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	08/23/2024

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
G0000	INITIAL COMMENTS This was a Post-Condition Revisit for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: August 19, 20, 21, 23, 2024 12-Month Unduplicated Skilled Admissions: 33 During this Post-Condition Survey, AM Home Health Care was found to be out of compliance with Conditions of Participation §484.55 Condition of participation: Comprehensive assessment of patients and §484.60 Condition of	G0000		

	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. QR 9/3/24			
G0412	Written notice of patient's rights 484.50(a)(1)(i)	G0412	**G0412**	2024-09-22

	(i) Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities; Based on observation, admission folder review, and interview, the home health agency failed to provide the patient a written notice of the patient's rights and responsibilities nor the agency's transfer and discharge policies in a manner understandable to persons with limited English proficiency for 1 of 1 home visit observations of an initial evaluation visit (Patient #10). Findings include: 1. During a home visit observation with Patient #10 on 8/19/24 beginning at 2:00 PM, Registered Nurse (RN) 1 was observed conducting an initial evaluation visit. Patient spoke limited English and Interpreter 7 was present translating English to Burmese. During the visit, RN 1 reviewed the agency's admission packet with Patient and showed him/her a copy of the agency's document regarding patient's rights written in English. The nurse advised Patient to review the information when he/she "had		**correct the deficiency?** **We will replace all Patient Rights and Responsibilities, Transfer and Discharge Policies that are currently in English and replace them with patient's primary language. All documentation will be in a language the patient is able to read and understand. These documents will be placed in all non-English speaking homes by 09/22/24.** **2. How are you going to prevent the deficiency from recurring in the future, even if it has already been corrected?** **We will prevent this from occurring in the future by having the required translated documentation added to all new admission packets moving forward. If the patient is non-English speaking, we will leave the translated paperwork in the**	

	time." Patient informed RN 1 that he/she had limited English reading proficiency. The nurse stated she thought the admission folder included a copy of the patient's rights in Burmese but failed to produce this version. 2. During an interview with Patient #10 and Person 10, a Burmese interpreter through a State Agency (SA) contractor, on 8/19/24 beginning at 3:17 PM, Patient #10 reported their written English proficiency was limited to reading dates and times of doctor appointments. Patient reviewed the English version of the agency's patient rights document and indicated they could not understand this document. Patient reported he/she was proficient at reading Burmese. 3. The review of the agency's sample admission packet evidenced a written notice of the patient's rights and responsibilities and the agency's transfer and discharge policies in English. The folder failed to evidence a written notice of these rights, responsibilities, and policies in a manner understandable to persons with		**education to all RN's regarding the importance of Patient Rights and Responsibilities, Transfer and Discharge Policies being in a language all patients can read and understand. This education will be completed by 9/22/24 and all new RN's and/or admitting clinicians will receive this education as part of their onboarding process.** **Our administrator will ensure that the translation of the documentation has been completed and that all non-English speaking patients have received the translated documents. All patients who are non-English speaking will have the translated paperwork in their primary**	

	limited English proficiency. 4. During an interview with Administrator on 8/19/24 beginning at 4:43 PM, she reported Burmese patients who had limited English reading proficiency would be provided a copy of the patient rights if the patient could read Burmese, as many of the agency's Burmese patient population could not read Burmese. 410 IAC 17-12-3(a)(1)(B)			
G0436	Receive all services in plan of care 484.50(c)(5) Receive all services outlined in the plan of care. Based on record review and interview, the home health agency failed to ensure patients received all services as outlined in the plan of care (POC) for 1 of 1 record reviewed which evidenced the agency failed to provide home health aide services as ordered in the POC (Patient #9). Findings include: 1. The agency "Client Bill of Rights" indicated the Patient and representative (if any) has	G0436	**G0436** **1. How are we going to correct the deficiency?** **We will complete chart audits on 100% of patients. We will determine if the services we have provided match what is in the plan of care. If they do not, we will contact the provider and notify them of any discrepancies found in the plan of care and determine the best course of action through collaboration with the provider's office. We will contact the patient**	2024-09-22

	the right to be notified of any changes in the care to be furnished. 2. The agency policy "Patient Notification of Changes" indicated the patient will be notified of any significant changes in the plan of treatment in a timely manner prior to care being rendered. 3. Patient #9's clinical record included POC for certification period 8/14/24 to 10/12/24 with orders for HHA visits 5 times a week for 8 weeks and then 1 time a week for 1 week. The clinical record for Patient #9 evidenced the last HHA visit was performed on 7/24/24. The record failed to evidence HHA visits have been made this certification period and failed to evidence missed visit collaboration documentation. 4. During an interview on 8/19/24 beginning at 12:26 PM, the Clinical Manager relayed Patient #9's insurance authorization had expired as of 7/24/24. At 12:35 PM, the Clinical Manager confirmed the clinical record for Patient #9 did not include any documentation of collaboration with the		**and/or representative via telephone and notify them of any discrepancies. If new orders are needed, the agency will request new orders from the physician. These chart audits and communication with the providers as well as the patients and/or their representatives will be documented on a communication note and retained in the patient's EMR by 09/22/24.** **2. How are you going to prevent the deficiency from recurring in the future, even if it has already been corrected?** **We will prevent this deficiency from occurring in the future by providing education to all RN's about having orders for all services that are provided to the patients. If there are services that a patient needs that are not in the plan of care, the RN's will contact the provider and**	

