DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157090	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/21/2023
NAME OF PROVIDER OR SUPPLIER Heritage Home Health Services LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 429 E. VERMONT ST, SUITE 110, INDIANAPOLIS, IN, 46202		

(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: 09-19, 09-20, and 09-21-2023 Current Census: 100 At this Emergency Preparedness survey, Heritage Home Health Services, LLC was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102.	E0000		

	QR by Area 3 on 09-26-2023.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: 09-19, 09-20, and 09-21-2023 Partial Extended Survey Announced 09-19-2023 at 4:47 PM. 12 Month Unduplicated Skilled Admissions: 486 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. QR completed by Area 3 on 09-26-2023.	G0000		

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 agency failed to ensure the patient's clinical record contained a complete list of the patient's current medications, and/or that the physician was promptly notified of any significant potential drug interactions identified, in 2 of 8 active clinical records reviewed. (Patients: #1, and 2) Findings Include: 1. A review of a The LTM Group policy with a revision date May 2023, was provided by the Corporate Compliance staff, Corp 1, on 09-20-2023 at 3:19 PM. The "Medication Profile" policy indicated but was not limited to, "... Medication profiles are updated for each change to reflect current medications, new, and/or discontinued...A drug regimen review will be preformed at the time of admission ... and with	G0536	1.Every start of care packet will include a blank medication profile. This form will be completed at the initial visit and updated with any new or changed medications. 2. The Administrator will randomly check start of care packets x 3 weeks to confirm blank medication profiles have been added. 3. Clinical Supervisor/QA RN will monitor orders with new medications or changes and will call patients after the next visit to confirm changes have been noted on the medication profile in the home folder x 20 days. 4. Clinical Supervisor/QA RN will review all medication profiles when reviewing OASIS to confirm reconciliation was completed and action taken as needed. 5. Education will be provided to all staff to reflect the Above Medication Profiles are completed and updated as needed in home folders by compliance manager on 10/11/2023 6. Education provided to reflect when an outside resource is taking care of medications and documented who and where by compliance manager on 10/11/2023. 1,3& 4 will be completed by Clinical Supervisor/QA RN by 10/21/2023. 2 will be completed by Administrator by 10/21/2023. 5 & 6 will be completed by compliance manager by 10/11/2023.	2023-10-11

	medication...will identify drug/food interactions, potential adverse effects and drug reactions ... the physician will be notified ...” 2. A home visit observation occurred on 09-20-2023 from 10:30 AM to 12:15 PM, at the residence of Patient #1’s. The Registered Nurse (RN), RN 1, was observed to initiate infusion therapy via Patient #1’s port. Patient 1 was observed completing an aerosol treatment via their nebulizer mask while RN 1 was setting up the infusion medication. RN 1 failed to review or ask Patient 1 of any medication changes or updates to Patient #1’s medications. A review of the clinical record of Patient #1 was completed on 09-20-2023, with a start of care date of 05-24-2023. Record review evidenced a document titled, “Patient Medication Record” which was signed by the Former Employee, RN 6 and dated 05-27-2023. The former employee RN 6, failed to evidence the medication			

reconciliation had been completed on admission date 05-24-2023. RN 1 failed to review/ask Patient #1 of any updated medications, failed to have completed an updated medication profile and med reconciliation and notify the physician, failed to have discontinued Tudorza Pressair Inhalation 100 milligrams (mg)/1 puff every 12 hours daily, and failed to add the new aerosol treatment Yupelri 175 micrograms (mcg)/3 milliliters (ml) 1 time daily at noon.

During an interview on 09-20-2023 at 11:10 AM, Patient #1 indicated their physician discontinued their old Tudorza Pressair Inhalation 100 mg)1 puff every 12 hours daily, added the new aerosol treatment Yupelri 175 mcg/3 ml 1 time daily at noon to help with their shortness of breath.

3. During an interview on 09-19-2023 at 3:58 PM, the Clinical Manager, Admin 2, confirmed Patient #1's medication profile and

	completed untimely. They also confirmed medication profiles are to be updated and reviewed with the patients every visit for changes for updates needed. On 09-19-2023 at 12:55 PM, Patient #2's record was reviewed. The clinical record evidenced a document titled "Patient Medication Record" dated 08-16-2023 by Registered Nurse (RN) 2. The document evidenced the medications Diltiazem HCL (sic Hydrochloride) and Metoprolol Succinate. According to WebMD, it indicated the drug interactions between the two medications were serious. The medication record failed to indicate whether the physician was not notified of the severe medication interactions. 410 IAC 17-14-1(a)(1)(B)			
G0564	Discharge or Transfer Summary Content 484.58(b)(1) Standard: Discharge or transfer summary content. The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to	G0564	1. Education will be provided to staff by Compliance Manager to reflect all summaries to be provided to appropriate Medical personnel or facility to ensure compliance with CFR(s): 484.58(b)(1), 2. The Clinical Supervisor/QA RN reviewing all dc and transfer OASIS will fax summaries to the appropriate person and or facility. 3. The Administrator will monitor the above process x10 days on all discharged and transferred patients to confirm compliance.	2023-10-11

	the receiving facility or health care practitioner to ensure the safe and effective transition of care. Based on record review and interview, the agency failed to ensure the physician received a complete transfer and discharge summary inclusive of goals and interventions for 2 of 3 inactive clinical records reviewed. (Patients #9 and 10) Findings Include: 1. On 09-20-2023 at 3:21 PM, the Patient Care Coordinator provided a May 2023 ACHC (Accreditation Commission for Health Care) Home Health policy titled “Discharge Planning, Policy No. 4-009.1”. The policy indicated but was not limited to, “ … 6. The organization will ensure all necessary medical information pertaining to the patient’s current course of treatment, treatment preferences, illness and post-discharge goals of care are sent to the … health care practitioner to ensure a safe and effective transition of care …” 2. On 09-20-2023 at 8:40 AM, Patient #10’s record was reviewed. The clinical record		1 will be completed by compliance manager by 10/11/2023 2 will be completed by Clinical supervisor/QA RN by 10/21/2023 3. will be completed by Administrator by 10/21/2023	

