STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K124	A. BUILDING B. WING	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AM HOME HEALTH CARE	2420 N COLISEUM BLVD STE 100, FORT WAYNE, IN, 46805

(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: 7/1, 7/2, 7/3,7/5/. and 7/8/2024 Active Census: 78 At this Emergency Preparedness survey, AM Home Health Care was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102	E0000		
G0000	INITIAL COMMENTS This visit was for a Federal	G0000		

	Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: July 1, 2, 3, 5, 8, 2024 12-Month Unduplicated Skilled Admissions: 28 Survey was announced as fully extended on 7/02/24 at 4:08 PM. During this Federal Recertification Survey, AM Home Health Care was found to be out of compliance with Conditions of Participation §484.60 Condition of participation: Care planning, coordination of services, and quality of care. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Based on the Condition-level deficiencies during the 7/08/24 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 7/02/24. Therefore, and pursuant to			

	section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency and/or competency evaluation program for a period of two years beginning July 08, 2024 and continuing through July 07, 2026.			
G0416	OASIS privacy notice 484.50(a)(1)(iii) (iii) An OASIS privacy notice to all patients for whom the OASIS data is collected. 416 OASIS Privacy Based on record review and interview, the agency failed to provide patients with the OASIS privacy notice for 1 of 1 agency surveyed. Findings include: A review of the patient admission packet on 7/5/2024 failed to include an OASIS privacy notice. During an interview on 7/5/2024 at 12:45 PM, the Administrator indicated they used to put the OASIS privacy notice in the patient admission folder, but it was missing from	G0416	1 The majority of the OASIS privacy notice was present in all patient records, however was missing a page. The agency will print alist of all current patients and then provide an OASIS privacy notice (all pages) to allwho require an OASIS assessment by August 6, 2024. The staff will notify the Clinical Manager after theyhave provided the OASIS privacy notice to a patient so that the patient can bechecked off the list. 2 To prevent this fromrecurring in the future, the agency will place an OASIS privacy notice in alladmission packets. The Clinical Manager will audit 10% of patient folders in the home to determine if agencyremains in compliance with providing OASIS privacy notices. If the agency isnot in	2024-08-06

	the packet.		compliance with the10% audit, then the agency will need to audit 100% of all client charts by theend of that month and monthly thereafter until the agency is at 100%compliance. The RN's who performed the SOC for the patient who did not have theOASIS privacy notice will undergo additional education by the end of the monthwhen noncompliance was noted. This education will be placed in the RN'spersonnel file. 3 The Clinical Manager will beresponsible for ensuring the above measures have been met. 4 All patients who have hadan OASIS assessment completed by AM Home Health Care will have an OASIS PrivacyNotice provided to them by August 6th, 2024.	
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	G0536	1 The agency RN's willcomplete medication reconciliation for 100% of all current patients. Thephysician or provider's office will be contacted for each patient andreconciliation of medications will occur. The RN will make sure that all	2024-08-06

	with drug therapy. Based on record review and interview, the home health agency failed to ensure an accurate review of all medications for 1 of 3 patients reviewed with home visit observations (Patient #3). Findings include: 1. A review of Patient #3's clinical record evidenced a start of care (SOC) on 5/09/24 and included a POC and medication profile for the certification period 5/09/24 to 7/07/24. The POC medication profile evidenced the following medications: a) Ibuprofen Oral Suspension 100 milligrams/5 milliliters (mg/ml), 10 ml every 6 hours as needed. The medication profile failed to include an indication for use. b) Magnesium Citrate 1.475 gram (g)/30 ml oral liquid, 150 ml daily as needed. The medication profile failed to include an indication for use. c) Polyethylene Glycol 17 g daily as needed. The medication profile failed to include an indication for use.		PRNmedications have an indication for use listed. The agency will also provide education to 100% of RN's regardingthe agency's policy for medication reconciliation. The agency will place proofof this education in all employee personnel files. 2 The agency will preventthis from recurring in the future by providing education to all new staffduring onboarding regarding medication reconciliation policy. The agency willprovide an annual in-service to all staff regarding the agency's medication reconciliationpolicy. Documentation for this education will be kept in the staff's personnelfile. The agency will also complete a 100% compliance audit on allSOC's, ROC's, and Recertifications going forward to ensure that medicationreconciliation was completed per the agency medication reconciliation policy. 3 The Clinical Manager willbe responsible for ensuring that the above medication reconciliations have	

