STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157552	A. BUILDING B. WING	07/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOY HEALTH SERVICES LLC	2825 E 96TH ST, INDIANAPOLIS, IN, 46240

(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 State Department of Health in accordance with 42 CFR S 484.22. Survey Dates: 7-18-2023, 7-19-2023, 7-20-2023, 7-24-2023, and 7-25-2023. Facility Number: IN003692 Provider Number: 157552 Census: 79 At this Emergency Preparedness survey, Joy Health Services, LLC. was found not in compliance with Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers, 42 CFR 484.22. QR completed by A3,	E0000		

	7/31/2023.			
E0004	Develop EP Plan, Review and Update Annually 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop 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: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan	E0004	The Emergency Preparedness Plan was updated April 2023. The desk review was done 7/28/2023.The EPP will bereviewed and updated annually or more often as necessary. The EP binderwill be kept in the Nursing office for quick access in the event of anemergency. The Administrator will beresponsible for implementation of the EPP.	2023-08-30

annually.

* [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.

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Based on record review and interview the agency failed to maintain their comprehensive emergency preparedness program by failing to ensure the program was updated every 2 years, in 1 of 1 Emergency Preparedness plan reviewed.

Findings include:

4. During an interview on 7-25-2023 at 11:25 AM, the Clinical Manager indicated the Emergency Preparedness (EP) binder present is not the latest version and that the agency's consultant may know the new one's whereabouts, but the consultant had been ill and was currently in recovery. The Clinical Manger indicated she would check for any electronic copies, files, emails, etc. among herself and/or other staff to see if any portion of the new EP could be produced. Indicated

	produce the new EP plan that they would be surveyed on the old. 5. On 7-25-2023 at 12:00 PM, Administrative Staff 5 handed this surveyor the Administrator's phone and indicated they had reached the consultant and they were on the line. This surveyor spoke briefly to the consultant, but ended the call when it was determined the consultant was currently receiving care in skilled facility. The administrator indicated the consultant had just informed them the new EP information should be within the agency, in a blue binder. The agency was unable to locate the binder. 1. A review of a binder containing a policy titled Emergency Preparedness & Pandemic/Infectious Disease Preparedness received from the Administrator indicated the Administrator had approved the plan on 03/02/2020. The plan indicated but was not limited to "PURPOSE: To ensure that Joy Health Services Home Health Agency is prepared for an emergency situation…The emergency preparedness/pandemic &			

	infectious disease preparedness plan will be reviewed annually or more often as necessary…" 2.During an interview with the Administrator on 07/24/2023 at 12:47 PM. She indicated the Emergency Preparedness Plan was up to date as of April 2023, but they were not able to locate the updated binder at this time. She indicated her Emergency Preparedness designee was on leave and she would contact them and locate it. 3. During a follow-up interview on 07/24/2023 at 2:07 PM, the administrator reported she had not located the updated Emergency Preparedness binder.			
E0024	Policies/Procedures-Volunteers and Staffing 483.73(b)(6) §403.748(b)(6), §416.54(b)(5), §418.113(b)(4), §441.184(b)(6), §460.84(b)(7), §482.15(b)(6), §483.73(b)(6), §483.475(b)(6), §484.102(b)(5), §485.68(b)(4), §485.542(b)(6), §485.625(b)(6), §485.727(b)(4), §485.920(b)(5), §491.12(b)(4), §494.62(b)(5). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph	E0024	JHS EP includes an emergency staffing plan and a plan thatincludes volunteers. A list of emergencystaff and volunteers, along with their phone numbers, and the policy andprocedure to address any surge event affecting client is located in the Nursingoffice. Update done 7/28/2023. The Administrator will be responsible for Volunteersand	2023-08-30

	(a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview the agency failed to ensure their emergency preparedness plan included an emergency staffing plan or strategy that included the use of volunteers or other emergency staffing personnel, in 1 of 1 Emergency Preparedness Plan reviewed. Findings include: Review of an agency document		staffing of the EPP.	

	dated 3-20-2023 titled, 'Emergency Preparedness/Pandemic & Infectious Disease Preparedness Policy' failed to evidence plans to utilize volunteers or other personnel to fulfill emergency staffing needs in the event of a surge of patient care needs during an emergency. On 7-25-2023 at 12:53 PM the agency's Emergency Preparedness Plan Binder was reviewed with the Administrator. The binder failed to evidence documentation of plan or strategy to utilize volunteers or other emergency staffing personnel in the event of a surge in patient care needs, during an emergency. On 7-25-2023 at 12:53 PM, when queried as to whether there were any existing documentation on volunteers or any additional personnel that would be utilized during an emergency, the Administrator was unable to produce documentation.			
E0030	Names and Contact Information 483.73(c)(1)	E0030	JHS has updated their EP Plan to reflect an updated list ofcontact information including	2023-08-30

	§403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the		information for all clients, entities providingservices under arrangements, next of kin, guardians, or custodians. Staff information is also included along withphone numbers as well as those of the volunteers. The physician list was updated as well. These will be reviewed annually forchanges. All this information will bekept in the Emergency Preparedness Binder in the Nursing office. The Administrator will be responsible for Volunteersand staffing of the EPP.	

following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Next of kin, guardian, or custodian.

(iv) Other RNHCIs.

(v) Volunteers.

*[For ASCs at §416.45(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Volunteers.

*[For Hospices at §418.113(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Hospice employees.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Other hospices.

*[For HHAs at §484.102(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Volunteers.

*[For OPOs at §486.360(c):] The communication plan must include all of the following:

(2) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Volunteers.

(iv) Other OPOs.

(v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA).

Based on record review and interview the agency failed to ensure they maintained updated names and contact information for the following: staff, entities providing services under arrangement, patients' physicians, and volunteers, in 1 of 1 Emergency Preparedness Plan reviewed.

Findings include:

4. Review of an agency document dated 3-20-2023 titled, 'Emergency Preparedness/Pandemic & Infectious Disease Preparedness

	requirement for updated names and contact information for patient's and their physicians. 5. On 7-25-2023 at 12:53 PM the agency's Emergency Preparedness Plan Binder was reviewed with the Administrator. The binder failed to evidence names and contact information for all patient's physicians. 6. On 7-25-2023 at 12:53 PM, when queried as to whether there were any existing documentation on updated names and contact information for patient's physicians that would be utilized during an emergency, the Administrator referenced a printed patient list in the front cover pocket of the EP binder, dated 3-08-2020, was unable to locate associated physician contact information and indicated this needed to be rectified. 1. A policy titled Emergency Preparedness & Pandemic/Infectious Disease Preparedness received from the Administrator evidenced an approval date of 03/02/2020. The plan indicated but was not			

	that Joy Health Services Home Health Agency is prepared for an emergency situation…The emergency preparedness/pandemic & infectious disease preparedness plan will be reviewed annually or more often as necessary…" 2. A review of an Emergency Preparedness (EP) binder provided by the Administrator, evidenced an Employee contact list dated 03/08/2020 and a Patient list dated 03/08/2020. 3. During an interview with the Administrator on 07/24/2023 at 12:15 PM she indicated there was another binder that she was unable to locate but the program is updated every year and was revised in April of 2023. The Administrator reported the individual they work with on EP is currently on leave and she can not locate the updated binder.			
E0039	EP Testing Requirements 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2),	E0039	JHS held a tabletop exercise and review of EP execution on7//28/2023 to evaluate effectiveness and areas needing improving. This review will be documented fully withidentified concerns and the follow up and	2023-08-30

	§485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.		who will oversee follow up and whenimprovement can be expected. Any EP thatoccurs will also be reviewed for effectiveness, documented in the same manner,the outcomes documented and follow up documented in the record. Any concerns will be taken to QAPI for actionand follow up as needed. The Administrator will be responsible for Volunteersand staffing of the EPP.	

