during April 24, 2023 survey, in which your agency was subject to a fully extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act, and continued at the first PCR survey on 06-06-2023 and 06-08-2023, Condition-level deficiencies were also cited during this PCR survey on 07-20-2023. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency continues to be precluded from operating or being the site of a home health aide training, skills competency, and/or competency evaluation program for a period of two years beginning April 24, 2023, and continuing through April 24, 2025. Quality Review Completed 09/14/2023			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and	G0528	Director of Nursing will in-service nurses on requirement for comprehensive assessments to accurately reflect patient's relevant medical history and current health problems and meet their needs by 09/20/23. Director of Nursing, ADON RN, and/or manager will review all active patients most recent comprehensive assessment to ensure it accurately reflect patient's relevant medical history and current health problems and meet	2023-10-08

	interview, the agency failed to ensure the comprehensive assessment reflected the patient's relevant medical history and current health problems; ability to identify and meet one's needs for 3 of 3 active patients whose records were reviewed. (Patients #2, 4 and 5) Findings include: 1. A review of an agency's undated policy titled 'DOCUMENTATION OF CHANGES TO THE MEDICAL RECORD C-873' revealed, "...Accuracy and correct documentation of the OASIS assessments are critical components...as well as regulation...3. If it is necessary to make an addition to a previous entry, this must be done using an addendum to the record...4. Changes to OASIS Documentation...b. The clinician who completes the assessment form is responsible for making changes (corrections, revisions, or additions) to the document. c...These changes must be documented in the record identifying the reason for the changes and the communication of those		their needs. Any comprehensive assessment that doesn't accurately reflect patient's relevant medical history and current health problems and meet their needs will be corrected by the nurse that did the assessment. Nurse will document date and reason assessment is being revised by 10/08/23. Director of Nursing, ADON, and/or manager will review all comprehensive assessments done each week to ensure they accurately reflect patient's relevant medical history and current health problems and meet their needs. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Administrator will contact the EMR (electronic medical record) vendor to inquire why oxygen is automatically marked when a pulse oximetry is documented on 9/14/23. Director of Nursing will educate nurse on requirement to contact MD when the diet patient/family state is to be followed isn't consistent with the patient's medical condition. 9/14/23. Director of Nursing will ensure MD is contacted to clarify diet/nutritional intake for patient cited in survey by 9/21/23. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

	changes to the authoring clinician...6. Electronic Health Records (EHR) ...Distinctly identify any amendment, correction or delayed entry, and Provide a reliable means to clearly identify the original content, the modified content, and the date and authorship of each modification of the records. b. Auditors...shall NOT consider any entries that do not comply with these principles..." A review of an agency's undated policy titled 'CLIENT REASSESSMENT/UPDATE OF COMPREHENSIVE ASSESSMENT C-155' revealed...The Comprehensive Assessment will be updated and revised as often as the client's condition warrants due to major decline or improvement in health status...2. Within forty-eight (48) hours of (or knowledge of) client return home from hospital admission of more than twenty-four (24) hours for any reason...To identify decline or improvement in health status, modify the plan of care and document changes that may affect care...9. The assessment will identify the problems, needs...10. Revisions to the plan of care must be			

	communicated...to the client, ..., caregiver, and all physicians...issuing orders..." A review of an agency's undated policy titled, 'COMPREHENSIVE CLIENT ASSESSMENT C-145' revealed, "...A thorough, well organized, comprehensive and accurate assessment...will be completed for all clients...2...a. The Comprehensive Assessment must accurately reflect the client's status..." 2. A review of the assessment for Patient #2, dated 07/31/2023, evidenced diagnoses, but not limited to multiple sclerosis (A disease in which the immune system eats away at the protective covering of nerves, resulting nerve damage that disrupts communication between the brain and the body), Abnormalities of gait and mobility, overweight and obesity. The assessment indicated Patient #2 had dependent, pitting severity, +3 edema, but did not indicate which extremity(s), oximeter reading was 96%, indicated patient was on oxygen but failed to indicate how may liters			

per minute, indicated lung sound were diminished, failed to identify if lung sounds were clear, crackles, rales, wheezes or rhonchi were present; indicated Patient #2 was incontinent of urine and uses a Purewick external catheter (uses suction and a soft, flexible wick to draw urine away from the body into a sealed collection canister, helping to keep skin dry), but failed to assess for odor, blood in urine, painful urination, and clarity; indicated Patient #2 scored 30 on the nutritional Health Screen, with 30-55 being a Moderate Nutritional Risk-Provide dietary education, consult with dietician PRN (as needed), and consult with the patient physician regularly. The assessment for Patient #2 failed to reflect Patient #2's current health problems and failed to identify a consultation with a dietician.

A review of the pediatric assessment for Patient #4, dated 08/16/2023, evidenced diagnoses, but not limited to Bainbridge Ropers Syndrome (a very rare genetic disorder characterized by abnormalities including severe psychomotor development, feeding

problems, severe postnatal growth delays, intellectual disabilities, and skeletal abnormalities), failure to thrive, hypotonicity (decreased muscle tone) of limbs, and G-tube (a tube is passed into a patient's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate) feedings. The assessment failed to indicate whether Patient #4's skin was clammy, cold, cool, diaphoretic, hot, or warm, heart sounds, skin color: cyanotic, dusky, pale, pink, flushed, or jaundice, lung sounds, gastrostomy (tube for feedings) size, date last changed, flushing amount/frequency; indicated there was a prosthesis/appliance but did not identify body part affected. The assessment for Patient #4 failed to reflect Patient #4's current health problems.

