STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157618	A. BUILDING B. WING	07/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAGON HOME HEALTHCARE	3601 HOBSON RD, SUITE 107, FORT WAYNE, IN, 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102. Survey Dates: July 05, 06, 07, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, and 27, 2023 Active Census: 187 At this Emergency Preparedness survey, Universal Home Healthcare of Indiana d/b/a Paragon Home Healthcare was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR by A3 on 08/07/2023.	E0000		

E0017	HHA Comprehensive Assessment in Disaster 484.102(b)(1) §484.102(b)(1) Condition for Participation: [(b) Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. At a minimum, the policies and procedures must address the following:] (1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55. Based on record review and interview, the home health agency failed to create an individualized patient emergency preparedness plan as part of the comprehensive assessment for 2 of 17 active records reviewed (Patients #2, 14). Findings include: 1. Review of Patient #2's clinical record indicated a start of care 06/23/2023 with an initial comprehensive assessment	E0017	**CorrectiveAction:** The Alternate Director of Clinical Services started an internalaudit review of all active clinical records on 8/7/23 to ensure the presence of a completed patient-individualized emergency preparedness plan. A 30% review ofactive charts was completed by the week ending 8/12/23. A 25% review of active chartswas completed by the week ending 8/19/23. A 45% review of active charts was completedby the week ending 8/26/23 to complete 100% audit of all active chart audits. In order to correct the abovedeficiency cited under E-0017, during the management meeting on 8/23/23, theAdministrator, Director of Clinical Services (DCS), and the Alternate Directorof Clinical Services (ADCS) reviewed the individualized patient emergencypreparedness plan as part of the comprehensive assessment. The Administratorhas ensured that an individualized emergency preparedness plan is part of thecomprehensive assessment	2023-09-20

	the Clinical Supervisor. The record failed to evidence an individualized emergency plan was created for Patient #2 at the time of admission. 2. Review of Patient #14's clinical record indicated a start of care of 06/29/2023 with an initial comprehensive assessment completed on 06/29/2023 by Registered Nurse (RN) 1. The record failed to evidence an individualized emergency plan was created for Patient #14 at the time of admission. 3. During an interview with the Administrator and Alternate Administrator conducted on 07/25/2023 beginning at 4:20 PM, the Alternate Administrator confirmed Patients #2 and #14 did not have a completed individualized patient emergency preparedness plan as part of the comprehensive assessment.		in the Admission packet and clinical records. Theclinical records with the deficiencies were identified and reviewed. The Administrator, Director ofClinical Services and the Alternate Director of Clinical Services havecompleted re-orientation of agency's policies pertaining to the requirement on8/23/23 provided by the Governing Body Chair. An in-service meeting wasconducted by the Administrator on 8/29/23 to educate all staff to discuss theimportance of an individualized patient emergency preparedness plan to be part ofthe comprehensive assessment. The Administrator has provided updated copy of the individualizedemergency preparedness plan to all participants on 8/29/23 and educated thestaff that any updates to individualized emergency preparedness must bedocumented as part of comprehensive assessment in patient charts. All staffunderstood and acknowledged the requirement. Allnew staff will be oriented of this requirement at the time of hire. The corrective actions wereimplemented on 8/7/23	

			and completed on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes n from 8/30/23 to 9/20/23. **Measures to assure Norecurrence:** In order to ensure that thereis no recurrence of this deficiency, the Alternate Director of ClinicalServices will utilize a chart audit tool and audit 100% of all active patientson a weekly basis to ensure that all clinical records show evidence ofindividualized emergency preparedness plan document as part of comprehensive andit is duly signed and dated by the patient or patient's representative, agencystaff and evidence of individualized emergency preparedness plan document mustbe present in home health agency's clinical record. This process of utilizingchart audit tool will help us identify any discrepancies in clinical recordsand take corrective measures	

			accordingly. **Monitoring:** In order to ensure the implementation and effectiveness of this corrective action, the followingmonitoring process will be put in place; the Alternate Director of Clinical Services will audit 100%of all new admissions and all current patients on a weekly basis to ensure thatpatient individualized emergency preparedness plan document is present aspart of comprehensive and it is duly signed and dated by the patient orpatient's representative, agency staff in home health agency's clinical record. The Director of ClinicalServices will monitor and review the Alternate Director of Clinical Services' auditfindings of all active patients. Weekly reports will be generated and resultswill be compiled and sent to the Administrator to ensure that processes haveimproved. This process will continue for each week for the next 30 days until100% compliance is achieved and to maintain this level of compliance all	

			newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart audit review. Quarterly audit results will be compiled and sent to theQAPI Committee for review. Once the threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. TheAdministrator will be responsible for corrective action of this deficiency,measure to assure no recurrence and monitoring of this deficiency.	

E0030	Names and Contact Information 483.73(c)(1) §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	E0030	**CorrectiveAction:** The Administrator has started implementation of an emergency preparedness communication plan on 7/31/23 and it was on completed on 8/27/23. In order to correct the above deficiency cited under E-0030, duringthe management meeting on 8/23/23, the Administrator, Director of Clinical Services (DCS) andthe Alternate Director of Clinical Services (ADCS) reviewed the EmergencyPreparedness Planning and Resource Manual and Agency policy 2.3.1 titled,"Communication Plan and Policy for Emergency Operations Plan (EOP) thatincluded an emergency preparednesscommunication plan that complied with Federal, State and local laws. TheAdministrator developed and maintained the emergency preparedness communicationplan to include all of the following required subject areas (1) Names andcontact information for the following: (i) Staff, (ii) Entities providingservices under	2023-08-29

	(iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(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) 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.		arrangement, (iii) Patients' physicians, (iv) Other[facilities], (v) Volunteers; and will ensure that it will be reviewed,maintained and updated at least annually and more often if any changes occur.The Communication Plan with the deficiencies was identified and reviewed. The Administrator, Director ofClinical Services and Alternate Director of Clinical Services have completedre-orientation of agency's policies pertaining to the requirement on 8/23/23provided by the Governing Body Chair. An in-service meeting was conducted bythe Administrator on 8/29/23 to educate all staff to discuss the importance ofimplementing an emergencypreparedness communication plan that complied with Federal, State and locallaws to include all of the following required subject areas (1) Names andcontact information for the following: (i) Staff, (ii) Entities providingservices under arrangement, (iii) Patients' physicians, (iv) Other[facilities], (v) Volunteers. All staff were informed and re-educated on therequirement that Patients'	

	*[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 home health agency failed to ensure its emergency preparedness communication plan included contact information for patients' physicians for 3 of 17 active records reviewed (Patients #3, 5, 19), which had the potential to affect all agency patients. Findings include: 1. Review of the clinical record		physicians list included their name, address, phonenumber and fax number to be current and educated the staff that any updates tothe Physician contact information must be reported to the Administrator to keep the communication plan current. Allstaff understood and acknowledged the requirement. All new staff will be oriented of thisrequirement at the time of hire. The above mentioned corrective actions were implemented on 7/31/23and completed on 8/29/23. **Measures to assure Norecurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Administrator will utilize an audit tool with the help of the Directorof Clinical Services (DCS) to ensure that preparednesscommunication plan that complies with Federal, State and local laws to includeall of the following required subject areas (1) Names and contact informationfor the following: (i) Staff, (ii) Entities providing services underarrangement, (iii)	

	of Patient #3 included a plan of care for the initial certification period of 06/28/2023 – 08/26/2023 which indicated the patient's attending physician was Physician U. The doctor's address, phone number, and fax number was listed as Physician Office W. During an interview with Person V, employee at Physician's Office W, conducted on 07/18/2023 starting at 2:17 PM, the employee reported Physician U had not worked at the office since 02/15/2023. Person V also reported there was no record of Patient #3 receiving care from any provider at Physician's Office W. During an interview with Patient #3 conducted on 07/18/2023 beginning at 2:21 PM, the patient reported Physician U practiced out of an office located in Upland, Indiana. Review of the agency's emergency preparedness communication plan failed to evidence the agency had Physician U's correct contact information in case of emergency. 2. Review of the clinical record		[facilities], (v)Volunteers; will be reviewed, maintained and updated at least annually or moreoften if any changes to the communication plan occur. This process will help us identifyand implement improvements in maintaining the emergencypreparedness communication plan and make corrective adjustments in the future. **Monitoring:** In order to ensure the implementation and effectiveness of thiscorrection action, the Administrator will be monitoring the EmergencyPreparedness Plan for evidence of successful maintenance of emergencycommunication plan on a monthly basis for the next 3 months to ensure properimplementation and to achieve 100% compliance. Once 100% compliance isachieved, this process will continue to be monitored on semi-yearly basis.Semi-yearly audit results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the Quality Committee will continue	

	of Patient #5 included a plan of care for the initial certification period of 06/14/2023 – 08/12/2023 which indicated the patient's attending physician was Physician T. During an interview with Person CC, employee at Physician's Office T, conducted on 07/18/2023 starting at 11:13 AM, the employee reported Physician T was not the attending physician for Patient #5. Person CC also reported there was no record of Patient #5 receiving care from Physician T in the patient's clinical chart. During an interview with Patient #5 on 07/19/2023 beginning at 11:05 AM, the patient confirmed Physician T was not their attending physician. Review of the agency's emergency preparedness communication plan failed to evidence the agency had the contact information for Patient #5's attending physician in case of emergency. 3. Review of the clinical record of Patient #19 included a plan of care for the initial certification period of		to audit100% of Emergency Plan including communication plan once a year to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. TheAdministrator will be responsible for corrective action of this deficiency,measure to assure no recurrence and monitoring of this deficiency.	

	indicated the patient's attending physician was Surgeon M. During an interview with Office Nurse N, Surgeon M's office nurse on 7/17/23 at 3:30 PM, the nurse reported there was no record of Patient #19 receiving care from Surgeon M. The office nurse confirmed Surgeon M had not provided any home care orders for Patient #19 nor had the patient received care from Surgeon M. Review of the agency's emergency preparedness communication plan failed to evidence the agency had the contact information for Patient #19's attending physician in case of emergency. 4. During an interview with the Administrator on 07/27/2023 beginning at 6:05 PM, the Administrator reported the agency kept a hard copy of referral information for all active patients in the office which could be accessed in case of emergency to obtain contact information for the patients' physicians. The Administrator confirmed the contact information for Patients #3, 5,			

	and 19's physicians were incorrect according to the referral information and the agency did not have the correct information for these patients' physicians in case of emergency.			
G0000	INITIAL COMMENTS This visit was a Federal and State complaint survey of a deemed home health provider. The survey was announced as fully extended on 07/07/2023 at 4:30 PM. Survey dates: July 05, 06, 07, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, and 27, 2023 Complaint #399021 was investigated, related and unrelated Federal and State findings. Unduplicated Skilled Admissions: 786 The administrator was notified of an Immediate Jeopardy on 07/21/23 at 10:20 AM at §484.60 Care Planning, Coordination of Services, and Quality of Care. The Immediate Jeopardy was identified as beginning on 06/28/2023. The	G0000		

	immediacy was not abated prior to survey exit. QR completed by A3 and A4 on 08-07-2023. During the survey, Universal Home Healthcare of Indiana d/b/a Paragon Home Healthcare was found to be out of compliance with Conditions of Participation 42 CFR 484.50 Patient Rights, 484.60 Care planning, coordination of services, and quality of care, 484.75 Skilled Professional Services, and 484.100 Clinical Records. Based on these condition-level deficiencies, Universal Home Healthcare of Indiana d/b/a Paragon Home Healthcare was subject to a partial or extended survey on July 7, 2023, pursuant to section 1891(c)(2)(D) of the Social Security Act. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, the agency is precluded from providing its own home health aide training and competency evaluation programs for a period of two years beginning July 27, 2023, and continuing through July 26, 2025. This deficiency report reflects			

	State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.			
G0406	Patient rights 484.50 Condition of participation: Patient rights. The patient and representative (if any), have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights. Based on record review and interview, the home health agency failed to ensure the patient was informed of a delay in start of therapy services (See G434), failed to ensure patients received all services as outlined in the plan of care (See G436), failed to ensure all patient records were kept confidential in accordance with the Health Insurance Portability and Accountability Act (See G438), failed to ensure patients were free from any reprisal for voicing a grievance to the agency (see Tag G448), and failed to investigate all patient complaints according to its policy (See G478). The cumulative effect of these	G0406	All tags (G0434, G0436, G0438, G0448 and G0478) were addressedindividually.	2023-09-20

	systemic problems had the potential to impact all 187 active patients which resulted in the agency being found out of compliance with the Condition of Participation 42 CFR 484.50 Patient Rights.			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record review and interview, the home health agency failed to ensure patients were informed of a delay in start of therapy services for 2 of 2 records which evidenced a lapse in time for therapy	G0434	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure patientswere informed of a delay in start of therapy services. 30% review of active charts wascompleted by week ending 8/12/23. 25% review of active charts was completed byweek ending 8/19/23. 45% review of active charts was completed by week ending8/26/23 to complete 100% audit of all active chart audits. In order to correct the above deficiency cited underG0434, during the management meeting on 8/23/23, the Administrator and Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the organization's policy, 12.12.2	2023-09-20

	and 17). Findings include: Review of an agency policy revised February 2022, titled "Patient Bill of Rights and Responsibilities" indicated Patients have the right to receive all services in the plan of care and the right to participate in, be informed about and consent or refuse care in advance of and during treatment. Review of Patient #14's clinical record included a plan of care for the initial certification period 06/26/2023 – 08/24/2023. The plan of care indicated the patient was to receive an Occupational Therapy (OT) evaluation and Physical Therapy (PT) evaluation for services. The record included an initial comprehensive assessment, conducted by Registered Nurse (RN) 1 on 6/29/2023, which indicated Patient #14's need for OT and PT services. The record included PT and OT evaluation visits were completed on 7/10/2023 by Physical Therapist 6 and Occupational Therapist 3. The record failed to evidence communication with the patient		titled "Consent", undersection XII of the policy titled "Patient Bill of Rights and Responsibilities12.1.4" that the clinician is to provide information to the patient bothorally and in writing: " The patient has the right to participate in, beinformed about and consent or refuse care in advance of and during treatment,where appropriate, with respect to: (i) Completion of all assessments; (ii) Thecare to be furnished, based on the comprehensive assessment; (iii) Establishingand revising the plan of care; (iv) The disciplines that will furnish the care;(v) The frequency of visits; (vi) Expected outcomes of care, includingpatient-identified goals, and anticipated risks and benefits; (vii) Any factorsthat could impact treatment effectiveness; and (viii) Any changes in the careto be furnished". The clinical records with the deficiencies were identifiedand reviewed. The Administrator, Director of Clinical Services and AlternateDirector of Clinical Services have completed re-orientation of agency'spolicies pertaining to the requirement on 8/23/23	

	regarding lapse in time for PT and OT services (6/29/2023 to 7/10/2023). During an interview on 7/19/23 beginning at 3:50 PM, the Alternate Clinical Supervisor stated there was not any documentation in the patient chart regarding the lapse in services. During an interview on 7/20/23 beginning at 2:58 PM, Patient #14 stated they were not notified by the home health agency in the delay of therapy services. Review of Patient #17's clinical record included a plan of care (POC) for the initial certification period 05/11/2023 – 07/09/2023. The POC indicated the patient was to receive Skilled Nursing (SN), Occupational Therapy (OT) and Physical Therapy (PT) services. The record included an initial comprehensive assessment, conducted by Registered Nurse (RN) 3 on 5/11/2023, which indicated Patient #17's need for SN, OT and PT services. The record included PT and OT evaluation visits were		provided by the GoverningBody Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care. The Alternate Administrator willschedule application demo on 9/15/23 and after training Agency staff,application will be in use on 9/20/23. An in-service meeting was conducted by the Administrator andattended by all staff on 8/29/23 to discuss the agency policy titled, "Consent"12.12.2 "under section XII of the policy titled Patient Bill of Rights andResponsibilities 12.1.4". All staff were informed and re-educated on therequirement that that the clinician is to provide information to the patientboth orally and in	

	completed on 5/15/2023 by Physical Therapist 4 and Occupational Therapist 5. The record failed to evidence communication with the patient regarding lapse in time for PT services (05/15/2023 to 06/08/2023). During an interview on 07/25/23 beginning at 10:09 AM, Patient #17 stated they did not request PT services to delay until 06/08/2023. During an interview on 07/25/23 beginning at 12:24 PM, PT 4 stated that they notified the office to schedule the PT frequency visits after the PT evaluation on 05/15/2023 and was not aware of the delay in services until later when they called to schedule a PT supervision visit on 06/08/2023. 410 IAC 17-12-3(b)(2)(D)(ii)(BB)		writing: " The patient has the right to participate in,be informed about and consent or refuse care in advance of and duringtreatment, where appropriate, with respect to: (i) Completion of allassessments; (ii) The care to be furnished, based on the comprehensiveassessment; (iii) Establishing and revising the plan of care; (iv) Thedisciplines that will furnish the care; (v) The frequency of visits; (vi) Expectedoutcomes of care, including patient-identified goals, and anticipated risks andbenefits; (vii) Any factors that could impact treatment effectiveness; and(viii) Any changes in the care to be furnished". Citations listed in theclinical record reviews were addressed. All staff understood and acknowledgedthe requirement and importance of the need to ensure patients were informed ofa delay in start of services. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on8/7/23 and completed on 8/29/23. Tostrengthen further ongoing	

			staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to ensure real-time visibility into patient care and to ensurepatients are informed of any delay in services. The Alternate Director ofClinical Services will utilize a chart audit tool and audit 100% of all activepatients on a weekly basis to ensure that all clinical records show evidence ofconsent form that the Patients are informed about, and consent or refuse carein advance of the disciplines that will furnish care and it is duly signed anddated by the patient or patient's	

			representative and evidence of consent formmust be present in home health agency's clinical record. The Alternate Directorof Clinical Services will further ensure that communication with the patient orpatient's representative is present documenting delay in services. This processof utilizing chart audit tool will help us identify any discrepancies inclinical records and take corrective measures accordingly. **Monitoring** In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place; the AlternateDirector of Clinical Services will audit 100% of all new admissions and allcurrent patients on a weekly basis to ensure that all clinical records showevidence of consent form that the Patients are informed about, and consent orrefuse care in advance of the disciplines that will furnish care and it is dulysigned and dated by the patient or patient's representative and evidence	

			in home health agency's clinical record. The Directorof Clinical Services will monitor and review Alternate Director of Clinical Services'audit findings of all active patients. Weekly reports will be generated andresults will be compiled and sent to the Administrator to ensure that processeshave improved. This process will continue for each week for the next 30 daysuntil 100% compliance is achieved and to maintain this level of compliance allnew employees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to	

			ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Directorof Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. Based on record review and interview, the home health agency failed to ensure patients received all services as outlined in the plan of care for 1 of 1 records reviewed which evidenced the agency failed to provide home health aide services as ordered in the plan of care (Patient #4). Findings include: Review of Patient #4's closed clinical record (start of care 05/22/23, discharge date 06/20/23) included a plan of	G0436	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 toensure patients received all services as outlined in the plan of care. 30% review of active charts wascompleted by week ending 8/12/23. 25% review of active charts was completed byweek ending 8/19/23. 45% review of active charts was completed by week ending8/26/23 to complete 100% audit of all active chart audits. In order to correct the above	2023-09-20

	care for the initial certification period 05/22/23 – 07/20/23 that indicated Patient was to receive home health aide services to assist with personal care and Activities of Daily Living (ADLS, tasks to perform self-care, such as bathing, toileting, ambulating, etc). The record included an initial comprehensive assessment, conducted by Registered Nurse (RN) 2 on 05/22/23, which indicated Patient #4 depended entirely on someone else for grooming, dressing, bathing, toileting, and transferring, was unable to ambulate nor wheel themselves in a wheelchair, and required assistance with meal set-up. The record failed to evidence Patient #4 received any home health aide visits nor received assistance with personal care needs from another agency service while Patient was on agency services. The record indicated Patient #4 was discharged on 06/20/2023 due to refusing a skilled nursing visit. Patient was re-admitted to the agency on 07/11/23 and was an active patient at the time of survey exit. During an interview with Patient		during the management meeting on 8/23/23, the Administrator and Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the organization's policy under section XII titled “Patient Bill ofRights and Responsibilities 12.1.3" that the patient has the right toreceive all services outlined in the plan of care”. The clinical records withthe deficiencies were identified and reviewed. The Administrator, Director ofClinical Services and Alternate Director of Clinical Services have completedre-orientation of agency’s policies pertaining to the requirement on 8/23/23provided by the Governing Body Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with “Home HealthNotify”, a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into	

	#4 on 07/07/23 beginning at 11:40 AM, Patient confirmed they did not receive home health aide services during the service dates of 05/22/23 – 06/20/23. During an interview with the Administrator and Alternate Clinical Supervisor on 07/11/23 beginning at 04:37 PM, the Alternate Clinical Supervisor confirmed Patient #4 did not receive home health aide services during the service dates of 05/22/23 - 06/20/23. During an interview with RN 2, on 07/13/23 beginning at 11:40 AM, the nurse confirmed Patient #4 had home health aide services ordered within their plan of care for the certification period 05/22/23 – 07/20/23. The nurse was unsure why Patient did not receive aide services.		patient care and to ensure that patients receive allservices as outlined in the plan of care.The Alternate Administrator will schedule application demo for 9/15/23 andafter training Agency staff, application will be in use on 9/20/23.	