	*[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation			

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

limited to the following:

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

(B) A mock disaster drill; or

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

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

*[For PACE at §460.84(d):]

(2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following:

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

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

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

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

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

(B) A mock disaster drill; or

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

	tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at			

	least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared			

	questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on interview and record review the agency failed to ensure a yearly tabletop exercise was documented, in 1 of 1 Emergency Preparedness Plans reviewed. Findings include: 1. Review of an agency document dated 3-20-2023 titled, 'Emergency Preparedness/Pandemic &			

	Policy' failed to evidence a plan to conduct a yearly table top exercise to test the agencies emergency plan, nor plans for an after action review. 2. Review of the agency's Emergency Preparedness (EP) binder failed to evidence documentation of a yearly tabletop exercise. 3. In an interview on 7-25-2023 at 12:53 PM, when queried as to whether a tabletop exercise had been done recently and where this might be documented, the Administrator indicated indicated they had an outage of sorts last week in the office, where they could not utilize their computers or phones and took action by calling I.T. and ensuring incoming calls were diverted to staff cell phones so that incoming calls and communications were not missed, notified all staff of same, and as soon as power was restored they took immediate action to ensure the incoming calls were rerouted back to the office. When queried as to where this was documented, the Administrator indicated there was no documentation, but planned to			

	use this as the agency's table top exercise. When queried as to an after action report being conducted and documented, the Administrator indicated this had not been done.			
G0000	INITIAL COMMENTS This visit was for a Post Condition Revisit and a full federal survey following a Federal and State complaint investigation survey (exit date of 5-5-2023) of a deemed home health agency. A partially extended survey was announced on 7-24-2023 at 2:10 PM. Survey Dates: 7-18-2023, 7-19-2023, 7-20-2023, 7-24-2023, and 7-25-2023. Unduplicated skilled patient admission in the prior 12 months: 79 During this survey, 1 Condition level deficiency, 5 Standard level deficiencies, and 2 Element level deficiencies were corrected. The Condition of Participation 42 CFR 484.75, Skilled Professional Services was	G0000		

	compliance. 1 Standard level deficiency was re-cited. Additional deficiencies were cited. Joy Health Services, LLC. was found to have been out of compliance with 42 CFR 484 et seq. and 410 IAC 17 et seq. in regard to the requirements for home health agencies. Based on the Condition-level deficiency cited during the 5-5-2023 survey, your Home Health Agency was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 5-5-2023. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency continues to be precluded from operating a home health aide training, skills competency, and/or competency evaluation program for a period of two years beginning 5-5-2023 and continuing through 5-4-2025. QR completed by A3, 7/31/2023			
G0484	Document complaint and resolution 484.50(e)(1)(ii)	G0484	On August 1, 2023, a mandatory in-service was held for alllicensed staff where results of	2023-08-30

	(ii) Document both the existence of the complaint and the resolution of the complaint; and Based on record review and interview the agency failed to ensure that complaint resolutions were documented in 1 of 1 complaint records reviewed. (Patient #1) Findings include: 1. Review of an agency document dated 10-23-2010, titled 'Complaint/Grievance Process' page 1 stated, "POLICY ... an investigation of the fact may be conducted within (5) days and the client may be notified verbally and/or in writing of the resolution within (15) days ... PURPOSE: 1. To ensure a timely resolution of a client's complaint/grievance...PROCEDURE ... 3. If the grievance cannot be solved to the client's satisfaction, the situation must be discussed with the Administrator for administrative review and if this cannot be resolved at the administrative level, this would be forwarded to the Board of Directors for review ...". Page 2 stated, "6.		survey were addressed. Staff are to report anycomplaint to the nursing administration for immediate follow-up and resolution. Agency has implemented a more detailed procedure to ensureall complaints are reported, investigated, resolved and documented in theComplaint/Resolution logbook. In-serviceheld to advise staff of new modified process and a copy given to staff on 8/4/23. The DON will review the Complaint Log and forms daily withNursing Administration. ADON willinvestigate all complaints and determine a possible resolution and report sameto DON and Administrator. DON is responsible..	

	the resolution of the complaint verbally and/or in writing by the Director of Nursing or the designated person, within (15) working days of the complaint. 2. A review of the clinical record for Patient #1 with a start of care date of 5-27-2023 and care period of 4-01-2023 through 6-30-2023, with diagnoses which included, but were not limited to: advanced age (90 years old), carpal tunnel syndrome (a common neurological disorder that occurs when the median nerve, which runs from your forearm into the palm of the hand, becomes pressed or squeezed at the wrists resulting in numbness, weakness, pain in your hand and wrist, and fingers may become swollen and useless), difficulty walking, severe obstructive sleep apnea (when an intermittent blockage occurs in the airway keeping air from moving through the windpipe while you're asleep), hypertension (high blood pressure is when the force of blood pushing against the artery walls is consistently too high), insulin dependent diabetes mellitus (or type 1 diabetes, when blood sugar			

	levels are too high and the pancreas doesn't make any insulin, caused by an autoimmune reaction), history of falling, was receiving attendant care services to assist with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), which included, but were not limited to: meal preparation, housekeeping, assistance with dressing and grooming, and bed making. A review of agency documents titled, 'Client/Employee Complaint and Resolution' revealed serial entries regarding Patient #1: A. 5-03-2023, "Complaint(s): Client asked aide to make her bed and the aide stated the morning aide should have done it, was also on her phone ... Investigation and Resolution: Employee in-serviced 5-04-2023 ... Follow-up and Comment: In-serviced aide and gave a verbal warning." B. 6-23-2023, "Complaint(s): Client stated aide was outside smoking most of time...Investigation and Resolution: Employee counseled and/or reprimanded 6-24-2023, Employee In-serviced 6-24-2023			