3. On 09/08/2023 at 2:30 PM, the administrator indicated anytime you document an oximeter reading on the assessment, the electronic medical record automatically marks the patient receiving oxygen, and indicated Patient #2 was not on oxygen. The

	administrator indicated that assessments won't be 100% accurate. When queried about Patient #2 dietary consult, the administrator stated, "We don't make referrals". On 09/08/2023 at 1:15 PM during an interview, the Administrator indicated the agency was now auditing the comprehensive assessments of all clinical records, checking the OASIS/non-OASIS and current Plans of Care to ensure continuity. The Administrator indicated that she had trained 3 non-clinical staff members to review the assessments, by reviewing OASIS and looking at diagnoses and went page by page to ensure elements had been completed. The Administrator indicated the agency had also been utilizing the services of a consultant who recommended the agency just needed to correct "current assessments", but older assessments could be updated when the next assessment was due. 4. A review of the pediatric			

assessment for Patient #5, dated 07-13-2023 evidenced diagnoses including, but not limited to: Charges Syndrome (a genetic condition that affects many parts of a child's body including their heart, nerves, genitals, eyes and ears. Feeding difficulty affects up to 90% of children with this syndrome and aspiration [when something you swallow "goes down the wrong way" and enters your airway or lungs] is seen in 60-70% of children), and underweight (means weight is lower than it should be for your health, healthy body weight depends on your sex and height, and for children, age). The assessment indicated the patient was to follow a 'regular' diet. Height: 5'4" Weight: 92 lbs.

5. On 08-08-2023 at 1:00 PM when queried as to the diet order for Patient #5, the Administrator indicated this what caregiver/family member told her. When queried as to whether the physician had been contacted to verify the diet or additional supplementation in light of the 'underweight' diagnosis, the Administrator indicated she had not contacted the physician to verify the

	matter. 410 IAC 17-15-1(a)			
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on observation, record review, and interview the agency failed to ensure patient's comprehensive assessment was updated and revised when there was a change in condition in 1 of 5 active clinical records reviewed. (Patient #3) Findings include: On 08-06-2023 at 9:30 AM, during a home visit with Patient #3 and Home Health Aide 1, the aide was observed assisting with showering the patient. The patient undressed and removed a light-colored abdominal binder. Patient was observed	G0544	Director of Nursing will educate nurse on requirement to do a follow assessment when patient has a change in condition which includes having a surgical procedure done by 9/14/23. Director of Nursing will educate nurse on requirement to contact MD to obtain post-op orders and precautions when patient has a surgical procedure done. Plan of care will be revised to reflect any new orders by 10/8/23. Director of Nursing will educate nurse on requirement to notify all MDs involved in a patient's care of any change in patient condition by 9/14/23. Director of Nursing will audit all documentation submitted weekly to ensure if there is a change in patient condition documented there is documentation all MDs involved in patient's care have been notified. Once 100% compliance is achieved 10% will 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.	2023-10-08

	standing upright in the shower while keeping their left hand over a small white dressing, approximately 1 and 1/2 inches high by 4 inches wide, to the left abdomen while using their right hand to lather shampoo into the crown of the head. The patient continued to reach up with the right hand to rinse the hair while agitating vigorously to ensure the hair was free of shampoo. Later, out of the shower, the patient was observed bending at the waist to retrieve an object from the bathroom floor. While getting dressed, the patient required assistance to replace the abdominal binder over the site of the abdominal dressing. Review of undated agency policy received from the Administrator on 08--08-2023 titled, 'CLIENT REASSESSMENT/UPDATE OF COMPREHENSIVE ASSESSMENT C-155' stated, "POLICY A comprehensive assessment will be updated and revised as often as the client's condition warrants ... Reassessments must be done at least ... 4. ... Significant change or new diagnosis ... PURPOSE To identify decline or improvement			

	in health status, modify the Plan of Care and document changes that may affect care ... SPECIAL INSTRUCTIONS ... 2. Clients are assessed when significant changes occur in their condition ... 6. A marked improvement or worsening of a client's condition, which changes the plan of care needed and was not anticipated in the plan of care, would be considered a significant change ... 10. Revisions to the plan of care must be communicated as follows: a. Any revision in a plan of care due to a patient's health status must be communicated to ... ALL physician/allowed non-physician practitioners issuing orders for AM PM Home Health Services plan of care." Review of the clinical record for Patient #3 evidenced a Start of Care date of 07-19-2023 with a Certification period of 07-19-2023 to 09-17-2023 and contained diagnoses which included, but were not limited to: Spondylolysis (cracks or small fractures to the vertebrae of the spine often cause by repetitive stress) of lumbar (lower spine) and cervical (the neck portion of your spinal			

repeated falls, presence of pain pump (small device, implanted with surgery, that allows direct delivery of medicine to the area needed) and was signed by RN 1. The Plan of Care evidenced the admitting nurse was aware of Patient #3's upcoming surgery on 08-24-2023 by Doctor 4 to replace the patient's pain pump battery.

The clinical record also failed to evidence the registered nurse scheduled or performed a nursing visit after the patient returned home from the 08-24-2023 procedure, failed to perform follow-up assessment, and failed to contact Doctor 4 for subsequent after-care orders or precautions.