	d) Pseudoeph-Bromphen-Cod 30-2-7.5 mg/ml, 10 ml three times a day as needed. The medication profile failed to include an indication for use. 2. During a home visit observation conducted with Patient #3 and RN 5 on 7/03/24 beginning at 10:51 AM, RN 5 failed to reconcile medications at the comprehensive assessment recertification observation visit. 3. During an interview on 7/03/24 beginning at 11:20 AM, RN 5 relayed they reconcile medication at every visit. 4. During an interview on 7/03/24 beginning at 1:51 PM, the Clinical Manager relayed medications should be reconciled at every visit. 5. During an interview on 7/03/24 beginning at 2:01 PM with the Alternate Clinical Manager and Administrator, the Administrator relayed the POC medication list had not been fully signed-off and has been in-process since SOC on 5/09/24. 410 IAC 17-14-1(a)(1)(B)		beencompleted for all current patients and that medication reconciliations auditswill be completed on all future SOC's, ROC's, and Recertifications. 4 The medicationreconciliations for all patients will be completed by August 6, 2024. The education for all staff regarding the agency medicationreconciliation policy will be completed with 100% of current staff by July 23,2024.	

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 include accurate visit frequency orders on the plan of care (POC) (See G574); failed to ensure services were provided only as ordered by a physician or allowed practitioner (See G580); failed to ensure the POC was reviewed with the physician at start of care (SOC) and/or at recertification (See G588) and failed to notify the physician regarding changes and need to	G0570	1 The agencywill audit 100% of all current patient charts. The charts will be reviewed todetermine if the patient care plans are individualized and are specific toneeds identified in the patient's comprehensive assessment. The ordereddisciplines and their measurable anticipated outcomes will be reviewed. Thecharts will be audited for documentation of coordination of care betweendisciplines and implementation of the plan of care. The audit will also includedetermination of specific education and training needs for patient andcaregivers and if they are listed in the plan of care. Any corrections neededwill be made and any new orders will be obtained through the patient'sphysicians. The agency will also provide in-service education toall RN's regarding the importance of the plan of care. Education will coverindividualization of the care plans, the need to order appropriate disciplines,documentation of coordination of care between	2024-08-06

	alter the POC (See G590). The cumulative effect of these systemic problems had the potential to impact all 78 active patients which resulted in the agency being found out of compliance with the Condition of Participation 42 CFR 484.60 Care Planning, Coordination of Services and Quality of Care.		disciplines, and educationalneeds for patient and caregiver. Documentation for this education will be kept in the staff's personnelfile. 2 The agencywill prevent this from recurring in the future by providing education to allnew staff during onboarding regarding care plan creation. Documentation forthis education will be kept in the staff's personnel file. The agency will also complete a 100% compliance auditon all SOC's, ROC's, and Recertifications going forward to ensure that careplans for each patient meet the needs specified in the comprehensive assessmentand that they are individualized. 3 TheClinical Manager will be responsible for ensuring that the above audits oncurrent care plans will be completed and that 100% of all care plans will beaudited on all future SOC's, ROC's, and Recertifications. The Clinical Manager will ensure	

			that all RN's areeducated on the expectation of what care plans will look like based on 484.60. 4 The auditson current patient charts and any corrections needed will be completed byAugust 6, 2024. The education for all RN's regarding care planeducation will be completed with 100% of current RN's by August 6, 2024.	
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments;	G0574	1 The agency will audit100% of current patients' charts for accuracy with visit frequency orders.Agency will look at frequency orders in the chart and compare them to what isscheduled and ensure orders are in place for all visits. The agency will also provide in-service education to all office staffregarding visit frequency orders, the importance of reporting missed visits tothe physician/provider, the need to request an order from physician/providerfor any extra visits required. Documentation for this education will be kept inthe staff's personnel file.	2024-08-06