	caregiver and/or physician while waiting on insurance authorization.		**provider to determine if the services are necessary and obtain orders for the services. No care will be provided until orders are obtained. This education will be completed by 9/22/24.** **All new RN's and/or admitting clinicians will receive this education as part of their onboarding process. In addition to education, this will be added to our QAPI program. Monthly audits of 10% of the census will include random patients, for the next 6 months at that time we will determine if an extension is needed and a Performance Improvement Plan will be implemented. Any findings in this time will be discussed during QAPI meetings.** **Our Director of Nursing will oversee the chart audit process and ensure that compliance has been**	

			Director of Nursing will also ensure that the required education stated above will be completed by 9/22/24 and that it is in all future onboarding sessions for new hires who complete admissions. **3. This deficiency will be corrected by monthly auditing of 10% of the census and any corrections needed will be addressed in QAPI and communication with physicians and family will be completed as necessary and will be documented in a communication note and maintained in the patient's**	
G0490	Accessibility 484.50(f)(1,2) Standard: Accessibility. Information must be provided to patients in plain language and in a manner that is accessible and timely to- (1) Persons with disabilities, including accessible web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. (2) Persons with limited English proficiency	G0490	**G0490** **1. How are we going to correct the deficiency?** **All Clinical Staff will be educated and reminded of Patient Rights that include addressing patients directly even when a translator is being used. Education to be**	2024-09-22

	no cost to the individual, including oral interpretation and written translations.Standard: Accessibility Information must be provided to patients in plain language and in a manner that is accessible and timely to- Based on observation, policy review, and interview, the Registered Nurse (RN) failed to speak directly to the patient with questions phrased in first-person when using an interpreter for 1 of 1 home visit observations of an initial evaluation visit (Patient #10). Findings include: The review of an agency policy titled "Client Bill of Rights" indicated the patient had the right to "have his/her ... person treated with respect, consideration and recognition of patient dignity and individuality ...." The review of a journal article titled "Do not lose your patient in translation: Using interpreters effectively in primary care," dated 02/27/23 and obtained from www.pubmed.ncbi.nlm.nih.gov, indicated when using a medical interpreter to translate, the medical professional should "speak directly to the patient in the first person, using 'I' and 'you' statements. Do not address the patient indirectly		**completed by 09/22/24.** **We will have our agency Patient Rights and Responsibilities and transfer discharge paperwork translated into a language that the patient can read and understand. We will provide all current non-English speaking patients with this updated translated document for their reference by 09/22/24.** **2. How are you going to prevent the deficiency from recurring in the future, even if it has already been corrected?** **We will prevent this from occurring in the future by including an English and/or documents in the patient's primary language. This will be done on initial evaluation and at the start of care. We will also provide education to all RN's regarding 484.50(a)(1)(i) and 410 IAC 17-12-3(a)(1)(B) and the importance of Patient**	

	via an interpreter in third-person language, for example, 'ask him' or 'tell her' ...." During a home visit observation with Patient #10 on 8/19/24 beginning at 2:00 PM, RN 1 was observed conducting an initial evaluation visit. Patient spoke limited English and Interpreter 7 was present translating English to Burmese. During the visit, RN 1 addressed Patient indirectly through the interpreter using third-person language. The nurse began questions with "ask [him/her] if [he/she] ... does [he/she] ever ... tell [him/her] ..." RN 1 instructed Interpreter 7 "Ask [him/her] if [he/she] ever feels like wanting to die," to which Patient began to respond before Interpreter 7 could translate the question for Patient.		**Rights. This education will be completed by 9/22/24 and all new RN's and/or admitting clinicians will receive this education as part of their onboarding/new hire process.** **3. Our administrator will ensure that the translation of the documentation has been completed and that all non-English speaking patients have received the translated documents.** **4. All non-English speaking patients will have these translated documents in their home by 09/22/24.** **5. The documented reference in the 2567 by the ISDH Surveyor was a study done in Africa for a primary care office "South African Family Practice" This does not address the cultural differences in the Burmese population nor in the home**	