On 09-08-2023 at 12:34 PM, when queried as to the agency having had foreknowledge of Patient #3's pre-scheduled procedure on 08-24-2023, and what should have transpired afterwards, the Administrator indicated the nurse should have spoken to the physician, and should have obtained post-op orders and precautions.

On 09-08-2023 at 2:10 PM, in a

	registered nurse with Doctor 4, verified that Patient #3 had same-day surgery on 08-24-2023 to replace a pain pump battery and was sent home with an abdominal dressing, an abdominal binder, and instructions as to what to do and not to do, for four (4) weeks following the procedure. Person 5 indicated these instructions included but were not limited to: “no bending, lifting, twisting…no elbows above your ears, and reaching up, over, across or down” and, “wearing abdominal binder (except when showering) at all times for the next 30 days”. Person 5 also indicated there had been no communications (no phone calls or faxes) on record from AM PM Home Health Services, LLC. On 09-08-2023 at 2:49 PM, in the telephone interview Person 7 a registered nurse with Doctor 6, the primary care physician for Patient #3, indicated there had been no communications (no phone calls or faxes) on record from AM PM Home Health Services, LLC.. 410 IAC 17-14-1(a)(1)(B)			

G0602	Communication with all physicians 484.60(d)(1) Assure communication with all physicians or allowed practitioners involved in the plan of care. Based on record review and interview the agency failed to ensure the skilled nurse collaborated with the ordering physician after home health admission visits or reassessments were performed, to ensure the plan of care was established with the ordering provider in 2 of 5 active clinical records reviewed. (Patients #2 and #3) Findings include: 1. A review of an agency's undated policy titled 'Clinical Documentation C-680' indicated but was not limited to, "... 4. Telephone or other communication with...physicians... or members of the health care team will be documented in clinical progress notes or other interagency communication forms...". A review of an agency's	G0602	Director of Nursing will educate nurse on requirement to collaborate with ordering physician after admission and recertification visits to ensure the plan of care is established with the physician. Call to MD is to be documented on 9/14/23. Director of Nursing will audit all admissions and recertifications done weekly to ensure there is documentation nurse collaborated care with the ordering physician to establish the plan of care for the new certification period. 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 do a follow assessment when patient has a change in condition which includes having a surgical procedure done on 9/14/23. Director of Nursing will in-service nurses on requirement to contact MD to obtain post-op orders and precautions when patient has a surgical procedure done. Plan of care will be revised to reflect any new orders by 10/8/23. Director of Nursing will educate nurse on requirement to notify all MDs involved in a patient's care of any change in patient condition on 9/14/23. Director of Nursing will audit all documentation submitted weekly to ensure if there is a change in patient condition documented there is documentation all MDs involved in patient's care have been notified. Once 100% compliance is achieved 10% will 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.	2023-10-08

	'Coordination of Client Services C-360' indicated but was not limited to, "...The coordination of care is provided by all disciplines and included communication with physicians...4. Agency will communicate with ALL physicians...who are writing orders..." 2. A review of the comprehensive assessment for Patient #2, dated 07/31/2023 evidenced that care coordination occurred between the skilled nurse and the ordering physician. The POC (Plan of Care) dated 07/31/2023 indicated Person 8 of Entity 1 was the ordering physician.			

	3. During an interview on 09/08/2023 at 10:59 AM with Person 3 of Entity 1 indicated that they never receive phone calls from the agency for collaboration and development of the POC, and further indicated the agency always faxes any documents for the physician's signature as the agency recently faxed over orders for home health aide services on 08/23/2023 for increased hours but failed to call them. During an interview on 09/08/2023 at 1:29 PM, the administrator indicated they call the physicians for orders/updates. 4. Review of an undated agency document titled, 'PLAN OF CARE C-580' stated, "POLICY Home Care services are furnished under the supervision and direction of the client's physician/allowed non-physician practitioner (NPP)...Planning for care is a dynamic process that addresses the care, treatment, and services to be provided. The plan will be consistently reviewed to ensure			

	that client needs are met, and will be updated as necessary... PURPOSE To provided guidelines for agency staff to provide a plan of care developed to meet individualized identified specific needs...To assure that the plan meets state/federal guidelines, and all applicable laws and regulations...SPECIAL INSTRUCTIONS... 10. Professional Staff shall promptly alert the physician/allowed non-physician provider (NPP) to any changes that suggest a need to alter the plan of care. 11. Verbal/telephone orders shall be obtained from the client's physician/allowed non-physician practitioner (NPP) for changes in the Plan of Care..." Review of undated agency document titled, 'SERVICES PROVIDED – C-100' stated, "Services will be coordinated by the Registered Nurse...managing the care. This will include implementing, revising, and updating the Plan of Care; physician conferencing... ' 5. Review of the clinical record			

	of Care date of 07-19-2023 with a Certification period of 07-19-2023 and contained diagnoses which included, but were not limited to: Spondylolysis (cracks or small fractures to the vertebrae of the spine often cause by repetitive stress) of lumbar (lower spine) and cervical (the neck portion of your spinal column) regions, Chronic pain, repeated falls, presence of pain pump (small device, implanted with surgery, that allows direct delivery of medicine to the area needed) and was signed by RN 1. The record evidenced the admitting nurse was aware of Patient #3's upcoming surgery on 08-24-2023 with Doctor 4 to replace a pain pump battery. The Aide Care Plan signed by RN 1 and dated 7-19-2023, failed to evidence updates had been made to the aide care plan after patient had surgery to replace the patient's pain pump battery on 08-24-2023. The clinical record failed to evidence the registered nurse scheduled or performed a nursing visit after the patient returned home from the 08-24-2023 procedure, failed to perform follow-up assessment, failed to contact the physician			