	"Transfer Summary", signed by the Clinical Manager on 05-03-2023. The document evidenced they received Skilled Nursing (SN) services, Occupational Therapy (OT), and Physical Therapy (PT) services from the agency. The summary failed to include goals and interventions. 3. On 09-20-2023 at 9:30 AM, Patient #9's record was reviewed. The clinical record evidenced a document titled "Transfer Summary", signed by the Clinical Manager on 08-08-2023. The document evidenced the patient received SN services from the agency. The summary failed to include goals and interventions. 4. During an interview with the Clinical Manager on 09-21-2023 at 11:33 AM, when queried regarding the contents to be included in the Transfer and Discharge summary, they indicated the summaries were to include goals and interventions.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi)	G0574	1. Education will be provided by Compliance Manager on 10/11/2023 to all staff to educate on CFR(s):484.60(a)(2)(i-xvi). 2. Clinical Supervisor/QA RN will review every	2023-10-11

	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 record review, and interview, the agency failed to ensure the patient's plan of care included all the required elements for 4 of 8 active clinical records reviewed. (Patients: #1, 2, 5 and 6) Findings Include:		Plan of Care to confirm all areas are in compliance with CFR(s):484.60(a)(2)(i-xvi) and complete. Review will be done with OASIS review. 3. Compliance team will review/audit no lass that 5% quarterly to confirm ongoing compliance. 1 will be completed by compliance manager on 10/11/2023. 2 will be completed by clinical supervisor/QA RN by 10/11/2023 and on going. 3 will be completed by compliance team by 10/11/2023 and on going.	

	1. A review of a The LTM Group policy with a revision date May 2023, was provided by the Corporate Compliance staff, Corp 1, on 09-20-2023 at 3:15 PM. The "Care Planning Process" policy indicated but was not limited to, "...the plan of care will include ... C. Reasonable, measurable, and individualized goals and outcomes...G. Equipment and supplies ..." 2. A review of the clinical record for Patient #1 was completed on 09-20-2023, with a start of care date of 05-24-2023. The record contained a plan of care for the recertification period of 07-23-2023 to 09-20-2023, electronically signed by the Clinical Manager, Admin 2, and dated 07-23-2023. The plan of care indicated in the section titled, "Durable Medical Equipment (DME) & Supplies" that the DME and supplies used in the home were a cane, sterile gloves, insertion kit, dressing supplies, grab bars, oxygen, exam gloves, tub/shower bench, sharps container and alcohol pads. During a home visit on 09-20-2023 at 10:30 AM, a			

	Patient #1's residence Patient #1 observed Patient #1 use their pulse oximeter (a fingertip device used to measure oxygen saturation levels in the body) from their table. Patient #1 was observed to complete an aerosol breathing treatment via a nebulizer and mask during the home visit. Review of the plan of care failed to indicate a complete list of the medical equipment and supplies in the home. During an interview on 09-19-2023 at 4:40 PM, the Clinical Manger, Admin 2 confirmed that all DME & supplies should be listed on the plan of care. 2. A review of the clinical record for Patient #5 was completed on 09-19-2023, with a start of care date of 09-14-2023. The record contained a plan of care for the initial certification period of 09-14-2023 to 11-12-2023. The plan of care indicated in the section titled, "DME & Supplies" that the DME and supplies used in the home were a cane, probe covers, dressing supplies, diabetic supplies, exam gloves, walker, alcohol pads, wound care supplies provided by Entity			

	3, a wound care center at an acute care facility. During a phone interview with Patient #5 on 09-21-2023 at 2:13 PM, Patient #5 indicated that they test their blood sugar 1 time a day with their glucometer and administer their own insulin with their insulin pen. Review of the plan of care failed to indicate a complete list of the medical list and supplies in the home. 3. A review of the clinical record for Patient #6 was completed on 09-20-2023, with a start of care date of 09-13-2023. The record contained a plan of care for the initial certification period of 09-13-2023 to 11-11-2023. The plan of care indicated in the section titled, "DME & Supplies" that the DME and supplies used in the home were probe covers, exam gloves, alcohol pads, and an electric scooter. The section titled, "Skilled Nurse Interventions" indicated Patient #6 was to have wound care to their left buttock and to be changed 3 times a week. During a phone interview on 09-20-2023 at 3:47 PM, Patient #6 confirmed the agency nurse			

came 3 times a week to cleanse, pack, and apply a dressing to their wound.

On 09-21-2023 at 12:55 PM, Patient #2's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 06-09-2022 and a certification period from 08-03-2023 to 10-01-2023. The plan of care listed the following diagnoses for Patient #2, Lymphedema (localized swelling in the body), Type 2 Diabetes Mellitus (a disease causing the body to be unable to regulate the blood glucose levels), Hypertension (high blood pressure), Fibromyalgia (a disorder where pain occurs throughout the body), and Spinal stenosis of the lumbar region (a conditions where the spaces in the spine narrow and put pressure on the spinal cord). The patient received Skilled Nursing services 1 time a week for 1 week and 2 times a week for 6 weeks during the certification period. The plan of care failed to evidence patient-centered goals.