	During an interview with RN 1 on 8/21/24 beginning at 1:47 PM, she reported when using a translator to conduct a visit with a patient who spoke limited English, she would ask questions for the patient in third-person language and have the translator direct the questions to the patient.		**However, a source was found through the web site Cultural Atlas, titled Myanmar (Burmese) Culture indicating that "...Indirect communication is preferred...and that eye contact should be diverted, and intense eye contact can be viewed as a challenge to the other person." Re-education of RNs to include culture appropriate literate taken from the Culture Atlas web site to be given to all current RNs and included in the onboarding process for all new employees.**	
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on observation, record review, and interview, the home health agency failed to conduct	G0510	**G0510 1. How are we going to correct the deficiency? Every new patient to AM Home Health will receive a comprehensive assessment within 48 hours of a completed referral being received. This comprehensive assessment will include at a minimum the following:**	2024-09-22

	an initial assessment visit within 48 hours of referral and included a review of all medications (see Tag G514); failed to complete a comprehensive assessment in a timely manner (see Tag G520) and failed to ensure an accurate review of all medications (See Tag G536). The scope and severity of these findings evidenced the agency failed to provide a patient-specific, comprehensive assessment in which all patient needs were identified, which resulted in AM Home Health Care being found out of compliance with Condition of Participation 42 CFR 484.55 Comprehensive assessment of patients.		**The patient's current health, psychosocial, functional, and cognitive status;** **The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;** **The patient's continuing need for home care;** **The patient's medical, nursing, rehabilitative, social, and discharge planning needs;** **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.** **The patient's primary**	

			caregiver(s), if any, and other available supports, including their: **Willingness and ability to provide care, and** **Availability and schedules;** **The patient's representative (if any);**	

			Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary. The OASIS data items determined by the Secretary must include clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only. **2. How will the agency prevent this from recurring in the future?** **The DON will audit 100% of all new SOC's to ensure they meet the requirements of 484.55. All staff will receive**	

			assessment, how to document a comprehensive assessment, and the timeline for completion. All new staff will receive the same training at onboarding. **3. The Director of Nursing will be responsible for these audits and for all education.** **4. All education will be completed by 9/22/24.** **5. All audits will be**	
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on observation, record review, and interview, the home health agency failed to conduct an initial assessment visit within 48 hours of referral for 1 of 5 records reviewed of patients who had an initial assessment visit conducted but had not yet received any services (Patient #18) and failed to ensure the initial assessment visit	G0514	**G0514** **1. How are we going to correct the deficiency?** **The agency will correct this deficiency by ensuring that all completed referrals are scheduled for an initial evaluation within 48 hours of the completed referral being received. If the agency is not going to be able to meet that expectation, the agency will not accept that patient. At the initial assessment, they will determine any immediate care or support needs for the patient. They**	2024-09-22

	included a review of all medications for 1 of 1 home visit observation of an initial assessment visit (Patient #10). Findings include: 1. The review of agency policy #2.7 titled "Guidelines for Assessment" indicated an initial assessment would be conducted "within 48 hours" and would include "... Medications and treatments ...." 2. During a home visit observation with Patient #10 on 8/19/24 beginning at 2:00 PM, Registered Nurse (RN) 1 was observed conducting an initial assessment visit. Patient had his/her medication bottles stored in both a Ziplock bag and a white basket. During the visit, RN 1 failed to review the medication bottles stored in the white basket. During an interview with Patient #10 on 8/19/24 beginning at 3:17 PM, Patient's medications stored in the white basket were reviewed. One bottle of Losartan-Hydroclorothiazide 50 milligrams (mg) – 12.5 mg (a combination of 2 medications used to treat high blood pressure) and one bottle of		**will document this initial assessment within the timely documentation requirements of the agency.** **2. To prevent this from recurring in the future, the agency will provide education to 100% of all staff who perform SOC assessments regarding the regulatory requirements for the initial assessment. All new staff who will perform SOC's will receive this same education at onboarding. The administrator will audit 100% of all new SOC's to ensure that the agency is 100% compliant with timely initiation of care. For any SOC that is not completed within the allowed 5-day window, the administrator will notify the DON and they will meet with the RN responsible for the SOC. They will review and document the conversation as to why the admission was not completed in time.** **3. The Director of Nursing will provide all education regarding timely initiation**	

	Atorvastatin 40 mg were observed stored in the white basket. One bottle of Amlodipine 10 mg was also observed in Patient's home. Patient reported he/she should be taking these medications but had been unable to locate the Losartan-Hydrochlorothiazide. RN 1 failed to review and include these medications on Patient's medication list during the initial assessment visit. During an interview with RN 1 on 8/21/24 beginning at 1:47 PM, she reported she did not review the medications in Patient's white basket during the initial assessment visit. The review of clinical records from Entity 11, a physician's office, included an office visit note dated 7/30/24. The visit note indicated Patient's active medications included Atorvastatin and Losartan-Hydrochlorothiazide. The visit note failed to evidence Amlodipine on Patient's active medications. During a follow-up interview with Patient on 8/21/24 beginning at 1:56 PM, Patient		**will ensure that all audits are completed.** **4. All education will be performed by 9/22/24.** **5. All audits will be performed by 09/22/24.**	