	for subsequent after-care orders or precautions, and failed to ensure the aide care plan was updated to reflect the same. On 08-08-2023 at 9:30 AM, Patient #3 and HHA 1 indicated the Administrator had been the admitting nurse on this case. On 08-08-2023 at 12:34 PM, when queried as to the agency's foreknowledge of Patient #3's pre-scheduled procedure on 08-24-2023, and what should have transpired afterwards, the Administrator indicated the nurse should have spoken to the physician, should have obtained post-op orders and precautions and agreed the aide plan of care should have been updated accordingly. On 08-08-2023 at 2:10 PM, Person 5, a registered nurse with Doctor 4, verified that Patient #3 had same- day surgery on 08-24-2023 to replace a pain pump battery and was sent home with an abdominal dressing and instructions as to what to do and not to do, for four (4) weeks following the procedure and subsequent medication			

	could be different for each patient, could not provide medication specifics for Patient #3 but indicated this was likely written on the sheet the patient was given to take home after the procedure. Person 5 also indicated that there were no communications (no phone calls or faxes) on record from AM PM Home Health Services, LLC.. On 08-08-2023 at 2:49 PM, Person 7 a registered nurse with Doctor 6, the primary care physician for Patient #3, indicated there were no communications (no phone calls or faxes) on record from AM PM Home Health Services, LLC.. 410 IAC 17-14-1(a)(1)(G)			
G0604	Integrate all orders 484.60(d)(2) Integrate orders from all physicians or allowed practitioners involved in the plan of care to assure the coordination of all services and interventions provided to the patient. Deficiency corrected 08-27-2023. Deficiency corrected	G0604	Deficiency corrected 8/27/23	2023-09-21

	08-27-2023			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure field staff followed appropriate infection control practices per agency policy while providing patient care in 2 of 2 home visits conducted. (Patients #8 and 9) Findings include: 1. A home visit for Patient #8 was conducted on 08/07/2023, at 8:30 AM, to observe HHA (home health aide) 2 perform personal care. HHA 2 assisted Patient #8 upstairs into bedroom. HHA 2 turned the water on in the tub, set the paper towels on bedside table, and placed their nursing bag on the end of the bed, took out gloves and hand soap, placed	G0682	Director of Nursing will in-service all clinical staff on appropriate infection control practices to include proper handwashing, proper use of gloves and using barriers by 10/8/23. Director of Nursing will make home visit with each nurse/aide to observe their implementation of infection control practices 10/8/23. Director of Nursing will ensure all nurses/aides receive annual in-service on appropriate infection control practices to include proper handwashing, proper use of gloves and using barriers. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-10-08

	counter in bathroom, put their gloves in their pocket. Washed their hands at the bathroom sink, donned gloves, assisted Patient #8 with undressing, and into the tub. HHA 2 doffed their gloves, opened a closet door in the bathroom and handed a wash cloth to Patient #8, then went into the bedroom and began to remove sheets from the bed, stopped, and donned a pair of gloves, then proceeded with changing sheets and making bed. When completed, they asked if Patient #2 was ready, and they responded yes. HHA 2 doffed their gloves, washed their hands for 20 seconds, donned a clean pair of gloves, washed and rinsed the patient's back, then doffed gloves, returned to their nursing bag, retrieved more gloves, then returned to the sink, washed their hands for 20 seconds, donned clean gloves. Patient #2 was ready for assistance to get out of tub, HHA 2 dried their back off, then began to dry their lower extremities. Patient #2 then wrapped the towel around them, and returned to the bedroom, while HHA 2 washed their hands at the sink for approximately 8-10 seconds,			

	and donned a clean pair of gloves. HHA 2 began applying lotion to Patient #2 lower extremities and back, doffed their gloves, washed hands for 8-10 seconds, handed Patient #2 their deodorant and perfume, donned a clean pair of gloves, emptied the tub, doffed their gloves, and washed their hands 8-10 seconds. HHA 2 opened the bathroom closet door to retrieve 2 additional pillow cases, and finished making the bed. HHA 2 failed to wash their hands before entering their nursing bag, failed to place barriers for towels and soap, while providing care, and failed to follow the agency's policy on hand hygiene. 2. A home visit for Patient #9 was conducted on 09/08/2023, at 6:30 AM, to observe HHA 4 perform personal care. HHA 4 created a barrier, donned gloves, placed nursing bag on the barrier, assisted Patient #9 to the restroom, closed the door, went back to the bedroom, turned the patient's mattress, and made the bed. HHA 4 reached into their nursing bag, pulled out a bottle			

	shelving unit on computer desk, doffed their gloves, went into the kitchen, washed for 20 seconds, dried their hands, and turned the water off with bare hands. HHA 4 donned a clean pair of gloves, rinsed and dried Patients #9 cup, opened the refrigerator for a bottle of water, opened and poured it into the cup. HHA 4 returned the cup to the bedroom, and Patient #9 indicated they were finished and requested assistance from HHA 4. HHA 4 returned to the bathroom to assist Patient #9, closing the door for privacy, at 6:46 AM, HHA 4 opened the door, and Patient #9 returned to their bedroom, HHA 4 doffed their gloves, washed their hands for 20 seconds, dried. donned a clean pair of gloves and returned to the bedroom to assist Patient #9 with undressing. Shirt, braces on lower extremities, and socks were removed. HHA 4 doffed their gloves, escorted Patient #9 to the bathroom, handed Patient #9 their toothbrush, then HHA 4 handed Patient #9 a small cup with mouthwash. While Patient #9 rinsed their mouth, HHA 4 donned a pair of gloves, set up the shower, at			