	(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 home health agency failed to ensure the plan of care included accurate visit frequency orders for 1 of 2 active records reviewed with home health aide (HHA) and attendant care services ordered (Patient #2). Findings include: 1. Review of Patient #2's clinical record included a plan of care (POC) for the certification period 6/07/24 to 8/05/24 which indicated the patient was to receive HHA visits 1 time a week for 1 week and then 5 times a week for 8 weeks. The record evidenced Patient #2 received 2 HHA visits for the week beginning 6/07/24 and received 7 HHA visits a week for the weeks of 6/09/24, 6/16/24, 6/23/24, and 6/30/24. The		2 The agency will preventthis from recurring in the future by performing an audit on 100% of all SOC,ROC's, and re-certifications for visit frequency orders and the schedule forthese orders. The agency will also provide education to all new nursing staff aboutthe importance of visit frequency accuracy and obtaining physician/providerorders for all visits made. Documentation for this education will be kept inthe staff's personnel file. 3 The Clinical Manager willbe responsible for ensuring the above audits and education are completed. 4 The audits for currentpatients will be completed by August 6, 2024. The education for all pertinent staff will be completed by August 6, 2024.	

	record failed to evidence physician orders for the above visit frequencies to exceed the POC orders of 1 visit for 1 week and then 5 visits for 8 weeks. 2. During an interview on 7/08/24 beginning at 10:37 AM, the Clinical Manager relayed the patient has a Medicaid prior authorization for HHA visits 7 days per week and the clinical record for Patient #2 did not include a physician order to reflect these frequencies. 410 IAC 17-13-1(a)(1)(C)(iii)			
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 record review and interview, the home health agency failed to ensure services were provided only as ordered by a physician or allowed practitioner for 4 of 5 active patient records reviewed (Patient #1, 3, 4 and 6). Findings include: 1. The agency policy "Physician's Plan of Treatment"	G0580	1 Extra PRN visits will continue to be included on the physician plan of care. The agency will audit 100% of allcurrent charts to ensure that all charts have physician orders for all visits,written or verbal orders. The agencywill also provide in-service education to all nursing staff regarding obtainingphysician/provider orders for all visits. Documentation for this education will be kept in the staff's personnelfile. 2 The agency will prevent this	2024-08-06

	indicated physician's orders are established and documented for the health care services the agency provides to those patients who are admitted to service with the agency and also indicated the physician's plan of care/treatment shall be reviewed by the attending physician not to exceed two (2) months (60 days) for the patient receiving skilled services. 2. The agency policy "Physician Responsibilities" indicated the plan of care for the patient will be developed in consultation with the physician and with the involvement of the patient and appropriate caregivers. 3. Review of Patient #1's clinical record included a start of care (SOC) on 5/09/16 and a POC for certification period 5/27/24 to 7/25/24 with orders for home health aide (HHA) service frequencies of 6 visits a week for 1 week; 7 visits a week for 7 weeks; and 5 visits a week for 1 week. The record evidenced HHA visits were performed on 5/27/24, 5/28/24, 5/29/24, 5/30/24, 5/31/24, 6/01/24, 6/02/24 and 6/03/24. The clinical record for Patient #1		fromrecurring in the future by performing an audit on 100% of all SOC, ROC's, andre-certifications for physician/provider orders. The agency will also provide education to all new nursing staff aboutthe importance of obtaining physician/provider orders for all visits.Documentation for this education will be kept in the staff's personnelfile. 3 The Clinical Manager will beresponsible for ensuring the above audits and education are completed. 4 The audits for current patients willbe completed by August 6, 2024. The education for all nursing staff will be completed by August 6,2024.	

	signed written order for the POC frequencies obtained prior to the above visits performed. During an interview on 7/02/24 beginning at 11:18 AM, RN 3 indicated they did not collaborate with the attending physician for the recertification POC frequency orders for Patient #1 and relayed the recertification POC is faxed to the physician for signature after the Clinical Manager approved it. 4. Review of Patient #3's clinical record evidenced a SOC on 5/09/24 and included a POC for the certification period 5/09/24 to 7/07/24 with orders for home health aide (HHA) service frequencies of 3 visits a week for 1 week and 6 visits a week for 8 weeks. The record evidenced HHA visits were performed on 5/09/24, 5/10/24, 5/11/24 and 5/12/24. The clinical record for Patient #3 failed to evidence a verbal or signed written order for the POC frequencies was obtained prior to the above visits performed. During an interview on 7/02/24 beginning at 1:51 PM, the			