	... Follow-up and Comment: verbal warning and in-services on the effects of second hand smoke ... " 3. In a telephone interview on 7/18/23 at 1:57 PM, Person A, family member of Patient #1, who received attendant care services, both an AM aide and a PM aide had discontinued services with the agency related to multiple incidents with evening shift aides. Indicated they had made multiple complaints over 2-3 months, " ... aides on their phones, not asking what [Patient #1] needed, not showing up on time, sometimes not showing up at all, sleeping on the floor, falling asleep in the chair ... " Person A indicated at no time was Patient #1 in danger, but stated "[Patient #1] is 90 years old, won't ask for anything and won't complain". Indicated was disappointed even after having spoken with the Administrator themselves, these concerns were not resolved stating, kept sending different people but that "there were no changes". Indicated was not asked if he/she were pleased with the solutions the agency provided and was not contacted after			

	changes were made to inquire if they were satisfied with the resolution. Indicated further, "[Administrator] knew and nothing changed" and as a result Person A had discontinued Patient #1's services and gone to another agency. In an interview on 7/24/23 at 2:12 PM, when queried as to the complaint/grievance process the Administrator indicated once the complaint is received, the complainant is called and they try to solve the problem, and the agency will reach out and follow-up. If the complainant is not pleased, "we go to plan B". Indicated this usually involves send out a different staff member to provide care. Indicated, "we always call them back". When queried as to where this would be documented, as this was not found on the complaint reports reviewed, the Administrator indicated that sometimes she writes things down one place, and then will transcribe it to the complaint report later. When queried as to where the resolution was documented for Patient #1, the Administrator indicated she believed she had			

	done so and would look for it. (This was not presented to surveyors during the survey.) 410 IAC 17-12-3(c)(2)			
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and interview the agency failed to ensure the comprehensive assessment reflected patients' current health, psychosocial, functional, and cognitive status in 3 of 8 active clinical records reviewed. (Patients #2, 5, and 7) Findings include: 1. Review of an agency document dated 10-18-2023 titled, 'Client Assessments' stated, "Policy A Qualified Practitioner will do an initial assessment and subsequent re-assessments on every client admitted to JOY HEALTH SERVICES, LLC for skilled or non-skilled services...2. A	G0528	A post survey mandatory in-service was held 8/1/23 for all skilledemployees on OASIS E sections pertaining to the new requirements. The subjectwill again be presented at a more detailed in-service on 8/22/23 to reinforcethe importance of this material. All documentation required for the comprehensiveassessment was discussed with a focus on client's current health, psychosocial,functional and cognitive status. The auditing done by 8/8/23, consisted of 10%of EMR's of skilled clients with close attention to these sections. 10% of theComprehensive assessments will be monitored monthly until 100% compliance isreached for 3 months then the results taken to QAPI for review to see ifsufficient time was allotted to validate the results before an audit of 20%quarterly will be maintained to prevent a recurrence of missing material.	2023-08-30

	must be completed on all clients incorporating the required OASIS elements...ii. The comprehensive assessment/OASIS will be incorporated into the client's clinical record...3. A Plan of Treatment will be developed from the information gathered during the initial assessment...4. The Assistant Director of Nursing will be responsible for the review of the plan of care and the Clinical assessments for accuracy..." 2. Review of the recertification comprehensive assessment of Patient #5 dated 7-07-2023, contained diagnoses which included, but were not limited to: presence of gastrostomy tube (also called a 'G-tube', a tube inserted through the belly that brings nutrition directly to the stomach), squamous cell carcinoma of skin of scalp and neck (relatively slow-growing malignant (cancerous) tumors that can spread to surrounding tissue if left untreated), dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage), pain related to neoplasm (a new		ADON will be responsible for the observation and review ofall Comprehensive assessments submitted quarterly to ensure documentation iscomplete. The report will be discussedat QAPI monthly for follow-up suggestions or plans. DON and ADON will call staff not following the procedure andfailure to follow the instructions will result in counselling, and anotheroffense will result in termination. DON is responsible.	

	and abnormal growth of tissue in some part of the body, especially as a characteristic of cancer), need for assistance with personal care, difficulty in walking, presence of other vascular implants and grafts (in this instance, a chemotherapy port, a small implantable device that attaches to a vein, usually in the upper chest area, allows healthcare providers to draw blood and give treatments including chemotherapy drugs without a needle stick, and can remain in place for weeks, months or even years), and tracheostomy status (a surgically created passageway from the skin of the anterior neck to the trachea (windpipe) used as a supportive measure in patients with various airway or breathing problems). The psychosocial assessment failed to evidence patient's language, culture, and religion. The clinical summary failed to evidence how the patient communicated with in light of their tracheostomy, failed to evidence of dates of visits to Emergency Room and Interventional Radiology for replacement of dislodged G-tube, outcome of the Interventional Radiology visit,			

	nor follow-up or orders. The diet assessment indicated patient was NPO status (to take nothing by mouth). “Height” “Weight” “Weight History” “Gain/Losses” were all left blank. In a section titled, 'Nutrition Needs: ... ‘Estimated Fluids needs:’ “ml/day” was entered without a corresponding numeric value, ‘Estimated Nutritional needs:’ “Kcals/day Gm protein/day” was entered, without a corresponding numeric value. On 7-19-2023 at 8:00 AM during a home visit for Patient #5 with RN 1, the patient was reclining in bed with head elevated and reached over to night stand, lifted an orange plastic container to mouth, and swallowed its contents. When queried as to what the patient had consumed, the RN 1 verified this was the patients AM dose of thyroid medication. Additionally, the walls of the home were adorned with religious pictures and items from the patient's home country in each room, most notably in the bedroom. In an interview on 7-25-2023 at 3:00PM, when queried			

regarding the documentation in the recertification assessment for Patient #5 in relation to their NPO (nothing by mouth) status, but this writer having witnessed the patient orally consume a medication, the Clinical Manager and Administrator had nothing to offer. When queried regarding the patient's tracheostomy status, the Clinical Manger indicated Patient #5 had only a stoma, and could not definitively answer if patient had the ability to speak, but the Administrator indicated the patient was able to communicate through physical gestures. When queried regarding the lack of documentation of weights, hydration and nutrition requirements, the Clinical Manager and Administrator both indicated the patient was weighed at their doctor's office every 2 weeks, that RN 1 would retrieve those visit notes from the doctor's office and additionally the nurse weighed patient on the patient's own scale at each home visit. Indicated would ensure this gets recorded in the record. Indicated further they would reach out to patient's physician for the patient's goal weight.

G0530	Strengths, goals, and care preferences 484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA; Based on record review and interview the agency failed to ensure the comprehensive assessment reflected patients' strengths and care preferences, and failed to include information that detailed patients' progress toward goals, including measurable outcomes in 4 (Patient #2, 3, 5, and 7) of 8 active clinical records reviewed. Findings include: 1. Review of an agency document dated 10-18-2023 titled, 'Client Assessments' stated, "Policy A Qualified Practitioner will do an initial assessment and subsequent re-assessments on every client admitted to JOY HEALTH SERVICES, LLC for skilled or non-skilled services...2. A comprehensive assessment must be completed on all	G0530	On 8/1/23 a mandatory in-service was held for skillednursing to address client's strengths, goals and preferences. It was again reinforced that the Care Plan isevolving and changes need to be made as client needs change or are met. Goal setting was emphasized, and measurable,attainable goals reinforced. Using the client's strengths and care preferencesare also to be included in the plan of care as this is information determineshow to measure their progress and outcomes. The goals should be the base forthe treatment plan. The basis of thecare plan is person centered care. An audit of Comprehensive assessments was done by 8/8/23 bynurse management to check for the client specific , individualized inclusion ofattainable, adjusted goals, measurable goals based on the client's strengths, andpreferences. We audited 10% of the client records from the criteria and willcontinue to audit 10% until a 100% compliance is achieved X 3	2023-08-30

	clients incorporating the required OASIS elements... ii. The comprehensive assessment/OASIS will be incorporated into the client's clinical record...3. A Plan of Treatment will be developed from the information gathered during the initial assessment...4. The Assistant Director of Nursing will be responsible for the review of the plan of care and the Clinical assessments for accuracy..." 2. Review of the recertification comprehensive assessment of Patient #5 dated 7-07-2023, contained diagnoses which included, but were not limited to: presence of gastrostomy tube (also called a 'G-tube', a tube inserted through the belly that brings nutrition directly to the stomach), squamous cell carcinoma of skin of scalp and neck (relatively slow-growing malignant (cancerous) tumors that can spread to surrounding tissue if left untreated), dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage), pain related to neoplasm (a new and abnormal growth of tissue		go to 20% quarterly. These will be evaluated, and resultsdiscussed at QAPI to prevent a recurrence. Patient centered care will bestressed. Any staff member not in compliancewill be counseled and if no improvement in 30 days will be terminated. Nursing management will be responsible for doing the monthlyaudits. Patterns will be brought to attention at QAPI for further action orsuggestions. Any staff member not in compliance will be counseled and ifno improvement in 30 days will be terminated. DON is responsible.	