	6:52 AM, HHA 4 assisted Patient #9 onto the shower chair, doffed their gloves, washed and dried their hands for 20 seconds and donned a clean pair of gloves. After the shower, HHA 4 dried and assisted Patient #9 with their underwear. Patient #9 went back to their bedroom, while HHA 4 proceeded to spray and wipe down shower chair and toilet. HHA 4 doffed their gloves, and performed hand hygiene for 20 seconds. Once in Patient #9 bedroom, HHA 4 donned a clean pair of gloves and assisted Patient #9 with deodorant and dressing. HHA 4 doffed their gloves, and handed Patient #9 their glasses. HHA 4 failed to wash their hands after making the patient's bed, before getting into their nursing bag, failed to create a barrier for the hand soap, failed to perform hand hygiene after undressing Patient #9 and before handing them their toothbrush and mouthwash, failed to perform hand hygiene after they applied deodorant and dressed Patient #9, and to follow the agency's policy on handwashing/hand hygiene. 3. A review of an agency’s			

	the administrator on 09/08/2023 titled, 'HANDWASHING/HAND HYGIENE D-330' revealed, " ... d. Between tasks on the same client ... f. After removing gloves. g. After touching objects that are potentially contaminated ... 2. When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by manufacturer to hands and rub hands together vigorously for at least 20 (twenty) seconds, covering all services of hand and fingers ... " 4. On 09/07/2023 at 2:30 PM, the administrator indicated HHA 2 shouldn't have reached into their nursing bag without washing their hands, that HHA 2 has been trained on hand hygiene and HHA 2 knew they should place a barrier. On 09/08/2023 at 1:15 PM, the administrator indicated HHA 4 shouldn't have reached into their nursing bag without washing their hands, and HHA 4 had been trained on setting area up using a barrier.			

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 (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Corrected 08/27/2023 Corrected 08/27/2023	G0684	Deficiency corrected 8/27/23.	2023-09-21
G0768	Competency evaluation 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under	G0768	Director of Nursing will audit all current aide employee files to ensure there is proof of written competency and skills competency completed by 10/08/23. Administrator instructed human resource staff that newly hired aides must do the written competency as well as the skills competency and completed documents must be completed and placed in their file by 10/08/23. Administrator will audit all newly hired aide employee files before they are assigned to see patients on their own to ensure there is documentation of the completed written competency and skills competency. (On-going) Agency is precluded from doing own competency testing at this time. Employee was	2023-10-08

	paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. Based on record review and interview, the agency failed to ensure a written competency and a skills competency was completed on 1 of 3 HHA record reviews. (HHA 3) Findings include: A review of of an agency's undated policy received from the administrator on 09/08/2023 titled 'PERSONNEL RECORDS D-180' revealed, "... Competency testing for home health aides and specific competencies per job title. On 09/08/2023 a review of HHA 3 personnel record with a hire date of 05/15/2023, failed to evidence a written and skills		CEO contacted that RN for copy of competency paperwork so it could be placed in employee file done 09/21/23. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

	competency testing performed by the agency. On 09/08/2023 at 10:40 AM during an interview with human resource 1 indicated they understood if a new hire that just completed the aide training and received their aide certificate the agency wouldn't need to perform a written and skilled competency testing after hire with the agency, they were certain the administrator observed HHA 3 during their check off for their Home Health Aide certification but didn't document it. 410 IAC 17-14-1(1)(A)			
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 observation, record review, and interview, the agency failed to ensure the aide	G0798	Director of Nursing will educate nurse on requirement to update aide care plan when there is a change in patient condition by 9/14/23. Director of Nursing will audit all current patient aide plans of care to ensure they have been updated if there has been a change in patient condition by 10/8/23. Director of Nursing will audit all nursing documentation submitted weekly and if there is documentation of a change in patient condition the current aide care plan will be reviewed to ensure it has been updated to reflect the change. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going)	2023-10-08

	care plan was updated after a change in condition of a patient in 1 of 5 active clinical records reviewed. (Patient #3) Findings include: On 09-06-2023 at 9:30 AM, during a home visit with Patient #3 and Home Health Aide (HHA) 1, the aide was observed assisting with showering the patient. The patient undressed and removed a light-colored abdominal binder. Patient was observed washing their own hair, standing upright in the shower while keeping their left hand over a small white dressing, approximately 1 and 1/2 inches high by 4 inches wide, to the left abdomen while using their right hand to lather shampoo into the crown of the head. The patient continued to reach up with the right hand to rinse the hair while agitating vigorously to ensure the hair was free of shampoo. Later, out of the shower, the patient was observed bending at the waist to retrieve an object from the bathroom floor. A review of an agency's undated policy provided by the Administrator on 09-08-2023		Director of Nursing will instruct nurse for patient cited in survey (#3) to revise aide plan of care to reflect changes as a result of outpatient procedure 8-24-2023 by 9/14/23. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