	taking Amlodipine. The medication was being prescribed by a doctor outside of Entity 11. 3. The review of Patient #18's clinical record indicated a referral for home health care services was received on 8/02/24. The record evidenced RN 4 conducted an initial assessment visit on 8/09/24. The record failed to evidence a reason the initial assessment visit was conducted greater than 48 hours after the referral was received. During an interview with RN 4 on 8/21/24 beginning at 4:59 PM, she reported she was assigned initial assessment visits by Scheduler 10. When queried on the reason Patient's initial assessment visit was conducted 7 days after the referral was received, RN 4 stated she did not know. During an interview with Administrator on 8/21/24 beginning at 3:51 PM, she reported an initial assessment visit should be conducted within 24-48 hours once the agency received a referral. Administrator did not know the			

	reason Patient #18's initial assessment visit was conducted more than 48 hours after the referral was received and the agency had not followed up with the nurse regarding the delay. 410 IAC 17-14-1(a)(1)(A)			
G0520	5 calendar days after start of care 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on record review and interview, the home health agency failed to complete a comprehensive assessment in a timely manner for 5 of 5 records reviewed of patients listed on the agency's active patient list but who had had a comprehensive assessment completed (Patients #15, 16, 17, 18, 19). Findings include: 1. The review of Patient #15's clinical record evidenced a verbal order for a home health evaluation was obtained by Administrator on 7/17/24. Registered Nurse (RN) 3	G0520	**G0520** **1. How are we going to correct this deficiency?** **The agency will complete this deficiency by admitting all new patients within 48 hours of receiving a completed referral and then completing the comprehensive assessment within 5 calendars of the start of care date. The agency will audit 100% of patients' charts who have been admitted within the last 90 days and determine if there are any charts where the comprehensive assessment has not been completed. Any charts found to be missing the comprehensive assessment will have one completed by**	2024-09-22

	visit on 7/18/24 and Patient signed admission consents, including a "Consent for Treatment," during this visit. The record failed to a comprehensive assessment had been completed. 2. The review of Patient #16's clinical record evidenced a verbal order for a home health evaluation was obtained by Administrator on 7/26/24, with an evaluation to be performed the week of 7/27/24. RN 2 conducted an initial assessment visit on 7/30/24 and Person 13, guardian for Patient, signed admission consents, including a "Consent for Treatment," during the visit. A plan of care indicated Patient's start of care was 7/27/24 with an initial certification period of 8/19/24 – 10/17/24. The plan of care evidenced skilled nursing and home health aide orders, effective 7/30/24 and 7/31/24, which included an order for home health visits to be conducted 8 hours per day, 7 days per week. The record failed to evidence a comprehensive assessment had been completed. 3. The review of Patient #17's		**09/22//2024. All staff who complete admissions will receive education regarding the need to complete every SOC within 5 calendar days.** **2. The agency will prevent this from recurring in the future by auditing 100% of all SOC's to ensure 100% of documentation is being completed within 5 calendar days of the SOC. If this is not being completed timely, the administrator will notify the DON and they will meet with the RN responsible for the SOC. They will review and document the conversation as to why the admission was not completed within 5 calendar days. Also, all new staff will be educated regarding the regulatory requirement of completing the comprehensive assessment within 5 calendar days.** **3. The Director of Nursing will provide all education regarding timely initiation of care. The Administrator will ensure that all audits are completed.**	

	clinical record evidenced a verbal order for home health care services evaluation was obtained by Administrator from Person 14, a physician, on 6/10/24. RN 1 conducted an initial assessment visit on 6/06/24 and Patient signed admission consents, included a "Consent for Treatment," during the visit. A plan of care indicated a start of care date of 5/29/24 and initial certification period of 5/29/24 – 7/27/24. The plan of care evidenced skilled nursing and home health aide orders, effective 6/06/24, which included orders for skilled nursing visits to be conducted once every other week "for medication box set up, [vital signs], pulse [oximeter reading], assessment and education" and home health aide visits to be conducted 3 hours per day, 7 days per week. The record failed to a comprehensive assessment had been completed. 4. The review of Patient #18's clinical record evidenced a verbal order for a home health evaluation was obtained by Administrator on 8/02/24. RN 4 conducted an initial assessment visit on 8/08/24 and Patient signed admission consents,		**4. All education will be performed by 9/22/24.** **5. All audits will be performed by 09/22/24.**	

	including a "Consent for Treatment," during the visit. A plan of care indicated a start of care date of 8/01/24 and initial certification period of 8/01/24 – 9/29/24. The plan of care evidenced skilled nursing and home health aide orders, effective 8/08/24, which included orders for skilled nursing visits to be conducted once every other week for "medication set up, assessment, vital signs, pulse [oximeter reading], and education" and home health aide visits to be conducted 6 hours per day, 7 days per week. The record failed to a comprehensive assessment had been completed. 5. The review of Patient #19's clinical record evidenced RN 2 conducted an initial assessment visit on 8/02/24 and Person 16, caregiver for Patient, signed admission consents, including a "Consent for Treatment," during the visit. A plan of care indicated a start of care date of 7/12/24 and initial certification period of 8/19/24 – 10/17/24. The plan of care evidenced skilled nursing and home health aide orders, effective 7/12/24, which included orders for home			

	conducted 6 hours per day, 7 days per week. The record failed to a comprehensive assessment had been completed. 6. During an interview with Administrator on 8/20/24 beginning at 1:37 PM, she reported she oversaw the admission process. Administrator stated after a referral for home care was received, an agency RN would conduct an initial assessment, then Administrator would create a plan of care. The plan of care would be faxed to the ordering provider, and once it was received back with a signature, Administrator would complete required insurance documentation and send to the patient's insurance for approval. Once the approval was received, the agency would conduct a comprehensive assessment within 24-48 hours, update the plan of care, and Patient's services would begin. Administrator reported Patients #15, 16, 17, 18, and 19 were still in the admission process and had not had a comprehensive assessment completed.			
G0536	A review of all current medications	G0536		2024-09-22