410 IAC 17-14-1(a)(1)(D)(ii, xiii)

G0578	Conformance with physician orders 484.60(b) Standard: Conformance with physician or allowed practitioner orders. Based on record review and interview, the agency failed to ensure all orders were followed from the referral source for 1 of 4 active records reviewed without a home visit. (Patient #7) Findings Include: 1. On 09-20-2023 at 12:35 PM, the Corporate staff member in charge of Compliance provided an undated policy titled "Wound Care Procedure and Policy for Clinicians". The policy indicated but was not limited to, " ... Continued/Ongoing Treatment 1. Approved disciplinary team ... will provide wound care per (sic according to) physician orders ..." 2. On 09-20-2023 at 11:20 AM, Patient #7's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 04-21-2023 and a certification period from 08-19-2023 to 10-17-2023. The	G0578	1. Education will be provided to staff by compliance manager including wound care procedure and policy on 10/11/2023. 2. LTM Clinical support will monitor wound documentation, orders and measurementsx 10 days to confirm compliance. Identified education or discipline recommendations will be forwarded to the administrator. 3. Clinical supervisor/QA RN reviewing orders will note any order change for wound care and review the following note to ensure compliance with above x 10 days. 1 will be provided by compliance manager and completed by 10/22/2023 2 will be completed by LTM support staff by 10/21/2023 3 will be completed by Clinical supervisor/QA RN and by completed by 10/21/2023	2023-10-11

	following diagnoses Type 2 Diabetes Mellitus (a disease causing the body to be unable to regulate the blood glucose levels) with a skin ulcer (an open sore), non-pressure chronic ulcer of the right ankle with the fat layer exposed, stage 3 pressure ulcer of the right heel, Diabetic Polyneuropathy (nerve damage in the spine affecting the extremities), Hypertension (high blood pressure), and Chronic Obstructive Pulmonary Disease (COPD, a condition where there was constriction of the airways causing difficulty breathing). The patient was to receive Skilled Nursing (SN) services 3 times a week for 8 weeks and 1 time a week for 1 week for wound care. The plan of care evidenced the following wound care orders, " … SN Interventions … Cleanse wound on right lateral ankle with NS (sic Normal Saline), apply xeroform to wound bed, cover with dry gauze and football dressing, secure with tape and netting, change dressings 3 times a week. …" The clinical record evidenced an order from Patient #7's wound care center, Entity 7, dated			

	order indicated, " ... DO NOT WRAP THE PATIENT'S FEET IN DRESSING OTHER THAN WHAT IS ORDERED. (Sic Patient #7) PRESENTED TO THE WOUND CENTER 0731-2023 WITH EXTREMELY TIGHT DRESSINGS IN PLACE, SOME OF THE LAYERS OF (sic Patient #7's) DRESSING WERE 2ND AND 3RD LAYERS FROM COMPRESSION BANDAGES. WE ARE ORDERING BULKY NON-COMPRESSIVE DRESSINGS, NOT COMPRESSION WRAPS. THE PATIENT HAS COMPROMISED BLOOD FLOW TO (sic Patient #7's) FEET. COMPRESSION WILL ONLY MAKE (sic Patient #7's) WOUNDS WORSE. ..." 3. During an interview with the Administrator and the Clinical Manager on 09-21-2023 at 11:32 AM, they indicated the wound care orders were to be followed as ordered. 4. During an interview with Licensed Practical Nurse (LPN) 1 on 09-21-2023 at 12:10 PM, they indicated they were to follow wound care orders as ordered by the physician.			
G0590	Promptly alert relevant physician of changes	G0590	1. All staff will be educated at meeting by compliance manager on 10/22/2023 on rule	2023-10-11

	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 agency failed to promptly alert the physician of changes in the patient's condition, for 1 of 1 active clinical record reviewed with changes in condition. (Patient: #1) Findings Include: 1. A review of a The LTM Group policy with a revision date May 2023, was provided by the Corporate Compliance staff, Corp 1, on 09-21-2023 at 10:30 AM. The "Reassessment/Recertification" policy indicated but was not limited to, "...A. There is a significant change in condition, care environment and/or support system ... 5. The physician will be notified of any of the above situations ..." 2. A home visit observation occurred on 09-20-2023 at 10:30 AM to 12:15 PM, at the		CFR(s)-484.60(c)(1). 2. Compliance department will audit no less than 5% of active records every quarter and ongoing to monitor for continued compliance. 3. Clinical Supervisor/QA RN will monitor 10 notes x10 days to confirm all changes have been documented as well as who was notified and if any new direction given. 1 and 2 will be done by compliance manager and completed by 10/11/2023 3 will be completed by clinical supervisor/QA RN by 10/21/2023.	

	Registered Nurse (RN) 1, was observed to initiate infusion therapy via Patient #1's upper right chest implanted port (a device that is placed under the skin, to administer intravenous therapy and treatment). Patient #1 was observed having a slumped posture and often hung their head down, used accessory muscles while taking breaths, had continuous thick sounding cough, short of breath when they talked, and had an unsteady gait upon ambulation. Patient #1 used their nasal cannula tubing connected to the oxygen concentrator in their mouth. RN 1 indicated to Patient #1, that their cough sounded worse this visit. A review of the clinical record for Patient #1 was completed on 09-19-2023, with a start of care date of 05-24-2023. The record evidenced a plan of care for the recertification period of 07-23-2023 to 09-20-2023. The plan of care indicated the patient's primary diagnosis was Alpha-1- Antitrypsin deficiency (a genetic condition that causes lung and liver disease) and the secondary diagnosis of Centrilobular Emphysema (chronic lung disease affecting			

	the upper lobes), additional diagnoses included Panlobular Emphysema (chronic lung disease affecting the lobes of the lungs), Anxiety Disorder, and Dependence on Supplemental Oxygen. During an interview on 09-20-2023 at 10:45 AM, Patient #1 indicated they needed more assistance with legal, financial, and community assistance. RN 1 indicated they would make the Clinical Manager aware. When queried about changes in patient condition and increased needs confirmed they reported to the Clinical Manager, Admin 2. 3. During an interview on 07-20-2023 at 4:10 PM, the Clinical Manager, Admin 2, confirmed that RN #1 did not notify them of Patient #1's change in condition, or need for a MSW for community assistance. Admin 2 further confirmed RN 1 did not notify the physician of the change in condition. 410 IAC 17-13-1(a) (2)			
G0608	Coordinate care delivery	G0608	1.Education regarding coordination of services will be provided by compliance manager	2023-10-11