	Clinical Manager relayed they did not collaborate with the physician for the POC frequencies for Patient #3 and indicated they faxed the POC to the physician for signature. 5. Review of Patient #4's clinical record evidenced a SOC on 4/23/24 and included a recertification POC for the certification period 6/22/24 to 8/20/24 with orders for home health aide (HHA) service frequencies of 6 visits a week for 8 weeks and 3 visits a week for 1 week. The record evidenced HHA visits were performed on 6/22/24, 6/23/24, and 6/25/24. The clinical record for Patient #4 failed to evidence a verbal or signed written order for the POC frequencies was obtained prior to the above visits performed. During an interview on 7/01/24 beginning at 4:02 PM, RN 1 relayed they only collaborate with the attending physician when there are changes and relayed they did not collaborate with the physician regarding the recertification POC frequencies for Patient #4. 6. Review of Patient #6's clinical			

	record evidenced a SOC on 6/18/24 and included a POC for the certification period 6/18/24 to 8/16/24 with orders for home health aide (HHA) service frequencies of 5 visits a week for 1 week; 7 visits a week for 7 weeks and 6 visits a week for 1 week. The record evidenced HHA visits were performed on 6/18/24, 6/19/24, 6/20/24, 6/21/24, 6/22/24, 6/23/24, 6/25/24, 6/26/24 and 6/27/24. The clinical record for Patient #6 failed to evidence a verbal or signed written order for the POC frequencies was obtained prior to the above visits performed. Surveyor attempted to contact RN 2 during survey on 7/02/24 at 11:18 AM with no response. A voicemail was left with a callback was requested. The Administrator informed Surveyor at 4:19 PM that RN 2 was on vacation and would be unavailable during the survey.			

	During an interview on 7/02/24 beginning at 4:20 PM, the Administrator indicated the clinical record for Patient #6 failed to include documentation of collaboration with the physician for the POC. 7. During an interview on 7/01/24 beginning at 2:05 PM, the Administrator indicated the RN creating the POC does not collaborate with the physician unless there is a problem and the POC is faxed to the physician for signature. 410 IAC 17-13-1(a)(1)(C)(iii)			
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date.	G0588	1 The agency will provide in-serviceeducation to all nursing staff regarding the need to collaborate with thephysician/provider after or during comprehensive assessment (Initial/SOC, ROC,or Recertification) to obtain verbal orders for the new plan of care beingcreated. The RN needs to document conversation with physician/provider oroffice staff outlining review of the new Plan of Care. Documentation ofreceived verbal order to proceed with new Plan of Care must also be	2024-08-06

	Based on record review and interview, the home health agency failed to ensure the plan of care (POC) was reviewed with the physician at start of care (SOC) and/or at recertification for 4 of 4 active patient records reviewed (Patient #1, 2, 3, and 4). Findings include: 1. The agency policy "Case Management and Assignments" indicated a written plan of treatment and orders will be obtained from the admitting physician and the case manager will obtain and implement physician orders. 2. The agency policy "Physician's Plan of Treatment" indicated physician's orders are established and documented for the health care services the agency provides to those patients who are admitted to service with the agency and also indicated the physician's plan of care/treatment shall be reviewed by the attending physician not to exceed two (2) months (60 days) for the patient receiving skilled services. 3. The agency policy "Physician Responsibilities" indicated the plan of care for the patient will		documented.Documentation for this education will be kept in the staff's personnel file. 2 The agency will prevent this fromrecurring in the future by performing an audit on 100% of all SOC, ROC's, andre-certifications for documentation of collaboration by the RN with thephysician/provider regarding the new POC and an order (verbal and then written)to begin the POC. The agency will also provide education to all new nursing staff abouthow collaboration should occur and be documented for new Plans' of Care, ROC'sand Recerts. Documentation for this education will be kept in the staff'spersonnel file. 3 The Clinical Manager will beresponsible for ensuring the above audits and education are completed. 4 The audits for current patients willbe completed by August 6, 2024. The education for all staff will be completed by August 6,2024	