	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 record review and interview, the home health agency failed to ensure an accurate review of all medications for 2 of 3 active patients reviewed with skilled nurse (SN) services (Patient #8, #11). Findings include: 1. Patient #8's clinical record evidenced a start of care (SOC) on 7/22/24 and included a POC and medication profile for the certification period 7/22/24 to 9/19/24. Clinical records were obtained from Entity 1 during the survey. Comparison of Entity 1's current medication orders list and the home health agency's POC medication profile evidenced the following discrepancies: a) FreeStyle Lancets (used to obtain blood sugar) four times a day was listed on Entity 1's current medication list. The		**G0536** **1. How are we going to correct this deficiency?**	

	the home health agency's POC medication profile. b) Linzess (used to treat constipation) 290 micrograms (mcg) daily was listed on Entity 1's current medication list. The medication was not listed on the home health agency's POC medication profile. c) Aspirin (used for hypertension) 81 mg daily was listed on Entity 1's current medication list. The medication was not listed on the home health agency's POC medication profile. d) Baclofen (used to treat pain) 10 mg at bedtime was listed on Entity 1's current medication list. The medication was not listed on the home health agency's POC medication profile. e) Calcium (used as a supplement) 600 + D 600 mg-5mcg (200 units) twice a day was listed on Entity 1's current medication list. The medication was not listed on the home health agency's POC medication profile. f) Escitalopram (used to treat depression) 20 mg daily was		**The RN's will review patient's medications listed in the HHA's chart to the medications listed on the patient's list in the home with each visit. The RN will ask if there are any new medications being taken or any medications that have been discontinued since the last nursing visit. Any changes will be documented and relayed to the physician's office for confirmation. This will be documented in the patient's chart including who the RN spoke with at the physician office. Current patient's medication lists will be reviewed with the patient's lists at home and updated at the next recertification or skilled nursing visit and or supervisory visit whichever comes first. All RN's will receive education regarding this process and the expectation that moving forward, all medication reviews will be completed with each nursing visit.** **2. The agency will prevent this from occurring in the future by completing**	

	listed on Entity 1's current medication list. The medication was not listed on the home health agency's POC medication profile. g) Polyethylene glycol (used to treat constipation) 17 grams daily was listed on Entity 1's current medication list. The medication was not listed on the home health agency's POC medication profile. h) Ranolazine ER (used to treat chronic chest pain) 500 mg twice a day was listed on Entity 1's current medication list. The medication was not listed on the home health agency's POC medication profile. i) Proctosol external cream (used to treat hemorrhoids) 2.5 % three times a day as needed was listed on the home health agency's POC medication profile. This medication was not listed on Entity 1's current medication list.		**with the RN during supervisory vits, recerts, SOC's, and skilled nursing visits to observe this process is being completed. If the RN is not completing this, the Administrator, DON, or ADON will meet with the RN and have a discussion regarding why the medications are not being reviewed. This documentation will go in the RN's personnel file. RN will be placed on a performance improvement plan if it is determined re-education was not effective.** **3. The Director of Nursing will oversee the audits on all current patients and the education for all RN's.** **4. All education will be performed by 9/22/24.** **5. All audits will be performed by 09/22/24.**	

	j) Carvedilol (used to manage heart failure) 125 mg twice a day was listed on the home health agency's POC medication profile. This medication was not listed on Entity 1's current medication list. During an interview on 8/21/24 beginning at 11:43 AM, the Clinical Manager relayed medications should be reviewed at each nursing visit. During an interview on 8/21/24 beginning at 6:02 PM, RN 6 relayed they filled Patient #8's medication box with the meds listed on the home health agency's medication profile list. 2. Patient #11's clinical record evidenced a start of care (SOC) on 7/22/24 and included a POC and medication profile for the certification period 7/22/24 to 9/19/24. Comparison of Entity 1's current medication orders and the home health agency's POC medication profile evidenced the following discrepancies: a) Acetaminophen (used to treat pain) 500 mg four times a day as needed was on Entity 1's			

current medication list. The medication was not listed on the home health agency's POC medication profile.

During a home visit observation on 8/19/24 beginning at 1:30 PM, Patient #11 relayed they had taken Acetaminophen for right hand pain a few days ago.

During an interview on 8/23/24 beginning at 8:23 AM, Person 9 verified Acetaminophen was prescribed as needed for Patient #11.