	titled, 'SKILLED PROFESSIONAL SERVICES C-200' revealed, "b. Development and evaluation of the plan of care in partnership with the client … and caregivers …" A review of an agency's undated policy provided by the Administrator on 09-08-2023 titled, 'HOME HEALTH AIDE SERVICES C-220' revealed, " … 1. The nurse … assesses the need for personal care services … a specific are plan is developed documenting the Aide services to be provided …" A review of an agency's undated policy provided by the Administrator on 09-08-2023 titled, 'HOME HEALTH AIDE SUPERVISION C-340' revealed, "1 … A copy of this written plan … revised periodically, as necessary." Review of the clinical record for Patient #3 evidenced a Start of Care date of 07-19-2023 with a Certification period of 07-19-2023 to 09-17-2023 and contained diagnoses which included, but were not limited to: Spondylolysis (cracks or small fractures to the vertebrae of the spine often cause by			

repetitive stress) of lumbar (lower spine) and cervical (the neck portion of your spinal column) regions, Chronic pain, repeated falls, presence of pain pump (small device, implanted with surgery, that allows direct delivery of medicine to the area needed). The Plan of Care evidenced the skilled nurse was aware of Patient #3's upcoming surgery on 08-24-2023 to replace a pain pump battery. The Aide Care Plan dated 7-19-2023, contained a frequency of home health aide visits 3 (three) times per week for 9 (nine) weeks and indicated the aide was to assist patient with shampooing weekly and showering each visit, "sponge bath up in chair" The Clinical record review failed to evidence a revised aide care plan post patient's surgery on 08-24-2023.

The clinical record failed to evidence the registered nurse ensured the aide care plan was updated to reflect revised physician orders post 08-24-2023, change in condition.

On 09-08-2023 at 12:34 PM,

	foreknowledge of Patient #3's pre-scheduled procedure on 08-24-2023, and what should have transpired afterwards, the Administrator indicated the nurse should have spoken to the physician, should have obtained post-op orders and precautions, and agreed the aide plan of care should have been updated accordingly.			

	On 09-08-2023 at 2:10 PM, in a telephone interview Person 5, a registered nurse with Doctor 4, verified that Patient #3 had same-day surgery on 08-24-2023 to replace a pain pump battery and was sent home with an abdominal dressing and instructions as to what to do and not to do, for four (4) weeks following the procedure. Person 5 indicated these instructions included but were not limited to: "no bending, lifting, twisting...no elbows above your ears, and reaching up, over, across or down" and "wearing abdominal binder (except when showering) at all times for the next 30 days". Person 5 also indicated that there had been no communications (no phone calls or faxes) on record from AM PM Home Health Services, LLC.. IAC 17-13-2(a)			
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;	G0800	Director of Nursing will in-service aides they are to follow the aide care plan. If patient is refusing tasks marked on care plan or requesting tasks not listed on care plan aide to notify the nurse. Aide is not to provide a task not marked on the care plan 10/8/23. Director of Nursing will audit all aide notes submitted weekly and compare note to aide care plan to ensure plan is being followed. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is	2023-10-08

	(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 record review and interview, the agency failed to ensure the HHA's (Home Health Aides) provided services delegated in the home health aide plan of care in 1 of 3 home visits conducted. (Patient #9). The findings include: A review of an agency's undated policy received from the administrator on 09/08/2023 titled, 'HOME HEALTH AIDE: DOCUMENTATION C-800,' revealed, "POLICY ... Home Health Aides will document care/services provided on the home health aide charting form. Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan ... 3. The designated Registered Nurse ... is responsible for reviewing the Home Health Aide's charting before it is placed in the chart ... " A review of an agency's undated policy received from the administrator on		maintained. (On-going) Director of Nursing will educate nurses on revising aide care plan based on patient needs/requests by 10/8/23. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

	09/08/2023 titled, 'HOME HEALTH AIDE SERVICES C-220' revealed, " ... 2. The aide will follow the care plan and will not initiate new services or discontinue services without contacting the supervising nurse ..." A review of an agency's undated policy received from the administrator on 09/08/2023 titled, 'HOME HEALTH AIDE: ASSIGNMENT C-780' revealed, "... 3. Any change in the assignment must be approved by the professional managing the client's care ..." A home visit for Patient #9 was conducted on 09/08/2023, at 6:30 AM, to observe HHA 4 perform personal care. At 6:46 AM shirt, braces on lower extremities, and socks were removed and Patient #9 was escorted to the bathroom. When the shower was completed, HHA 4 indicated Patient #9 does not like their hair washed every day, so HHA 4 only shampoos Patient #9 2 times a week, on Tues and Thurs. HHA 4 assisted Patient #9 with drying, and putting underwear on, then escorted			

	Patient #9 with deodorant and dressing, put their shirt on, then Patient #9 laid down on their bed, HHA 4 put tube socks on the patient lower extremities, put their braces on, and pulled the top of the tube socks down over the braces to protect their skin. A review of Patient #9 Home Health Aide Plan of Care on 09/08/2023 revealed Patient #9 was to receive a shampoo each visit and failed to evidence the aide was to remove or place braces on Patient #9 bilateral lower extremities. A review of Patient #9 Aide Visit Notes from 08/27/2023 through 09/08/2023 failed to evidence the aide removing or applying braces to the lower extremities. Aide Visit notes on: 08/28/2023,08/29/2023, 08/30/2023, 09/01/2023, 09/04/2023, 09/05/2023, 09/06/2023, and 09/08/2023 failed to evidence the HHA provided a shampoo. During an interview on 09/08/2023 at 7:40 AM with HHA 4 indicated they have been removing and applying the braces to Patient #9's lower			