			An in-service meeting was conducted by the Administrator andattended by all staff on 8/29/23 to discuss the agency policy under section XIIof the policy titled Patient Bill of Rights and Responsibilities 12.1.3".All staff were informed and re-educated on the requirement that "the patienthas the right to receive all services outlined in the plan of care". Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the requirementand importance of the need to ensure that the home health agency provides homehealth services as ordered in the plan of care. All new staff will be orientedof this requirement at the time of hire. The corrective actions wereimplemented on 8/7/23 and completed on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No**	

			recurrence In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to ensure real-time visibility into patient care and to ensure that patients receive allservices as outlined in the plan of care.The Alternate Director of Clinical Services will utilize a chart audit tool andaudit 100% of all active patients on a weekly basis to ensure that all clinicalrecords show patient receiving all home health services as ordered and outlinedin the plan of care and evidence must be present in the clinical record. Thisprocess of utilizing chart audit tool will help us identify any discrepanciesin clinical records and take corrective measures accordingly. **Monitoring** In order to ensure	

			implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place; the AlternateDirector of Clinical Services will audit 100% of all new admissions and allcurrent patients on a weekly basis to ensure that all clinical records showpatient receiving all home health services as ordered and outlined in the planof care and evidence must be present in the clinical record. The Director ofClinical Services will monitor and review Alternate Director of Clinical Services'audit findings of all active patients. Weekly reports will be generated andresults will be compiled and sent to the Administrator to ensure that processeshave improved. This process will continue for each week for the next 30 daysuntil 100% compliance is achieved and to maintain this level of compliance allnew employees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops	

			and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the quarterlychart audit review. Quarterly audits results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the QAPI Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Directorof Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0438	Have a confidential clinical record 484.50(c)(6)	G0438	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure all patientrecords were kept confidential in accordance	2023-09-20

	Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164. Based on record review and interview, the home health agency failed to ensure all patient records were kept confidential in accordance with the Health Insurance Portability and Accountability Act (HIPAA), 45 CFR Part 164, for 3 of 4 active records which evidenced protected health information was sent to an incorrect fax number (Patients #3, 5, 15). Findings include: Review of the clinical record of Patient #5 included a plan of care for the initial certification period of 06/14/2023 – 08/12/2023 which indicated the patient's attending physician was Physician T. The record evidenced the plan of care and an order for the patient's home care services was faxed to Physician T on 07/06/2023. The record failed to evidence the correct attending physician for Patient #5. During an interview with Person CC, employee at Physician's Office T, conducted on 07/18/2023 starting at 11:13		with the Health InsurancePortability and Accountability Act (HIPAA). 30% review of active charts wascompleted by week ending 8/12/23. 25% review of active charts was completed byweek ending 8/19/23. 45% review of active charts was completed by week ending8/26/23 to complete 100% audit of all active chart audits. The Administratorhas verified that all individual employees, direct and indirect, with access toany part of a patient's clinical record, will have an individual login,specific to them alone, and their activity in the patient's record, will havethe capability to be tracked as to when they are in each patient's clinicalrecord and any changes that are made within the clinical record on 8/25/23. In order to correct the above deficiency cited underG0438, during the management meeting on 8/23/23, the Administrator and Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the organization's policy under section XII titled "Patient Bill ofRights and Responsibilities	

	AM, the employee reported Physician T was not the attending physician for Patient #5. Person CC also reported there was no record of Patient #5 receiving care from Physician T in the patient's clinical chart. During an interview with Patient #5 on 07/19/2023 beginning at 11:05 AM, the patient reported Physician DD as their attending physician. During an interview with Person EE on 7/19/2023 beginning at 11:10 AM, Person EE verified that Physician CC was the attending physician for Patient #5. They stated there are no records or documents received from the home health agency in the Patient's clinical chart. Review of the clinical record of Patient #15 included a plan of care for the initial certification period of 05/09/2023 – 07/07/2023 which indicated the patient's attending physician was Physician Z. The record evidenced an order for the patient's home care services was faxed to Physician Z on 06/07/2023 and the plan of care had not yet been faxed to Physician Z. The record failed		12.1.3" that the patient has the right Have aconfidential patient record and access to or release of patient information andrecords in accordance with Health Insurance Portability and Accountability Act(HIPAA) law and regulation". The clinical records with the deficiencies wereidentified and reviewed. The Administrator, Director of Clinical Services andAlternate Director of Clinical Services have completed re-orientation ofagency's policies pertaining to the requirement on 8/23/23 provided by theGoverning Body Chair. The Administrator has completed contact information validationfor all active Patient Physicians on 8/27/23. All active clinical recordsreview was completed on 8/26/23. The Alternate Administrator is in coordinationwith "Home Health Notify", a HIPAA compliant communication application for theAgency, clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care and to ensure all	

	to evidence the correct attending physician for Patient #15. During an interview with Person BB on 7/18/2023 beginning at 2:05 PM, Person BB verified Physician AA was the attending physician for Patient #15 and the Patient's clinical chart does not include any scanned documentation from the home health agency. Person BB stated they would make Physician AA aware of patient was receiving home health services. During an interview on 7/18/2023 at 3:00 PM, the Office Assistant confirmed faxes of physician orders and plans of care were sometimes sent to the wrong fax number. The Office Assistant was unable to quantify the number of times it occurred. The ADM indicated no record of improper disclosure of protected health information (PHI) was kept. 1. 45 Code of Federal Regulation (CFR) 164.306 indicated the home health agency must ensure the confidentiality of all electronic protracted health information the agency transmitted.		confidential in accordance with the Health Insurance Portability andAccountability Act (HIPAA). The Alternate Administrator will scheduleapplication demo for 9/15/23 and after training Agency staff, application willbe in use on 9/20/23. An in-service meeting was conducted by the Administrator andattended by all staff on 8/29/23 to discuss the agency policy under section XIIof the policy titled Patient Bill of Rights and Responsibilities 12.1.3".All staff were informed and re-educated on the requirement that "that thepatient has the right Have a confidential patient record and access to orrelease of patient information and records in accordance with Health InsurancePortability and Accountability Act (HIPAA) law and regulation". Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the requirementand importance of the need to ensure that the patient has the right Have aconfidential patient record and access to or release of patient	

	2. Review of the clinical record of Patient #3 included a plan of care for the initial certification period of 06/28/2023 – 08/26/2023 which indicated the patient's attending physician was Physician U. The doctor's address, phone number, and fax number was listed as Physician Office W. The record evidenced the plan of care and an order for the patient's home care services was faxed to Physician U at Physician Office W on 07/10/2023 by Office Staff 5. During an interview with Person V, employee at Physician's Office W, conducted on 07/18/2023 starting at 2:17 PM, the employee reported Physician U had not worked at the office since 02/15/2023. Person V also reported there was no record of Patient #3 receiving care from any provider at Physician's Office W. During an interview with Patient #3 conducted on 07/18/2023 beginning at 2:21 PM, the patient reported Physician O practiced out of an office in Upland, Indiana. Review of the clinical record of Patient #19 included a plan of		information andrecords in accordance with Health Insurance Portability and Accountability Act(HIPAA) law and regulation. All new staff will be oriented of this requirementat the time of hire. The corrective actions were implemented on 8/7/23 andcompleted on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to ensure real-time visibility into patient care and to ensure	

	care for the initial certification period of 6/28/23–8/26/23 which indicated the patient's attending physician was Physician M. The record evidenced an order for the patient's home care services was faxed to Physician M on 02/08/2023 by Former Employee 1. During an interview with Surgeon M's office nurse on 7/17/23 at 3:30 PM, the nurse reported there was no record of Patient #19 receiving care from Surgeon M. The office nurse confirmed Surgeon M had not provided any home care orders for Patient #19.		confidential in accordance with the Health InsurancePortability and Accountability Act (HIPAA). The Alternate Director of ClinicalServices will utilize a chart audit tool and audit 100% of all active patientson a weekly basis to ensure that all clinical records reflect physician contactinformation which includes but is not limited to Physician name, address, phonenumber, fax number is validated and it must be present in the clinical record.This process of utilizing chart audit tool will help us identify anydiscrepancies in clinical records and take corrective measures accordingly. TheAlternate Administrator will utilize an individual login audit tool to ensurethat all individual employees, direct and indirect, with access to any part ofa patient's clinical record, will have an individual login, specific to themalone, and their activity in the patient's record, will have the capability tobe tracked as to when they are in each patient's clinical record and anychanges that are made within the clinical record.	

			Monitoring In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place; TheAlternate Administrator will utilize an individual login audit tool to ensurethat all individual employees, direct and indirect, with access to any part ofa patient's clinical record, will have an individual login, specific to themalone, and their activity in the patient's record, will have the capability tobe tracked as to when they are in each patient's clinical record and anychanges that are made within the clinical record on a monthly basis. The AlternateDirector of Clinical Services will audit 100% of all new admissions and allcurrent patients on a weekly basis to ensure that all clinical records reflectphysician contact information which includes but is not limited to Physicianname, address, phone number, fax number is correct and is being clearly documentedin the clinical record. The Director of Clinical Services will monitor andreview Alternate Director of Clinical Services' audit findings of all activepatients. Weekly	

			reports will be generated and results will be compiled andsent to the Administrator to ensure that processes have improved. This processwill continue for each week for the next 30 days until 100% compliance isachieved and to maintain this level of compliance all new employees at the timeof hire will be oriented with this requirement. If compliance is not achievedat the desired target of 100% compliance and any deficiencies are identifiedwithin 30 days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. The Administratorand QAPI Committee will send a written report to the Governing Body quarterlyfor their	

			recommendations. The Director of Clinical Services will be responsible for correctiveaction of this deficiency, measure to assure no recurrence and monitoring ofthis deficiency.	
G0448	Freedom from discrimination or reprisal 484.50(c)(11) Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the HHA or an outside entity. Based on record review and interview, the home health agency failed to ensure patients were free from retaliation after submission of a grievance to the agency for 1 of 1 records resulting in a discharge following a grievance report. (Patient #4). Review of agency policy #12.3.1 titled "Complaint Resolution," revised 02/2022, indicated patients were encouraged to voice complaints to the agency "without fear of ... reprisal for doing so or unreasonable interruption of care."	G0448	**CorrectiveAction:** The Administrator started internal audit review of allcomplaint logs on 8/7/23 to ensure patients were free from retaliation aftersubmission of a grievance to the agency. 100% review of complaint logs wascompleted by week ending 8/12/23. One complaint was documented, investigated,follow-up was completed and complaint was resolved and action was taken. 100%review of complaint logs was repeated and completed by week ending 8/19/23 andno complaints were received. 100% review of complaint logs was repeated andcompleted by week ending 8/26/23 and no complaints were received. In order to correct the above deficiency cited underG0448,	2023-09-20

	Review of the agency's complaint log evidenced a complaint documented on 06/21/23 at 10:27 AM, by the Alternate Administrator. The documentation indicated Patient #4 called the agency to ask when their skilled nursing visit would be and was told the Licensed Practical Nurse (LPN) 2 had conducted visits on 06/05/23 and 06/09/23; Patient reported the nurse did not conduct visits on these dates. The documentation indicated Patient refused further skilled nursing services until their complaint was addressed. The complaint log indicated the Alternate Administrator contacted Patient #4 on 06/22/23 at 10:27 AM to "inform [the patient] of discharge due to refusal on nursing visit." Review of Patient #4's closed clinical record (start of care 05/22/23, discharge date 06/20/23) indicated Patient's diagnoses included an open wound to the right buttock, dependence on wheelchair for ambulation, and reduced mobility. The record evidenced a physician order, documented by Registered Nurse (RN) 2 and		during the management meeting on 8/23/23, the Administrator and Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the organization's policy under section XII titled "Patient Bill ofRights and Responsibilities 12.1.4" that the patient has the right to befree from any discrimination or reprisal for exercising his/her rights or forvoicing grievances to the Agency or an outside entity" and complaint resolutionpolicy 12.3.1 "Patients are encouraged to make suggestions for improving careand/or register complaints to Agency personnel without fear of coercion,discrimination or reprisal for doing so or unreasonable interruption of care".The clinical records and complaint logs with the deficiencies were identifiedand reviewed. The Administrator, Director of Clinical Services and AlternateDirector of Clinical Services have completed re-orientation of agency'spolicies pertaining to the requirement on 8/23/23 provided by the GoverningBody Chair.	

	dated 06/20/23, for the discharge of Patient #4 due to "refusing services," effective 06/20/23; the record evidenced the nurse completed a Discharge Summary for Patient #4, signed and dated 06/23/23. The record failed to evidence any home health services were provided by the agency after 06/14/2023. During an interview with the Administrator and Alternate Administrator conducted on 07/07/23 beginning at 4:30 PM, the Administrator reported Patient #4 refused a skilled nurse visit on 06/20/23, so the agency discharged Patient, effective 06/20/23. During an interview with Office Manager X, an employee of Patient #4's attending physician's office, conducted on 07/17/23 beginning at 3:59 PM, the office manager stated Office Employee 6 called the physician's office on 06/22/23 and reported Patient #4 was discharged from the home health agency due to "noncompliance." 410 IAC 17-12-3(b)(2)(B)		All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care and to ensure patients were free fromretaliation after submission of a grievance to the agency. The AlternateAdministrator will schedule application demo for 9/15/23 and after trainingAgency staff, application will be in use on 9/20/23. An in-service meeting was conducted by the Administrator andattended by all staff on 8/29/23 to discuss the agency policy under section XIIof the policy titled Patient Bill of Rights and Responsibilities 12.1.4 andcomplaint resolution policy 12.3.1. All staff were informed and re-educated onthe requirement that the	

			from anydiscrimination or reprisal for exercising his/her rights or for voicinggrievances to the Agency or an outside entity and patients are encouraged tomake suggestions for improving care and/or register complaints to Agencypersonnel without fear of coercion, discrimination or reprisal for doing so orunreasonable interruption of care. Citationslisted in the clinical record reviews and complaints logs were addressed. Allstaff understood and acknowledged the requirement and importance of the need toensure that the patient has the right to be free from any discrimination orreprisal for exercising his/her rights or for voicing grievances to the Agencyor an outside entity and patients are encouraged to make suggestions forimproving care and/or register complaints to Agency personnel without fear ofcoercion, discrimination or reprisal for doing so or unreasonable interruptionof care. All new staff will be oriented of this requirement at the time ofhire. The corrective actions were implemented on 8/7/23 and completed on	

			8/29/23. Tostrengthen further ongoing complaint resolution process, hiring and trainingnew staff and to ensure successful outcomes of the implemented correctiveactions, will continue to further test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to ensure real-time visibility into patient care and to ensurepatients were free from retaliation after submission of a grievance to theagency. The Alternate Administrator will utilize a complaint log audit tool andaudit 100% of all patient complaints on a weekly basis to ensure that all complaintlogs reflect that	

			patients free from any discrimination or reprisal forexercising his or her rights or for voicing grievances to the HHA or an outsideentity, complaints are fully documented, investigated, resolved and it must bepresent in the complaint logs. This process of utilizing complaint audit toolwill help us identify any discrepancies in the complaint process and resolutionand take corrective measures accordingly. **Monitoring** In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place; the Administratorwill monitor and review Alternate Administrator's audit findings of all activepatients. Weekly reports will be generated and results will be compiled andsent to the Administrator to ensure that processes have improved. This processwill continue for each week for the next 30 days until 100% compliance isachieved and to maintain this level of compliance all new employees	

			at the timeof hire will be oriented with this requirement. If compliance is not achievedat the desired target of 100% compliance and any deficiencies are identifiedwithin 30 days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the audit review. Quarterly auditsresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the QAPI Committee will continue to audit 25% of complaintlogs quarterly to ensure compliance is maintained. The Administrator and QAPICommittee will send a written report to the Governing Body quarterly for theirrecommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	

G0478	Investigate complaints made by patient 484.50(e)(1)(i) (i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics: Based on record review and interview, the home health agency failed to investigate all patient complaints according to its policy for 1 of 1 patient complaints regarding skilled nursing visits fraudulently documented (Patient #4). Findings include: Review of agency policy #12.3.1 titled "Complaint Resolution," revised 02/2022, indicated the agency would investigate all complaints regarding care which failed to be furnished and would implement investigative measures "based on the nature of the complaint." Review of the agency's complaint log evidenced a complaint filed by Patient #4 and documented on 06/21/23 at 10:27 AM by the Alternate Administrator. The documentation indicated	G0478	**CorrectiveAction:** The Administrator started internal audit review of allcomplaint logs on 8/7/23 to ensure patients were free from retaliation aftersubmission of a grievance to the agency. 100% review of complaint logs wascompleted by week ending 8/12/23. One complaint was documented, investigated,follow-up was completed and complaint was resolved and action was taken. 100%review of complaint logs was repeated and completed by week ending 8/19/23 andno complaints were received. 100% review of complaint logs was repeated andcompleted by week ending 8/26/23 and no complaints were received. In order to correct the above deficiency cited underG0478, during the management meeting on 8/23/23, the Administrator and Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the organization's policy under section XII titled "Patient Bill ofRights and Responsibilities	2023-09-20

	Patient #4 reported they received an insurance bill for skilled nurse visits conducted on 06/05/23 and 06/09/23 by Licensed Practical Nurse (LPN) 2, however Patient reported the nurse did not conduct visits on these dates. The documentation indicated Patient #4 requested a billing statement from the agency and declined further home health services until their complaint was resolved. The Alternate Administrator documented they conducted a review of Patient's clinical record and advised Patient the visits in question were "verified." The documentation indicated the agency's billing invoices would not be available until the end of Patient's certification period (07/20/23). The complaint documentation indicated the Alternate Administrator spoke with Patient #4 on 06/22/23 at 10:27 AM and informed Patient they were being discharged from agency "due to refusal [of] nursing visit." The documentation indicated Patient remained "adamant" LPN 2 did not conduct the two visits in question.		right "tohave complaints investigated and complaint resolution policy 12.3.1 that theAgency will investigate complaints made by a patient, the patient'srepresentative (if any) and the patient's caregivers and family". The clinicalrecords and complaint logs with the deficiencies were identified and reviewed. TheAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 8/23/23 provided by the Governing Body Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care and to investigate all patientcomplaints. The Alternate Administrator will schedule application demo	

	The complaint documentation indicated Patient #4 called and spoke with the Alternate Administrator on 06/23/23 at 2:10 PM to again report LPN 2 did not conduct skilled nursing visits on 06/05/23 and 06/09/23. Patient #4 reported a durable medical equipment (DME) company had been at their home at the time of one of the nursing visits in question and Patient requested the agency verify with the DME company the presence or absence of a nurse in the home. The complaint documentation indicated the Alternate Administrator referred Patient #4 to their primary care provider (PCP) and Patient's report of a DME company's presence in their home at the time of the nursing visit in question was "irrelevant." The complaint documentation indicated Patient #4 called and spoke with the Alternate Administrator a second time on 06/23/23 at 2:45 PM, this time requesting a 3-way call "to verify what the inside of [the patient's] house looks like" and wanted LPN 2 to identify the DME company which was present in the home at the time		for9/15/23 and after training Agency staff, application will be in use on 9/20/23. An in-service meeting was conducted by the Administrator andattended by all staff on 8/29/23 to discuss the agency policy under section XIIof the policy titled Patient Bill of Rights and Responsibilities 12.1.4 andcomplaint resolution policy 12.3.1. All staff were informed and re-educated onthe requirement that the patient has the right "to have complaints investigatedand that the Agency will investigate complaints made by a patient, thepatient's representative (if any) and the patient's caregivers and family. Citations listed in the clinical recordreviews and complaints logs were addressed. All staff understood andacknowledged the requirement and importance of the need to ensure that thepatient has the right "to have complaints investigated and that the Agency willinvestigate complaints made by a patient, the patient's representative (if any)and the patient's caregivers and family.	

	of the nurse visit in question. The Alternate Administrator's documentation indicated they again referred Patient to their PCP for further records requested. The complaint documentation and Patient #4's clinical record failed to evidence any further investigation regarding the complaint was conducted by the agency. During an interview with the Alternate Administrator conducted on 07/17/23 beginning at 11:24 AM, the employee reported they did not follow up with any DME company regarding Patient #4's allegation due to Patient not providing the name of the DME company.		All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on8/7/23 and completed on 8/29/23. Tostrengthen further ongoing complaint resolution process, hiring and trainingnew staff and to ensure successful outcomes of the implemented correctiveactions, will continue to further test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence** In order to ensure that there is no recurrence of thisdeficiency, Alternate Administrator has made a process update and the Agencywill be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to ensure real-time visibility into patient care and to investigateall patient complaints. The Alternate Administrator will utilize a complaintlog audit tool and	

			complaints on a weekly basis toensure that all complaint logs reflect that patient complaints are fullydocumented, investigated, resolved and it must be present in the complaint logs.This process of utilizing complaint audit tool will help us identify anydiscrepancies in the complaint process and resolution and take correctivemeasures accordingly. **Monitoring** In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place; theAdministrator will monitor and review Alternate Administrator's audit findingsof all active patients. Weekly reports will be generated and results will becompiled and sent to the Administrator to ensure that processes have improved.This process will continue for each week for the next 30 days until 100%compliance is achieved and to maintain this level of compliance all newemployees at	

			with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will continueto be monitored on a quarterly basis and will be included in the audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 25% ofcomplaint logs quarterly to ensure compliance is maintained. The Administratorand QAPI Committee will send a written report to the Governing Body quarterlyfor their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	