410 IAC 17-14-1(a)(1)(B)

During an interview with Person 12, caregiver for Patient #8, on 8/23/24 beginning at 10:55 AM, he/she reported Patient's active medications included: Linzess, Aspirin, Baclofen, Calcium + Vitamin D supplement, Escitalopram, Polyethylene glycol, Ranolaxine ER, and Carvedilol. Person 12 also reported Patient was taking Protocosol as needed for hemorrhoids. The caregiver stated Patient had picked up all medications after they were prescribed and had a supply of all medications in their home.

G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the home health agency failed to ensure the plan of care included accurate visit frequency orders (See Tag G574); failed to ensure services were provided only as ordered (See Tag G580); failed to ensure the plan of care was reviewed with the physician at start of care and/or at recertification (See Tag G588); failed to alert the attending physician for changes in the plan of care (See Tag G590); failed to conduct and document coordination of care with the patient and/or caregiver regarding	G0570	**G0570** **1. How are we going to correct this deficiency?** **The agency will audit 100% of current patient charts. The charts will be reviewed to determine if the patient care plans are individualized and are specific to needs identified in the patient's comprehensive assessment. The audits will determine if all plans of care contain:** **All pertinent diagnoses;** **The patient's mental, psychosocial, and cognitive status;** **The types of services, supplies, and equipment required;** **The frequency and duration of visits to be made;** **Prognosis;** **Rehabilitation potential;** **Functional limitations;**	2024-09-22

	(see Tag G608), and failed to initiate services for patients accepted for services in a timely manner and according to the plan of care for 5 of 5 records reviewed of patients listed on the agency's active patient list but who had not received any services (Patients #15, 16, 17, 18, 19). The cumulative effects of these systemic problems evidenced the agency failed to meet patients' medical, nursing, rehabilitative, and social needs, which resulted in AM Home Health Care continuing to be found out of compliance with Condition of Participation 42 CFR 484.60 Care planning, coordination of services, and quality of care. Findings include: 1. The review of Patient #15's clinical record evidenced a verbal order for a home health evaluation was obtained by Administrator on 7/17/24. Registered Nurse (RN) 3 conducted an initial assessment visit on 7/18/24 and Patient signed admission consents, including a "Consent for Treatment," during this visit. The record failed to evidence a plan of care had been created for Patient nor had Patient received any further services from the agency.		**Activities permitted;** **Nutritional requirements;** **All medications and treatments;** **Safety measures to protect against injury;** **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.** **Patient and caregiver education and training to facilitate timely discharge;** **Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;** **Information related to any advanced directives; and** **Any additional items the HHA or physician or allowed practitioner may choose to include;** **The audit will also look to**	

	2. The review of Patient #16's clinical record evidenced a verbal order for a home health evaluation was obtained by Administrator on 7/26/24, with an evaluation to be performed the week of 7/27/24. RN 2 conducted an initial assessment visit on 7/30/24 and Person 13, guardian for Patient, signed admission consents, including a "Consent for Treatment," during the visit. A plan of care indicated Patient's start of care was 7/27/24 with an initial certification period of 8/19/24 – 10/17/24. The plan of care evidenced skilled nursing and home health aide orders, effective 7/30/24 and 7/31/24, which included an order for home health visits to be conducted 8 hours per day, 7 days per week. The record indicated the plan of care was faxed to Patient' primary care provider on 8/09/24 for signature and received back with signature on 8/20/24. The record failed to evidence Patient had received any services from the agency. 3. The review of Patient #17's clinical record evidenced a verbal order for home health		**orders, including verbal orders, are recorded in the plan of care. The audit will determine if physician/provider orders are being followed and that coordination of care is being documented.** **If anything is found out of compliance with this audit, the chart will be brought back into compliance with the next recertification period. This audit will be added to the HHA's QAPI program focus until 100% compliance is achieved.** **The agency will also provide in-service education to all RN's regarding the importance of the plan of care. Education will cover individualization of the care plans, the need to order appropriate disciplines, documentation of coordination of care between disciplines, and educational needs for patient and caregiver. The in-service will cover 484.60. Documentation for this**	

	obtained by Administrator from Person 14, a physician, on 6/10/24. RN 1 conducted an initial assessment visit on 6/06/24 and Patient signed admission consents, included a "Consent for Treatment," during the visit. A plan of care indicated a start of care date of 5/29/24 and initial certification period of 5/29/24 – 7/27/24. The plan of care evidenced skilled nursing and home health aide orders, effective 6/06/24, which included orders for skilled nursing visits to be conducted once every other week "for medication box set up, [vital signs], pulse [oximeter reading], assessment and education" and home health aide visits to be conducted 3 hours per day, 7 days per week. The record failed to evidence a current plan of care nor had Patient received any services from the agency. 4. The review of Patient #18's clinical record evidenced a verbal order for a home health evaluation was obtained by Administrator on 8/02/24. RN 4 conducted an initial assessment visit on 8/08/24 and Patient signed admission consents, including a "Consent for		**the staff's personnel file.** **2. To prevent this from occurring in the future, the agency will continue to audit 100% of all new SOC charts for compliance with 484.60. If noncompliance is discovered, the DON and administrator will meet with the staff who are out of compliance and determine the reason for non-compliance. This conversation will be documented and placed in the employee's personal file.** **3. The Administrator will ensure all audits are completed and the DON will ensure all education is provided.** **4. The agency will be in compliance with all new plans of care within the last 60 days by 9/22/24** **5. All education will be**	