	in some part of the body, especially as a characteristic of cancer), need for assistance with personal care, difficulty in walking, presence of other vascular implants and grafts (in this instance, a chemotherapy port, a small implantable device that attaches to a vein, usually in the upper chest area, allows healthcare providers to draw blood and give treatments including chemotherapy drugs without a needle stick, and can remain in place for weeks, months or even years), and tracheostomy status (a surgically created passageway from the skin of the anterior neck to the trachea (windpipe) used as a supportive measure in patients with various airway or breathing problems). The assessment failed to evidence patient strengths, care preferences, or patient-centered goals. The assessment contained a goal of, "Client and family will understand that chemo has side effects that are common to the nature of the medication and usually don't require emergency intervention." The assessment failed to evidence the presence a port, the location of the port, the condition of the skin around			

	the port, the status of the port/whether currently in use, who was responsible to access and/or manage the port, and how often the port was to be accessed/managed, nor when the port was last accessed/managed, or when this was next due. The assessment contained a goal, related to 'G-tube (Self Care Deficit - feeding)', "Client will tolerate feedings well for the next 60 days" the goal and related interventions failed to establish a baseline weight for the patient, weight, goals, or reportable parameters, gains or losses. In an interview on 7-25-2023 at 3:00 PM, when queried regarding the documentation in the recertification assessment for Patient #5 When queried regarding the lack of goal-oriented documentation related to patient's chemo port and G-tube status, including weights and meeting hydration and nutrition requirements, the Clinical Manager and Administrator both indicated the patient was weighed and managed at their doctor's office every 2 weeks, where the			

	treatments, and that RN 1 would retrieve those visit notes from the doctor's office, additionally the nurse had been weighing patient on the patient's own scale at each home visit. Indicated would ensure this gets recorded in the record. Indicated further they would reach out to patient's physician for the patient's goal weight. 1. A review of the recertification assessment for Patient #2, dated 06/19/23, indicated goals a primary diagnosis of pulmonary artery stenosis (a birth defect that causes a narrowing of the large blood vessel that takes blood from the right ventricle of the heart to the lungs, where it is oxygenated. If surgically unrepaired, the child is at high risk for an enlarged heart and high blood pressure in the right side of the heart and may experience symptoms such as shortness of breath, poor activity endurance, fatigue, failure to gain weight and/or grow, episodes of poor oxygenation, significantly differing right and left blood pressures, and swelling of the extremities and/or abdomen.			

	Secondary diagnoses were chronic respiratory failure with hypoxia (insufficient oxygen), failure to thrive (failure to gain weight and/or height), unspecified chronic respiratory disease, unspecified abnormalities of breathing, tracheoesophageal fistula (TEF - an abnormal opening between the trachea and esophagus that typically requires surgical intervention) following a tracheostomy (artificial opening in the trachea from outside the neck), congenital diaphragmatic hernia (a defect in the muscle between the chest and the abdomen. The assessment indicated goals of: "Client's personal care and grooming will be completed without any difficulties ... Client will be free of Covid - 19 infection ... Client's NG (Nasogastric) tube (a small, flexible tube inserted into a nostril and down to the stomach and used for liquid nutrition) will remain [sic] Patient/Client's bolus NG feedings will provide supplemental nutrition ... Patient will maintain weight within acceptable limits as set by physician. Weight loss parameter ... any loss of weight equaling 1 lb. or more in a			

	month to be reported to MD/patient's family ... Client will have personal care/hygiene/safety measures/Mobility/Nutrition/ADLs/IADLs [Activities of Daily Living/Instrumental Activities of Daily Living] needs met ... SN [Skilled Nurse] will demonstrate proper care of client ... " The assessment failed to evidence individualized, patient specific, and measurable goals pertinent to the patient's current diagnoses and need for home health care. The assessment also failed to evidence care preferences specific to a 5-year such as preferred ways to comfort self and be comforted, use of a favorite toy/blanket/security item, preferred words for making needs known, preferred foods, preferred activities, and preferred movies and/or games. 2. A review of the recertification comprehensive assessment for Patient #3, dated 05/27/23, evidenced a primary diagnosis of Down Syndrome and secondary diagnoses of type 1 diabetes, attention-deficit hyperactivity disorder, asthma, hypothyroidism, obstructive			

	assessment indicated goals of "Patient will verbalize s/s [signs and symptoms] of hypo and hyperglycemia [low/high blood sugar] and importance of being compliant with diet, blood glucose checks, and insulin and/or hypoglycemic regimen ... Skilled nurse will administer appropriate insulin dose ... Clinical summary will be completed on Patient assessment ... " The assessment failed to evidence individualized, patient-specific, and measurable goals that were pertinent to the patient's current diagnoses and reason for home health care. On 07/24/23 at 3 PM, the Administrator indicated that Patient #3 was cognitively and developmentally low functioning and did not have the skills or developmental ability to manage their type 1 diabetes, including the ability to independently check blood sugars, verbalize signs/symptoms, and manage diet compliance. The Administrator also indicated that goals for the clinical summary and delivery of insulin were not patient-related goals.			

	3. A review of the recertification comprehensive assessment for Patient #7, dated 06/20/23, indicated a primary diagnosis of fetal alcohol syndrome and secondary diagnoses of severe intellectual disabilities, unspecified convulsions, urinary incontinence, and other speech disturbances. The assessment evidenced goals of "Client will be free of covid - 19 ... Client will be free of injury related to falls ... Areas of common use and the client's room will be kept free of clutter and pathways clear for safe ambulation ... Client's personal care [sic] hygiene, grooming, nutritional needs ... mobility, safety will be completed without difficulties ... Client will be provided the proper appropriate care ... " The assessment failed to evidence individualized, patient-specific, and measurable goals pertinent to the patient's current diagnoses and needs, and failed to evidence specific care preferences such as favorite foods, methods to manage agitation and change, and food and entertainment preferences. 4. On 07/24/23 at 3 PM, the			