	extremities since they started servicing the patient, and indicated the patient instructed them on how they wanted the socks and braces applied. On 09/08/2023 at 1:17 PM, the administrator indicated the home health aides were probably instructed by the patients on how to apply the braces or appliances and indicated they needed to change the Aide Care Plan.			
G0818	HH aide supervision elements 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights.	G0818	Director of Nursing will educate nurse on updating aide care plan based on change in patient condition or patient's request and ensuring aide furnishes care in a safe and effective manner by 9/14/23. Director of Nursing will educate nurse on completing aide supervisory note appropriately. This includes reviewing aide notes from last sup visit to current sup visit comparing them to aide care plan 9/14/23. Director of Nursing will audit all supervisory visit notes submitted weekly to ensure they are completed appropriately. Once 100% compliance has been achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will in-service aides that they are to follow the aide care plan. If patient is refusing tasks marked on care plan or requesting tasks not listed on care plan aide to notify the nurse. Aide is not to provide a task not marked on the care plan by 10/8/23.	2023-10-08

	Based on observation, record review, and interview the agency failed to ensure the registered nurse updated the aide care plan, ensuring aide furnished care in a safe and effective manner to the patient, in 2 of 3 home visits observed. (Patient #3 and 9). Findings include: 5. A review of an agency's undated policy titled, 'HOME HEALTH AIDE: DOCUMENTATION C-800,' revealed, "POLICY ... Home Health Aides will document care/services provided on the home health aide charting form. Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan ... 3. The designated Registered Nurse ...is responsible for reviewing the Home Health Aide's charting before it is placed in the chart ... " A review of an agency's undated policy titled, 'HOME HEALTH AIDE SERVICES C-220' revealed, "...2. The aide will follow the care plan and will not initiate new services or discontinue services without		Director of Nursing will audit all aide notes submitted weekly and compare note to aide care plan to ensure plan is being followed. Once 100% compliance is achieved 10% will be audited quarterly to ensure compliance is maintained. (On-going) Director of Nursing will educate nurse on revising aide care plan based on patient needs/requests by 9/14/23. The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	

	contacting the supervising nurse..." A review of an agency's undated policy titled, 'HOME HEALTH AIDE: ASSIGNMENT C-780' revealed, "3. Any change in the assignment must be approved by the professional managing the client's care..."			

	6. A home visit for Patient #9 was conducted on 09/08/2023, at 6:30 AM, to observe HHA 4 perform personal care. At 6:46 AM shirt, braces on lower extremities, and socks were removed and Patient #9 was escorted to the bathroom. When the shower was completed, HHA 4 indicated Patient #9 does not like their hair washed every day, so HHA 4 only shampoos Patient #9 2 times a week, on Tues and Thurs. After personal care was provided, HHA 4 escorted Patient #9 to their bedroom, assisted Patient #9 with deodorant and dressing, put their shirt on, then Patient #9 laid down on their bed, HHA 4 put tube socks on the patient lower extremities, put their braces on, and pulled the top of the tube socks down over the braces to protect their skin. A review of Patient #9 Home Health Aide Plan of Care on 09/08/2023 revealed Patient #9 was to receive a shampoo each visit and failed to evidence the aide was to remove or place braces on Patient #9 bilateral lower extremities. A review of Patient #9 Aide Visit			

	Notes from 08/27/2023 through 09/08/2023 failed to evidence the aide removing or applying braces to the lower extremities. Aide Visit notes on: 08/28/2023,08/29/2023, 08/30/2023, 09/01/2023, 09/04/2023, 09/05/2023, 09/06/2023, and 09/08/2023 failed to evidence the HHA provided a shampoo. A review of a Supervisory Visit Note dated 09/07/2023 at 1:46 PM and signed by the administrator indicated the HHA followed the Plan of Care, that the HHA appeared to be competent when providing services, adheres to Standard Precautions per agency policy, good personal grooming habits, adheres to the dress code, and uses proper body mechanics when the Administrator did not perform a home visit.			

	7. On 09/08/2023 at 1:17 PM, the administrator indicated the home health aides were probably instructed by the patients on how to apply the braces or appliances and indicated they needed to change the Aide Care Plan to reflect what the aide actually performed. 410 IAC 17-14-1(n) 1. Review of undated agency document titled, 'HOME HEALTH AIDE SUPERVISION – C-340' stated, "POLICY Agency shall provide home health aide services under the direction and supervision of the registered professional nurse... for personal care services when services are indicated or ordered by the physician...SPECIAL INSTRUCTIONS The Nursing Supervisor... or designated registered nurse will give the home health aide direction for client care by way of the Care Plan...any change in the Care Plan must be signed and dated by the nurse..." Review of undated agency document titled, 'SERVICES PROVIDED – C-100' stated,			

	"Services will be coordinated by the Registered Nurse...managing the care. This will include implementing, revising, and updating the Plan of Care; physician conferencing; scheduling of visits; supervision of health team members, and conferencing with health team members to plan and evaluate client care.' 2. Review of the clinical record for Patient #3 evidenced a Start of Care date of 07-19-2023 with a Certification period of 07-19-2023 and contained diagnoses which included, but were not limited to: Spondylolysis (cracks or small fractures to the vertebrae of the spine often cause by repetitive stress) of lumbar (lower spine) and cervical (the neck portion of your spinal column) regions, Chronic pain, repeated falls, presence of pain pump (small device, implanted with surgery, that allows direct delivery of medicine to the area needed), and was signed by RN 1. The Plan of Care evidenced the admitting nurse was aware of Patient #3's upcoming surgery on 08-24-2023 with Doctor 4 to replace a pain pump battery. The Aide Care Plan dated			