	be developed in consultation with the physician and with the involvement of the patient and appropriate caregivers. 4. A Review of Patient #1's clinical record evidenced a SOC on 5/09/16 and included a recertification POC for the certification period 5/27/24 to 7/25/24. The record failed to evidence documentation of collaboration with the physician for the recertification POC orders. During an interview on 7/02/24 beginning at 11:18 AM, RN 3 indicated they did not collaborate with the attending physician for the recertification POC orders for Patient #1 and relayed the recertification POC is faxed to the physician for signature after the Clinical Manager approves it. 5. Review of Patient #2's clinical record evidenced a SOC on 7/19/16 and included a recertification POC for the certification period 6/07/24 to 8/05/24. The record failed to evidence documentation of collaboration with the physician for the recertification POC orders.			

	During an interview on 7/02/24 beginning at 1:37 PM, RN 4 relayed they created the recertification POC for Patient #2 and did not collaborate with the attending physician regarding the recertification POC orders and the Clinical Manager faxed the POC to the physician for signature. 6. Review of Patient #3's clinical record evidenced a SOC on 5/09/24 and included a POC for the certification period 5/09/24 to 7/07/24. The record failed to evidence documentation of collaboration with the physician for the SOC POC orders. During an interview on 7/02/24 beginning at 1:51 PM, the Clinical Manager relayed they did not collaborate with the physician for the POC for Patient #3 and indicated they faxed the POC to the physician for signature. 7. Review of Patient #4's clinical record evidenced a SOC on 4/23/24 and included a recertification POC for the certification period 6/22/24 to 8/20/24. The record failed to evidence documentation of collaboration with the physician			

	for the recertification POC orders. During an interview on 7/01/24 beginning at 4:02 PM, RN 1 relayed they only collaborate with the attending physician when there are changes and relayed they did not collaborate with the physician regarding the recertification POC for Patient #4. 8. During an interview on 7/01/24 beginning at 2:05 PM, the Administrator indicated the RN creating the POC does not collaborate with the physician unless there is a problem and the POC is faxed to the physician for signature. 410 IAC 17-13-1(a)(2)			
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to ensure the physician or	G0590	1 The agency will provide in-serviceeducation to all nursing staff regarding the need to collaborate with thephysician/provider after or during comprehensive assessment (Initial/SOC, ROC,or Recertification) to obtain verbal orders for the new plan of care beingcreated. The RN needs to document conversation with physician/provider oroffice staff	2024-08-06

	allowed practitioner was promptly notified of the need to alter the plan of care (POC) related to the start of care (SOC) date for 4 of 4 patient records reviewed with mock SOC and POC dates (Patient #3, 4, 5 and 6). Findings include: 1. The agency policy "Care Plan" indicated a regular review of the health needs/problems, plan and goals will be reviewed with the patient, family, physician and others involved in the care of the patient. 2. The agency policy "Case Management and Assignments" indicated a written plan of treatment and orders will be obtained from the admitting physician and the case manager will obtain and implement physician orders. 3. The agency policy "Physician's Plan of Treatment" indicated physician's orders are established and documented for the health care services the agency provides to those patients who are admitted to service with the agency and also indicated the physician's plan of care/treatment shall be reviewed by the attending		outlining review of the new Plan of Care. Documentation ofreceived verbal order to proceed with new Plan of Care must also be documented.Documentation for this education will be kept in the staff's personnel file. 2 The agency will prevent this fromrecurring in the future by performing an audit on 100% of all SOC, ROC's, andrecertifications for documentation of collaboration by the RN with thephysician/provider regarding the new POC and an order (verbal and then written)to begin the POC. The agency will also provide education to all new nursing staff abouthow collaboration should occur and be documented for new Plans' of Care, ROC'sand Recerts. Documentation for this education will be kept in the staff'spersonnel file. 3 The Clinical Manager will beresponsible for ensuring the above audits and education are completed. 4 The audits for current	