	484.60(d)(4) 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 record review, and interview the agency failed to ensure the patient clinical records included information about the services the patient receives by other agencies and failed to ensure they coordinated care delivery to meet the patent's needs for 4 of 4 active patients receiving other agency services records reviewed. (Patients: #1, 4, 6, and 7) Findings Include: 1. A review of a The LTM Group policy with a revision date May 2023, was provided by the Patient Care Coordinator, Admin 4, on 09-21-2023 at 10:32 AM. The "Coordination Of Services With Other Providers" policy indicated but was not limited to, "... To ensure the coordination of services provided by the organization and by other service providers...other service providers will be documented in the clinical record..." During the Entrance Conference		during 10/11/2023 meeting. 2.Clinical Supervisor/QA RN will review coordination of care summaries in 10 charts x 10 days to monitor that coordination of care is in place and policy followed. 1 will be completed by compliance manager by 10/11/2023 2 will be completed by clinical supervisor/qa rn by 10/21/2023	

on 07-19-2023 at 9:05 AM, the Administrator confirmed the agency shares patients with other providers. The Administrator further indicated that care is coordinated and documented in the communication notes in the patient’s clinical record.

2. A review of the clinical record for Patient #1 was completed on 09-20-2023. The record contained a document titled, “Nursing Services Coordination Form” from Entity 1, an infusion company. The Entity 1 ‘s form had a section for the agency signature and date which was left blank.

A review of the communication notes dated 05-24-2023 to 09-20-2023 failed to evidence documentation of coordination of care with Entity 1, the infusion company.

During a home visit on 09-20-2023 at 10:30 AM, Patient #1 confirmed they received all their infusion supplies and medication from Entity 1.

3. A review of the clinical record for Patient #4 was completed on 09-19-2023. The record

	"Patient Information." The patient information document indicated Patient #4's residence was at Entity 4, an assisted living facility. A review of the communication notes dated 05-19-2023 to 09-19-2023 failed to evidence documentation of coordination of care with Entity 4. A call was placed to Patient #4 for an interview on 09-19-2023 at 1:40 PM, no return call. 4. A review of the clinical records for Patient #6 was completed 09-20-2023. The clinical record contained a document titled, "Referral Form" from Entity 3, the acute care facility's wound care center. The referral form indicated skilled wound care orders for Patient #6 for their left buttock to clean with wound cleanser, pat dry, place algidex wick in tunneled area of wound cover with a 2x2 gauze and mepilix border dressing 3 times a week.			

A review of the communication notes dated 09-13-2023 to 09-20-2023 failed to evidence documentation of coordination of care with Entity 2 and Entity 3.

During a phone interview on 09-20-2023 at 3:47 PM, Patient #6 confirmed they go to Entity 2, an acute care facility's dialysis center, for dialysis treatments, every Monday, Wednesday, and Friday. Patient #6 further confirmed they go to Entity 3, an acute care facility 's wound center for wound assessments, and they provide wound care supplies.

On 09-20-2023 at 11:20 AM, Patient #7's clinical record was reviewed. The clinical record evidenced wound care orders from Entity 7 and indicated the patient received wound care treatment from the entity as well. The clinical record failed to evidence coordination of care from the agency to Entity 7 regarding Patient #7's wounds.

During an interview with the Clinical Manager on 09-21-2023 at 11:32 AM, they indicated there was no coordination of care to the other providers the

	patient saw from the agency. 410 IAC 17-14-1(a)(1)(F)			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on record review, and interview, the agency failed to ensure it prepared and/or provided all patients with an up-to-date written medication schedule, for 4 of 4 home visits observed. (Patients: #1, 2, 3, and 11) Findings Include: 1. A review of a The LTM Group policy with a revision date May 2023, was provided by the Corporate Compliance staff, Corp 1, on 09-20-2023 at 3:19 PM. The “Medication Profile” policy indicated but was not limited to, “...4. Each patient will receive appropriate written material for specific medications he/she is receiving...” 2. A home visit observation occurred on 09-20-2023 at	G0616	SEE Plan of Correction for tag G0536 1. education will be provided by compliance manager to reflect Medication Profile policy, Reconciliation, Interventions on 10/11/2023. Appropriate staff and medical providers will be notified as warranted. 2. Clinical Supervisor/QA RN will review all interactions during OASIS review and confirm Dr. was notified and reconciliation was completed. 1 will be completed by compliance manager on 10/11/2023 2 will be completed by clinical supervisor/qa rn by 10/21/2023	2023-10-11

residence of Patient #1. The Registered Nurse (RN), RN 1, was observed setting up the intravenous medications for Patient #1's infusion. RN 1 indicated they had left their tablet in their vehicle with the medication list and questions to ask Patient #1.

During an interview on 09-20-2023 at 11:10 AM, Patient #1 confirmed they did receive a written medication list.

3. A home visit observation occurred on 09-20-2023 at 12:26 PM, at the residence of Patient #11. The Physical Therapist (PT), PT 1, was observed completing strengthening exercises with Patient #11. A review of Patient #11's agency folder evidenced a blank medication list.

During an interview on 09-20-2023 at 12:26 PM, Patient #11 confirmed everything they received from the agency was in the agency folder.