	Patients #2, 3, and 7 were reviewed with the Administrator and Clinical Manager. The Administrator verbalized that the goals were not patient-specific, measurable, and individualized and were not pertinent to their current diagnoses or need for home care. The Administrator stated they were working on improving goal writing, but the clinicians were using the drop-down phrases in the charting software and not creating individualized goals.			
G0534	Patient's needs 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the agency failed to ensure all patients received a comprehensive assessment that included their medical, nursing, rehabilitative, social, and discharge planning needs for 3 of 9 active records reviewed. (Patients #2, 3, 7) Findings include: 1. A review of the recertification	G0534	On 8/1/23 an in-service was held to educate the staff on thecomprehensive assessment process and all the components to give a thoroughpicture of the client. Licensed staff hasaccess to client's admission H/P for reference to past medical conditions and wereeducated to read it before seeing clientThis gives an indication of discharge status as well. All areas on the assessment are to beaddressed including medical, nursing, rehab, social and discharge planningneeds. There is another in-service scheduled 8/22/23 where this will beaddressed again with the	2023-08-30

	comprehensive assessment for Patient #2, dated 06/19/23, evidenced a primary diagnosis of pulmonary artery stenosis and secondary diagnoses including, but not limited failure to thrive and expressive language delay. The comprehensive assessment failed to evidence the plan for surgical intervention of the pulmonary artery disease and a plan to monitor, mitigate, and manage the signs/symptoms of pulmonary artery stenosis and heart failure including, but not limited to, frequency of physical assessments, oxygen saturation/blood pressure/respiration parameters, long and short-term weight gain parameters, specific nutritional intake and when to provide Pediasure supplements. The assessment failed to indicate the degree of expressive speech delay and whether the patient received or required speech therapy and failed to evidence discharge planning related to a medically fragile patient transitioning to kindergarten. 2. A review of the recertification comprehensive assessment for Patient #3, dated 05/27/23,		point of person-centered care as focus to prevent arecurrence. By 8/8/23 10% of skilled clients' records were audited forComprehensive assessment completeness. Nursing administration will monitor 10%of all comprehensive assessments monthly until 100% compliance is achieved for3 consecutive months. The results will be taken to QAPI for review and toverify results will prevent a recurrence. Then 20% of the records will be monitored quarterlyfor compliance. Results of findings willbe taken to QAPI for input and suggestions quarterly thereafter. An employee's first offense will result in counselling with 30-daymonitoring and a recurrence will result in termination. DON is responsible.	

	evidenced the patient was 16 years old, with a primary diagnosis of Down Syndrome and secondary diagnoses including, but not limited to, type 1 diabetes, attention-deficit hyperactivity disorder, and right ear hearing loss. The assessment failed to evidence whether the patient wore a hearing aid or required assistance for the hearing impaired, was functionally and developmentally able to manage their disease process, a plan for long-term nursing assistance for insulin injections, needs related to managing hyperactivity, and planning related to preparation for adulthood, including ability to earn a living and live independently. 3. A review of the recertification comprehensive assessment for Patient #7, dated 06/30/23, evidenced a primary diagnosis of fetal alcohol syndrome and secondary diagnoses including, but not limited to, severe intellectual disabilities and other speech disturbances. The assessment failed to evidence social and discharge planning needs that included the primary caregiver's limitations due to			

	chronic lung disease, involvement of father and siblings, and the need for continued services due to the patient's permanent disabilities. On 07/24/23 at 3 PM, the Administrator indicated the comprehensive assessments for Patient's 2, 3, and 7 did not include all medical needs, discharge planning needs, or rehabilitative needs. 410 IAC 17-14-1(a)(1)(B)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements;	G0574	A mandatory in-service was held 8/1/23 to educate staff onthe policy and procedure of writing a Care Plan. The Comprehensive Care Plans are to includepertinent diagnoses, client specific interventions, nutritional requirements,client specific measurable goals, and outcomes, updated, measurable andachievable goals related to the specific client were addressed. They are to bere-evaluated at every recertification, change of condition, ROC, transfer,hospitalization for current information. Hospitalization RIsk A&B is part	2023-08-30

	(x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview the agency failed to establish a plan of care that contained pertinent diagnoses, patient specific interventions, psychosocial status, nutritional requirements and patient specific measurable goals and outcomes in 6 of 8 active clinical records reviewed. (Patients #2,3,5,7,8, and 9) The findings include: Review of the plan of care for Patient #5 for the certification period of 7-11-2023 through 9-08-2023, contained orders for attendant care services and skilled nursing 300-324 hours per month "hours use as needed per client/caregiver		of QA currently and isongoing. Records of SOC, ROC, recerts, transfer, D/C's will bemonitored monthly until 100% compliance is achieved. Staff failing to complywill receive a 30-day notice to change and follow the process or at end of 30days they will be terminated. Nursing administration will be performing the audits withthe reports going to DON and read at QA. DON responsible	

	with diagnoses which included, but were not limited to: Attention to gastrostomy (also called a 'G-tube', a tube inserted through the belly that brings nutrition directly to the stomach), squamous cell carcinoma of skin of scalp and neck (relatively slow-growing malignant (cancerous) tumors that can spread to surrounding tissue if left untreated), dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage), pain related to neoplasm (a new and abnormal growth of tissue in some part of the body, especially as a characteristic of cancer), need for assistance with personal care, difficulty in walking, presence of other vascular implants and grafts (in this instance, a chemotherapy port, a small implantable device that attaches to a vein, usually in the upper chest area, allows healthcare providers to draw blood and give treatments including chemotherapy drugs without a needle stick, and can remain in place for weeks, months or even years), and tracheostomy status (a surgically created passageway			

	from the skin of the anterior neck to the trachea (windpipe) used as a supportive measure in patients with various airway or breathing problems). A section titled, 'Safety Measures' stated, "Oxygen Precautions". The plan failed to include specific orders for care of the tracheostomy. The plan of care failed to evidence the presence a port, the location of the port, the status of the port/whether currently in use, who was responsible to access and/or manage the port, and how often the port was to be accessed/managed, nor when the port was last accessed/managed, nor when this was next due. The plan of care also failed evidence the name and contact number for the oncologist who was involved in the patient's care, who there cared for the port, and when the treatments had started or were due to be completed. A section titled, 'Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)', failed to evidence a current frequency and duration for nursing visits and attendant care visits and failed to detail specific skilled treatments and			

	individualized care that would be provided by the skilled nurse. The narrative stated, "Client is NPO, with formula feedings and medications given through G-tube by SN and caregiver". A section titled, 'Goals/Rehabilitation Potential/Discharge Plans' included goals related to 'G-tube (Self Care Deficit - feeding)', "Client will tolerate feedings well for the next 60 days". The plan of care failed to evidence a baseline weight had been established for the patient, weight goals or reportable parameters, gains, or losses, care and maintenance goals for the g-tube site and surrounding tissue, and did not evidence plans or goals for monitoring, maintaining or improving nutrition and hydration requirements and status. In an interview on 7-25-2023, when queried regarding the documentation in the recertification assessment and plans of care regarding Patient #5 having oxygen precautions, the Clinical Manager and Administrator both indicated the patient did not have oxygen. In relation to the patient's NPO (nothing by			

	mouth) status, and this writer having observed the patient orally consume a medication, the Clinical Manager and Administrator had nothing to offer. When queried regarding the patient's tracheostomy status, the Clinical Manger indicated Patient #5 had only a stoma, and could not definitively answer if patient had the ability to speak, but the Administrator indicated the patient was able to communicate through physical gestures. When queried regarding the lack of documentation of weights, hydration and nutrition requirements for the patient, the Clinical Manager and Administrator both indicated the patient was weighed at their doctor's office every 2 weeks when they had a chemotherapy treatment, that RN 1 would retrieve those visit notes from the doctor's office and additionally the nurse weighed patient on the patient's own scale at each home visit. Indicated would ensure this gets recorded in the record. Indicated further they would reach out to patient's physician for the patient's goal weight.			