	physician not to exceed two (2) months (60 days) for the patient receiving skilled services. 4. The agency policy "Physician Responsibilities" indicated the plan of care for the patient will be developed in consultation with the physician and with the involvement of the patient and appropriate caregivers. 5. Review of Patient #3's clinical record evidenced a referral received on 4/12/24 with a SOC on 4/12/24 and a mock POC was created for the certification period 4/12/24 to 6/10/24. Patient #3's actual SOC was on 5/09/24 and included a POC for the certification period 5/09/24 to 7/07/24. The record failed to include documentation of collaboration with the physician regarding the SOC date and POC certification period dates needing to be altered due to pending insurance authorization. During an interview on 7/02/24 beginning at 1:51 PM, the Clinical Manager relayed they did not collaborate with the physician for the actual POC frequencies on 5/09/24 for Patient #3 and indicated they		August 6, 2024. The education for all staff will be completed by August 6,2024	

	faxed the new POC to the physician for signature. 6. Review of Patient #4's clinical record evidenced a referral received on 2/16/24 with a SOC on 2/16/24 and a mock POC was created for the certification period 2/26/24 to 4/25/24. Patient #4's actual SOC was 4/23/24 and included an initial POC for the certification period 4/23/24 to 6/21/24. The record failed to include documentation of collaboration with the physician regarding the SOC date and POC certification period dates needing to be altered due to pending insurance authorization. During an interview on 7/01/24 beginning at 4:02 PM, RN 1 relayed they only collaborate with the attending physician when there are changes and relayed they did not collaborate with the physician regarding the initial POC frequencies for Patient #4 during the 4/23/24 SOC visit. 7. Review of Patient #5's clinical record evidenced a referral received on 4/12/24 and a mock POC was created for the			

	6/27/24. Patient #4 was listed on the active census report provided to Surveyor on 7/01/24. The electronic medical record failed to include documentation of Patient #5 being an active patient and failed to include documentation of collaboration with the physician regarding the mock SOC date and POC certification period dates not being accurate due to still pending insurance authorization. During an interview on 7/01/24 beginning at 4:35 PM, the Administrator relayed Patient #5 is not an active patient and is still pending insurance authorization. 8. Review of Patient #6's clinical record evidenced a referral received on 5/20/24 with SOC on 5/21/24 and a mock POC was created for the certification period 5/27/24 to 7/25/24. Patient #6's actual SOC was 6/18/24 and included a POC for the certification period 6/18/24 to 8/16/24. The record failed to include documentation of collaboration with the physician regarding the SOC date and POC certification period dates needing to be altered due to			

pending insurance authorization.

Surveyor attempted to contact RN 2 during survey on 7/02/24 at 11:18 AM with no response. A voicemail was left with a call back was requested. The Administrator informed Surveyor at 4:19 PM that RN 2 was on vacation and would be unavailable during survey.

During an interview on 7/02/24 beginning at 4:20 PM, the Administrator indicated the clinical record for Patient #6 failed to include documentation of collaboration with the physician for the actual POC on 6/18/24.

9. During an interview on 7/02/24 beginning at 2:05 PM, the Administrator relayed the home health agency created a mock POC that was sent to the physician for signature. The relayed once insurance approval was received, the patient was admitted to home health. A new actual SOC visit and POC was created after insurance approval was received for the above patients.

10. During an interview on 7/03/24 beginning at 4:45 PM,

	the Administrator relayed the physician and/or attending practitioner is made aware of the mock POC via the fax cover sheet. Surveyor requested copies of these fax cover sheets and the Administrator relayed they were unable to locate any of the fax cover sheets for the above patients. 410 IAC 17-13-1(a)(2)			
G0656	Improvements are sustained 484.65(c)(3) The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained. Based on record review and interview, the agency failed to document improvement actions and evaluate the success of the actions on quality improvement activities for 1 of 1 agency surveyed. Findings include: The agency quality assessment and performance improvement (QAPI) committee minutes for 9/21/2023 indicated a performance improvement plan (PIP) to reduce hospitalizations	G0656	1 The agency will audit QAPI meetingminutes from the last 12 months and determine if performance improvement wasmet through actions taken and just not documented or if the performanceimprovement plans need to be ended and new ones implemented.	2024-08-06