On 09-20-2023 at 2:33 PM, a home visit observation was conducted at Patient #2's residence. The patient's admission packet failed to

	medications. The admission packet evidenced a medication list last reviewed on 02-02-2023. On 09-20-2023 at 4:06 PM, a home visit observation was conducted at Patient #3's residence. The Skilled Nurse (SN) requested the medication list for the patient from Person 8, Patient #3's spouse, and they indicated they had not received a medication list for the patient. The admission packet failed to evidence a current medication list for the patient. During an interview with the Administrator and the Clinical Manager on 09-21-2023 at 11:32 AM, they indicated the medication lists in the home were to reflect the current medications the patients were taking, any changes to medications, and written in layman's terms.			
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard	G0682	1. Education will be provided by compliance manager to all staff to ensure compliance with CFR(s):484.70(a) 2. Competency training will be provided on hire and annually to be discipline specific. To include infection, control, hand hygiene, bag technique and IV preparation for administration by HR and Education staff. 3. HR will monitor all competencies are	2023-10-11

	precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure the Registered Nurse (RN) practiced proper hand hygiene, gloving, infection control practices, and bag technique while providing intravenous therapy to a patient in 1 of 1 patient observed receiving intravenous therapy by the agency. (Patient #1) Findings Include: 1. A review of a The LTM Group policy with a revision date May 2023, was provided by the Corporate Compliance staff, Corp 1, on 09-20-2023 at 3:18 PM. The "Hand Hygiene" policy indicated but was not limited to, "Purpose: To prevent cross-contamination and home care-acquired infections ... Hand decontamination using an alcohol-based hand rub should be performed: A. Before having direct contact with patients. B. Before donning sterile gloves ... C. After contact with a patient's intact skin ..." 2. A review of a The LTM Group policy with a revision date May 2023, was provided by the Corporate Compliance staff, Corp 1, on 09-20-2023 at 3:15 PM. The "Bag Technique" policy		completed, signed and dated with all new hires and annually. HR will notify Administration of any staff out of compliance. 1 will be completed by compliance manager by 10/11/2023 2 & 3 will be completed by HR by 10/11/2023 and be on going. 4 HR will review all active field staff employee charts to confirm competencies, TB, Job descriptions present signed and dated. This will be completed in 10 days. 4 will be completed by HR by 10/21/2023	

indicated but was not limited to, "... personnel will consistently implement principles to maximize efficient use of the patient care supply bag when used in caring for patients ..."

3. A home visit observation occurred on 09-20-2023 at 10:30 AM to 12:15 PM, at the residence of Patient #1. The Registered Nurse (RN) 1, was observed setting up Patient #1's infusion therapy. RN 1 obtained infusion supplies, the medication vials, infusion bag, tubing, port needle and tubing, dressings, a 50 cubic centimeter (cc) syringe with 4 needles and place them on the kitchen counter. The RN failed to place a barrier under the supplies, failed to perform hand hygiene, and failed to don gloves. The RN then withdrew the medicine from 1 vial with the 50 cc syringe and inserted the needle into the intravenous (iv) bag and failed to cleanse the iv bag port of entry prior to insertion with an alcohol pad. The RN completed the same process with the 4 vials of medication administration into the iv bag. RN #1 failed to don gloves, failed to cleanse the iv-bag port with an alcohol swab prior to

	inserting the needle of the syringe. The RN was then observed to obtain vital signs. The RN dropped their stethoscope on the floor cleansed the tubing but failed to cleanse the bell prior to using it on the Patient #1's chest. RN #1 then put their blood pressure cuff, thermometer, stethoscope, and pulse oximeter back in their bag. The RN failed to clean their equipment prior to placing the equipment back in their bag. RN #1 was observed to cleanse Patient #1's implanted port on their right upper chest. RN #1 cleansed they out skin around the port site then cleansed the port site. The RN failed to use a new swab to cleanse the port site. RN 1 grabbed the iv pole from behind Patient #1then hung the iv bag and inserting spike from the iv tubing. RN 1 failed to complete hand hygiene and don new gloves after they obtained the iv pole.			

	During an interview on 09-20-2023 at 12:15 PM, when queried RN regarding infection control indicated they had forgotten to clean the iv bag port prior to inserting the needle into the iv bag. A review of the employee file for RN 1, on 09-21-2023, contained a document titled, “Learning Center Report” indicated RN 1 completed basic training on home care rules and regulations on 08-29-2023. 4. During an interview on 09-20-2023 at 4:10 PM, the Clinical Manger, confirmed a barrier should have been placed under the supplies, gloves should have been worn setting up the medicine for infusion, hand hygiene is to be performed after touching items and patients, and the iv bag port should have been cleaned prior to insertion of the needle from the syringe of medicine.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes;	G0716	SEE PLAN OF CORRECTION FOR TAG G0578 1. Education will be provided to all staff by compliance manager regarding would care orders, interventions, goals, measurements and documentation on 10/11/2023.	2023-10-11

	Based on record review and interview the agency failed to ensure wound care interventions were documented in skilled visit notes for 2 of 3 active clinical records reviewed with orders for wound care. (Patients #2 and 7) Findings Include: 1. On 09-20-2023 at 12:35 PM, the Corporate Staff member in charge of Compliance provided an undated policy titled "Wound Care Procedure and Policy for Clinicians". The policy indicated but was not limited to, " ... Continued/Ongoing Treatment ... 2. At each visit the patient's skin will be assessed. At each dressing change the wound will be assessed and documentation will include a description of the wound bed, drainage, signs and symptoms of infection, healing and peri wound skin condition. ..." 2. On 09-21-2023 at 12:55 PM, Patient #2's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 06-09-2022 and a certification period from 08-03-2023 to 10-01-2023. The		2. LTM Clinical support will monitor 10 wound visits in 10 days to ensure compliance with CFR(s): 484.75(b)(6). 1 will be completed by compliance manager by 10/11/2023 2 will be completed by LTM clinical support by 10/21/2023	

diagnoses for Patient #2, Lymphedema (localized swelling in the body), Type 2 Diabetes Mellitus (a disease causing the body to be unable to regulate the blood glucose levels), Hypertension (high blood pressure), Fibromyalgia (a disorder where pain occurs throughout the body), and Spinal stenosis of the lumbar region (a conditions where the spaces in the spine narrow and put pressure on the spinal cord). The patient received Skilled Nursing (SN) services 1 time a week for 1 week and 2 times a week for 6 weeks during the certification period The plan of care evidenced orders for the patient's Lymphedema diagnosis. The orders indicated the Bilateral Lower Extremities were to be cleaned with soap and water, patted dry, skin moisturizer applied, and wrapped with Circaid (sic a compression wrap) wraps 2 times a week.