	plan of care indicated a start of care date of 8/01/24 and initial certification period of 8/01/24 – 9/29/24. The plan of care evidenced skilled nursing and home health aide orders, effective 8/08/24, which included orders for skilled nursing visits to be conducted once every other week for "medication set up, assessment, vital signs, pulse [oximeter reading], and education" and home health aide visits to be conducted 6 hours per day, 7 days per week. The record failed to evidence Patient had received any services from the agency. 5. The review of Patient #19's clinical record evidenced RN 2 conducted an initial assessment visit on 8/02/24 and Person 16, caregiver for Patient, signed admission consents, including a "Consent for Treatment," during the visit. A plan of care indicated a start of care date of 7/12/24 and initial certification period of 8/19/24 – 10/17/24. The plan of care evidenced skilled nursing and home health aide orders, effective 7/12/24, which included orders for home health aide visits to be			

	days per week. The record failed to evidence Patient had received any services from the agency. 6. During an interview with Administrator on 8/20/24 beginning at 1:37 PM, she reported she oversaw the admission process. Administrator stated the following: a. For Patient #15, the agency had not yet conducted an initial evaluation, as Administrator was waiting on Scheduler 10 to notify her of the date for initial evaluation. Administrator would then obtain a verbal order for evaluation from Patient's provider. b. For Patient #16, Administrator had sent a plan of care and Face-to-Face to the ordering provider on 8/09/24. Administrator had received a signed plan of care and Face-to-Face from the ordering provider on 8/20/24 and was working on submitting all required paperwork to Patient's insurance. c. For Patient #17, the agency was waiting to receive a signed plan of care and Face-to-Face			

	from the ordering provider. d. For Patient #18, RN 4 had conducted Patient's initial assessment late. The agency was waiting to receive a signed plan of care and Face-to-Face from the ordering provider. e. For Patient #19, the agency was waiting to receive a signed plan of care and Face-to-Face from the ordering provider. During a follow-up interview with Administrator on 8/20/24 beginning at 4:53 PM, she reported she was not aware Patient #15's initial assessment had been completed. During a second follow-up interview with Administrator on 8/21/24 beginning at 3:51 PM, Administrator reported Clinical Manager was responsible for following up with ordering physicians to obtained signed plans of care. Administrator also reported she would need to write a new plan of care for Patient #17, as the documented plan of care had expired. 8. During an interview with Clinical Manager on 8/23/24 at 10:20 AM, she reported the			

	regarding agency staff's attempts to obtain a physician-signed Plan of Care and Face-to-Face for Patients #15, 16, 17, 18 and 19. 410 IAC 17-13-1(a)(1)			
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; (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	G0574	**G0574** **1. How are we going to correct this deficiency?** **The agency will audit 100% of current patients' charts for accuracy with visit frequency orders. Agency will look at frequency orders in the chart and compare them to what is scheduled and ensure orders are in place for all visits. Any frequency visits that are found to be out of compliance will be corrected immediately by contacting the physician and receiving an interim verbal order that will be confirmed by fax requesting a return signature. This interim order will then be placed in the patient's chart.**	2024-09-22

	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 only home health aide (HHA) services ordered (Patient #12). Findings include: 1. Patient #12's clinical record included a plan of care (POC) for the certification period 7/12/24 to 9/09/24 which indicated the patient was to receive HHA visits 1 time a week for 1 week, 5 times a week for 8 weeks and then 1 time a week for 1 week. The record evidenced Patient #12 received 7 HHA visits a week for the weeks beginning 8/04/24 and 8/11/24. The record failed to evidence physician orders for the above visit frequencies to exceed the POC orders of 5 visits a week for 8 weeks. 2. During an interview on		**The agency will also provide in-service education to all staff regarding visit frequency orders, the importance of reporting missed visits to the physician/provider, the need to request an order from the physician/provider for any extra visits required. Documentation for this education will be kept in the staff's personnel file.** **2. The agency will prevent this from recurring in the future by adding this to the HHA's QAPI program for monthly monitoring of all new SOC's, ROC's and recertifications for a period of no less than 6 months or until 100% of compliance is achieved.** **The agency will also provide education to all new staff about the importance of visit frequency accuracy and obtaining physician/provider orders for all visits made. Documentation for this education will be kept in the staff's personnel file.** **3. The DON will be**	