1. A policy titled "Plan of Care" received from the Administrator dated 08/15/2005, indicated but was not limited to "The attending physician will participate in the care planning process by reviewing and revising therapeutic and diagnostic orders...Procedure 1. Physician orders are individualized, based on client's needs, and include: A. Patient diagnoses B. Treatment and/or procedures to be done, including type frequency, duration and goals... E. Description of any medical, physical, psychosocial or environmental precautions, or limitations and activities permitted 4. The attending physician's recertification will be obtained at intervals of at least every sixty days when the client's plan of care of reviewed and client recertified, or more

	often if warranted. 5. Orders will be reviewed and revised based on: A. Changes in the client's physical and psychosocial condition B. The Client's response to care. C. The client's outcome related to treatment. D. When changes occur regarding diagnosis, treatment including procedures and medications." 2. Review of an agency document dated 8/15/2005, titled, 'Care Planning Process' stated, "...Purpose To Provide clinical directions to the staff providing direct patient care...Procedure: ... 2. Based on the client's identified needs, the plan of care will include (but is not limited to): i. Identified client problems and needs ii. Reasonable and measurable, individualized goals iii. Specific services to be provided iv. Actions to be taken to meet those client goals v. Type frequency, and duration of above actions vi. Equipment and supplies			

vii. Prognosis"

3. A review of the clinical record for Patient #8 evidenced a Plan of Care POC) date for the certification period of 06/09/2023-08/07/2023 and signed by the physician on 07/20/2023. The POC evidenced orders for skilled nursing 2 times daily 2-5 days, 1-2 hours per shift x 60 days and a home health aide (HHA) 3-5 week x60 days and respite HHA 48-60 hours per month. Patient #8's diagnoses included but not limited to quadriplegia (a form of paralysis affecting the limbs and body from the neck down), pressure ulcer of left buttock, stage 4 (wound penetrating all three layers of skin, exposing muscle, tendons, and bones), Pressure ulcer of left hip, stage 4, pressure ulcer right ischium (part of hip bone), stage 4. The Plan of Care indicated Patient #8 was seen at Entity B, a wound care clinic, and all information would be sent to the

	wound clinic. The goals and initial assessment will be completed by skilled nursing(SN) every 56-60 days for recertification to provide a synopsis of client condition and evaluation, client will be free of Covid-19 infection, client's personal care and grooming will be completed to client's satisfaction with their input during care episode, client will be provided appropriate care necessary during this 60 days, coordination of care will be completed at least every 60 days, client/caregiver will demonstrate wound (s) free of signs and symptoms of infection, SN will perform and record wound measurements weekly and report to medical director any questions, concerns, or changes, SN will monitor wound dressing each week and wound healing during certification period. During an interview on 02-20-2023 at 11 AM the Admin reported that Patient #8 no longer goes to Entity B, a wound			

	followed by the Patient's primary care physician for wound orders. A care coordination note dated 05/05/2023 at 1:00 PM indicated but was not limited to "(Patient #8's name) is non compliance [sic] with repositioning therefore difficult for the wound to heal. Client/caregiver versed with repositioning and good diet for wound healing..." A care coordination note dated 06/16/2023 at 1:30 PM indicated but was not limited to "(Patient #8's name) is non compliance [sic] with repositioning therefore difficult for the wound to heal. Client/caregiver versed with repositioning and good diet for wound healing... Patient #8"s POC failed to evidence accurate information related to the Physician following wounds, failed to contain measurable and individualized			

	interventions to address the Patient's non-compliance related to wound healing and failed to follow agency policy to revise POC. 4. A record review of Patient #9's clinical record occurred on 07/20/2023 for the certification period of 05/27/2023 to 07/25/2023 with orders for recertification period of 05/27/2023 to 07/25/2023 and orders for Skilled Nursing 2-4 nights/2-4 days, 7-11 hours per shift x 60 days. The POC evidenced diagnoses of cerebral palsy (abnormal brain development before, during, or after birth that may effect movement, posture, coordination and learning impairment), asthma, dysphagia (impaired swallowing), contracture (occurs when muscles, tendons and or joints shorten causing loss of movement), disorder of speech and language,			

	gastro-intestinal reflux (digestive disease in which stomach acid or bile flows back into the lining of the tube connecting your mouth and stomach causing irritation), and encounter for attention to gastronomy (a surgically placed device to give direct access to the stomach for feeding and hydration). The plan of care evidenced goals with seizure precautions with no diagnosis of seizures or historical information related to evidence of seizures, client be free of Covid-19 infections, nutritional/hydration status maintained. The plan of care failed to evidence goals for the diagnoses of asthma, dysphagia, or impaired movement and contractures. During an interview with the administrator on 07-20-2023 at 4:15 PM she indicated the POC should include goals related to skin care related to the patients			

	immobility and that they are trying to establish a pain assessment tool appropriate for adults with disabilities in case where they are not able to state their pain level or if they are in pain. 1. A review of the plan of care for Patient #2, dated 06/22/23 - 08/20/23, indicated a primary diagnosis of pulmonary artery stenosis and secondary diagnoses including, but not limited to, chronic respiratory failure with hypoxia, failure to thrive, tracheo-esophageal fistula following a tracheostomy, expressive language disorder, and hypertensive heart disease with heart failure. The plan of care failed to evidence the diagnoses were updated since the patient's fistula was repaired, and the tracheostomy was permanently removed and failed to evidence goals or interventions to monitor and mitigate breathing problems and signs and symptoms of heart failure. The plan of care indicated nutritional requirements of "Tube: used: No tube feeding (Freq/Amt): 240 ml of pediasure and oral			

	feeding as tolerated. Diet/Formula: Pediasure" The patient's goals included " ... Client can have 1 can of pediasure 2-4 x/day while awake [can take per oral if tolerated] Pediasure to supplement diet ... the Nurse will assess weight loss by measuring weight weekly and document ... continued weight loss will be called to the attention of the family and a consultation will be requested for a nutritionist to evaluate." Weight goals included "Patient will maintain weight within acceptable limits as set by physician ... Any loss of weight equaling 1 lb. or more in a month to be reported to MD/patient's family for follow up." The plan of care failed to evidence patient specific interventions to facilitate weight gain, such as small, frequent snacks, specific requirements for the amount and volume of pediasure to supplement and amount or calorie equivalent of oral intake required, and weight and vital sign parameters; failed to evidence measurable goals for the patient's growth, management of heart failure, and management of unrepaired pulmonary artery stenosis; and			