The clinical record of Patient #2 evidenced documents titled "Skilled Nurse Visit". The SN visit notes dated 08-21-2023, 09-04-2023, and 09-11-2023 by Licensed Practical Nurse (LPN) 2 indicated in the section titled

	"Skin", the comments evidenced "wraps applied". The visit notes failed to evidence the Bilateral Lower Extremities were cleansed with soap and water and skin moisturizer was applied. The SN visit notes for Patient #2 dated 09-04-2023 and 09-11-2023 failed to evidence a wound assessment was performed by LPN 2 on the patient's Bilateral Lower Extremities During an interview with LPN 2 on 09-21-2023 at 2:37 PM, they indicated they clean, dry, and wrap Patient #2's legs and document the interventions performed for every visit. 3. On 09-20-2023 at 11:20 AM, Patient #7's clinical record was reviewed. The clinical record evidenced a plan of care with a start of care date of 04-21-2023 and a certification period from 08-19-2023 to 10-17-2023. The plan of care evidenced the following diagnoses Type 2 Diabetes Mellitus (a disease causing the body to be unable to regulate the blood glucose levels) with a skin ulcer (an open sore), non-pressure chronic ulcer of the right ankle with the			

fat layer exposed, stage 3 pressure ulcer of the right heel, Diabetic Polyneuropathy (nerve damage in the spine affecting the extremities), Hypertension (high blood pressure), and Chronic Obstructive Pulmonary Disease (COPD, a condition where there was constriction of the airways causing difficulty breathing). The patient was to receive Skilled Nursing (SN) services 3 times a week for 8 weeks and 1 time a week for 1 week for wound care. The plan of care evidenced the following wound care orders, " ... SN Interventions ... Cleanse wound on right lateral ankle with NS (sic Normal Saline), apply xeroform to wound bed, cover with dry gauze and football dressing, secure with tape and netting, change dressings 3 times a week. ..."

The clinical record for Patient #7 evidenced SN visit notes, by LPN 1, dated 08-21-2023, 08-23-2023, 08-29-2023, and 08-31-2023 failed to evidence a wound assessment was performed.

The SN visit note for Patient #7 dated 09-13-2023 by LPN 2 evidenced the right ankle

	wound, right lateral foot, and left lateral malleolus were open, and failed to evidence a wound description including any signs and symptoms of infection, drainage, and any pain associated with the wounds. The SN visit note for Patient #7 dated 09-14-2023 by LPN 2 evidenced the intergluteal cleft was open and failed to evidence a wound description including any signs and symptoms of infection, drainage, and any pain associated with the wound. During an interview with LPN 2 on 09-21-2023 at 12:10 PM, they indicated they were to follow wound care orders as ordered, document the assessment and descriptions, and include measurements and pictures every 2 weeks. LPN 2 indicated they were to document all interventions performed for Patient #7 in the visit notes. 4. During an interview on 09-21-2023 at 11:32 AM, the Administrator and Clinical Manager indicated wound care orders were to be performed and documented as often as the order called for them. The			

	Administrator indicated all interventions performed were to be documented in the assessment. 410 IAC 17-14-1(a)(2)(B)			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on observation, record review, and interview, the agency failed to ensure the after-hours-on-call number was operating and available to the public, patients, and employees as noted after 2 of 2 unsuccessful attempts to reach the after-hours phone number. Findings Include: 1. On 09-21-2023 at 11:18 AM, the Patient Care Coordinator provided an April 2017 Joint Commisssion Home Health policy titled "On-call/Weekend Staffing". The policy indicated but was not limited to, " ... Policy ... There will be on-call staff available after office hours Monday through Friday, and 24 hours a day on weekends and	G0948	1. On Call/after hours answering system (RE-Lite) has been adjusted to randomly do electronic monitoring by calling and confirming calls are going through, calls are returned in timely manner and all calls addressed as needed. This started on 10/4/2023 and will be ongoing. The LTM support staff will be notified of any issues immediately. 2. Compliance Manager will make random calls to after hours # x 10 days to confirm calls are being answered and or returned timely. 1 has been completed by RElite and compliance manager on 10/4/2023 2 will be completed by compliance manager on 1021023	2023-10-04

	holidays ... Procedure ... " Clinical staff must respond to a page within 15 minutes ..." 2. On 09-19-2023 at 7:35 PM, an attempt to call the after-hours-on-call phone was made. A voicemail was left on the answering machine requesting a return call. The on-call number was listed in the admission packet as the office phone number. The agency failed to answer the on-call phone. 3. On 09-20-2023 at 7:07 PM, an attempt to call the after-hours-on-call phone was made. A voicemail was left on the answering machine requesting a return call. The agency failed to answer the on-call phone. 4. During an interview with the Administrator and Clinical Manager on 09-21-2023 at 11:32 AM, they indicated the office phone number was also the after-hours-on-call number. The Administrator indicated the call was to be transferred to one of their phones (the Administrator and Clinical Manager), and the			