	and emergency room visits for non – emergent care. The minutes for the 12/21/2023 meeting included monthly data which included the number of hospitalizations and emergency room use. The minutes for the 6/27/20234 meeting indicated the PIP for hospitalizations continued. The minutes failed to document actions taken to reduce hospitalization /emergency room usage. During an interview on 7/3/2024 at 2:30 PM, the Administrator indicated they provided patients with a symptom list with what to do and a "Call me first" sign to encourage patients to call the agency before going to the emergency room. The Administrator could not identify when they started that campaign or the effect on the hospitalization/ emergency room rates. 410 IAC 17 – 12 – 2(a)		The agency will review 484.65 and 410 IAC 17-12-2(a) Theywill document this as a part of their QAPI meetings. They will document anyperformance improvement plans that are ended and how the measure was met. Theywill document any new performance improvement plans put into place, whatactions will be taken, and how the improvements will be monitored. The agency will provide an in-service training to all nursing staffabout QAPI and it's purpose within the agency. The in-service will include anynew performance improvement projects that the QAPI team has created and how thePIP will impact the staff and what their expectations are. 2 The agency will prevent this fromrecurring in the future by placing quarterly QAPI meetings on the calendar.They will audit the QAPI meeting minutes every 6 months to ensure that the QAPIteam is following 484.65. The agencywill provide education to all new staff regarding the QAPI condition	

			home health agency. This will happen during onboarding. 3 The administrator will be responsiblefor ensuring the QAPI meetings and education are completed. 4 The QAPI meeting and all educationwill be completed by August 6, 2024.	
G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure employees followed standards of practice for hand hygiene and bag technique to reduce the spread of infections for 3 of 3 home visit observations (Patients #1, 2, and 3). Findings include: 5. During a home visit observation conducted with Patient #3 and RN 5 on 7/03/24 beginning at 10:51 AM, RN 5 was observed wearing gloves while performing an assessment	G0682	1 The agency will review Infection Control withall staff through an In-Service. 100% of all direct care staff will be completecompetency check off on hand hygiene and bag technique. 2 The agency will prevent this from occurringin the future by educating all new staff at onboarding about infection controland bag technique and completing hand hygiene and bag technique check offs.Annually, all staff will complete an in-service on infection control andannually, all staff will complete a competency check off for hand hygiene andbag technique. 3 The Clinical Manager will be responsible forensuring all education and competency	2024-08-06

	of Patient #3. RN 5 removed their gloves and failed to perform hand hygiene. During an interview on 7/03/24 beginning at 11:20 AM, RN 5 relayed hand hygiene should be performed before touching the patient and before the next patient. 6. During an interview on 7/03/24 beginning at 1:51 PM, the Clinical Manager indicated hand hygiene should be performed before an assessment, before and after gloves, before and after you touch the patient, before and after med refills and when you leave the patient home. 410 IAC 17–12–1(m) 1. The agency bag technique policy indicated the supply bag was to be placed on an impermeable barrier, required hand hygiene before the removal of supplies, and the bag should be kept closed after removing the supplies. 2. The Centers for Disease Control and Prevention (CDC) hand hygiene for healthcare		check offs are completed. 4 All education and competency checks will becompleted by August 6, 2024.	

	workers, retrieved from https:// www.cdc.gov/ clean- hands/hcp/ clinical-safety /index.html, identified standard hand hygiene practice as the use of hand washing or use of alcohol – based hand rub before touching a patient or their surroundings, moving from a dirty site to a clean site, after removing gloves, and before switching tasks. 3. During a home visit observation on 7/1/2024 at 12:08 PM, registered nurse (RN) 3 completed an assessment on Patient #1. The assessment included tasks that required the nurse to touch the patient with gloved hands. The last part of the assessment involved the nurse touching the patient's feet with gloved hands. Following the assessment, RN 3 filled Patient #1's medication tray with medications, in which they removed the pills from a bottle and placed them into the pill tray. RN 3 failed to remove gloves and perform hand hygiene after touching the patient's feet and before touching the medication. During an interview on			