	7-19-2023 contained a frequency of home health aide visits 3 (three) times per week for 9 (nine) weeks and indicated the aide was to assist patient with shampooing weekly and showering each visit, "sponge bath up in chair", and failed to evidence updates had been made to the aide care plan after patient had surgery to replace the patient's pain pump battery on 08-24-2023. The clinical record also failed to evidence the registered nurse scheduled or performed a nursing visit after the patient returned home from the 08-24-2023 procedure, failed to perform follow-up assessment, failed to contact the provider for subsequent after-care orders or precautions, and failed to ensure the aide care plan was updated to reflect the same. 3. On 08-06-2023 at 9:30 AM during a home visit with Patient #3 and Home Health Aide 1, the aide was observed assisting with showering the patient. The patient explained she had a shower chair attached to the wall with a hinge but that they preferred not to use this as it as the surface was flat and became			

	slippery when wet, and that they had slipped off it more than once but not since the agency had been providing services. The patient undressed and removed a light-colored abdominal binder. Patient stood for half of the shower, was observed washing their own hair, standing upright in the shower while keeping their left hand over a small white dressing, approximately 1 and 1/2 inches high by 4 inches wide, to the left abdomen while using their right hand to lather shampoo into the crown of the head. The patient continued to reach up with the right hand to rinse the hair while agitating vigorously to ensure the hair was free of shampoo. Later, out of the shower, the patient was observed bending at the waist to retrieve an object from the bathroom floor. Patient #3 and HHA 1 indicated the Administrator had been the admitting nurse. 4. On 08-08-2023 at 12:34 PM, when queried as to the agency's foreknowledge of Patient #3's pre-scheduled procedure on 08-24-2023, and what should have transpired afterwards, the Administrator indicated the			

	nurse should have spoken to the physician, should have obtained post-op orders and precautions, and agreed the aide plan of care should have been updated accordingly. On 8-08-2023 at 2:10 PM, in a telephone interview Person 5, a registered nurse with Doctor 4, verified that Patient #3 had same- day surgery on 08-24-2023 to replace a pain pump battery and was sent home with an abdominal dressing and instructions as to what to do and not to do, for four (4) weeks following the procedure. Person 5 indicated these instructions included but were not limited to: “no bending, lifting, twisting…no elbows above your ears, and reaching up, over, across or down” and “wearing abdominal binder (except when showering) at all times for the next 30 days”. Person 5 also indicated that there had been no communications (no phone calls or faxes) on record from AM PM Home Health Services, LLC..			

N0000	Initial Comments This visit was for a State Re-Licensure survey of a Home Health Provider conducted by the Indiana Department of Health. Survey dates: 09-06-2023, 09-07-2023, and 09-08-2023 12-Month unduplicated skilled admissions: 3 Census: 22	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."	
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.	N0458	Administrator will in-service staff who assist with human resources that new employees must be orientated to their specific job and sign a job description by 10/08/23. Administrator will review all current employee files to ensure they have documentation of orientation to their specific job and a signed job description by 10/08/23. Administrator/human resource designee will audit all new employee files to ensure they have documented orientation to their specific job and a signed job description. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-10-08

(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 new hires received and signed job descriptions and orientation to their specific job duties in 1 of 3 HHA (Home Health Aides) personnel file review. (HHA 3)

Findings include:

A review of an agency's undated policy received from the administrator on 09/08/2023 titled 'PERSONNEL RECORDS D-180' revealed, "... a. The personnel record for an employee will include, but not limited to :... Signed job description, orientation checklist - completed and signed..."

On 09/08/2023, a personnel record review of HHA 3, hire date of 5/15/2023, which failed to evidence a job description

	orientation to their specific job duties. On 09/08/2023 at 10:40 AM, during an interview with human resource 1 indicated they did not know where HHA 3 documents are located.			
N9999	Final Observations 410 IAC16-27-1.5-5 Approved dementia training for home health aides. Based on record review and interview, the agency failed to ensure HHA (Home Health Aides) had completed six (6) hours of an approved dementia program in 2 of 3 home health aide personnel records reviewed. (HHA 1 and 3) Findings include: A review of of an agency's undated policy received from the administrator on	N9999	Administrator will educate staff that assist with human resources that newly hired aides must complete the required 6 hours of dementia training within 60 days of hire 9/21/23. Administrator will review all current aide employee files to ensure each aide has completed the required initial 6 hours of dementia training and have copy of completion certificate in their file. Any aide who hasn't completed the initial 6 hours of training will be required to complete it by 10/8/23. Administrator/human resource designee will audit all new aide files within 60 days of hire to ensure they have completed the required initial 6 hours of dementia training and have a copy of the certificate of completion in their file. (On-going) The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is corrected and will not recur.	2023-10-08

RECORDS D-180' revealed, "... Competency testing for home health aides and specific competencies per job title ..."

A review on 09/07/2023, of personnel record of HHA1, hire date 4/10/18, failed to evidence 6 hours of an approved dementia program.

A review on 09/07/2023, of personnel record of HHA 3, hire date 5/15/23, failed to evidence 6 hours of an approved dementia program.

During an interview on 09/07/2023 at 10:10 AM, the administrator presented a blank sign in sheet, and indicated it was for the dementia training. When queried, if HHA's received a certificate upon completion of the dementia training, the administrator indicated they did not.

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	9/21/2023 2:21:36 PM