	"pinged" when a call was made. The Administrator indicated they had not received a phone call on 09-19-2023 and 09-20-2023. The Administrator indicated they had updated their on-call system recently. 410 IAC 17-12-1 (c)(1)			
G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on observation, record review, and interview, the agency failed to ensure that all Nurses appropriately and accurately assessed their patients according to professional standards for 1 of 2 nurse home visits completed. (Patient #1) Findings include 1. A review of a The LTM Group policy with a revision date May 2023, was provided by the Corporate Compliance staff, Corp 1, on 09-20-2023 at 3:18 PM. The "Ongoing Assessments" policy indicated but was not limited to, "...Using	G0984	1.Education will be provided to all staff related to standards of practice with lung inspection and assessment. 2.Clinical supervisor/QA RN will monitor documentation of assessments on 10 notes in 10 days to confirm compliance. 1 will be completed by compliance manager by 10/11/2023. 2 will be completed by clinical supervisor/QA RN by 10/21/2023	2023-10-11

	clinician will reassess the patient for: ... D. breath sounds. E. skin integrity ...” 2. Constantine, L., MSN, RN, C-FNP. (2004, June 15). Overview of Nursing Health Assessment. Retrieved January 16, 2019, from rn.com " ... PULMONARY ASSESSMENT: When examining the pulmonary system ... Inspect the thoracic cage, palpate the thoracic cage, Auscultate the anterior and posterior chest: Have patient breath slightly deeper than normal through their mouth, Auscultate from C-7 to approximately T-8, in a left to right comparative sequence. You should auscultate between every rib ... Identify any adventitious breath sounds ... " 3. Nurse.org, dated April 7, 2020, indicated: "How to Conduct a Head-to-Toe Assessment: ... LENGTH OF ASSESSMENT ... the duration of the exam is directly in correlation to the patient's overall health status. Health patients with limited health histories may be completed in less than 30 minutes” The Order			

of a Head-to-Toe Assessment:
1. GENERAL STATUS: Vital signs; ... Temperature; ... Pain.
2. HEAD, EARS, EYES, NOSE, THROAT ... 3. NECK ... 4. RESPIRATORY: Listen to lung sounds front and back; Assess respiratory expansion level; Ask about coughing; Palpate thorax.
5. CARDIAC: Palpate the carotid and temporal pulses bilaterally; Listen to heartbeat. 6. ABDOMEN: ... Ask about problems with bowel or bladder. 7. PULSES: Check pulses in arms/legs/feet including, Radial, Femora, Posterior tibial, Dorsalis pedis.
8. EXTREMITIES: ... Check capillary refill on fingernails/toenails. 9. SKIN: Check skin turgor; Check for lesions, abrasions, rashes; Check for tenderness, lumps, lesions; Check if patient is pale, clammy, dry, cold, hot, flushed. 10. NEUROLOGICAL: Oriented x3; Assess gait; Check coordination; Assess reflexes; Check Glasgow Coma Scale."

4. A home visit observation occurred on 09-20-2023 at 10:30 AM to 12:15 PM, at the

	Registered Nurse (RN) 1, was observed completing an assessment on Patient #1. The RN was observed to auscultate posterior lung sounds in four fields, then placed the bell of the stethoscope to auscultate the apical heart. RN 1 failed to reassess the anterior lung fields. During an interview on 09-20-2023 at 4:10 PM, the Clinical Manager, indicated confirmed the skilled nurses are to do a head-to-toe assessment and listen to all fields of the lungs during an assessment of their patients.			
N0000	Initial Comments This visit was for a State Re-licensure survey of a Home Health Agency. Survey Dates: 09-19-2023, 09-20-2023, and 09-21-2023 Census: 486	N0000		

	Unduplicated Skilled Admissions: 100 QR completed by Area 3 on 09/26/2023.			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the agency failed to ensure the Clinical Manager's nursing license was verified before they started seeing patients for 1 of 1 Clinical	N0458	1.All HR Education/Orientation/New Hire documents noted in Policy No 1-022.01 will be completed via electronic system before patient care can be performed by the clinicians. All documents will be signed and dated once completed. The employee supervisor will confirm completion, signature and date. The supervisor will sign off and date after confirmation. Scheduling will not be able to staff any case with any clinician that has not had confirmation from their supervisor. 2.All HR current records are being reviewed to confirm above has been done by current staff and will be completed by 10/2/12023. 3.All staff will be trained on the electronic HR orientation/education system to enable confirmation from above in completed, signed and dated. Education is being provided by Compliance Manager on 10/11/2023 1. & 2. completed by Clinician Supervisor and HR 3. Completed by Compliance Manager.	2023-10-21

Manager, failed to ensure the employee records included all dated in-service, orientation, and job description information for 5 of 5 active employee files reviewed who provided care for patients (Clinical Manager, Registered Nurse (RN) 1, RN 3, Licensed Practical Nurse (LPN) 1, and Occupational Therapist (OT) 1).

Findings Include:

1. On 09-21-2023 at 2:46 PM, the Corporate staff member in charge of Compliance provided a May 2022 ACHC (Accreditation Commission of Home Care) policy titled “Orientation”. The policy indicated but was not limited to, “ … Procedure … C. Job related responsibilities (job description) … F. Infection prevention and control within the organization … G. Performance Standards … 5. Orientation of new and reassigned personnel may include verbal or written instructions …”

2. On 09-21-2023 at 12:18 PM, the employee records were reviewed. The employee file for the Clinical Manager evidenced

verifying the Clinical Manager’s license was verified before they saw patients. The Human Resources Director evidenced on 09-21-2023 at 1:59 PM, the Clinical Manager’s license was verified on 10-22-2022. The employee record of the Clinical Manager evidenced their first patient contact date was 04-16-2022. The record failed to evidence the Clinical Manager’s license was verified before their first patient contact date. The record failed to evidence a signed and dated job description for the Clinical Manager. The record failed to evidence their orientation checklist, in-service training, and annual evaluations.

3. On 09-21-2023 at 12:18 PM, the employee records were reviewed. The employee records for OT 1 and RN 3 failed to evidence a signed and dated job description, orientation checklist, and in-service training.