	indicated they did not remove gloves and perform hand hygiene before touching the patient's medication. RN 3 indicated they should have performed hand hygiene before touching medication. 4. During a home visit observation on 7/1/2024 at 1:30 PM, RN 4 placed the nursing bag on the couch with no barrier underneath it. After completing all tasks, RN 4 retrieved a small trash bag from the nursing bag and gathered up the trash. During an interview immediately after the visit, RN 4 indicated they normally placed the empty trash bag on the couch, as a barrier for the nursing bag. When asked, RN 4 indicated they forgot to use the barrier today.			
G0808	Onsite supervisory visit every 14 days 484.80(h)(1)(i) If home health aide services are provided to a	G0808	1 The agency will review audit 100% of patientcharts who have home health aides assigned. They will ensure that that homehealth aide supervisory visits are scheduled on 100% of	2024-08-06

	patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit. Based on record review and interview, the home health agency failed to ensure the registered nurse (RN) supervised the home health aide (HHA) every 14 days for 1 of 2 active clinical records reviewed of patients receiving skilled nurse (SN) and HHA services (Patient #2). Findings include: 1. Review of Patient #2's clinical record included a plan of care (POC) for the certification period 6/07/24 to 8/05/24 and included orders for skilled nursing (SN) and home health aide (HHA) services. The record evidenced the registered nurse performed HHA supervisory visits on 6/03/24 and 6/19/24. The clinical record failed to evidence RN 4 performed HHA supervisory visits every 14 days. 2. During an interview on 7/02/24 beginning at 1:37 PM, RN 4 indicated HHA supervisory visits should be performed		charts who have homehealth aides. The agency will provideeducation to 100% of RN's regarding the CoP's and Indiana regulations for homehealth aide supervision. Documentationfor this education will be kept in the staff's personnel file. 2 The agency will prevent this fromrecurring in the future by providing education to all new RN's about HomeHealth Aide supervision. This education will be placed in their personnel file. The agency will audit 100% of all new charts if the homehealth aide has been ordered. They will audit for supervisory visits beingscheduled as per regulatory requirements. The agency will spot check 5 charts a month for compliancewith home health aide supervisory regulations. If the 5 charts are not 100%compliant with home health aide supervision, then the agency will audit 100% ofall home health aide charts monthly until 100% compliance is reached. When	

	every 14 days and relayed the HHA supervisory visit for Patient #2 was not done on time. 3. During an interview on 7/02/24 beginning at 2:05 PM, the Administrator indicated HHA supervisory visits should be done every 14 days. 4. During an interview on 7/03/24 beginning at 1:51 PM, the Clinical Manager indicated HHA supervisory visits should be completed every 14 days. 410 IAC 17-14-1(n)		100%compliance is reached, the agency will return to 5 charts per month. All RN'swho had charts out of compliance, will undergo additional education on homehealth aide supervision and that education will be placed in their personnelfile. The education will be completed by the end of the month that was found tonot be in compliance. 3 The Clinical Manager will beresponsible for ensuring all education and all charts audits are completed. All initial chartaudits and education will be completed by August 6, 2024.	
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: July 1, 2, 3, 5, 8, 2024 12-month Unduplicated Skilled	N0000		

	Admissions: 28			
N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the agency organizational chart failed to outline administrative control and lines of authority for delegating responsibility to the patient care level for 1 of 1 agency surveyed. Findings include: A review of the organizational chart evidenced the organizational structure of the agency, from the Governing Body to the Home Health Aides and Attendants. The organizational chart failed to reach the patient level. During an interview on 7/5/2024 at 12:35 PM, the Administrator indicated they did	N0440	1 The agency will updateit's current organizational chart to reflect the patients the agency providescare to. 2 To prevent this fromoccurring in the future, the agency will continue to place patients on theorganizational chart when the chart is updated. 3 The administrator will beresponsible for updating the organizational chart. 4 The organizational chartwill be updated and will replace all old organizational charts by July 9,2024.	2024-07-09

	not know the organizational chart needed to include the patient.			

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
Sheryl Roth	Administrator	7/24/2024 1:56:02 PM