	failed to evidence the patient's progress toward goals from the previous certification period. 2. A review of the plan of care for Patient #3, dated 05/30/23 - 07/28/23, evidenced a primary diagnosis of Down Syndrome with secondary diagnoses including, but not limited to, attention-deficit hyperactivity disorder, asthma, and type 1 diabetes. The plan of care failed to evidence interventions to manage the patient's behaviors, manage and mitigate asthma exacerbations. The patient's nutrition orders indicated low concentrated sweets and low carb. The plan of care failed to evidence orders defining “low carb”, blood sugar parameters, frequency of blood sugar testing, and interventions to monitor, mitigate, and treat hypo and hyper glycemia. Goals included "Patient will verbalize s/s [signs and symptoms] of hypo and hyperglycemia and importance of being compliant with diet ... Skilled nurse will administer appropriate insulin does ... Clinical summary will be completed on Patient assessment ..." The plan of care failed to evidence patient-specific goals and			

	pertinent interventions and failed to include progress made toward goals from previous cert period. 3. A review of the plan of care for Patient #7, dated 07/03/23 - 08/31/23, evidenced a primary diagnosis of fetal alcohol syndrome and secondary diagnoses including, but not limited to, severe intellectual disabilities, unspecified convulsions, and other speech disturbances. Goals included "Client will be free of Covid-19 infection ..." The plan of care failed to evidence a seizure plan to manage and mitigate seizures and failed to evidence interventions consistent with assisting the patient to communicate and make needs and wants known. The goals included "Client will be free of Covid-19 ... Client's personal care ... will be completed without difficulty." The goals failed to be pertinent and measurable and failed to include interventions appropriate to the current diagnoses.			
G0592	Revised plan of care	G0592	An in-service was held 8/1/23 and a more detailed one willbe	2023-08-30

	484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on record review and interview the agency failed to evidence a revised plan of care containing updated patient information, measurable outcomes, and goals for 3 of 8 active clinical records reviewed. (Patients #2, 5, and 8) The findings include: Review of the plan of care for Patient #5 for the certification period of 7-11-2023 through 9-08-2023, contained orders for attendant care services and skilled nursing 300-324 hours per month "hours use as needed per client/caregiver request; subject to change", with diagnoses which included, but were not limited to: Attention to gastrostomy (also called a 'G-tube', a tube inserted through the belly that brings nutrition directly to the stomach), squamous cell carcinoma of skin of scalp and		held 8/22/23 to re-educate licensed nurses on the Care Plan and the need tokeep it current with updated client information, measurable outcomes and clientspecific goals and progress toward those goals. It was reinforced to the staffthe importance of an accurate assessment and how it can help with the care planregarding client progress and ability to reach goals. By 8/8/23 10% of EMR's for skilled clients were audited forthe completion of comprehensive assessments. Going forward 10% will be monitoredmonthly until there are 3 consecutive months of compliance to insure they reflectcurrent information on the client, updated comprehensive assessment, revised progresstoward client's goals and measurable outcomes in achieving them. They areperson-centered as well. Once this is achieved, 20% will be monitored quarterlywith results taken to QAPI for input and suggestions thereafter to preventrecurrence. Nursing administration will monitor 10% of the EMR's	

	neck (relatively slow-growing malignant (cancerous) tumors that can spread to surrounding tissue if left untreated), dysphagia (difficulty swallowing foods or liquids, arising from the throat or esophagus, ranging from mild difficulty to complete and painful blockage), pain related to neoplasm (a new and abnormal growth of tissue in some part of the body, especially as a characteristic of cancer), need for assistance with personal care, difficulty in walking, presence of other vascular implants and grafts (in this instance, a chemotherapy port, a small implantable device that attaches to a vein, usually in the upper chest area, allows healthcare providers to draw blood and give treatments including chemotherapy drugs without a needle stick, and can remain in place for weeks, months or even years), and tracheostomy status (a surgically created passageway from the skin of the anterior neck to the trachea (windpipe) used as a supportive measure in patients with various airway or breathing problems). A section titled, '60 day summary of care' included but was not limited to, "Client has had 1 ER visit due to		monthlyfor current updated care plans along with MD orders generating changes inclient's condition that would generate a new care plan. This also will be discussed at Case Conferences weekly as afollow-up. Failure of nurses to comply with the process will result inwritten discipline and if it recurs termination will result. DON is responsible.	

	dislodgement of GT, and one additional urgent visit to Interventional Radiology due to another dislodgement one month later. Further diagnosis and treatment will be determined by MD's." The record failed to evidence dates of the visits, outcome from the interventional radiology visit, and any subsequent follow-up or physician orders. In an interview on 7-25-2023 at 3:00PM, when queried regarding the documentation in the recertification assessment and plan of care for Patient #5's two emergent/urgent visits, one to the Emergency Room and one to Interventional Radiology, both related to displacement of the G-tube, dates those visits occurred, or additional information, the Clinical Manager and Administrator had nothing to offer. 1. A review of the plan of care for Patient #2, for certification period 06/22/23 - 08/20/23, indicated diagnoses including, but not limited to, chronic respiratory failure with hypoxia (respiratory failure requiring mechanical ventilation) and tracheo-esophageal fistula (TEF			

	- an opening between the esophagus and trachea.) An unrepaired TEF would result in aspiration of oral and stomach contents into the airways and lungs and is inconsistent with a patient receiving oral intake as desired. The patient's nutritional orders included pediasure orally, if desired, and regular oral intake as tolerated. On 07/24/23 at 3 PM, the Administrator indicated the patient no longer had a tracheostomy, mechanical ventilation, or oxygen, and was a picky eater but consumed nutrition orally as desired. The Administrator indicated the plan of care needed to be updated to include current and pertinent diagnoses, goals, and interventions. 1. A review of an agency document titled "Plan of Care" indicated but was not limited to "Policy...The attending physician will participate in the care planning process by reviewing and revising therapeutic and diagnostic orders...Procedure 1. Physician orders are individualized, based on client's needs, and include: A. Patient			

	procedures to be done, including type frequency, duration and goals…4. The attending physician's recertification will be obtained at intervals of at least every sixty days when the client's plan of care of reviewed and client recertified, or more often if warranted…A. Changes in the client's physical and psychosocial condition B. The Client's response to care…" 2. A review of the clinical record for Patient #8 evidenced a recertification period of 06/09/2023 to 08/07/2023 with orders for skilled nursing 2 times daily 2-5 days, 1-2 hours per shift x 60 days and a home health aide (HHA) 3-5 week x60 days and respite HHA 48-60 hours per month. Patient #8's diagnoses included but not limited to quadriplegia (a form of paralysis affecting the limbs and body from the neck down), pressure ulcer of left buttock, stage 4 (wound penetrating all three layers of skin, exposing muscle, tendons, and bones), Pressure ulcer of left hip, stage 4, pressure ulcer right ischium (part of hip bone), stage 4. The Plan of Care indicated Patient #8 was seen at Entity B a wound			

	clinic. All information would be sent to the wound clinic. During an interview on 07-20-2023 at 11 AM the Administrator reported that Patient #8 no longer goes to Entity B, and that information was carried over from the previous plan of care and should not be there. She indicated the patient is currently followed by the their primary care physician only for wound orders and communication. The plan of care failed to be updated to reflect Patient #8's primary wound care physician.			
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview, the agency failed to ensure all services were coordinated and integrated to identify all patient needs and services available, and to avoid duplication of services for 3 of 9 active clinical records reviewed.	G0606	At the 8/1/23 mandatory in-service, and at a more detailedin-service to be scheduled for 8/22/23 nursing staff will continue to be educatedto inquire about all other providers that our clients receive services from andexplain the necessity of Coordination of Care to identify all the client'sneeds. Previously, JHS had sent out aninvitation to all our outside providers to discuss Coordination of Care withthem and to avoid duplication of services. The DON has contacted families usingother	2023-08-30