G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment included a medication review which was complete, accurate, and identified any significant drug interactions for 11 of 21 total patient records reviewed (Patient #: 1, 3, 5, 7, 9, 10, 14, 15, 18, 19, 20). Review of an agency policy revised February 2021, titled "Medication Reconciliation" indicated the admitting RN, PT or SLP will create and document a complete list of medications that patient is taking at home, including dose, strength, route and frequency. Any concerns or discrepancies (duplications, omissions, changes, contraindications and/or unclear information) will be	G0536	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure thecomprehensive assessment included a medication review which was complete,accurate, and identified any significant drug interactions. 30% review ofactive charts was completed by week ending 8/12/23. 25% review of active chartswas completed by week ending 8/19/23. 45% review of active charts was completedby week ending 8/26/23 to complete 100% audit of all active chart audits. In order to correct the above deficiency cited underG0536, during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 8.15.1 titled, "Medication Reconciliation". Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Director of Clinical Services and	2023-09-20

	patient's physician/practitioner. Review of an agency policy revised February 2022, titled "Initial Assessments/Comprehensive Assessments" indicated each patient's comprehensive assessment includes a review of all medications the patient is currently taking and concerns identified by clinician during medication review must be reported to physician/practitioner. Review of the clinical record of Patient #5 included a plan of care for the initial certification period of 06/14/2023 – 08/12/2023 which indicated the patient's attending physician was Physician T. The record evidenced a physician's order for the patient's home care services, including moderate drug interactions was faxed to the incorrect physician on 7/06/2023. The record failed to evidence the drug interactions were faxed to the correct physician for review. Review of the clinical record of Patient #14 indicated Registered Nurse (RN) 1 conducted an initial		Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 8/23/23 provided by the Governing Body Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care and to ensure the comprehensiveassessment included a medication review which was complete, accurate, andidentified any significant drug interactions. The Alternate Administrator willschedule application demo for 9/15/23 and after training Agency staff,application will be in use on 9/20/23. An in-service was be conducted by the Director of ClinicalServices on 08/29/23	

	comprehensive assessment on 6/29/2023. The record failed to evidence the clinician conducted a review of Patient #14's medications for potential adverse effects and drug reactions; failed to update the medication profile with current meds based on hospital discharge instructions and failed to collaborate with physician regarding medication differences. During an interview on 7/26/2023 beginning at 2:31 PM, RN 1 indicated that they collaborated with the after hours physician during SOC for medication updates. The clinical record failed to evidence these medication updates to the medication profile. Review of the clinical record of Patient #15 indicated Registered Nurse (RN) 3 conducted an initial comprehensive assessment on 5/09/2023. The record failed to evidence the clinician conducted a review of Patient #15's medications for potential adverse effects and drug reactions; failed to update the medication profile with current meds based on hospital		with all staff. During the meeting, the DCS discussedagency policy 8.15.1 titled, "Medication Reconciliation" and the importance ofthe requirement to review of all medications the patient is currently using inorder to identify any potential, adverse effects and drug reactions, includingineffective drug therapy, significant side effects, significant druginteractions, duplicate drug therapy, and noncompliance with drug therapy.Citations listed in the clinical record reviews were addressed. All staffunderstood and acknowledged the agency policy 8.15.1 titled, "MedicationReconciliation" and the requirement to have a registered nurse (RN) perform acomprehensive drug review of all current medications. All new staff will beoriented of this requirement at the time of hire. The corrective actions wereimplemented on 8/7/23 and completed on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue	

	discharge instructions and failed to collaborate with physician regarding medication differences. Patient #15 also received weekly PT/INR lab testing (a blood test that measures how long it takes blood to clot) which resulted in changes in warfarin (a Blood thinner used to treat and prevent blood clots). The record failed to evidence the warfarin changes were updated on the medication profile. During an interview on 7/24/2023 beginning at 3:49 PM, RN 3 indicated that they contact the physician at every SOC for mediation review and contact the Coumadin Clinic weekly with PT/INR results and medication changes. Review of the clinical record of Patient #19 indicated Registered Nurse (RN) 2 conducted an initial comprehensive assessment on 6/28/2023. The record failed to evidence the clinician conducted a review of Patient #19's medications for potential adverse effects and drug reactions; failed to update the medication profile with current medications in the home and		tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to ensure real-time visibility into patient care and to ensure thecomprehensive assessment included a medication review which was complete,accurate, and identified any significant drug interactions. The AlternateDirector of Clinical Services will utilize a chart audit tool to ensure thatall active clinical records include review of all medications the patient iscurrently using in order to identify any potential, adverse effects and drugreactions, including ineffective drug therapy, significant side effects,significant drug interactions, duplicate drug	

	failed to collaborate with physician regarding medication differences.		therapy, and noncompliance withdrug therapy is present in the clinical record. This process of utilizingactive chart audit tool on all admissions will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In order to ensure implementation and effectiveness ofthis corrective action, the Alternate Director of Clinical Services will audit100% of all new admissions and all current patients on a weekly basis to ensurea registered nurse (RN) performs a comprehensive drug review of all medicationsthe patient is currently using in order to identify any potential, adverseeffects and drug reactions, including ineffective drug therapy, significantside effects, significant drug interactions, duplicate drug therapy, andnoncompliance with drug therapy is being clearly documented in the clinicalrecord. The Director of Clinical Services will monitor and review AlternateDirector of	

	During a home visit observation conducted with Patient #19 and Licensed Practical Nurse (LPN) 1 on 7/14/2023 beginning at 11:00 AM, Patient #19 was observed wearing on their right lower back, a Buprenorphine 7.5 mcg transdermal patch (used to relieve severe pain in people who are expected to need pain medication around the clock for a long time and who cannot be treated with other medications. It is in a class of medications called opiate (narcotic) analgesics). LPN 1 stated this was new and Caregiver responded they were unsure what it was or where it came from. LPN 1 removed the transdermal patch after caregiver was unable to identify. LPN 1 reviewed all medications in the home with caregiver and found several new medications that were not on the medication profile. LPN 1 failed to update the physician regarding new medications found in the home and failed to collaborate with the pain clinic regarding the transdermal patch that patient was wearing. During an interview on 7/13/2023 with Registered Nurse (RN) 2 beginning at 2:20		Clinical Services' audit findings of all new admissions and currentpatients. Reports will be generated and results will be compiled to ensureprocesses have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue foreach week for the next 30 days until 100% compliance is achieved. After 30days, this process will continue to be monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. The Directorof Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no	

	PM, RN 2 indicated the medications are verified in the home during every visit. During an interview on 7/17/2023 with the Clinical Supervisor beginning at 1:39 PM, the Clinical Supervisor indicated when new medications are found in the home, the physician should be called to make sure the medication is appropriate and the medication profile is to be updated. During an interview on 7/20/2023 beginning at 4:13 PM, LPN 1 verified they did not collaborate with the physician regarding medication discrepancies in the home. A review of the clinical record for Patient #1, for certification period 4/3/2023 – 6/9/2023, failed to evidence documentation of a medication review which identified adverse reactions, significant drug interactions, and duplicate drug therapy. A review of the clinical record for Patient #7, for certification period 6/27/2023 – 8/25/2023, failed to evidence		recurrence and monitoring of this deficiency.	

	review which identified adverse reactions, significant drug interactions, and duplicate drug therapy. A review of the clinical record for Patient #9, for certification period 5/15/2023 – 7/13/2023, failed to evidence documentation of a medication review which identified adverse reactions, significant drug interactions, and duplicate drug therapy. A review of the clinical record for Patient #10, for start of care 4/21/2023, failed to evidence documentation of a medication review which identified adverse reactions, significant drug interactions, and duplicate drug therapy. A review of the clinical record for start of care 6/15/2023, failed to evidence documentation of a medication review which identified adverse reactions, significant drug interactions, and duplicate drug therapy. A clinical record review for Patient #18 for certification period 5/15/2023 – 7/13/2023, failed to evidence documentation of a medication			

	review which identified adverse reactions, significant drug interactions, and duplicate drug therapy. A review of the clinical record for Patient #20, start of care 2/13/2023, failed to evidence documentation of a medication review which identified adverse reactions, significant drug interactions, and duplicate drug therapy. During an interview on 7/25/2023 at 4:35 PM, the alternate director of nursing (ADON) confirmed the electronic medical record (EMR) did not track or save the medication interaction reports, which the agency used as a medication review. The agency printed reports, scanned to the physician, and kept them in a binder in the office for a short period of time. The ADON indicated they had no printed reports for any patients prior to June 2023. Review of the clinical record of Patient #3 indicated Physical Therapist (PT) 4 conducted an initial comprehensive assessment on 06/28/2023. The record failed to evidence the			

	clinician conducted a review of Patient #3's medications for potential adverse effects and drug reactions.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the home health agency failed to ensure all patients had one plan of care for all home health services (See G572). Based on observation, record review, and interview, the home health agency failed to ensure the plan of care was individualized, patient-specific,	G0570	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure all patientshad one plan of care for all home health services received, theplan of care was individualized, patient-specific, included all medications,all treatments orders, and risk factors and patient-specific interventions forre-hospitalization and Emergency Department visits, all services and treatmentswere provided as ordered by a physician, notify any physician involved in the patient's care of achange in patient's wound measurements or to any changes in thepatient's condition or needs that suggest that outcomes are not being achievedand/or that the plan of care should be altered and ensure collaboration between homehealth agency staff, Assisted Living Facility (ALF) staff, Wound Clinics andany	2023-09-20

	treatments orders, and risk factors and patient-specific interventions for re-hospitalization and Emergency Department visits (See G574), failed to ensure all services and treatments were provided as ordered by a physician (See G580), failed to notify any physician involved in the patient's care of a change in patient's wound measurements (See G590) and failed to failed to ensure collaboration between home health agency staff and Assisted Living Facility (ALF) staff (See G608). Findings include: 1. Review of agency policy titled "Initial Assessments/Comprehensive Assessments" revised February 2021, indicated that the initial comprehensive assessment should include but not be limited to "relevant diagnosis and current health status, including all active health and medical problems … physical assessment …." 2. Review of agency policy titled "Reassessments/Update of the Comprehensive Assessment" revised February 2021, indicated		other healthcare facilities. 30% review of active charts was completed byweek ending 8/12/23. 25% review of active charts was completed by week ending8/19/23. 45% review of active charts was completed by week ending 8/26/23 tocomplete 100% audit of all active chart audits. In order to correct the above deficiency cited under G0570,during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.9.1 titled, "Care Planning Process", 9.10.1titled, "Plan of Care-CMS#485 and Physician Orders" and 9.13.1 titled,"Coordination of Patient Care". The clinical records with the deficiencies wereidentified and reviewed. The Alternate Administrator is in coordination withEMR vendor to ensure that all home health services are documented within oneplan of care and the feature will be implemented and enhancement request hasbeen submitted to the EMR vendor. The customer support team for the EMR vendorhas forwarded the	

	staff should "reassess each patient with each home visit on an ongoing basis to evaluate current problems and needs as well as to adjust the care provided." The policy also indicated patients should be reassessed when a significant change in condition or status occurred. 3. Review of agency policy titled "Care Planning Process" revised February 2021, indicated that the plan of care would be "developed and implemented" with the patient's physician and/or practitioner and would include but not be limited to "interventions (physician/practitioner orders)." It also indicated staff providing care should coordinate "initially and ongoing," with coordination to include but not be limited to the patient's "problems and needs" and "specific care or services to be provided." 4. Review of agency policy titled "Plan of Care-CMS#485 and Physician/Practitioner Orders" revised February 2022, indicated that the individualized plan of care (POC) must specify the care and services necessary		request to the product management team and effective date ofthis feature update will be provided by them. The clinical records with thedeficiencies were identified and reviewed. The Administrator, Director ofClinical Services and Alternate Director of Clinical Services have completedre-orientation of agency's policies pertaining to the requirement on 8/23/23provided by the Governing Body Chair. All active clinical records review wascompleted on 8/26/23. An in-service was be conducted by the Director of ClinicalServices on 08/29/23 with all staff. During the meeting, the DCS discussed agencypolicy 9.9.1 titled, "Care Planning Process", 9.10.1 titled, "Plan ofCare-CMS#485 and Physician Orders" and 9.13.1 titled, "Coordination of PatientCare" and the importance of the requirement that each patient must receive thehome health services that are written in an individualized plan of care thatidentifies patient-specific measurable	

	to meet the patient-specific needs as identified in the comprehensive assessment, including all medications and treatments. The policy also indicated all patient care orders, including verbal orders, must be recorded in the POC. 5. Review of agency policy titled "Coordination of Patient Care" revised February 2021, indicated staff should "assure communication with all physicians/practitioners involved in the plan of care" and "coordinate care delivery to meet the patient's needs." The policy also indicated staff should notify the patient's physician/practitioner with any changes in the patient's condition. 6. Review of agency policy titled "Physician-Practitioner Orders-Verbal Orders" revised February 2022, indicated that drugs and treatments should be administered by the Agency staff only as ordered by the physician / practitioner and the orders should be obtained prior to the provision of any care. 7. Review of a Patient #19's clinical record included an		outcomes and goals, and which isestablished, periodically reviewed, and signed by a doctor of medicine,osteopathy, or podiatry acting within the scope of his or her state license,certification, or registration, the plan of care wasindividualized, patient-specific, included all medications, all treatmentsorders, and risk factors and patient-specific interventions forre-hospitalization and Emergency Department visits, that the drugs, services, andtreatments are administered only as ordered by a physician or allowedpractitioner, notify any physician involved in the patient's care of a changein patient's wound measurements or to any changes in thepatient's condition or needs that suggest that outcomes are not being achievedand/or that the plan of care should be altered and ensure collaboration between home healthagency staff, Assisted Living Facility (ALF) staff, Wound Clinics and any otherhealthcare facilities. Citations listed in the clinical record reviews wereaddressed. All staff understood and acknowledged	

	admission Comprehensive Assessment (CA), dated 6/28/23 and completed by Registered Nurse (RN) 2, which evidenced the patient had one Stage 3 pressure ulcer wound (type of wound caused by prolonged pressure to a body site, described as stages from 1 – 4 or unstageable) to the right buttock and one wound to the left posterior calf which was not described and/or staged. The CA indicated that RN 2 performed wound care to the right buttock and left posterior calf during the visit however the note failed to evidence the nurse obtained orders for home care services nor treatments, including wound care treatment orders. A plan of care (POC) for Patient #19's initial certification period 6/28/23–8/26/23 listed Surgeon M as the attending physician directing the patient's home care. The POC failed to evidence wound treatment orders nor a physician signature. During an interview with RN 2 on 7/20/23 at 4:30 PM, the nurse confirmed they performed wound care to Patient #19's right buttock and		the agency policy 9.9.1titled, "Care Planning Process", 9.10.1 titled, "Plan of Care-CMS#485 andPhysician Orders" and 9.13.1 titled, "Coordination of Patient Care" and therequirement. All new staff will be oriented of this requirement at the time ofhire. The corrective actions were implemented on 8/7/23 and completed on8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Director of Clinical Services will utilize a chartaudit tool to ensure that all active clinical records include that each patientreceives the home health services that are written in an individualized plan ofcare that identifies patient-specific measurable outcomes and goals, and whichis established, periodically reviewed, and	

	left posterior calf wounds without physician orders. RN 2 confirmed they did not contact a physician / provider for Start of Care (SOC) or wound treatment orders. The clinical record indicated subsequent skilled nurse visits on 6/30/23, 7/05/23, 7/07/23, 7/10/23 and 7/12/23 documented by LPN 1 and a skilled nurse visit on 7/02/23 documented by RN 2, in which wound care was performed to the patient's right buttock wound despite no wound treatment orders documented. LPN 1's visit note dated 6/30/23 indicated the R buttock wound measured 1 centimeter (cm) in length by 1 cm in width by 0.1 cm in depth. LPN 1's visit note dated 7/05/23 indicated the right buttock wound had increased to 4 cm x 4 cm x 1.0 cm but failed to evidence the nurse notified Surgeon M nor any other providers of the increased wound measurements. During an interview with LPN 1, on 7/13/23 at 9:29 AM, the nurse confirmed they did not obtain any wound care treatment orders for Patient #19		signed by a doctor of medicine,osteopathy, or podiatry acting within the scope of his or her state license,certification, or registration and to have all services integrated into theoverall plan of care, the plan of care was individualized, patient-specific, included allmedications, all treatments orders, andrisk factors and patient-specific interventions for re-hospitalization andEmergency Department visits, all services and treatments were provided asordered by a physician, notify any physician involved in the patient's care ofa change in patient's wound measurements or to any changes in the patient'scondition or needs that suggest that outcomes are not being achieved and/orthat the plan of care should be altered and ensure collaboration between homehealth agency staff, Assisted Living Facility (ALF) staff, Wound Clinics andany other healthcare facilities and documentation is present in the clinicalrecord. This process of utilizing active chart audit tool on all admissionswill help us identify any discrepancies in the clinical	

	and failed to update RN 2 nor notify the physician regarding the increased wound measurements. The clinical record revealed wound clinic visit notes and treatment orders from Wound Clinic O, scanned into the record on 07/13/2023. The clinic visit note indicated Patient #19 was first seen by the wound clinic on 7/06/23. Patient's home health clinical record failed to evidence the agency incorporated the clinic's wound care orders into the plan of care. During a home visit observation with Patient #19 on 7/14/23 beginning at 11:00 AM, LPN 1 was observed measuring Patient's right buttock wound. The wound's measurement was observed to have increased to 5 cm x 2.5 cm x 1.0 cm with tunneling measuring 0.5 cm at 1 o'clock. LPN 1 was observed performing wound care to the left posterior calf and a wound to the left first finger. The record failed to evidence LPN 1 notified any physician of the increased right buttock wound measurements nor obtained any wound care orders for any		records and re-educateall staff on the above mentioned requirement. **Monitoring:** In order to ensure implementation and effectiveness ofthis corrective action, the Alternate Director of Clinical Services will audit100% of all new admissions and all current patients on a weekly basis to ensurepatient receives the home health services that are written in an individualizedplan of care that identifies patient-specific measurable outcomes and goals,and which is established, periodically reviewed, and signed by a doctor ofmedicine, osteopathy, or podiatry acting within the scope of his or her statelicense, certification, or registration and to have all services integratedinto theoverall plan of care, the plan of care was individualized, patient-specific,included all medications, all treatments orders, and risk factors andpatient-specific interventions for re-hospitalization and Emergency Departmentvisits, all	

	of Patient's wounds. During an interview with RN 2 on 7/20/23 at 4:30 PM, the nurse confirmed that they were not aware that the right buttock wound had increased in size. During an interview with Surgeon M's office nurse on 7/17/23 at 3:30 PM, they reported the MD had not provided any verbal or written orders for home care. During an interview with a nurse at Wound Clinic O on 7/20/23 2:10 PM, the nurse reported the clinic had no record of providing verbal orders to the agency regarding home care services and/or treatments. The wound nurse also reported the clinic had no record of agency staff reporting a change in Patient's right buttock to the wound clinic. The clinical record indicated Patient #19 was deceased as of 7/20/23, however no cause of death was documented and no discharge visit had been completed. The cumulative effect of these systemic problems indicated the home health agency's was		services and treatments were provided as ordered by a physician,notify any physician involved in the patient's care of a change in patient'swound measurements or to any changes in the patient's condition or needs thatsuggest that outcomes are not being achieved and/or that the plan of careshould be altered and ensure collaboration between home health agency staff,Assisted Living Facility (ALF) staff, Wound Clinics and any other healthcare facilities and is being clearly documented in theclinical record. The Director of Clinical Services will monitor and reviewAlternate Director of Clinical Services' audit findings of all new admissionsand current patients. Reports will be generated and results will be compiled toensure processes have improved. If any deficiencies are identified, they willcontinue to be addressed with each personnel as needed. This process willcontinue for each week for the next 30 days until 100% compliance is achieved.After 30 days, this process will continue to be monitored on a quarterly basisand will be included in the	

	unable to ensure provision of quality health care, which resulted in the agency being found out of compliance for the condition of participation 484.60 Care planning, coordination of services, and quality of care. 410 IAC 17-13-1(a)		quarterly chart audit review. Quarterly auditresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the Quality Committee will continue to audit 20% of clinicalrecords quarterly to ensure compliance is maintained. The Administrator andQAPI Committee will send a written report to the Governing Body quarterly fortheir recommendations. The Director of Clinical Services will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the	G0572	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure all patientshad one plan of care for all home health services received and that the physicianwas consulted in the development and/or revision of the plan of care regardingthe therapy services and any other	2023-09-20

	physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the home health agency failed to ensure all patients had one plan of care for all home health services received for 2 of 15 records reviewed with patients receiving therapy services (Patients #3, 7). Findings include: Review of an agency policy revised February 2022, titled "Plan of Care-CMS #485 and Physician/Practitioner Orders" indicated the Plan of Care must be signed by a physician or authorized practitioner acting within the scope of his or her state license, certification or registration; all patient care orders, including verbal orders, must be recorded in the plan of care and the physician/practitioner who established the Plan of care must sign and date. Review of the clinical record for Patient #7, certification period 6/27/2023 – 8/25/2023, evidenced separate physical therapy and occupational		services and all plan of cares werecompleted with consulting the physician for input. 30% review of active chartswas completed by week ending 8/12/23. 25% review of active charts was completedby week ending 8/19/23. 45% review of active charts was completed by weekending 8/26/23 to complete 100% audit of all active chart audits. In order to correct the above deficiency cited underG0572, during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.9.1 titled, "Care Planning Process". The clinicalrecords with the deficiencies were identified and reviewed. The AlternateAdministrator is in coordination with EMR vendor to ensure that all home healthservices are documented within one plan of care and the feature will beimplemented and enhancement request has been submitted to the EMR vendor. Thecustomer support team for the EMR vendor has forwarded the request to theproduct	

	therapy plans of care, which were not integrated into the overall plan of care. Review of the clinical record for Patient #10, certification period 6/20/2023 – 8/18/2023, evidenced a physician's order which included the disciplines, frequencies, and nursing interventions to be provided for the certification period. There was no documentation of physician input into the development and / or revision of the plan of care. During an interview on 7/18/2023 at 4:05 PM, RN 3 indicated they completed the plan of care without consulting the physician for input. Review of the clinical record of Patient #3 included a plan of care for the initial certification period of 06/28/2023 – 08/26/2023 which indicated the patient was to receive physical therapy (PT) and occupational therapy (OT) services. The record indicated Occupational Therapist (OT) 3 conducted an OT Evaluation		management team and effective date of this feature update will beprovided by them. The clinical records with the deficiencies were identifiedand reviewed. The Administrator, Director of Clinical Services and AlternateDirector of Clinical Services have completed re-orientation of agency'spolicies pertaining to the requirement on 8/23/23 provided by the GoverningBody Chair. All active clinical records review was completed on 8/26/23. An in-service was be conducted by the Director of ClinicalServices on 08/29/23 with all staff. During the meeting, the DCS discussedagency policy 9.9.1 titled, "Care Planning Process" and the importance of therequirement that each patient must receive the home health services that arewritten in an individualized plan of care that identifies patient-specificmeasurable outcomes and goals, and which is established, periodically reviewed,and signed by a	

	also indicated the therapist created a separate plan of care for OT services for Patient #3 on 06/29/2023.		doctor of medicine, osteopathy, or podiatry acting within thescope of his or her state license, certification, or registration. Citationslisted in the clinical record reviews were addressed. All staff understood andacknowledged the agency policy 9.9.1 titled, "Care Planning Process" and therequirement to have all services integrated into the overall plan of care. Allnew staff will be oriented of this requirement at the time of hire. Thecorrective actions were implemented on 8/7/23 and completed on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Director of Clinical Services will utilize a chartaudit tool to ensure that all active	

			each patientreceives the home health services that are written in an individualized plan ofcare that identifies patient-specific measurable outcomes and goals, and whichis established, periodically reviewed, and signed by a doctor of medicine,osteopathy, or podiatry acting within the scope of his or her state license,certification, or registration and to have all services integrated into theoverall plan of care, and that the physician was consulted in the developmentand/or revision of the plan of care regarding the therapy services and anyother services and all plan of cares were completed with consulting thephysician for input and documentation is present in the clinical record. Thisprocess of utilizing active chart audit tool on all admissions will help usidentify any discrepancies in the clinical records and re-educate all staff onthe above mentioned requirement. **Monitoring:** In order to ensure	

			effectiveness ofthis corrective action, the Alternate Director of Clinical Services will audit100% of all new admissions and all current patients on a weekly basis to ensurepatient receives the home health services that are written in an individualizedplan of care that identifies patient-specific measurable outcomes and goals,and which is established, periodically reviewed, and signed by a doctor ofmedicine, osteopathy, or podiatry acting within the scope of his or her statelicense, certification, or registration and to have all services integrated intothe overall plan of care, and that the physician was consulted in thedevelopment and/or revision of the plan of care regarding the therapy servicesand any other services and all plan of cares were completed with consulting thephysician for input and is being clearly documented in the clinical record. TheDirector of Clinical Services will monitor and review Alternate Director ofClinical Services' audit findings of all new admissions and current patients.Reports will be generated and results will be compiled to ensure processes	

			haveimproved. If any deficiencies are identified, they will continue to beaddressed with each personnel as needed. This process will continue for eachweek for the next 30 days until 100% compliance is achieved. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audit results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQuality Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0574	Plan of care must include the following	G0574	**CorrectiveAction:**	2023-09-20

	484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to ensure the plan of care was		The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure the plan ofcare was individualized, patient-specific, included all medications, alltreatments orders, and risk factors and patient-specific interventions forre-hospitalization and Emergency Department visits. 30% review of active chartswas completed by week ending 8/12/23. 25% review of active charts was completedby week ending 8/19/23. 45% review of active charts was completed by weekending 8/26/23 to complete 100% audit of all active chart audits. In order to correct the above deficiency cited underG0574, during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.10.1 titled, “Plan of Care-CMS#485 and PhysicianOrders”. The clinical records with the deficiencies were identified andreviewed. The Administrator, Director of Clinical Services and	

	included all medications, all treatments orders, and risk factors and patient-specific interventions for re-hospitalization and Emergency Department visits for 5 of 17 active records reviewed (Patients #3, 10, 14, 15, 19). Review of Patient #14's clinical record evidenced a plan of care (POC) for the certification period of 06/26/2023 – 8/24/2023 faxed to the physician on 7/10/23 for signature and a Start of Care comprehensive assessment (CA) completed by RN 1 on 6/29/2023. The CA indicated Patient #14 had a surgical incision wound to the left lower leg. The CA indicated RN 1 did not assess the surgical incision. The POC failed to include wound care orders for the surgical incision. During an interview on 7/26/23 beginning at 2:31 PM, RN 1 indicated they did not assess the surgical incision to the left lower leg and Patient #14 indicated there were staples present in the wound. Review of Patient #15's clinical		AlternateDirector of Clinical Services have completed re-orientation of agency'spolicies pertaining to the requirement on 8/23/23 provided by the GoverningBody Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care and to ensure the plan of care wasindividualized, patient-specific, included all medications, all treatmentsorders, and risk factors and patient-specific interventions forre-hospitalization and Emergency Department visits. The Alternate Administratorwill schedule application demo for 9/15/23 and after training Agency staff,application will be in use on 9/20/23.	

	record evidenced a plan of care (POC) for the certification period of 5/09/2023 – 7/07/2023 with the incorrect physician listed on the POC and a Start of Care comprehensive assessment (CA) completed by RN 3 on 5/09/2023. The CA medication list indicated Patient #15 had sliding scale insulin (the amount of insulin to take based on the blood sugar glucose reading) ordered before meals and at bedtime. The CA failed to evidence blood sugar glucose monitoring physician orders for the sliding scale insulin. During an interview on 7/18/2023 beginning at 4:12 PM, the Alternate Clinical Supervisor indicated the blood sugar glucose monitoring orders should be included in the plan of care and/or on a physician's order. The Alternate Clinical Supervisor confirmed that the clinical record failed to evidence these orders for blood sugar glucose monitoring. During an interview on 7/13/2023 at 2:20 PM, RN 2 indicated he/ she always included the physical therapy interventions as the physical therapists always do the same thing.		An in-service was be conducted by the Director of ClinicalServices on 08/29/23 with all staff. During the meeting, the DCS discussedagency policy 9.10.1 titled, "Plan of Care-CMS#485 and Physician Orders" andthe importance of the requirement that the plan of care was individualized,patient-specific, included all medications, all treatments orders, and riskfactors and patient-specific interventions for re-hospitalization and EmergencyDepartment visits. Citations listed in the clinical record reviews were addressed.All staff understood and acknowledged the agency policy 9.10.1 titled, "Plan ofCare-CMS#485 and Physician Orders" and the requirement that the plan of carewas individualized, patient-specific, included all medications, all treatmentsorders, and risk factors and patient-specific interventions forre-hospitalization and Emergency Department visits. All new staff will beoriented of this requirement at the time of hire. The corrective actions wereimplemented on 8/7/23 and completed on 8/29/23.	

G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on observation, record review, and interview, the home health agency failed to ensure all services and treatments were provided as ordered by a physician for 10 of 21 total records reviewed (Patients #1, 3, 4, 5, 6, 7, 14, 15, 19, 21). 4. Review of the clinical record of Patient #5 included a plan of care for the initial certification period of 06/14/2023 – 08/12/2023 which indicated the patient was to receive physical therapy (PT) and occupational therapy (OT) services. The record failed to evidence a verbal nor written plan of care was obtained by the agency and failed to evidence the correct attending physician. During an interview with Person CC, employee at Physician's Office T, conducted on 07/18/2023 starting at 11:13 AM, the employee reported Physician T was not the	G0580	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure all servicesand treatments were provided as ordered by a physician. 30% review of activecharts was completed by week ending 8/12/23. 25% review of active charts wascompleted by week ending 8/19/23. 45% review of active charts was completed byweek ending 8/26/23 to complete 100% audit of all active chart audits. In order to correct the above deficiency cited underG0580, during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.10.1 titled, "Plan of Care-CMS#485 and PhysicianOrders". The clinical records with the deficiencies were identified andreviewed. The Administrator, Director of Clinical Services and AlternateDirector of Clinical Services have completed re-orientation of	2023-09-20

	#5. Person CC also reported there was no record of Patient #5 receiving care or verbal orders from Physician T in the patient's clinical chart. During an interview with Patient #5 on 07/19/2023 beginning at 11:05 AM, the patient reported Physician DD as their attending physician. During an interview with Person EE on 7/19/2023 beginning at 11:10 AM, Person EE verified that Physician DD was the attending physician for Patient #5. They stated there are no records, documents or orders received from the home health agency in the Patient's clinical chart. 5. Review of the clinical record of Patient #6 included a plan of care for the initial certification period of 06/09/2023 – 08/07/2023 which indicated the patient was to receive physical therapy (PT) and occupational therapy (OT) services and listed Patient #5's attending physician was Physician HH. The record failed to evidence a verbal nor written plan of care was obtained by the agency. During an interview with		agency'spolicies pertaining to the requirement on 8/23/23 provided by the GoverningBody Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care and to ensure all services andtreatments were provided as ordered by a physician. The Alternate Administratorwill schedule application demo for 9/15/23 and after training Agency staff,application will be in use on 9/20/23. An in-service was be conducted by the Director of ClinicalServices on 08/29/23 with all staff. During the meeting, the DCS discussedagency policy 9.10.1 titled, "Plan of Care-CMS#485 and Physician Orders" andthe	

	Physical Therapist (PT) 4 conducted on 07/25/2023 beginning at 11:20 AM the therapist confirmed they did not receive verbal orders for Patient #6's plan of care interventions and frequencies from the attending physician. The record indicated Occupational Therapist (OT) 2 conducted an OT Evaluation visit on 06/13/2023. The record also indicated the therapist created a separate plan of care for OT services for Patient #6 on 06/13/2023. During an interview with Occupational Therapist (OT) 2 conducted on 7/25/2023 beginning at 3:13 PM, OT 2 confirmed they did not contact the attending physician for verbal orders for Patient #6's OT plan of care. 7. Review of the clinical record of Patient #14 included a plan of care for the initial certification period of 06/26/2023 – 08/24/2023 which indicated the patient was to receive physical therapy (PT) and occupational therapy (OT) services and listed Patient #14's attending physician was		importance of the requirement that the drugs, services, and treatments areadministered only as ordered by a physician or allowed practitioner. Citationslisted in the clinical record reviews were addressed. All staff understood andacknowledged the agency policy 9.10.1 titled, "Plan of Care-CMS#485 andPhysician Orders" and the requirement that the drugs, services, and treatmentsare administered only as ordered by a physician or allowed practitioner. Allnew staff will be oriented of this requirement at the time of hire. Thecorrective actions were implemented on 8/7/23 and completed on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency,	

	Physician II. The record failed to evidence a verbal nor written plan of care was obtained by the agency. During an interview with Physical Therapist (PT) 6 conducted on 07/25/2023 beginning at 11:15 AM, PT 6 confirmed they did not contact the attending physician for verbal orders for Patient #14's PT plan of care During an interview with Occupational Therapist (OT) 3 conducted on 7/25/2023 beginning at 3:30 PM, OT 3 confirmed they did not contact the attending physician for verbal orders for Patient #14's OT plan of care. 8. Review of the clinical record of Patient #15 included a plan of care for the initial certification period of 05/09/2023 – 07/07/2023 which indicated the patient was to receive skilled nurse (SN), physical therapy (PT) and occupational therapy (OT) services and listed Patient #15's attending physician was Physician Z. The record failed to evidence a verbal nor written plan of care was obtained by		made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to ensure real-time visibility into patient care and to ensure allservices and treatments were provided as ordered by a physician. The AlternateDirector of Clinical Services will utilize a chart audit tool to ensure thatall active clinical records include the drugs, services, and treatments areadministered only as ordered by a physician or allowed practitioner anddocumentation is present in the clinical record. This process of utilizingactive chart audit tool on all admissions will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In order to ensure implementation and effectiveness ofthis corrective action, the Alternate Director of	

	the agency and failed the evidence the correct attending physician. During an interview with Person BB on 7/18/2023 beginning at 2:05 PM, Person BB verified Physician AA was the attending physician for Patient #15. Person BB stated they would make Physician AA aware of patient was receiving home health services. During an interview with Physical Therapist (PT) 6 conducted on 07/25/2023 beginning at 11:15 AM, PT 6 confirmed they did not contact the attending physician for verbal orders for Patient #15's PT plan of care During an interview with Occupational Therapist (OT) 3 conducted on 7/25/2023 beginning at 3:30 PM, OT 3 confirmed they did not contact the attending physician for verbal orders for Patient #15's OT plan of care. 9. Review of the clinical record of Patient #19 included a plan of care for the initial certification period of 6/28/2023 – 8/26/2023 which		of all new admissions and all current patients on a weekly basis to ensurethat the drugs, services, and treatments are administered only as ordered by aphysician or allowed practitioner and is being clearly documented in theclinical record. The Director of Clinical Services will monitor and review AlternateDirector of Clinical Services' audit findings of all new admissions and currentpatients. Reports will be generated and results will be compiled to ensureprocesses have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue foreach week for the next 30 days until 100% compliance is achieved. After 30days, this process will continue to be monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI	

	receive skilled nurse (SN), physical therapy (PT) and occupational therapy (OT) services and listed Patient #19's attending physician was Physician M. The record failed to evidence a verbal nor written plan of care was obtained by the agency and failed the evidence the correct attending physician. During an interview with Person N on 7/17/23 beginning at 3:30 PM, Person N reported that Physician M was not the attending physician for Patient #19 and indicated that there is not any documentation that Physician M had given any home health physician orders for Patient #19. During an interview with Person P on 7/19/23 beginning at 8:31 AM, Person P reported that Patient #19 is not yet a patient of Physician FF. Patient #19 had an initial appointment with Physician FF scheduled for 8/31/23. Person P also indicated that Physician FF would not have given any orders for home health until a relationship had been established with Patient #19.		Committee willsend a written report to the Governing Body quarterly for theirrecommendations. The Director of Clinical Services will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	During an interview with Physical Therapist (PT) 4 conducted on 07/25/2023 beginning at 11:20 AM the therapist confirmed they did not receive verbal orders for Patient #19's plan of care interventions and frequencies from the attending physician. The record indicated Occupational Therapist (OT) 2 conducted an OT Evaluation visit on 06/13/2023. The record also indicated the therapist created a separate plan of care for OT services for Patient #19 on 06/13/2023. A review of the clinical record for Patient #1, diagnosed with quadriplegia and pressure wounds, for start of care 4/3/2023, evidenced a referral for home care dated 4/3/2023. The order included the need for nursing services and interventions, home health aide services, physical therapy, occupational therapy, and speech therapy for evaluation and treatment. The record included plans of care which included physical therapy, occupational therapy, speech therapy and a home health			

	The plans of care for physical, occupational, and speech therapy included a statement that the physician was notified and agreed with the plan of care. The record included 11 additional orders, presented as verbal orders from Person R, a physician. During an interview on 7/19/2023 starting at 11:54 AM, Person H indicated Patient #1 established care on 4/13/2023, 10 days after the home health start of care. Person H confirmed the office was never contacted for orders or input into patient's care until 7/11/2023, thirty-three (33) days after patient was discharged from the agency. A review of the clinical record for Patient #7, for certification period 6/27/2023 – 8/25/2023, evidenced a referral for home care with start of care orders, with registered nurse (RN) 2's electronic signature and date of 6/27/2023. During an interview on 7/18/23 at 9:21 AM, Person L verified Patient #7 was a patient of Person GG but had never given verbal or written orders for			

	home health care. During an interview on 7/19/2023 at 11:03 AM, RN 2 indicated the office staff always got the start of care orders. A review of the clinical record for Patient #21 for certification period 6/22/2023 – 8/20/2023, evidenced a start of care order completed by RN 2. During an interview on 7/19/2023 at 11:03 AM, RN 2 indicated he/ she did not get orders for the start of care, the agency office staff got the orders.			

	1. Review of an agency policy revised February 2022, titled "Plan of Care-CMS #485 and Physician/Practitioner Orders" indicated the Plan of Care must be signed by a physician or authorized practitioner acting within the scope of his or her state license, certification or registration; all patient care orders, including verbal orders, must be recorded in the plan of care and the physician/practitioner who established the Plan of care must sign and date. 2. Review of the clinical record of Patient #3 included a plan of care for the initial certification period of 06/28/2023 – 08/26/2023 which indicated the patient was to receive physical therapy (PT) services at a frequency of 2 visits per week for 4 weeks then 1 visit per week for 1 week. A separate OT plan of care indicated the patient was to receive OT services at a frequency of 1 visit per week for 1 week then 2 visits per week for 3 weeks. The plan of care listed Patient #3's attending physician was Physician O. The doctor's address, phone number, and fax			

	Office W. During an interview with Person V, employee at Physician's Office W, conducted on 07/18/2023 starting at 2:17 PM, the employee reported Physician O had not worked at the office since 02/15/2023. Person V also reported there was no record of Patient #3 receiving care from any provider at Physician's Office W. During an interview with PT 3 conducted on 07/25/2023 beginning at 11:20 AM the therapist confirmed they did not receive verbal orders for Patient #3's plan of care from an advanced care practitioner. The record evidenced Patient #3 received PT visits on 06/30/2023, 07/04/2023, 07/05/2023, 07/11/2023, 07/12/2023, 07/19/2023, and 07/24/2023, and OT visits on 07/06/2023, 07/07/2023, 07/10/2023, 07/13/2023, 07/18/2023, 07/21/2023, and 07/25/2023. The record failed to evidence a verbal nor written orders for PT and OT services was obtained by the agency prior to providing services on the above dates.			