4. On 09-21-2023 at 12:18 PM, the employee records were reviewed. The employee records for RN 1 and LPN 1 failed to evidence a signed and dated

orientation checklist.

5. During an interview with the Administrator and Clinical Manager on 09-21-2023 at 2:25 PM, the Administrator indicated the electronic medical record system was used for the clinician's orientation checklist and in-service training. They indicated once the clinician completed the tasks a completion was sent to the clinician through email. The Administrator indicated they did not have the orientation checklist and in-service information for the requested clinicians. The Clinical Manager indicated they had their in-service training, orientation checklist, and annual evaluation at their branch office and was unable to provide it by the end of the survey. The Administrator indicated the missing job descriptions were because the clinicians took them home and never returned them. The Administrator indicated dates were not included because they switched human resource systems and were told to just sign the job descriptions and they lost their original documents.

N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was	N0464	1.All new Hires will be advised at time of job offer that we will need a copy of a negative TB test within the last 12 months. If one is not provided the employee will be required to do a 2 step TB test. Day1 of orientation- TB test given, Day 4 Site will be assessed and documented. if applicable for 2 step Day 8 second TB test given, Day 11 site will be assessed and documented. 2.Clinical Supervisor/QA RN will notify and proved results to Hr. Clinician can then see patients. If employee has had or has a positive result a chest x ray will be required with a negative result prior to any patient care. 3. All staff educated on the above during meeting by Compliance Manager on 10/11/2023. 4. HR will notify clinicians of annual TB requirements. Failure to follow requirements will be reported to Administrator by HR. 1.,& 4 will be completed by HR. 2 will be completed by Clinical Supervisor/QA RN 3 will be completed by Compliance Manager	2023-10-11

subject to subdivision (3).

(5) Any person having a positive finding on a tuberculosis evaluation may not:

(A) work in the home health agency; or

(B) provide direct patient contact;

unless approved by a physician to work.

(6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person:

(A) working for the home health agency; or

(B) having direct patient contact;

has had a negative finding on a tuberculosis examination within the previous twelve (12) months.

Based on record review and interview, the agency failed to ensure the field employees received a 2 step Tuberculosis test for 4 of 5 active employee records reviewed. (Clinical Manager, Registered Nurse (RN) 1, Licensed Practical Nurse (LPN) 1, and Occupational Therapist (OT) 1)

Findings Include:

1. On 09-21-2023 at 2:46 PM, the Corporate staff member in charge of Compliance provided a document titled “Tuberculosis Prevention” developed by the Indiana Department of Health. The Corporate staff member

	their policy. The policy indicated but was not limited to, " ... 1. Any person with a negative history of tuberculosis ... must have a baseline two-step tuberculin skin test ... 2. The second step of a two-step tuberculin skin test ... must be administered one (1) to (3) weeks after the first tuberculin skin test ..." 2. On 09-21-2023 at 12:18 PM, the employee records were reviewed. The Clinical Manager, RN 1, LPN 1, and OT 1's employee records failed to evidence they received a 2nd step skin test before first patient contact. During an interview on 09-21-2023 at 2:25 PM, the Administrator indicated they misunderstood how the 2nd step Tuberculosis skin test worked and did not have the 2nd step for the requested clinicians. The agency failed to follow their policy for the 2 step Tuberculosis skin test.			
N0518	Patient Rights 410 IAC 17-12-3(e)	N0518	1.All staff will be educated by Compliance Manager on Advance Directive requirements at meeting on 10/22/2023. 2.All start of care packets will be compliant with rule 12 sec 3 (e). Advance Directives will be placed in every start of care packet and	2023-10-11

Rule 12 Sec. 3(e)

(e) The home health agency must inform and distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law. The home health agency may furnish advanced directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

Based on record review and interview, the agency failed to ensure their admission packets contained the most up-to-date Advance Directive information for 1 of 1 agency.

Findings Include:

1. On 09-20-23 at 3:20 PM, the Corporate Staff member in charge of Compliance provided a May 2022 ACHC (Accreditation Commission for Health Care) policy titled, “Advance Directives”. The policy indicated but was not limited to, “ ... Procedure 1. Upon admission, the clinician will provide information, orally and in writing, regarding a patient’s right to make decisions concerning health care ... the right to execute Advance Directives, and applicable organization policies. Written information ... will be provided

reviewed with patient/caregiver at start of care.

3. Administrator will randomly pull a start of care packet in the next 20 days (no less than 10) to confirm Advance Directives are present in the start of care packets.

4.Clinical Supervisor/QA/RN will call no less than 10 ew start of care patient's in 20 days to confirm Advance Directive was reviewed and a copy left in the Home folder.

1 will be completed by Compliance Manager on 10/11/2023.

2 & 4 will be completed by Clinical Supervisor/QA RN by 10/21/2023.

3. will be completed by Administrator by 10/21/2023

to the adult patient. …"

2. On 09-19-2023 at 10:24 AM, the Admission packet was reviewed. The agency's admission packet evidenced an undated document titled "Advance Directives". The document failed to evidence all the information included in the agency's current policy was provided to the patients.

3. On 09-20-2023 at 11:30 AM, a home visit observation was conducted at Patient #11's residence. The patient's admission packet failed to evidence the agency's Advance Directive policy.

4. On 09-20-2023 at 2:33 PM, a home visit observation was conducted at Patient #2's residence. The patient's admission packet failed to evidence the agency's Advance Directive policy.

5. On 09-20-2023 at 4:06 PM, a home visit observation was conducted at Patient #3's residence. The patient's admission packet failed to evidence the agency's Advance Directive policy.

6. During and interview with the

	Administrator and Clinical Manager on 09-21-2023 at 11:32 AM, when queried regarding the Advance Directives policy, they indicated they had not put the policy in the admission packets for the patients.			

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
TAMMY TURNMIRE	COMPLIANCE MANAGER	10/5/2023 5:30:56 PM