	(Patients #2, 3, and 7) Findings include: 1. A review of the plan of care for Patient #2, dated 06/22/23 - 08/20/23, evidenced the patient received services provided by Joy Health Services and funded via Medicaid Waiver, a type of Medicaid funding applied for and managed by a company specializing in waiver case management. The record failed to evidence communication notes or care coordination notes with a case management company responsible for disseminating the waiver services. 2. A review of the plan of care for Patient #3, dated 07/03/23 - 08/31/23, evidenced the patient received home health aide services 7-9 hours, 3 - 5 x/week. The plan of care failed to evidence the patient received waiver services and failed to evidence care coordination and integration with a case management company responsible for disseminating the waiver services or with		providers for care and they will be listed in the EMR and contacted atleast quarterly for their input into the Plan of Care or as the client needarises. The EMR now contains a section for additional providers to secure thisinformation and prevent recurrence. Nursingadministration is following up with staff nurses reminding them to inquire ifadditional providers are used by our clients. This is also now a part added to the Case Conference weekly to keep upto date with any changes. By 8/8/23 10%of client's records were audited to verify this. The upcoming in-service on8/22/23 will address again the need to provide coordination of care with allservices the client receives, without duplication of services, and the need tomake it client specific. A monthly audit will be done by nursing administrationto verify at least 10 % of the clients have accurate Coordination of Care informationwith outside services. Once this goalhas been reached successfully for 3 continuous months then 20% of skilledrecords will be audited quarterly for compliance with	

	another agency providing the waiver services. 3. On 07/19/23 at 9:30 AM, during a home visit, Patient #7's mother stated the patient receives 52 hours/week of waiver services through another unnamed agency. 4. On 07/24/23 at 2:09 PM, the Administrator indicated case coordination meetings occur every Friday, and provided documentation to support what was discussed. A review of the case coordination worksheets 07/01/23 - 07/21/23 failed to evidence a sign in list or other type of documentation which indicated who participated in and/or was present for the meetings and failed to evidence a waiver case management company or case manager was contacted for Patients #2 and 3. The Administrator indicated there was no further documentation for care coordination and/or integration. 410 IAC 17-12-2(h)		findings to QAPI forfollow up and suggestions to prevent recurrence in the future. DON is responsible .	
G0682	Infection Prevention 484.70(a)	G0682	On 8/1 23 at the in-service an Individual hands-onobservation of handwashing was done and	2023-08-30

	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 record review, observation, and interview the agency failed to ensure field staff adhered to infection control precautions during patient care in 2 of 4 home visits observed. (Employees: RN 1 and LPN 1) Findings include: 1. Review of an agency document dated 4-02-2023, titled, 'Universal Precautions' page 2 stated, "...GENERAL PRECAUTIONS 1. Hand washing: hand washing will be performed to prevent cross-contamination between clients and personnel. A. hands and other skin surfaces should be washed with soap and warm water immediately and thoroughly before and after client contact, if contaminated with body substances, before and after gloves are worn... b. Use soap, warm water and friction for hand washing. Lather and scrub for ten seconds. Rinse well, beginning at fingertips, so dirty water runs off at wrists. Dry hands on		competencies done for all active RN'sand LPN's including the 2 staff involved. By 8/22/23 handwashing in-servicepolicy and procedure will again be presented and competencies done for allactive field employees. JHS will ensure all active field staff will be re-educatedon the handwashing policy and procedure per JHS policy. Case managers will monitor 80% of their staff that have beenseen that week until 100% compliance is reached. Any staff member failing to comply will becounselled and monitored for 30 days for improvement. If no improvement is demonstrated or arefusal to follow procedure, staff member will be terminated. Information obtained from Case Managers will be documentedand discussed at QAPI for input/suggestions. DON is responsible.	

paper towels. Use dry paper towels to turn off faucets."

2. On 7-19-2023 at 8:00 AM, during a home observation for Patient #5, RN 1 was observed performing hand hygiene before patient care began. Went to the sink in the patient's bathroom, turned on faucet handles and washed hands with soap and water, applying friction to all surfaces for greater than 30 seconds, rinsed hands under running water then reached over to the right of the sink where there was a light green hand towel hanging from a towel bar on the wall, the towel appeared used and winkled, dried hands, then reached over further to the right to grab a few sheets of toilet paper from a holder on the wall, and used this to turn the faucet handles and shut off the water. Disposed of the toilet paper in the trash.

On 7-20-2023 at 4:18 PM, when discussing the infection control breach during the home visit for Patient #5 with RN 1, the Administrator indicated, "we have to supply [RN 1] with paper towel".

During a home visit on 07/19/23 at 10:40 AM, Licensed Practical Nurse (LPN) 1 was observed providing tracheostomy (an artificial opening through the neck and into the windpipe, or trachea, to allow for breathing) change and care to Patient #4. Prior to initiating the care, LPN 1 completed hand hygiene using soap and water. After rubbing her hands together for 10 seconds, LPN 1 rinsed them, turned the tap of with her ungloved right hand, then dried both hands with a paper towel. LPN 1 donned clean gloves and removed the patient's trach tube (artificial tube inserted into the tracheostomy opening in the neck). LPN 1 discarded her gloves, completed a 10-second hand wash with soap and water, turned off the faucet with her bare hand, and donned a new pair of gloves. LPN 1 wet a gauze 4x4 with tap water and wiped the patient's neck and tracheostomy opening, or stoma, and discarded the gauze

and gloves. LPN 1 repeated hand hygiene with soap and water, rubbed her hands together for 7 seconds, turned off the faucet with her bare hand, dried with a paper towel, and donned clean gloves. LPN 1 inserted a clean, lubricated trach tube it into the patient's trach stoma and secured the trach ties. LPN 1 discarded her gloves and completed a 10 second hand washing with soap and water, then turned off the water with her bare hand and exited the room with Patient #4. A dispenser of hand sanitizer was observed on the countertop. When questioned as to when hand sanitizer was used, LPN 1 indicated the agency preferred soap and water hand hygiene and alcohol-based sanitizer was only used in the absence of soap and water. When questioned concerning the length of time required for hand washing with soap and water, LPN 1 indicated it was necessary to wash quickly because a trach change was a time sensitive procedure and lengthening the time for handwashing in between gloving put the patient's stoma at risk for closure.

	On 7/19/23 at 2:30 PM, the Administrator and Clinical Manager indicated staff were instructed that handwashing with soap and water was preferable to using hand-sanitizer. Alcohol-based hand sanitizer was used only when soap and water were not available. When asked how frequently the LPN needed to change gloves during a trach change, the Administrator and Clinical Manager indicated they needed to reference the policy.			

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
Joy Adewopo	Administrator	8/15/2023 4:52:20 PM