	3. Review of Patient #4's closed clinical record (start of care 05/22/2023, discharge date 06/20/2023) included a plan of care for the initial certification period 05/22/2023 – 07/20/2023 which indicated the patient was to receive skilled nursing and home health aide services. The record indicated skilled nursing visits were documented as conducted on 05/22/2023, 05/24/2023, 05/31/2023, 06/02/2023, 06/05/2023, 06/09/2023 and 06/14/2023. The plan of care also indicated Nurse Practitioner X was the patient's primary practitioner. The record failed to evidence a verbal nor written order for the patient's plan of care was obtained by the agency. During an interview with Office Manager X, employee of Nurse Practitioner X's medical office, conducted on 07/17/2023 beginning at 3:59 PM, the office manager reported Patient #4 was a patient of a physician in the office whom Nurse Practitioner X worked under. Office Manager X reported there was no record of the office giving any home health orders for Patient #4 during the			

	dates of service of 05/22/2023 – 06/20/2023.			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on observation, record review, and interview, the home health agency failed to notify any physician involved in the patient's care of a change in patient's wound measurements for 1 of 1 home visits where a wound was noted to have increased in size. (Patient #19) Review of agency policy titled "Coordination of Patient Care" revised February 2021, indicated staff should "assure communication with all physicians/practitioners involved in the plan of care" and "coordinate care delivery to meet the patient's needs." The policy also indicated staff should notify the patient's physician/practitioner with any	G0590	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to notify any physicianinvolved in the patient's care of a change in patient's wound measurements or toany changes in the patient's condition or needs that suggest that outcomes arenot being achieved and/or that the plan of care should be altered. 30% review of active charts wascompleted by week ending 8/12/23. 25% review of active charts was completed byweek ending 8/19/23. 45% review of active charts was completed by week ending8/26/23 to complete 100% audit of all active chart audits. The ClinicalManagers are notifying physicians of any changes in thepatient's condition or needs that suggest that outcomes are not being achievedand/or that the plan of care should be altered on a daily basis effective8/27/23. The	2023-09-20

	changes in the patient's condition. Review of a Patient #19's clinical record included an admission Comprehensive Assessment (CA), dated 6/28/23 and completed by Registered Nurse (RN) 2, which evidenced the patient had one Stage 3 pressure ulcer wound (type of wound caused by prolonged pressure to a body site, described as stages from 1 – 4 or unstageable) to the right buttock and one wound to the left posterior calf which was not described and/or staged. The clinical record included a skilled nursing visit note for the visit conducted on 06/30/2023 by Licensed Practical Nurse (LPN) 1 which indicated the right buttock wound measured 1 centimeter (cm) in length by 1 cm in width by 0.1 cm in depth. LPN 1's visit note dated 7/05/23 indicated the right buttock wound had increased to 4 cm x 4 cm x 1.0 cm but failed to evidence the nurse notified the patient's attending physician nor any other providers of the increased wound measurements.		Alternate Director of Clinical Services is also added to theClinical Managers/Physician communication group to ensure proper follow up iscompleted on a weekly basis and more often if needed effective 9/18/23. In order to correct the above deficiency cited underG0590, during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.13.1 titled, "Coordination of Patient Care". Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 8/23/23 provided by the Governing Body Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in	

	During an interview with LPN 1, on 7/13/23 at 9:29 AM, the nurse confirmed they failed to notify Patient #19's physician regarding the increased wound measurements. During a home visit observation with Patient #19 on 7/14/23 beginning at 11:00 AM, LPN 1 was observed measuring Patient's right buttock wound. The wound's measurement was observed to have increased to 5 cm x 2.5 cm x 1.0 cm with tunneling measuring 0.5 cm at 1 o'clock. The nurse did not attempt to contact Patient #19's physician during the visit and the record failed to evidence LPN 1 notified any physician of the increased right buttock wound measurements. During an interview with a nurse at Wound Clinic O on 7/20/23 2:10 PM, the nurse reported the clinic had no record of agency staff reporting a change in Patient's right buttock to the wound clinic. The clinical record indicated Patient #19 was deceased as of 7/20/23, however no cause of death was documented and no discharge visit had been		HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care and to notify any physician involved in thepatient's care of a change in patient's condition or needs that suggest thatoutcomes are not being achieved and/or that the plan of care should be altered.The Alternate Administrator will scheduleapplication demo for 9/15/23 and after training Agency staff, application willbe in use on 9/20/23. An in-service was be conducted by the Director of ClinicalServices on 08/29/23 with all staff. During the meeting, the DCS discussedagency policy 9.13.1 titled, "Coordination of Patient Care" and the importanceof the requirement that the HHA must promptly alert the relevant physician(s)or allowed practitioner(s) to any changes in the patient's condition or	

	completed.		outcomes are not being achieved and/or that the plan of careshould be altered. Specifically, the Agency clinicians must notify anyphysician involved in the patient's care of a change in patient's woundmeasurements. Citations listed in the clinical record reviews were addressed.All staff understood and acknowledged the agency policy 9.13.1 titled,"Coordination of Patient Care" and the requirement that the HHA must promptlyalert the relevant physician(s) or allowed practitioner(s) to any changes inthe patient's condition or needs that suggest that outcomes are not beingachieved and/or that the plan of care should be altered. All new staff will beoriented of this requirement at the time of hire. The corrective actions wereimplemented on 8/7/23 and completed on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23.	

			Measuresto assure No recurrence: In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to ensure real-time visibility into patient care and to notify anyphysician involved in the patient's care of a change in patient's condition or needs that suggest that outcomesare not being achieved and/or that the plan of care should be altered. The Alternate Director of Clinical Services willutilize a chart audit tool to ensure that all active clinical records include thatthe relevant physician(s) or allowed practitioner(s) are promptly alerted toany changes in the patient's condition or needs that suggest that outcomes arenot being achieved and/or that the plan of care should be altered anddocumentation is present in	

			the clinical record. This process of utilizingactive chart audit tool on all admissions will help us identify any discrepanciesin the clinical records and re-educate all staff on the above mentionedrequirement. **Monitoring:** In order to ensure implementation and effectiveness ofthis corrective action, the Alternate Director of Clinical Services will audit100% of all new admissions and all current patients on a weekly basis to ensurethat the relevant physician(s) or allowed practitioner(s) are promptly alertedto any changes in the patient's condition or needs that suggest that outcomesare not being achieved and/or that the plan of care should be altered and isbeing clearly documented in the clinical record. The Director of ClinicalServices will monitor and review Alternate Director of Clinical Services' auditfindings of all new admissions and current patients. Reports will be generatedand results will be compiled to ensure processes have improved. If	

			anydeficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for each week for the next 30days until 100% compliance is achieved. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly chart audit review. Quarterly audit results will be compiled and sentto the QAPI Committee for review. Once threshold is met, the Quality Committeewill continue to audit 20% of clinical records quarterly to ensure compliance is maintained. The Administrator and QAPI Committee will send a written reportto the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0608	Coordinate care delivery 484.60(d)(4)	G0608	**CorrectiveAction:** The Alternate Director of Clinical Services started	2023-09-20

	Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. Based on observation, record review and interview, the home health agency failed to ensure collaboration between home health agency staff and Assisted Living Facility (ALF) staff for 2 of 2 ALF active patient records reviewed (Patient's #6 and #9). Findings include: 1. Review of an agency policy revised February 2021, titled "Coordination of Patient Care" indicated care will be coordinated with other involved external organizations and staff will communicate with other individuals or organizations involved in the patient's care. 2. During a home visit observation conducted with Patient #6 and Occupational Therapist (OT) 1 on 7/06/23 beginning at 9:00 AM, OT 1 was observed performing therapy activities with Patient #6. After care was provided, OT 1 failed to collaborate with staff at the Assisted Living Facility (ALF) before exiting the facility. Review of Patient #6's clinical record failed to evidence any		internalaudit review of all active clinical records on 8/7/23 to ensure collaborationbetween home health agency staff, Assisted Living Facility (ALF) staff, WoundClinics and any other healthcare facilities. 30% review of active charts wascompleted by week ending 8/12/23. 25% review of active charts was completed byweek ending 8/19/23. 45% review of active charts was completed by week ending8/26/23 to complete 100% audit of all active chart audits. The AlternateDirector of Clinical Services has completed coordination of care with allAssisted Living Facilities (ALF), Wound Clinics and any other healthcarefacilities as of 8/27/23. Contact person has been established at thesefacilities, proper protocols have been set for weekly case conferences and moreoften if needed. The Clinical Managers are conducting coordination of care withAssisted Living Facilities (ALF), Wound Clinics and other healthcare facilities on adaily basis effective 8/27/23. The Alternate Director of Clinical Services isalso added to the Other healthcare facilities communication group including	

	coordinating communication between home health agency staff and ALF staff regarding POC or therapy services provided. 3. During an interview on 7/07/23 beginning at 3:58 PM, the Administrator indicated that home health agency staff should collaborate with ALF staff at each visit and should update the communication binder in the facility during every visit. 410 IAC 17-12-2 (g) A review of the clinical record for Patient #9, for certification period 5/15/2023 – 7/13/2023, included nursing visit notes for 6/7, 6/23, 6/28, and 6/30/2023, which failed to document coordination with the assisted living facility.		butnot limited to AssistedLiving Facilities (ALF), Wound Clinics to ensure proper follow up iscompleted on a weekly basis and more often if needed effective 9/18/23. In order to correct the above deficiency cited underG0608, during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.13.1 titled, “Coordination of Patient Care”. Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency’s policies pertaining to therequirement on 8/23/23 provided by the Governing Body Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with “Home HealthNotify”, a HIPAA	

			application for the Agency, clinicians,inter-disciplinary teams, Patients and Physicians to ensure real-timevisibility into patient care and to ensure collaboration between home healthagency staff and Assisted Living Facility (ALF) staff. The AlternateAdministrator will schedule application demo for 9/15/23 and after trainingAgency staff, application will be in use on 9/20/23. An in-service was be conducted by the Director of ClinicalServices on 08/29/23 with all staff. During the meeting, the DCS discussedagency policy 9.13.1 titled, “Coordination of Patient Care” and the importanceof the requirement to coordinate care delivery to meet the patient's needs, andinvolve the patient, representative (if any), and caregiver(s), as appropriate,in the coordination of care activities and ensure collaboration between homehealth agency staff and external organizations including Assisted LivingFacility. Citations listed in the clinical record	

			understood and acknowledged the agency policy 9.13.1 titled, "Coordinationof Patient Care" and the requirement to coordinate care delivery to meet thepatient's needs, and involve the patient, representative (if any), andcaregiver(s), as appropriate, in the coordination of care activities and ensurecollaboration between home health agency staff and external organizationsincluding Assisted Living Facility. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on8/7/23 and completed on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has	

			theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to ensure real-time visibility into patient care and to ensurecollaboration between home health agency staff and Assisted Living Facility(ALF) staff.The Alternate Director of ClinicalServices will utilize a chart audit tool to ensure that all active clinicalrecords include to coordinate care delivery to meet the patient's needs, andinvolve the patient, representative (if any), and caregiver(s), as appropriate,in the coordination of care activities and ensure collaboration between homehealth agency staff and external organizations including Assisted LivingFacility and documentation is present in the clinical record. This process ofutilizing active chart audit tool on all admissions will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement.	

			Monitoring: In order to ensure implementation and effectiveness ofthis corrective action, the Alternate Director of Clinical Services will audit100% of all new admissions and all current patients on a weekly basis to ensureto coordinate care delivery to meet the patient's needs, and involve thepatient, representative (if any), and caregiver(s), as appropriate, in thecoordination of care activities and ensure collaboration between home healthagency staff and external organizations including Assisted Living Facility andis being clearly documented in the clinical record. The Director of ClinicalServices will monitor and review Alternate Director of Clinical Services' auditfindings of all new admissions and current patients. Reports will be generatedand results will be compiled to ensure processes have improved. If anydeficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for each week for the	

			next 30days until 100% compliance is achieved. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly chart audit review. Quarterly audit results will be compiled and sentto the QAPI Committee for review. Once threshold is met, the Quality Committeewill continue to audit 20% of clinical records quarterly to ensure compliance is maintained. The Administrator and QAPI Committee will send a written reportto the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0642	Program scope 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve	G0642	**CorrectiveAction:** The Alternate Director of Clinical Services implementedutilization of EMRs tracking and analysis of data regardingpatient use of emergency care services, hospital admissions, and	2023-09-20

	health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. Based on record review and interview, the home health agency failed to measure, track, and analyze all quality indicators according to its Quality Assessment and Performance Improvement (QAPI) policy, which had the potential to affect all agency patients and staff. Findings include: Review of an agency policy #10.1.1 titled "Quality Assessment and Performance Improvement (QAPI) Plan and Program" indicated the agency would collect data regarding but not limited to use of emergency care services, hospital admissions, and hospital re-admissions. Review of the agency's QAPI meeting minutes for 2022 and 2023 failed to evidence the agency measured, tracked, and analyzed data regarding emergency care services,		hospitalre-admission on 8/7/23.The Alternate Director of Clinical Services started internal audit review ofall active clinical records on 8/7/23 to ensure tracking and analysisof data regarding patient use of emergency care services, hospital admissions,and hospital re-admission.30% review of active charts was completed by week ending 8/12/23. 25% review ofactive charts was completed by week ending 8/19/23. 45% review of active chartswas completed by week ending 8/26/23 to complete 100% audit of all active chartaudits. In order to correct the above deficiency cited, theAdministrator and Director of Clinical Services and Alternate Director ofClinical Services reviewed and discussed the agency policy 10.1.1 titled, "QualityAssurance and Performance Improvement (QAPI) Program". During this managementmeeting on 8/23/23, deficiencies cited in QAPI documentation under G-0642 werereviewed, addressed and discussed in detail. The Administrator,	

	hospital admissions, and hospital re-admissions. During an interview with the Administrator conducted on 07/27/2023 beginning at 2:34 PM, the Administrator confirmed all quality indicators tracked and analyzed by the QAPI committee were documented within the QAPI meeting minutes and logs. During a follow up interview with the Administrator conducted on 07/27/2023 beginning at 5:30 PM, the Administrator was unable to evidence where the QAPI committee documented the tracking and analysis of data regarding patient use of emergency care services, hospital admissions, and hospital re-admission. 17-12-2(a)		Alternate Director of Clinical Services have completedre-orientation of agency's policies pertaining to the requirement on 8/23/23provided by the Governing Body Chair. Anin-service was conducted by the Administrator on 8/29/23 with all staff. Duringthe meeting, the Administrator discussed the agency policy 10.1.1 titled,"Quality Assurance and Performance Improvement (QAPI) Program" and theimportance of the requirement to measure, track, and analyze all qualityindicators according to its Quality Assessment and Performance Improvement(QAPI) Program policy. Citations listed in the QAPI documentation wereaddressed with all staff. The Administrator re-educated all staff on theimportance of this requirement. All staff understood and acknowledged theagency policy 10.1.1 titled, "Quality Assurance and Performance Improvement(QAPI) Program" and the importance of the requirement to measure, track,	

			andanalyze all quality indicators according to its Quality Assessment andPerformance Improvement (QAPI) Program policy. All new staff will be oriented of this requirement at the time of hire. The Administrator concluded that the agency willdocument the measurement, tracking, and analysis of all quality indicatorsaccording to its Quality Assessment and Performance Improvement (QAPI) Programpolicy after the end of this quarter in next quarterly QAPI meeting minutes. Thecorrective actions were implemented on 8/7/23. **Measuresto assure No recurrence** In orderto ensure that there is no recurrence of this deficiency, the Administratorwill utilize an audit tool with the help of the Director of Clinical Servicesto ensure that the organization measure, track, and analyze all qualityindicators according to its Quality Assessment and Performance Improvement(QAPI) Program.	

			and implement improvementsin maintaining the Quality Assessment and Performance Improvement (QAPI) Programand make corrective adjustments in the future. **Monitoring** In order to ensure implementation and effectiveness of thiscorrective action, the Administrator will audit 100% of Quality Assessment andPerformance Improvement (QAPI) Program progress on a monthly basis to ensure thatthe organization measures, tracks, and analyzes all quality indicatorsaccording to its Quality Assessment and Performance Improvement (QAPI) Program.Monthly reports will be generated by QAPI Committee and results will becompiled and sent to the Administrator to ensure that processes have improved.This process will continue every month for the next three months until 100%compliance is achieved and to maintain this level of compliance, all new staffat the time of hire will be oriented with this requirement. If compliance isnot achieved at	

			the desired target of 100% compliance and if any deficienciesare identified within three months, they will continue to be addressed withstaff re-training and re-education in workshops and in-services and with eachindividual personnel as needed. Once 100% compliance is achieved, the QAPICommittee will continue to audit QAPI Program on a semi-annual basis to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body semi-annually for their recommendations. TheAdministrator will be responsible for corrective action of this deficiency,measure to assure no recurrence and monitoring of this deficiency.	
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects.	G0658	**CorrectiveAction:** The Administrator along with Director of ClinicalServices has implemented Wound Care Management as Performance Improvementeffective 8/21/23. The Administrator concluded that the agency will	2023-09-20

	(1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the home health agency failed to evidence the agency conducted at least one performance improvement project (PIP) annually, which had the potential to affect all agency patients and staff. Findings include: Review of the agency's Quality Assessment and Performance Improvement (QAPI) meeting minutes for 2022 and 2023 failed to evidence the agency conducted at minimum 1 PIP annually. During an interview with the Administrator conducted on 07/27/2023 beginning at 2:34 PM, the Administrator was unable to state what PIP(s) were performed by the agency in 2022 nor 2023 and was unable to provide documentation of		documentthe above mentioned performance improvement project undertaken, the reasons forconducting this initiative, and the measurable progress achieved on thisproject. The completion date of performance improvement project will be8/20/24. In order to correct the above deficiency cited, theAdministrator and Director of Clinical Services and Alternate Director ofClinical Services reviewed and discussed the agency policy 10.6.1 titled,"Performance Improvement Projects". During this management meeting on 8/23/23,deficiencies cited in QAPI documentation under G-0658 were reviewed, addressedand discussed in detail. The Administrator, Director of Clinical Services andAlternate Director of Clinical Services have completed re-orientation ofagency's policies pertaining to the requirement on 8/23/23 provided by theGoverning Body Chair.	

	PIPs conducted by the agency after 2019.		An in-service was conducted by the Administrator on8/29/23 with all staff. During the meeting, the Administrator discussed theagency policy 10.6.1 titled, "Performance Improvement Projects" and theimportance of the requirement that the organization documents the performance improvementprojects undertaken, the reasons for conducting these initiatives, and themeasurable progress achieved on these projects. Citations listed in the QAPIdocumentation were addressed with all staff. The Administrator re-educated allstaff on the importance of this requirement. All staff understood andacknowledged the agency policy 10.6.1 titled, "Performance ImprovementProjects" and the importance of the requirement that the organization documentsthe performance improvement projects undertaken, the reasons for conductingthese initiatives, and the measurable progress achieved on these projects. All new staff will be oriented of thisrequirement at the time of hire.	

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 and interview, the home health agency failed to follow accepted standards of practice and their own policies to prevent the transmission of infections and communicable diseases for 2 of 3 Physical Therapist (PT) home visits observed (Patient's #3 and #5) and 1 of 2 Licensed Practical Nurse (LPN) home visits observed (Patient #19). Findings include: 1. Review of an agency policy revised July 2021, titled "Hand Hygiene Policy and Compliance Program" indicated staff should perform hand hygiene before and after direct patient care and before re-entering the nursing bag or patient's clean supplies. 2. Review of an agency policy revised July 2021, titled "Exposure Control Plan: OSHA Regulations" indicated	G0682	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to follow acceptedstandards of practice and their own policies to prevent the transmission ofinfections and communicable diseases. 30% review of active charts was completedby week ending 8/12/23. 25% review of active charts was completed by weekending 8/19/23. 45% review of active charts was completed by week ending8/26/23 to complete 100% audit of all active chart audits. In order to correct the above deficiency cited underG-0682, in Management meeting on 8/23/2023, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed,discussed the agency policies 5.4.1 titled "Exposure Control Plan: OSHARegulations", 5.7.1 titled "Hand Hygiene Policy and ComplianceProgram" and 3.1.1 titled "Equipment Maintenance" under InfectionPrevention and Control section. The clinical	2023-09-20

	Thermometers will be wiped with alcohol pad after each use; stethoscopes and blood pressure cuffs will be cleansed with an Agency approved disinfectant after each use by the employee who has possession of the equipment; and hands should be washed before re-entering the nursing bag. 3. Review of an agency policy revised February 2022, titled "Equipment Maintenance" indicated blood pressure cuffs, thermometers and pulse oximeters should be cleaned after each use with an agency approved disinfectant. 4. During a home visit observation conducted with Patient #3 and Physical Therapist (PT) 3 on 7/05/23 beginning at 4:34 PM, PT 3 was observed using a cloth gait belt (a wide cloth belt used to assist with moving residents) around Patient #3's waist. PT 3 removed the gait belt after Patient #3 was transferred and cleaned with a small alcohol wipe. PT 3 failed to properly clean the cloth gait belt. 5. During an interview on		wereidentified and reviewed. The Administrator, Director of Clinical Services and AlternateDirector of Clinical Services have completed re-orientation of agency'spolicies pertaining to the requirement on 8/23/23 provided by the GoverningBody Chair. An in-service was conducted by Director of Clinical Serviceson 8/29/23 and attended by all staff. During the meeting, the DCS discussed theimportance of the requirement that hand hygiene, using correct technique andequipment must be cleaned after each use with an agency approved disinfectantafter each use by the employee who has possession of the equipment; and handsshould be washed before re-entering the nursing bag. Citations listed in the homevisits were addressed with the field staff. Based on the deficiency listed, theDCS reiterated agency's policy, "Hand Hygiene Policy and ComplianceProgram 5.7", states that the agency will follow the Centers for DiseaseControl and	

	7/10/23 at 3:30 PM, the Alternate Clinical Supervisor indicated each patient should have an individualized gait belt that stayed in their home as the small alcohol pads are not sufficient for cleaning. 6. During a home visit observation conducted with Patient #5 and PT 1 on 7/06/23 beginning at 1:00 PM, PT 1 was observed performing an assessment which included vitals of Patient #5. PT 1 failed to cleanse the blood pressure cuff, thermometer and pulse oximeter before placing back in the nursing bag. PT 1 was also observed using a cloth gait belt around Patient #5's waist. PT 1 removed the gait belt after Patient #5's care was provided and failed cleanse the cloth gait belt and failed to perform hand hygiene before re-entering the nursing bag. 7. During a home visit observation conducted with Patient #19 and Licensed Practical Nurse (LPN) 1 on 7/14/23 beginning at 11:00 AM, LPN 1 was observed providing wound care to Patient #19. LPN failed to remove gloves and complete hand hygiene prior to		Prevention (CDC) guidelines for hand hygiene: Put enough sanitizeron your hands to cover all surfaces ... Rub your hands together until they feeldry (this should take around 20 seconds) and agency policy "EquipmentMaintenance" to ensure that the equipment must be cleaned after each use withan agency approved disinfectant after each use by the employee who haspossession of the equipment; and hands should be washed before re-entering thenursing bag. All staff understood and acknowledged the significance of ensuringthat they follow proper Hand technique and accepted infection control practicesmust be followed as per guidelines and all field staff will be able to demonstrateit as well. All new staff will be oriented of this requirement at the time ofhire. The corrective actions were implemented on 8/7/23 and completed on8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue	

	re-entering the nursing bag for additional supplies. 8. During an interview on 7/10/23 at 3:30 PM, the Alternate Clinical Supervisor indicated staff should have removed gloves and performed hand hygiene before touching the bag, equipment and before touching the patient and after every usage/every visit and indicated that each patient should have an individualized gait belt that stayed in their home. 410 IAC 17-12-1(m)		from 8/30/23 to 9/20/23. **Measuresto assure No recurrence** In order to ensure that there is no recurrence of thisdeficiency, the Alt DCS will utilize a supervisory visit audit tool to ensurethat hand hygiene techniques and equipment maintenance policy is being followedby all field staff. This process of utilizing supervisory visit audit tool onall staff will help us identify any discrepancies in the supervisory visitspertaining to staff compliance and re-educate all staff including contractedpersonnel on the above mentioned requirement. **Monitoring:** In order to ensure implementation and effectiveness of thecorrective action, the following monitoring process will be put into place. TheAlternate DCS will do random supervisory visits on all field staff every 2weeks to monitor and ensure that all staff is following the policy for	

			handhygiene techniques and equipment must be cleaned after each use with an agencyapproved disinfectant after each use by the employee who has possession of theequipment; and hands should be washed before re-entering the nursing bag. Thisprocess will continue for the next 3-6 months until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this policy. If compliance is not achieved at the desiredtarget of 100% compliance, the DCS will provide re-education of "Hand hygieneand compliance program" and "Equipment Maintenance" Policy and procedure inin-service to all field staff and provide individual training to all fieldstaff including therapy staff that are not in compliance. The Infection ControlCommittee will analyze and track data from infection control surveillancesystem and trend the field staff that are not compliant with "Hand hygiene andcompliance program" "Equipment Maintenance" Policy and procedure as mandated.The Administrator	

			will conduct a meeting with the Clinical Management team,Infection Control Committee and field staff to discuss the process. Ifnon-compliance continues, the agency will no longer provide patients tonon-compliant field staff until acceptable level of compliance is demonstratedand is achieved by the field staff. Once threshold is met the QAPI Committeewill continue to audit 20% of supervisory visits quarterly to ensure complianceis maintained. The Administrator and QAPI Committee will send a written reportto the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0700	Skilled professional services 484.75 Condition of participation: Skilled professional	G0700	All tags (G0706, G0716, G0718 and G0724) were addressed individually	2023-09-20

services.

Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in §409.44 of this chapter, and physician or allowed practitioner and medical social work services as specified in §409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care.

Based on observation, record review, and interview, the skilled professional failed to conduct a thorough and complete ongoing assessment (see tag G706) and failed to ensure the physical therapist instructed the physical therapy assistant on patient specific interventions (see Tag G724). Based on record review and interview, the home health agency failed to ensure all visit note documentation was completed in a timely manner (see Tag G716) and failed to ensure collaboration with other providers (see Tag G718).

Based on the cumulative effect of these systemic issues, the home health agency's skilled professional failed to provide services which met quality of care standards, which resulted in the agency being found of compliance with Condition of Participation 42 CFR 484.75 Skilled professional services.

G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient; Based on observation, record review, and interview, the skilled professional failed to conduct a thorough and complete ongoing assessment for 1 of 4 wound care home visit observations with a skilled professional performing the visit (Patient #19) and 4 of 13 records reviewed of a patient with wounds (Patient's #11, 14, 20 and 23). Findings include: 1. Review of an agency policy revised February 2021, titled "Reassessments/Update of the Comprehensive Assessment" indicated staff will reassess each patient with each home visit on an ongoing basis to evaluate current problems and needs as well as to adjust the care provided. Such reassessments will be documented on discipline-specific visit notes. 2. Review of Patient #11's	G0706	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure a thorough andcomplete ongoing assessment. 30% review of active charts was completed by weekending 8/12/23. 25% review of active charts was completed by week ending8/19/23. 45% review of active charts was completed by week ending 8/26/23 tocomplete 100% audit of all active chart audits. In order to correct the above deficiency cited underG0706, during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.7.2 titled, "Reassessments/Update of theComprehensive Assessment". The clinical records with the deficiencies wereidentified and reviewed. The Administrator, Director of Clinical Services and AlternateDirector of Clinical Services have completed	2023-09-20

	recertification comprehensive assessment completed on 7/14/23 by RN 2. The assessment narrative indicated RN 2 performed wound care during visit. The record failed to evidence detailed wound identifiers and descriptions. During an interview on 7/24/23 beginning at 4:08 PM, RN 2 indicated they looked at the wounds and performed wound care and they did not contact the physician for wound care updates or frequency orders for the next certification period. 3. Review of Patient #14's clinical record included a plan of care for the initial certification period of 6/26/23 – 8/24/23. The plan of care indicated the patient was to receive physical and occupational therapy services. The record included an initial comprehensive assessment completed on 6/29/23 by RN 1. The assessment summary indicated Patient #14 had a left above knee amputation surgical wound to the left leg. The record failed to evidence any further documentation regarding the surgical incision after the 6/29/23		re-orientation of agency'spolicies pertaining to the requirement on 8/23/23 provided by the GoverningBody Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care and to document that a thorough ongoingassessment has been conducted and completed. The Alternate Administrator willschedule application demo for 9/15/23 and after training Agency staff,application will be in use on 9/20/23. An in-service was be conducted by the Director of Clinical Serviceson 08/29/23 with all staff. During the meeting, the DCS discussed agency policy9.7.2 titled, "Reassessments/Update of the	

	comprehensive assessment was performed. During an interview on 7/27/23 at 1:58 PM, Physical Therapist (PT) 6 stated they did not document the wound information on the visit notes and the surgical incision is now healed. 4. During a home visit observation conducted with Patient #19 and Licensed Practical Nurse (LPN) 1 on 7/14/23 beginning at 11:00 AM, LPN 1 failed to perform an assessment to Patient's 19's right foot after spouse reported that patient was seeing a podiatrist later that afternoon for an area of discomfort to the right foot. During an interview on 7/20/23 at 4:13 PM, LPN 1 stated they did not perform a complete skin assessment after spouse had reported an area of discomfort to the right foot. 5. A review of the clinical record for Patient #20, start of care 2/13/2023, evidenced a comprehensive assessment dated 2/13/2023 completed by registered nurse (RN) 3. The assessment indicated the		Comprehensive Assessment" and theimportance of the requirement to conduct ongoing interdisciplinary assessmentof the patient during each home visit and on an on-going basis, reassesspatients to evaluate current problems and needs as well as to adjust the careprovided. Such reassessments would be documented on discipline-specific visitnotes. Citations listed in the clinical record reviews were addressed. Allstaff understood and acknowledged the agency policy 9.7.2 titled,"Reassessments/Update of the Comprehensive Assessment" and the requirement toconduct ongoing interdisciplinary assessment of the patient during each home visitand on an on-going basis, reassess patients to evaluate current problems andneeds as well as to adjust the care provided. Such reassessments would bedocumented on discipline-specific visit notes. All new staff will be orientedof this requirement at the time of hire. The corrective actions wereimplemented on 8/7/23 and completed on 8/29/23.	

	patient had no wounds. Review of a skilled visit note dated 2/20/2023 by RN 3 identified 2 wounds on the right buttock. During an interview on 7/24/2023 at 1:10 PM, RN 3 indicated Patient #20 self-reported buttocks wounds but refused to allow the nurse to assess them. RN 3 confirmed the patient self – report of wounds should have been noted on the comprehensive assessment. Review of clinical record for Patient #23 (start of care 05/16/2023, discharge date 06/13/2023) included a plan of care for the initial certification period of 05/16/2023 - 07/14/2023 which indicated the patient had a surgical wound requiring a wound vac to the left foot. The plan of care indicated the patient was to receive skilled nursing services with nursing interventions to include but not be limited to skin assessment and performing wound care to the left foot wound. The record indicated skilled nursing visits were conducted on 05/16/2023, 05/17/2023, 05/19/2023, 05/22/2023, 05/23/2023,		Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue to furthertest our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to document that a thorough ongoing assessment has been conductedand completed. The Alternate Director of Clinical Services will utilize a chartaudit tool to ensure that all active clinical records include documentation conductingongoing interdisciplinary assessment of the patient during each home visit andon an on-going basis, reassess patients to evaluate current problems and needsas	

	05/24/2023, 05/29/2023, 05/31/2023, 06/02/2023, and 06/16/2023. The record failed to evidence a complete wound assessment, including appearance of wound bed, presence or absence of draining, and measurements of the wound, was completed and documented by the nurse during the above visit dates.		well as to adjust the care provided. Such reassessments would be documentedon discipline-specific visit notes and documentation is present in the clinicalrecord. This process of utilizing active chart audit tool on all admissionswill help us identify any discrepancies in the clinical records and re-educate allstaff on the above mentioned requirement. **Monitoring:** In order to ensure implementation and effectiveness of thiscorrective action, the Alternate Director of Clinical Services will audit 100%of all new admissions and all current patients on a weekly basis to ensure to conductongoing interdisciplinary assessment of the patient during each home visit andon an on-going basis, reassess patients to evaluate current problems and needsas well as to adjust the care provided. Such reassessments would be documentedon discipline-specific visit notes and is being clearly	

			record. The Director of Clinical Services will monitor and review AlternateDirector of Clinical Services' audit findings of all new admissions and currentpatients. Reports will be generated and results will be compiled to ensureprocesses have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue foreach week for the next 30 days until 100% compliance is achieved. After 30days, this process will continue to be monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. The Director of Clinical Services	

			will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the home health agency failed to ensure all visit note documentation was completed in a timely manner per agency policy for 2 of 17 active patient records reviewed (Patient's #18 and #19). Findings include: 1. Review of an agency policy revised October 2017, titled "Timely Submission of Patient Documentation" indicated itineraries, with all visit reports attached must be submitted the next scheduled workday, not exceeding seven (7) calendar days. 2. Review of Patient #19's clinical record calendar included a Skilled Nurse (SN) visit was	G0716	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure all visit notedocumentation was completed in a timely manner. 30% review of active charts wascompleted by week ending 8/12/23. 25% review of active charts was completed byweek ending 8/19/23. 45% review of active charts was completed by week ending8/26/23 to complete 100% audit of all active chart audits. In order to correct the above deficiency cited underG0716, during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 11.5.1 titled, "Timely Submission of PatientDocumentation". The	2023-09-20

	performed on 7/02/23. The record evidenced the skilled nurse visit note, which included important wound documentation updates, was completed on 7/13/23, eleven (11) days after the visit was performed. Registered Nurse 2 failed to follow agency policy regarding timely submitting documents. During an interview on 7/13/23 beginning at 2:55 PM, the Alternate Clinical Supervisor indicated all documents should be completed within 7 days of the visit per policy and is expected to be completed on the same day. During an interview on 7/12/23 beginning at 4:03 PM, Registered Nurse (RN) 2 indicated they did complete the visit on 7/02/23 and they had not completed the documentation yet. 410 IAC 17-14-1(a)(1)(E) A clinical record review for Patient #18 for certification period 5/15/2023 – 7/13/2023 evidenced a list of patient tasks. The list included a nursing discharge visit, a nursing		clinical records with the deficiencies were identified andreviewed. The Administrator, Director of Clinical Services and AlternateDirector of Clinical Services have completed re-orientation of agency'spolicies pertaining to the requirement on 8/23/23 provided by the GoverningBody Chair. An in-service was be conducted by the Administrator on08/29/23 with all staff. During the meeting, the Administrator discussed agencypolicy 11.5.1 titled, "Timely Submission of Patient Documentation" and theimportance of the requirement that all visit note documentation is completed ina timely manner per agency policy. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the agency policy11.5.1 titled, "Timely Submission of Patient Documentation" and the importanceof the requirement that all visit note documentation is completed in a timelymanner per agency policy. All new staff will be	

	physician order, all scheduled for 5/18/2023. The tasks were "Not Yet Started" as of 7/13/2023. During an interview on 7/13/2023 at 10:50 AM, the alternate director of nursing (ADON) was unable to provide documentation of the nursing discharge information for Patient #18. The ADON indicated the 5/18/2023 nursing discharge visit, discharge summary and physician order were not completed.		oriented of this requirement atthe time of hire. The corrective actions were implemented on 8/7/23 andcompleted on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Director of Clinical Services will utilize a chartaudit tool to ensure that all visit note documentation is completed in a timelymanner per agency policy in all active clinical records. This process ofutilizing active chart audit tool on all admissions will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:**	

			In order to ensure implementation and effectiveness ofthis corrective action, the Alternate Director of Clinical Services will audit100% of all new admissions and all current patients on a weekly basis to ensureall visit note documentation is completed in a timely manner per agency policy.The Director of Clinical Services will monitor and review Alternate Director ofClinical Services' audit findings of all new admissions and current patients.Reports will be generated and results will be compiled to ensure processes haveimproved. If any deficiencies are identified, they will continue to beaddressed with each personnel as needed. This process will continue for eachweek for the next 30 days until 100% compliance is achieved. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audit results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQuality Committee will continue to audit 20% of clinical records quarterly toensure	

			compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, the home health agency failed to ensure collaboration with other providers for 3 of 3 active clinical records reviewed who received services from a wound clinic (Patients #9, 16, and 19) and 1 of 1 clinical record review whom received services from a pain clinic (Patient #19).	G0718	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure collaborationwith other providers. 30% review of active charts was completed by week ending8/12/23. 25% review of active charts was completed by week ending 8/19/23. 45%review of active charts was completed by week ending 8/26/23 to complete 100%audit of all active chart audits. In order to correct the above deficiency cited underG0718, during the management meeting on 8/23/23, the	2023-09-20

	Findings Include: Findings include: 1. Review of an agency policy revised February 2021, titled "Coordination of Patient Care" indicated care will be coordinated with other involved external organizations and staff will communicate with other individuals or organizations involved in the patient's care. 4. Review of the clinical record of Patient #19 included a plan of care for the initial certification period of 6/28/2023 – 8/26/2023 which evidenced a plan of care completed by Registered Nurse (RN) 2. The plan of care failed to include collaboration with the wound clinic and the pain clinic as another provider of care. 5. During an interview on 7/17/23 beginning at 1:39 PM, the Clinical Supervisor stated the home health agency nurse should have collaborated with an outside wound clinic at Start of Care and with any changes. 410 IAC 17-13-1(d) A review of the clinical record for Patient #9, for the		Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.13.1 titled, "Coordination of Patient Care". Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 8/23/23 provided by the Governing Body Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensure real-timevisibility into patient care and to ensure communication with all physiciansinvolved in the plan of care and other health care practitioners (asappropriate) related to the current plan of	

	certification period 5/15/2023 – 7/13/2023, evidenced a plan of care completed by registered nurse (RN) 2. The plan of care failed to include collaboration with other care providers, a wound clinic. A review of the clinical record for Patient #16 evidenced a plan of care for certification period 6/15/2023 – 8/13/2023. The plan of care failed to include collaboration with the wound clinic as another provider of care.		care. The Alternate Administratorwill schedule application demo for 9/15/23 and after training Agency staff,application will be in use on 9/20/23. An in-service was be conducted by the Director of ClinicalServices on 08/29/23 with all staff. During the meeting, the DCS discussedagency policy 9.13.1 titled, "Coordination of Patient Care" and the importanceof the requirement that the HHA staff must communicate with all physiciansinvolved in the plan of care and other health care practitioners (asappropriate) related to the current plan of care. Citations listed in theclinical record reviews were addressed. All staff understood and acknowledgedthe agency policy 9.13.1 titled, "Coordination of Patient Care" and therequirement that the HHA staff must communicate with all physicians involved inthe plan of care and other health care practitioners (as appropriate) relatedto the current plan of care. All new staff will be oriented of this	

			requirementat the time of hire. The corrective actions were implemented on 8/7/23 andcompleted on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians and to ensure communication with all physicians involved in the planof care and other health care practitioners (as appropriate) related to thecurrent plan of care. The Alternate Director of Clinical Services will utilizea chart audit tool to ensure that all active	

			clinical records include communicationwith all physicians involved in the plan of care and other health carepractitioners (as appropriate) related to the current plan of care anddocumentation is present in the clinical record. This process of utilizingactive chart audit tool on all admissions will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In order to ensure implementation and effectiveness ofthis corrective action, the Alternate Director of Clinical Services will audit100% of all new admissions and all current patients on a weekly basis to ensurecommunication with all physicians involved in the plan of care and other healthcare practitioners (as appropriate) related to the current plan of care and isbeing clearly documented in the clinical record. The Director of ClinicalServices will monitor and review Alternate Director of Clinical Services' auditfindings	

			of all new admissions and current patients. Reports will be generatedand results will be compiled to ensure processes have improved. If anydeficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for each week for the next 30days until 100% compliance is achieved. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly chart audit review. Quarterly audit results will be compiled and sentto the QAPI Committee for review. Once threshold is met, the Quality Committeewill continue to audit 20% of clinical records quarterly to ensure compliance is maintained. The Administrator and QAPI Committee will send a written reportto the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

G0724	Supervise skilled professional assistants 484.75(c) Standard: Supervision of skilled professional assistants. Based on observation, record review, and interview the agency failed to provide physical therapy patient-specific interventions for 1 of 2 physical therapy assistant home observations, with the potential to affect all patients receiving physical therapy assistant services. Findings include: 1. Review of an agency policy regarding the supervision of physical therapy assistants (PTA) indicated the PTA completes tasks that were planned, delegated, and supervised by the physical therapist (PA). 2. A home observation of a physical therapy service for Patient #2, performed by PTA 2 occurred on 7/5/2023. During the visit, the PT evaluation and plan of care (POC), both dated 6/27/2023, were not documented.	G0724	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to provide physicaltherapy patient-specific interventions and to ensure that all current patientsreceiving physical therapy services have a written PT evaluation that isdeveloped in consultation with the Physician by Licensed Physical Therapist andthe same PT evaluation is being followed by PTAs. 30% review of active chartswas completed by week ending 8/12/23. 25% review of active charts was completedby week ending 8/19/23. 45% review of active charts was completed by weekending 8/26/23 to complete 100% audit of all active chart audits. In order to correct the above deficiency cited underG0724, during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 4.10.1 titled, “Supervision of Physical	2023-09-20

	3. During an interview after the visit, PTA 2 indicated they completed visits on 6/30/2023 and 7/5/2023 without the availability of the evaluation and POC. PTA 2 indicated the exercises with Patient #2 were standard. PTA 2 indicated they spoke with the physical therapist every two weeks if there was an issue.		TherapyAssistants and Occupational Therapy Assistants". The clinical records with thedeficiencies were identified and reviewed. The Administrator, Director ofClinical Services and Alternate Director of Clinical Services have completedre-orientation of agency's policies pertaining to the requirement on 8/23/23provided by the Governing Body Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care and to ensure that all current patientsreceiving physical therapy services have a written PT evaluation that isdeveloped in consultation with the Physician by Licensed Physical Therapist andthe same PT evaluation is being followed by PTAs and supervision of	

			provide physical therapy patient-specific interventions.The Alternate Administrator will schedule application demo for 9/15/23 andafter training Agency staff, application will be in use on 9/20/23. An in-service was be conducted by the Director of ClinicalServices on 08/29/23 with all staff. During the meeting, the DCS discussedagency policy 4.10.1 titled, “Supervision of Physical Therapy Assistants andOccupational Therapy Assistants” and the importance of the requirement that thePTAs must provide physical therapy patient-specific interventions and ensurethat all current patients receiving physical therapy services have a written PTevaluation that is developed in consultation with the Physician by LicensedPhysical Therapist and the same PT evaluation is being followed by PTAs.Citations listed in the clinical record reviews were addressed. All staffunderstood and acknowledged the agency	

			ofPhysical Therapy Assistants and Occupational Therapy Assistants" and therequirement that the PTAs must provide physical therapy patient-specificinterventions and ensure that all current patients receiving physical therapyservices have a written PT evaluation that is developed in consultation withthe Physician by Licensed Physical Therapist and the same PT evaluation isbeing followed by PTAs.. All new staff will be oriented of this requirement atthe time of hire. The corrective actions were implemented on 8/7/23 andcompleted on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has	

			theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to ensure supervision of physical therapy assistants to providephysical therapy patient-specific interventions and ensure that all currentpatients receiving physical therapy services have a written PT evaluation thatis developed in consultation with the Physician by Licensed Physical Therapistand the same PT evaluation is being followed by PTAs. The Alternate Director ofClinical Services will utilize a chart audit tool to ensure that in all activeclinical records the PTAs must provide physical therapy patient-specificinterventions and documentation is present in the clinical record. This processof utilizing active chart audit tool on all admissions will help us identifyany discrepancies in the clinical records and re-educate all staff on the abovementioned requirement.	

			Monitoring: In order to ensure implementation and effectiveness of thiscorrective action, the Alternate Director of Clinical Services will audit 100%of all new admissions and all current patients on a weekly basis to ensure thePTAs must provide physical therapy patient-specific interventions, ensure thatall current patients receiving physical therapy services have a written PTevaluation that is developed in consultation with the Physician by LicensedPhysical Therapist and the same PT evaluation is being followed by PTAs and isbeing clearly documented in the clinical record. The Director of ClinicalServices will monitor and review Alternate Director of Clinical Services' auditfindings of all new admissions and current patients. The Supervising willconduct random supervisory visits on all PTA staff every 2 weeks to monitor andensure that all therapy assistants are following the above mentioned processfor all active wound care patients.	

			Reports will be generated and results willbe compiled to ensure processes have improved. If any deficiencies areidentified, they will continue to be addressed with each personnel as needed.This process will continue for each week for the next 30 days until 100%compliance is achieved. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audit results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the Quality Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

G1008	Clinical records 484.110 Condition of participation: Clinical records. The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically. Based on record review and interview, the home health agency failed to obtain orders for wound care and document the wound care provided (See G1014), failed to ensure the clinical record accurately identified the attending physician name and contact information (See G1020), failed to authenticate clinical record documentation (See G1024), failed to secure the clinical record from unauthorized use (See G1028), and failed to provide a copy of the clinical record upon patient request (See G1030). The cumulative effect of these systemic problems evidenced	G1008	All tags (G1014, G1020, G1024, G1028 and G1030) were addressedindividually	2023-09-20

	inability to maintain clinical records which were complete, accurate, appropriately authenticated, secure, and available to the patient, which resulted in the agency being found out of compliance with Condition of Participation 42 CFR 484.110 Clinical Records.			
G1014	Interventions and patient response 484.110(a)(2) All interventions, including medication administration, treatments, and services, and responses to those interventions; Based on observation, record review, and interview, the home health agency failed to obtain wound care orders and failed to document all wound care that was performed during home visit observations for 1 of 2 skilled nurse wound care home visit observations (Patient #19). Findings include: 1. Review of an agency policy revised in February 2021, titled Reassessments/Update of the Comprehensive Assessment indicated staff will reassess each patient with each home visit on	G1014	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure obtaining woundcare orders and to document all wound care that was performed, allinterventions, including medication administration, treatments, and services,and responses to those interventions. 30% review of active charts was completed by week ending8/12/23. 25% review of active charts was completed by week ending 8/19/23. 45%review of active charts was completed by week ending 8/26/23 to complete 100%audit of all active chart audits. The Clinical Managers and Alternate Directorof Clinical Services have verified all wound care orders, allinterventions,	2023-09-20

	current problems and needs as well as to adjust the care provided. Such reassessments will be documented on discipline-specific visit notes. 2. During a home visit observation conducted with Patient #19 and Licensed Practical Nurse (LPN) 1 on 7/14/23 at 11:00 AM, LPN 1 performed wound care to Patient #19's left first finger, left posterior calf, and right upper buttock areas. The Skilled Nurse (SN) visit noted failed to evidence documentation of wound care being performed to the left first finger and left posterior calf. The clinical record failed to show evidence of physician orders for wound care for Patient #19. 3. During an interview on 7/13/2023 at 9:29 AM, LPN 1 indicated they performed wound care on Patient #19 based upon a verbal discussion with Registered Nurse (RN) 2 who performed the Start of Care (SOC) visit on 6/28/2023. 4. During an interview on 7/14/23 beginning at 11:45 AM, LPN 1 indicated they have been performing wound care on		including medication administration, treatments, and serviceseffective 8/27/23 and continue to do so for all new admissions and currentpatients. In order to correct the above deficiency cited underG1014, during the management meeting on 8/23/23, the Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.7.2 titled, "Reassessments/Update of theComprehensive Assessment". The clinical records with the deficiencies wereidentified and reviewed. The Administrator, Director of Clinical Services andAlternate Director of Clinical Services have completed re-orientation ofagency's policies pertaining to the requirement on 8/23/23 provided by theGoverning Body Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication	

	Patient #19's left first finger, left posterior calf, and right buttock since Start of Care and have not collaborated with the physician regarding wound care updates.		application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into patient care to obtain wound care orders and todocument all wound care that was performed, all interventions, including medicationadministration, treatments, and services, and responses to those interventions in Agency EMR. The Alternate Administrator willschedule application demo for 9/15/23 and after training Agency staff,application will be in use on 9/20/23. An in-service was be conducted by the Director of ClinicalServices on 08/29/23 with all staff. During the meeting, the DCS discussedagency policy 9.7.2 titled, "Reassessments/Update of the ComprehensiveAssessment" and the importance of the requirement to reassess each patient witheach home visit on an ongoing basis to evaluate current problems and needs aswell as to adjust the care to	

			and to document allwound care performed, all interventions, including medicationadministration, treatments, and services, and responses to those interventions. Such reassessments would bedocumented on discipline-specific visit notes. Citations listed in the clinicalrecord reviews were addressed. All staff understood and acknowledged the agencypolicy 9.7.2 titled, "Reassessments/Update of the Comprehensive Assessment" andthe requirement to reassess each patient with each home visit on an ongoingbasis to evaluate current problems and needs as well as to adjust the care toprovide obtain wound orders and to document all wound care performed, allinterventions, including medication administration, treatments, and services,and responses to those interventions. Such reassessments would be documented ondiscipline-specific visit notes. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on8/7/23 and	

			completed on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians to obtain wound care orders and to document all wound care that wasperformed, allinterventions, including medication administration, treatments, and services,and responses to those interventions inAgency EMR. The Alternate Director of Clinical Services will utilize a chartaudit tool to ensure that all active clinical records include to reassess eachpatient with each	

			home visit on an ongoing basis to evaluate current problemsand needs as well as to adjust the care to provide obtain wound orders and todocument all wound care performed, all interventions, including medication administration,treatments, and services, and responses to those interventions. Such reassessments would be documented ondiscipline-specific visit notes and documentation is present in the clinicalrecord. This process of utilizing active chart audit tool on all admissionswill help us identify any discrepancies in the clinical records and re-educateall staff on the above mentioned requirement. **Monitoring:** In order to ensure implementation and effectiveness ofthis corrective action, the Alternate Director of Clinical Services will audit100% of all new admissions and all current patients on a weekly basis to ensureto reassess each patient with each home visit on	

			evaluatecurrent problems and needs as well as to adjust the care to provide obtainwound orders and to document all wound care performed, all interventions,including medication administration, treatments, and services, and responses tothose interventions. Such reassessmentswould be documented on discipline-specific visit notes and is being clearlydocumented in the clinical record. The Director of Clinical Services willmonitor and review Alternate Director of Clinical Services' audit findings of allnew admissions and current patients. Reports will be generated and results willbe compiled to ensure processes have improved. If any deficiencies areidentified, they will continue to be addressed with each personnel as needed.This process will continue for each week for the next 30 days until 100%compliance is achieved. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audit results will be compiled	

			and sent to the QAPICommittee for review. Once threshold is met, the Quality Committee will continueto audit 20% of clinical records quarterly to ensure compliance is maintained.The Administrator and QAPI Committee will send a written report to theGoverning Body quarterly for their recommendations. The Director of Clinical Services will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G1020	Contact info for primary care practitioner 484.110(a)(5) Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA; and	G1020	**CorrectiveAction:** The Alternate Director of Clinical Services started internalaudit review of all active clinical records on 8/7/23 to ensure the accuracy ofthe correct attending physician. 30% review of active charts was completed byweek ending 8/12/23. 25% review of active charts was completed by week ending8/19/23. 45% review of active charts was completed by week ending 8/26/23 tocomplete 100% audit of all	2023-09-20

	Based upon record review and interview, the home health agency failed to ensure the accuracy of the correct attending physician for 5 of 21 total clinical records reviewed (Patient #1, 3, 5, 15, and 19). Findings include: 1. Review of the clinical record of Patient #1 included a plan of care for the initial certification period of 4/03/2023 – 5/31/2023 which indicated the patient's attending physician was Physician R. The record failed to evidence the correct contact information for Physician R. During an interview with Person H, conducted on 7/19/2023 starting at 11:54 AM, the employee reported Physician R was not the attending physician for Patient #1 until care was established on 4/13/23. Person H also reported there was no record of Patient #1 receiving home health services from this agency in the patient's clinical chart. 2. Review of the clinical record of Patient #3 included a plan of care for the initial certification		active chart audits. In order to correct the above deficiency cited underG-1020, during the management meeting on 8/23/23, the Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 11.1.1 titled "Medical Record Content". Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 8/23/23 provided by the Governing Body Chair. All active clinical records review was completed on8/26/23. The Alternate Administrator is in coordination with "Home HealthNotify", a HIPAA compliant communication application for the Agency,clinicians, inter-disciplinary teams, Patients and Physicians to ensurereal-time visibility into	

	08/26/2023 which indicated the patient's attending physician was Physician U. The doctor's address, phone number, and fax number was listed as PhysicianW's Office. The record failed to evidence the correct contact information for Physician U. During an interview with Person V, an employee at Physician W's Office, conducted on 07/18/2023 at 2:17 PM, the employee reported Physician U had not worked at the office since 02/15/2023. Person V also reported there was no record of Patient #3 receiving care from any provider at Physician W's office. During an interview with Patient #3 conducted on 07/18/2023 at 2:21 PM, the patient reported Physician U is their attending physician and they moved to an Upland, Indiana office. 3. Review of the clinical record of Patient #5 included a plan of care for the initial certification period of 06/14/2023 – 08/12/2023 which indicated the patient's attending physician was Physician T. The record failed to evidence the correct		patient care and to ensure the accuracy of thecorrect attending physician. The Alternate Administrator will scheduleapplication demo for 9/15/23 and after training Agency staff, application willbe in use on 9/20/23. An in-service was conducted by the Director of ClinicalServices on 8/29/23 with all staff. During the meeting, the DCS discussedagency policy 11.1.1 titled "Medical Record Content" and the importance of therequirement that the name/contact information for the patient's primary carephysician/practitioner or other health care professional who will beresponsible for providing care and services to the patient must be present inthe clinical record. Citations listed in the record reviews were addressed withall staff. The Director of Clinical Services re-educated all staff on theimportance of this requirement. All staff understood and acknowledged theagency policy 11.1.1 titled "Medical Record Content" and	

	attending physician for Patient #5. During an interview with Person CC, an employee at Physician T's office, conducted on 07/18/2023 at 11:13 AM, the employee reported Physician T was not the attending physician for Patient #5. Person CC also reported there was no record of Patient #5 receiving care from Physician T in the patient's clinical chart. During an interview with Patient #5 on 07/19/2023 at 11:05 AM, the patient reported Physician DD as their attending physician. During an interview with Person EE on 7/19/2023 at 11:10 AM, Person EE verified that Physician CC was the attending physician for Patient #5. They stated there are no records or documents received from the home health agency in the Patient's clinical chart. 4. Review of the clinical record of Patient #15 included a plan of care for the initial certification period of 05/09/2023 – 07/07/2023 which indicated the patient's attending physician was Physician Z. The record failed to		name/contact information for the patient's primary carephysician/practitioner or other health care professional who will beresponsible for providing care and services to the patient must be present inthe clinical record. All new staff will be oriented of this requirement at thetime of hire. The corrective actions were implemented on 8/7/23 and completedon 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence:** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator has made a process update and theAgency will be utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients andPhysicians and to	

	evidence the correct attending physician for Patient #15. During an interview with Person BB on 7/18/2023 beginning at 2:05 PM, Person BB verified Physician AA was the attending physician for Patient #15 and the Patient's clinical chart does not include any scanned documentation from the home health agency. Person BB stated they would make Physician AA aware that the patient was receiving home health services. 5. Review of the clinical record of Patient #19 included a plan of care for the initial certification period of 6/28/2023 – 8/26/2023 which indicated the patient's attending physician was Physician M. The record failed to evidence the correct attending physician for Patient #19. During an interview with Person N on 7/17/23 at 3:30 PM, Person N reported that Physician M was not the attending physician for Patient #19 and indicated that there is not any documentation that Physician M had given any home health physician orders		ensure the accuracy of the correct attending physician. The AlternateDirector of Clinical Services will utilize a chart audit tool to ensure thatthat the name/contact information for the patient's primary carephysician/practitioner or other health care professional who will beresponsible for providing care and services to the patient must be present in theclinical record. This process of utilizing chart audit tool will help usidentify any discrepancies in clinical records and take corrective measuresaccordingly. **Monitoring** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the Alternate Director ofClinical Services will utilize a chart audit tool and audit 100% of all activeclinical records on a weekly basis to ensure that all clinical records showevidence that the name/contact information for the patient's primary	

	for Patient #19. During an interview with Person P on 7/19/23 beginning at 8:31 AM, Person P reported that Patient #19 is not yet a patient of Physician FF. Patient #19 had an initial appointment with Physician FF scheduled for 8/31/23. Person P also indicated that Physician FF would not have given any orders for home health until a relationship had been established with Patient #19.		other health care professional who will beresponsible for providing care and services to the patient must be present inthe clinical record. The Director of Clinical Services will monitor and review AlternateDirector of Clinical Services' audit findings of all new admissions and currentpatients. Weekly reports will be generated and results will be compiled andsent to the Administrator to ensure that processes have improved. This processwill continue for each week for the next 30 days until 100% compliance isachieved and to maintain this level of compliance all new employees at the timeof hire will be oriented with this requirement. If compliance is not achievedat the desired target of 100% compliance and any deficiencies are identifiedwithin 30 days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and	

			sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. TheAdministrator will be responsible for corrective action of this deficiency,measure to assure no recurrence and monitoring of this deficiency.	
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure clinical records were appropriately authenticated (signed, dated, and timed by the person completing the document,	G1024	**CorrectiveAction:** The Alternate Director of Clinical Services startedinternal audit review of all active clinical records on 8/7/23 to ensureclinical records were appropriately authenticated (signed, dated, and timed bythe person completing the document, with the use of a unique electronicsignature) represented accurate information, and completed by a person whoprovided care to the patient. 30% review of active charts was completed by	2023-09-20

	with the use of a unique electronic signature) represented accurate information, and completed by a person who provided care to the patient, in 1 of 1 agency survey, with the potential to affect all patients. Findings include: The clinical record of Patient #23 (start of care 05/16/2023, discharge date 06/14/2023) indicated the patient had a primary diagnosis of a surgical wound to the left foot and the patient was to receive skilled nursing services with interventions to include but not be limited to wound care. The plan of care indicate the patient's left foot wound required wound vac changes 3 times a week, to be done by the home health nurse. The record indicated the Patient #23 missed a skilled nursing visit on 06/08/2023 due to the patient having a doctor's office visit to have their wound vac removed. The record evidenced Licensed Practical Nurse (LPN) 2 documented a skilled nurse visit was completed, including a wound vac change, for Patient #23 on 06/09/2023, the day after the patient had their		weekending 8/12/23. 25% review of active charts was completed by week ending8/19/23. 45% review of active charts was completed by week ending 8/26/23 tocomplete 100% audit of all active chart audits. The Administrator has verifiedthat all individual employees, direct and indirect, with access to any part ofa patient's clinical record, will have an individual login, specific to themalone, and their activity in the patient's record, will have the capability tobe tracked as to when they are in each patient's clinical record and anychanges that are made within the clinical record on 8/25/23. In order to correct the above deficiency cited underG-1024, during the management meeting on 8/23/23, the Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 11.3.1 titled "Medical Record Entries andAuthentication". The clinical records with the deficiencies were identified andreviewed.	

	wound vac removed. The visit's Electronic Visit Verification (EVV) evidenced a patient signature which was not similar to the patient's EVV on previous visit dates not conducted by LPN 2. During an interview conducted on 07/27/2023 beginning at 10:48 AM with a nurse at Patient #23's attending physician's office, the nurse confirmed Patient #23 was seen in the office on 06/08/2023 and a non-removable cast was placed on the wound during the visit. The office nurse also confirmed no further wound vac dressings would have been required after 06/08/2023. The record also included a discharge visit documented as completed on 06/13/2023 by RN 2. The visit's EVV evidenced the visit was conducted on 06/16/2023, 3 days after the patient was discharged from the agency. During an interview with the Administrator conducted on 07/27/2023 beginning at 11:30 AM, the Administrator reported the agency was aware of the allegations of falsification of		The Administrator, Director of Clinical Services and AlternateDirector of Clinical Services have completed re-orientation of agency'spolicies pertaining to the requirement on 8/23/23 provided by the GoverningBody Chair. All active clinical records review was completed on 8/27/23. An in-service was conducted by the Administrator on 8/29/23with all staff. During the meeting, the Administrator discussed agency policy 11.3.1titled "Medical Record Entries and Authentication" and the importance of therequirement to ensure clinical records were appropriately authenticated(signed, dated, and timed by the person completing the document, with the useof a unique electronic signature) represented accurate information, andcompleted by a person who provided care to the patient. Citations listed in therecord reviews were addressed with all staff. The Alternate Administrator hassubmitted enhancement	

	visits or visit notes by LPN 2 and was investigating the allegations. 1. The clinical record for Patient #1 for the certification period 4/3/2023 - 6/9/2023 was reviewed on 07/06/2023 and evidenced the following: A recertification assessment with a date of 6/1/2023 last modified by Person Q, a registered nurse (RN). A note from a QA (Quality Assurance) employee requesting Person Q change the assessment date from 6/12/2023 to 6/01/2023 due to the original date being outside of the acceptable timeframe. A note in response to QA's request from Person Q indicating the date would not be changed as the document was completed on 6/12/2023. Initially reviewed HHA (home health aide) supervisory notes indicating they were incomplete for the specified dates. Further into the review the notes went from incomplete to completed status. During an interview on		request to the EMR team to ensure that all clinicalrecords requiring signature must also have Time stamp next to it, to limitpermissions to QA staff and to have authors authenticate signatures withcurrent date only. The Administrator re-educated all staff on the importance ofthis requirement. All staff understood and acknowledged the agency policy 11.3.1titled "Medical Record Entries and Authentication" and the requirement toensure clinical records were appropriately authenticated (signed, dated, andtimed by the person completing the document, with the use of a uniqueelectronic signature) represented accurate information, and completed by aperson who provided care to the patient must be present in the clinical record.All new staff will be oriented of this requirement at the time of hire. Thecorrective actions were implemented on 8/7/23 and completed on 8/29/23. Tostrengthen further ongoing audit, hiring and training new staff and to ensuresuccessful outcomes of the implemented corrective actions, will continue	

	7/6/2023 the ADON (Alternate Director of Nursing) indicated they did not complete the supervisory notes but did complete the QA of the supervisory notes. The ADON indicated the EMR (electronic medical record) activity log evidenced Person Q was assigned to complete the note and could not explain why only their name/input appeared on the note. 2. The clinical record for Patient #2 for the certification period 6/23/2023-8/32/2023 was reviewed on 07/06/2023 and evidenced the following: A Physical Therapy Evaluation completed by PT (Physical Therapist) 5. The EMR activity log indicated the Physical Therapy Evaluation and POC (Plan of Care) were completed by PT 5 on 7/5/2023 but the electronic signature applied to the document was dated 6/27/2023. 3. The clinical record for Patient #4 for the certification period 5/22/2023-6/20/2023 was reviewed on 07/06/2023 and evidenced the following: A 6/5/2023 nursing visit note		tofurther test our processes from 8/30/23 to 9/20/23. **Measuresto assure No recurrence** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Director of Clinical Services will utilize a chartaudit tool to ensure clinical records were appropriately authenticated (signed,dated, and timed by the person completing the document, with the use of aunique electronic signature) represented accurate information, and completed bya person who provided care to the patient must be present in the clinicalrecord. This process of utilizing chart audit tool will help us identify anydiscrepancies in clinical records and take corrective measures accordingly. TheAlternate Administrator will utilize an individual login audit tool to ensurethat all individual employees, direct and indirect, with access to any part ofa patient's clinical record, will have an individual login, specific to themalone, and their activity in the patient's record, will have the capability tobe tracked as to	

	signed by LPN (Licensed Practical Nurse) 2. The accompanying location verification log failed to include a visit start time, end time, or the GPS verified location data. A GPS location verification log for the visit date 6/9/2023 that indicated the visit began at 3:06 PM and ended at 3:51 PM. The document failed to evidence the GPS verified location data. During a home visit on 7/11/2023 at 10:00 AM Patient #4 indicated LPN 2 failed to perform visits on 6/5/2023 and 6/9/2023 and presented their electronic benefits statement that indicated Patient #4's insurance was billed for the two missed visit dates. The spouse of Patient #4 confirmed they did not receive services on 6/5/2023 or 6/9/2023. 4. The clinical record for Patient #7 for the certification period 6/27/2023-8/25/2023 was reviewed on 07/06/2023 and evidenced the following: A POC with the electronic signature for RN 2 dated 6/27/2023. The activity log for this POC indicated the		when they are in each patient's clinical record and anychanges that are made within the clinical record. **Monitoring:** In order to ensure implementation and effectiveness of this correctiveaction, the following monitoring process will be put in place, The AlternateAdministrator will utilize an individual login audit tool to ensure that allindividual employees, direct and indirect, with access to any part of apatient's clinical record, will have an individual login, specific to themalone, and their activity in the patient's record, will have the capability tobe tracked as to when they are in each patient's clinical record and anychanges that are made within the clinical record on a monthly basis. The Alternate Director of ClinicalServices will utilize a chart audit tool and audit 100% to ensure clinicalrecords were appropriately authenticated (signed, dated, and timed by theperson completing the document, with the use of a unique electronic	

	staff member, was the only employee identified as accessing the document. During an interview on 7/20/2023 at 2:20 PM, RN 2 indicated they did not know how their electronic signature got affixed to the POC. 5. The clinical record for Patient #9 for the certification period 5/15/2023-7/13/2023 was reviewed on 07/06/2023 and evidenced the following: A POC with the electronic signature of RN 2 dated 5/10/2023. The document activity log indicated RN 2 did not complete or save the POC. The EMR activity log indicated only QA and office personnel had accessed the document. A PTA (Physical Therapy Assistant) Supervisory note with an electronic signature dated 5/12/2023 by PT 5. The EMR activity log indicated the note was not completed by PT 5 but by non-clinical personnel. A nursing visit note for a visit electronically signed by LPN 2 and dated 5/22/2023 indicating wound care was added/updated on 5/22/2023. The EMR activity		signature)represented accurate information, and completed by a person who provided careto the patient must be present in the clinical record. The Director of ClinicalServices will monitor and review Alternate Director of Clinical Services' auditfindings of all new admissions and current patients. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each week for thenext 30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled	

	log indicated QA had added "Wound care is added/updated" on 7/6/2023. During an interview on 7/7/2023 at 10:07 AM, LPN 2 indicated they did not alter the visit note on 7/6/2023. LPN 2 indicated they were not aware of any visit notes being changed by someone else without LPN 2's permission. 6. The clinical record for Patient #10 with a start of care date of 4/21/2023 was reviewed on 07/06/2023 and evidenced the following: A physician order dated 5/22/2023 with the typewritten name a physician and date of 6/19/2023. The EMR activity log indicated QA had created he document on 6/23/2023, seven days after the physician's signature. A 4/21, 5/5, 5/22, 5/26, and 6/3 dated physician order with a typewritten note indicating the document was signed by Physician[GJ1] R. Physician R does not have access to the agency's EMR in order to sign orders. 7. The clinical record for Patient		and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. The Administrator will be responsible for correctiveaction of this deficiency, measure to assure no recurrence and monitoring ofthis deficiency.	

	6/15/2023-8/13/2023 was reviewed on 07/06/2023 and evidenced the following: A Physical Therapy Evaluation completed by PT 5 signed and dated electronically on 6/22/2023. Review of the EMR activity log indicated PT 5 completed the document on 7/3/2023 and the document was later backdated by another employee. A verbal physician order dated and signed electronically by PT 5 on 6/22/2023. The EMR activity log indicated PT 5 had not created or completed the physician order. A document titled Referral for Home Care electronically signed and dated by RN 2 on 6/15/2023. The EMR activity log indicated RN 2 submitted the document to QA on 6/18/2023 and 6/21/2023 but had not signed or dated the document. During an interview on 7/18/2023 at 9:21 AM, RN 2 indicated they are not responsible for getting verbal orders for patient start of care but that was the responsibility of the office staff.			

	8. The clinical record for Patient #18 for the certification period 5/15/2023-7/13/2023 was reviewed on 07/06/2023 and evidenced the following: A POC signed and dated electronically by RN 2. The EMR activity log indicated RN 2 did not sign or create/update the document. 8. The clinical record for Patient #21 for the certification period 6/22/2023-8/20/2023 was reviewed on 07/06/2023 and evidenced the following: A start of care order signed and dated electronically by RN 2 on 6/22/2023. The activity log indicated RN did not access the document until 6/25/2023. The document failed to include the correct signature date. 9. The location verification log was reviewed for patient #23 for a 6/9/2023 dated nursing visit. The log indicated LPN 2 provided care from 12:22 PM to 12:55 PM and was GPS verified. The locations logs indicated LPN 2 was also providing care to other patients at separate locations at the exact same time as the visit for patient #23.			

	10. During an interview on 7/7/2023 at 10:15 AM regarding electronic signatures in the EMR, the Administrator and Alternate Director of Nursing (ADON) indicated the typed name and date on a document represented the electronic signature and that the typed name of the physician, on a plan of care was an electronic signature as well. 11. During an interview on 7/7/2023 at 10:30 AM with the EMR information technology (IT) representative (Representative A) for the agency's EMR system, Representative A indicated an electronic signature was affixed to a document by the person entering a unique password. Representative A confirmed a person would require access to the EMR to affix their signature and indicated there was no time stamp as the agency chose not to utilize that option. The representative verified Persons R, S, TJ, all physicians, did not have access to the EMR and could not sign EMR documents electronically. Upon further discussion, Representative A indicated the agency could choose the physician's name			

	from a list and the name would show on the signature line. Representative A confirmed the agency could change the name and/ or date of the signature. 12. During a telephone interview on 7/12/2023 at 11:48 PM with Person Q, an RN, described the process of signing any document. Person Q indicated a box pops open which requests your password, and then affixes your electronic signature. Person Q indicated they did not know where the date came from, and relayed they are able to change to the correct date. 13. Upon request the Administrator and ADON confirmed their patients' physicians did not have access to their EMR. The ADON demonstrated the process of choosing a physician from a list (which the agency entered), and this action placed the name of the physician on the signature line in a document in the EMR. 410 IAC 17-15-1(a)(7)			
G1028	Protection of records	G1028	**CorrectiveAction:** TheAlternate Director of Clinical	2023-09-20

	484.110(d) Standard: Protection of records. The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164. Based on observation, record review, and interview, the agency failed to establish procedures to secure the clinical records from unauthorized use in 1 of 1 agency surveyed, with the potential to affect all patients. Findings include: 1. A review of an agency policy last revised in 2018 titled Information Confidentiality, Security and Data Integrity indicated the agency would use technology advancements to improve confidentiality, privacy, and security. 2. During an interview on 7/7/2023 at 10:33 AM, the Administrator indicated 3 contracted Quality Assurance individuals (Persons C, D, and E) were permitted access to the electronic medical record (EMR). The Administrator confirmed Persons C, D, and E were		Services started internal audit review of allactive clinical records on 8/7/23 to ensure securing the clinical records fromunauthorized use. 30% review of active charts was completed by week ending8/12/23. 25% review of active charts was completed by week ending 8/19/23. 45%review of active charts was completed by week ending 8/26/23 to complete 100%audit of all active chart audits. The Administrator has verified that allindividual employees, direct and indirect, with access to any part of apatient's clinical record, will have an individual login, specific to themalone, and their activity in the patient's record, will have the capability tobe tracked as to when they are in each patient's clinical record and anychanges that are made within the clinical record on 8/25/23. In order to correct the above deficiency cited underG-1028, during the management meeting on 8/23/23, the Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policies 6.1.1 titled	

	identified on the document activity log as “Assurance, Quality” (QA). The Administrator indicated there were 3 separate logins, one for each QA individual, for the EMR. 3. During a phone interview on 7/7/2023 at 10:40 AM, the EMR company information technology (IT) representative confirmed activity stamps or electronic signatures were based on unique logins. The IT representative indicated there were only 1, not 3, logins for QA that were being used by multiple people. 4. During an interview on 7/7/2023 at 11:15 AM, the Office Assistant demonstrated the process for faxing documents to physicians. The Office Assistant indicated the faxes sent to the physician were stored on Google Drive until they were returned with a signature. The Office Assistant did not know if Google Drive was encrypted. The Administrator indicated Google Drive was secure because it required a password and was part of Gmail (a web-based email program). The		“Information Management Plan”, 6.4.1titled “Patient Confidentiality” and 6.7.1 titled "InformationConfidentiality, Security and Data Integrity". The clinical records withthe deficiencies were identified and reviewed. The Administrator, Director ofClinical Services and Alternate Director of Clinical Services have completedre-orientation of agency’s policies pertaining to the requirement on 8/23/23provided by the Governing Body Chair. An in-service was conducted by the Administrator on 8/29/23with all staff. During the meeting, the Administrator discussed agency policies6.1.1 titled “Information Management Plan”, 6.4.1 titled “PatientConfidentiality” and 6.7.1 titled "Information Confidentiality, Securityand Data Integrity" and the importance of the requirement to have clinicalrecord, its contents, and the information contained therein must be safeguardedagainst loss or unauthorized use. Citations	

	if the Google Drive was encrypted. The Administrator had no information on how Google Drive was set up and whether it met federal security regulations. 5. During an interview on 7/12/2023 at 11:15 AM, the Administrator confirmed Person F, a therapy contractor, had access to the agency's EMR. 6. During a telephone interview on 7/12/2023 at 11:25 AM, Person F indicated two people shared the same login to the EMR. 7. During an interview on 7/19/2023 at 2:33 PM, Person I, supervisor of Persons C, D, and E, confirmed the EMR did not identify which of the 3 made an entry using the QA login. 8. During an interview on 7/27/2023 at 1:15 PM, the director of nursing (DON) indicated they had a box of referrals in their car. 9. During an interview at 3:00 PM on 7/12/23, the Administrator indicated the agency's contracted QA, Persons C, D, and E, did review and have access to the personal		wereaddressed with all staff. The Administrator re-educated all staff on theimportance of this requirement. The Administrator informed the attendees thatpermissions to QA staff have been limited and all clinical entries withdiscrepancies will be returned to clinicians for review. The AlternateAdministrator sent an enhancement request to EMR team to ensure that QA staffis not permitted to save any entries as evidenced in activity logs. Googledrive will not be used to store any confidential, HIPPA related information. Allstaff understood and acknowledged the agency policies 6.1.1 titled “InformationManagement Plan”, 6.4.1 titled “Patient Confidentiality” and 6.7.1 titled"Information Confidentiality, Security and Data Integrity" and therequirement to have clinical record, its contents, and the informationcontained therein must be safeguarded against loss or unauthorized use. All newstaff will be oriented of this requirement at the time of hire. To strengthen further ongoing audit, hiringand training new staff and to ensure successful	

	and health information of their patients via the electronic medical record system. When asked, the administrator relayed he had no personnel files for these contracted staff, had no evidence that these contracted employees had completed a national criminal background, and had no contract with these individuals that included the protection of patients' personal identifiable and confidential information. 410 IAC 17-15-1(c)		outcomes of the implementedcorrective actions, will continue to further test our processes from 8/30/23 to9/20/23. **Measuresto assure No recurrence** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Director of Clinical Services will utilize a chartaudit tool to ensure to have clinical record, its contents, and the informationcontained therein to be safeguarded against loss or unauthorized use must bepresent in the clinical record. This process of utilizing chart audit tool willhelp us identify any discrepancies in clinical records and take correctivemeasures accordingly. The Alternate Administrator will utilize an individuallogin audit tool to ensure that all individual employees, direct and indirect,with access to any part of a patient's clinical record, will have an individuallogin, specific to them alone, and their activity in the patient's record, willhave the capability to be tracked as to when they are in each patient'sclinical record and any	

changes that are made within the clinical record.

Monitoring

In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place, theAlternate Administrator will utilize an individual login audit tool to ensurethat all individual employees, direct and indirect, with access to any part ofa patient's clinical record, will have an individual login, specific to themalone, and their activity in the patient's record, will have the capability tobe tracked as to when they are in each patient's clinical record and anychanges that are made within the clinical record on a monthly basis. The AlternateDirector of Clinical Services will utilize a chart audit tool and audit 100% toensure to have clinical record, its contents, and the information containedtherein must be safeguarded against loss or unauthorized use. The Director ofClinical Services will monitor and review Alternate Director of Clinical Services'audit findings of all new admissions and

			current patients. Weekly reports willbe generated and results will be compiled and sent to the Administrator toensure that processes have improved. This process will continue for each weekfor the next 30 days until 100% compliance is achieved and to maintain thislevel of compliance all new employees at the time of hire will be oriented withthis requirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQAPI Committee will continue to audit 20% of clinical records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body	

			quarterly for their recommendations. TheAdministrator will be responsible for corrective action of this deficiency,measure to assure no recurrence and monitoring of this deficiency.	
G1030	Retrieval of records 484.110(e) Standard: Retrieval of clinical records. A patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first). Based on record review and interview, the agency failed to provide the patient with a copy of their clinical record upon request for 1 of 1 patient who made a clinical record request. (Patient #4). Findings include: During a home observation of a comprehensive assessment for Patient #4 on 7/11/2023, the patient indicated they requested copies of visit notes and billing statements for July. Patient #4 indicated the Alternate Administrator said the patient had to retrieve the clinical records from the primary care physician (PCP) and the billing for July	G1030	**CorrectiveAction:** The Administrator created an administrative audit toolon 7/31/23 to document, ensure that all record requests are placed there and toprovide the patient with a copy of their clinical record upon request. In order to correct the above deficiency cited underG-1030, during the management meeting on 8/23/23, the Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 11.1.1 titled "Medical Record Content ". Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Director of Clinical Services and	2023-08-29

	unavailable. During an interview on 7/11/2023 at 4:37 PM, the Administrator indicated the agency would provide medical records to the patient if requested. The Administrator denied Patient #4 requested medical records. During an interview on 7/17/2023 at 11:24 AM, the Alternate Administrator confirmed Patient #4 was told to get medical records from their primary care physician. The Alternate Administrator indicated the medical records would be the signed orders from the PCP. The Alternate Administrator confirmed visit notes were part of the patient record and were not with the PCP and confirmed the requested billing information was not provided to Patient #4. IAC 410 17-12-3(b)(3)		Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 8/23/23 provided by the Governing Body Chair. An in-service was conducted by the Administrator on 8/29/23with all staff. During the meeting, the Administrator discussed agency policy11.1.1 titled "Medical Record Content " and the importance of therequirement to have patient's clinical record (whether hard copy or electronicform) to be made available to a patient, free of charge, upon request at thenext home visit, or within 4 business days (whichever comes first). Citationslisted in the record reviews were addressed with all staff. The Administratorre-educated all staff on the importance of this requirement. The AlternateAdministrator has created an administrative binder to ensure that all recordrequests are placed there. All staff understood and acknowledged the agencypolicy	

			11.1.1 titled “Medical Record Content " and the requirement to havepatient's clinical record (whether hard copy or electronic form) to be madeavailable to a patient, free of charge, upon request at the next home visit, orwithin 4 business days (whichever comes first). All new staff will be orientedof this requirement at the time of hire. The corrective actions wereimplemented on 7/31/23 and will be completed on 8/29/23. **Measuresto assure No recurrence** In order to ensure that there is no recurrence of thisdeficiency, the Alternate Administrator will utilize an administrative audittool to ensure to have patient's clinical record (whether hard copy orelectronic form) to be made available to a patient, free of charge, uponrequest at the next home visit, or within 4 business days (whichever comesfirst). This process of utilizing administrative audit tool will help usidentify any discrepancies in administrative records and take	

correctivemeasures accordingly.

Monitoring

In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place, theAlternate Administrator will utilize an administrative audit tool to ensure tohave patient's clinical record (whether hard copy or electronic form) to bemade available to a patient, free of charge, upon request at the next homevisit, or within 4 business days (whichever comes first). The Administratorwill monitor and review Alternate Administrator’s audit findings of all new patientrecord requests. Weekly reports will be generated and results will be compiledand sent to the Administrator to ensure that processes have improved. Thisprocess will continue for each week for the next 30 days until 100% complianceis achieved and to maintain this level of compliance all new employees at thetime of hire will be oriented with this requirement. If compliance is notachieved at the desired

			target of 100% compliance and any deficiencies areidentified within 30 days, they will continue to be addressed with staffre-training and re-education in workshops and in-services and with eachindividual personnel as needed. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will continueto audit 20% of clinical records quarterly to ensure compliance is maintained.The Administrator and QAPI Committee will send a written report to theGoverning Body quarterly for their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0000	Initial Comments	N0000		

	This visit was a State complaint survey of a deemed home health provider. Survey dates: July 05, 06, 07, 10, 11, 12, 13, 14, 17, 18, 19, 20, 21, 24, 25, 26, and 27, 2023 Complaint #399021 was investigated, related and unrelated State findings are cited. Unduplicated Skilled Admissions: 786 QR: Area 2 8/9/23			
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:	N0458	**Corrective Action:** TheAdministrator started review of all 45 personnel files on 7/31/23. Review of 100% personnel files was completed on8/8/23 and it was concluded that all Personnel files are in compliance andinclude documented evidence of a copy of current license, signed jobdescription and received agency/job specific orientation, criminalbackground checks, license verification and annual evaluation. In orderto correct the above deficiency cited, in Management meeting on 8/23/2023, the Administratorand Director of Clinical Services (DCS) reviewed, discussed the agency policy4.8.1 titled "Personnel Records" under Human Resources Section.During this meeting,	2023-09-20

(1) Receipt of job description.

(2) Qualifications.

(3) A copy of limited criminal history pursuant to IC 16-27-2.

(4) A copy of current license, certification, or registration.

(5) Annual performance evaluations.

Based on record review and interview, the agency failed to maintain employee records which included criminal background checks, license verification, orientation, and receipt of a job description for 10 of 15 employee records reviewed and 3 of 3 quality assurance contract employees, with the potential to affect all patients.

Findings include:

1. A review of the employee record for Physical Therapy Assistant (PTA) 2, date of hire 10/25/2022, failed to evidence orientation nor a job description.

2. A review of the employee record for Home Health Aide 1, evidenced a hire date of 02/14/23 and failed to evidence a national criminal background check was completed before first patient contact of 02/21/23. The backgound check was

deficiencies cited under N-0458 were reviewed, addressedand discussed in detail. The Administrator has completed re-orientation ofagency's policies pertaining to the requirement on 8/23/23 provided by the GoverningBody Chair.

Anin-service meeting was conducted by the Administrator and attended by all staffon 8/29/23 to discuss agency policy 4.13.1 titled "Personnel Records"under Human Resources Section. During this meeting, deficiencies cited underN-0458 were reviewed, addressed and discussed in detail with all staff. TheAdministrator emphasized on the importance that the Home Health agency isrequired to have a copy of current license(s), signed job description(s) and havereceived agency/job specific orientation(s), annual evaluation(s) and nationalcriminal background check for all staff in their personnel records, includingthe staff that will have direct contact with patients. All staff understood andacknowledged the requirement. All active staff or newly hired staff willprovide and the agency will maintain documented evidence of a copy of currentlicense(s), signed job description(s) and have received agency/jobspecific orientation(s), annual evaluation(s) and national criminal backgroundcheck in their Personnel records. The Administrator has also utilized theLicense/Personnel Records tracking system in EMR on 8/27/23 and will enter allcompleted information by 9/20/23.

Theabove mentioned corrective actions were implemented on 7/31/23 and will be completedon 9/20/23.

Measures to assure No recurrence:

In orderto ensure that there is no recurrence of this deficiency, the HR Manager hasmade a process update to tracking all License/Personnel Records in EMR as wellwith Hire date and expiration date and it will alert the staff andAdministrator of any upcoming expiring documents. The HR Manager will also utilizean HR audit tool to ensure that all personnel record contents are current andall personnel files contain evidence of a copy of current license(s), signedjob description(s) and have received agency/job specific

	completed on 3/27/2023, more than 3 weeks after the first patient contact. 3. A review of the employee record for Medical Social Worker (MSW) 1 evidenced a hire date of 3/22/23 and a first patient contact date of 3/25/23. The record failed to evidence a completed criminal background check or a receipt of the job description. 4. A review of the employee record for Occupational Therapist (OT) 5, hire date of 3/19/23 failed to evidence a completed orientation. 5. A review of the employee record for Registered Nurse (RN) 2, date of hire 3/18/23, failed to evidence a criminal background check completed within 3 weeks of the first patient contact. 6. A review of the employee record for Physical Therapist (PT 1), date of hire 8/01/23, failed to evidence a criminal background check within 3 weeks of the first patient contact. 7. A review of the employee record for PTA 3, date of hire,		orientation(s),annual evaluation(s) and national criminal background check. This process ofutilizing EMR's License/Personnel records Tracking system and HR audit toolwill help us identify any discrepancies in the personnel files and enforce allstaff to have their files completed and up to date prior to providing patientcare in the home. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilize EMR'sLicense/Personnel records Tracking system and the HR audit tool and audit 100%of all personnel file records on a monthly basis to ensure that all activepersonnel file records show documented evidence of a copy of currentlicense(s), signed job description(s) and have received agency/jobspecific orientation(s), annual evaluation(s) and national criminal backgroundcheck. The Administrator will review HR Manager's audit findings of all activepersonnel file records. Monthly reports will be generated and results will becompiled and sent to the Administrator to ensure that processes have improved.This process will continue for each month for the next 3 months until 100%compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within the next 3 months, they will continue to beaddressed with staff re-training and re-education in workshops and in-servicesand with each individual personnel as needed. After 3 months, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly HR audit review. Quarterly audits results will be compiled and sentto the QAPI Committee for review. Once threshold is met, the QAPI Committeewill continue to audit 100% of personnel file records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations.	

	9/21/2021, failed to evidence a criminal background check was completed within 3 weeks of the first patient contact. 8. A review of the employee record for office staff 6, whom had access to patients health and identifiable information, hired in 2020, failed to show evidence of a criminal background check, orientation, or an annual job evaluation. 9. A review of the employee record for the Alternate Administrator, with undeclared date of hire, failed to evidence job orientation. 10. A review of the employee record for Office Assistant 5, with access to patient's health and identifiable information, hired in 2022 failed to evidence a criminal background check or orientation. 11. During an interview on 7/12/23 at 4:30 PM, the Administrator relayed they had no employee files and no evidence that a national criminal background check was conducted for the quality assurance staff (Persons C, D, and E), these individuals were		The Administrator will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	administrator further indicated he was not aware if these individuals worked within the united states or were from outside of the united states. 12. During an interview on 7/25/23 at 4:45 PM, the Administrator confirmed they had no other documents to provide for the employee record review.			

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
Muhammad Chaudhry	President	9/29/2023 5:06:11 PM