	HHA 16 confirmed they provide care to Patient #12 7 days a week. 3. During an interview on 8/21/24 beginning at 11:43 AM, the Clinical Manager relayed the clinical record for Patient #12 did not include a physician order to reflect exceeding the POC visit frequencies. 410 IAC 17-13-1(a)(1)(C)(iii)		**responsible for ensuring the above audits and education are completed.** **4. The audits for current patients will be completed by 09/22/24.** **5. The education for all staff will be completed by 9/22/24.**	
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 2 of 3 active patient records reviewed with skilled nurse (SN) and home health aide (HHA) services (Patient #11 and 13). Findings include: 1. The agency policy "Physician's Plan of Treatment" indicated physician's orders are	G0580	**G0580** **1. How are we going to correct this deficiency?** Theagency will audit 100% of current patients' charts for accuracy with visitfrequency orders. Agency will look at frequency orders in the chart and comparethem to what is scheduled and ensure orders are in place for all visits. Any frequency visits that are found to be outof compliance will be corrected immediately by contact the physician andreceiving an interim verbal order that will be confirmed by fax requesting areturn signature. This interim	2024-09-22

	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. Patient #11's clinical record included a plan of care (POC) for certification period 8/09/24 to 10/07/24 with orders for home health aide (HHA) service frequencies of 1 visit a week for 1 week; 5 visits a week for 8 weeks; and 1 visit a week for 1 week and SN visit frequencies of 1 visit every other week. The record evidenced HHA visits were performed on 8/09/24, 8/12/24, 8/13/24, 8/14/24, 8/15/24, 8/16/24, 8/19/24 and 8/20/24 and a SN visit was performed on 8/19/24 . The clinical record for Patient #11 failed to include a verbal or		order will then be placed in the patient'schart. Theagency will also provide in-service education to all clinical staff regardingvisit frequency orders, the importance of reporting missed visits to thephysician/provider, the need to request an order from physician/provider forany extra visits required. Documentation for this education will be kept in thestaff's personnel file. **2. The agency will prevent this from recurring in the future by adding this to the HHA's QAPI program for monthly monitoring of all new SOC's, ROC's and recertifications for a period of no less than 6 months or until 100% of compliance is achieved.** **3. The DON will be responsible for ensuring the above audits and education are completed.** **4. The audits for current patients will be completed by 9/22/24.** **5. The education for all**	

	signed written order for the POC frequencies was obtained prior to the above visits performed. During an interview on 8/20/24 beginning at 1:11 PM, RN 4 indicated they did not document a verbal order for the recertification POC after collaboration with the attending physician and relayed the recertification POC is faxed to the physician for signature after the Clinical Manager approves it. 4. Patient #13's clinical record evidenced a start of care (SOC) on 8/15/24. The record evidenced HHA visits were performed on 8/15/24, 8/16/24, 8/17/24, 8/18/24, 8/19/24 and 8/20/24. The clinical record for Patient #13 failed to include a POC for certification period 8/15/24 to 10/13/24 and failed to include a verbal or signed written order for the HHA frequencies was obtained prior to the above visits performed. During an interview on 8/20/24 beginning at 3:33 PM, HHA 17 relayed they provided HHA services beginning on 8/15/24 as directed by the skilled nurse.		**staff will be completed by 9/22/24.**	

	During an interview on 8/21/24 beginning at 1:56 PM, RN 1 relayed they were still working on the POC for Patient #13 and had not collaborated with the physician for POC orders. 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. 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 1 of 1 active patient record reviewed with a new SOC (Patient #13) and 1 of 1 active record reviewed with a recertification since the last survey (Patient #11). Findings include: 1. The agency policy "Case Management and Assignments" indicated a written plan of treatment and orders will be	G0588	**G0588** **1. How are we going to correct this deficiency?** **The agency will provide in-service education to all staff covering agency policies "Case Management & Assignments", "Physician's Plan of Treatment", and "Physician Responsibilities". The in service will cover the need to collaborate with the physician/provider after or during comprehensive assessment (Initial/SOC, ROC, or Recertification) to obtain verbal orders for the new plan of care being created. The RN will document the conversation with the physician/provider or office staff outlining review of the new Plan of**	2024-09-22

	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 be developed in consultation with the physician and with the involvement of the patient and appropriate caregivers. 4. Patient #13's clinical record evidenced a SOC on 8/15/24. The record failed to evidence a POC for the certification period 8/15/24 to 10/13/24 and failed to include documentation of a verbal or written order for SOC and/or the POC. During an interview on 8/21/24		**Care. Documentation of received verbal order to proceed with new Plan of Care will also be documented. Documentation for this education will be kept in the staff's personnel file.** **2. The agency will prevent this from recurring in the future by performing an audit on 100% of all new SOC, ROC's, and recertifications for documentation of collaboration by the RN with the physician/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 staff about how collaboration should occur and be documented for new Plans of Care, ROC's and Recerts. Documentation for this education will be kept in the staff's personnel file.** **3. The DON will be responsible for ensuring the above audits and education are completed.** **4. The audits for current**	

	beginning at 1:56 PM, RN 1 relayed they were still working on the POC for Patient #13 and had not collaborated with the physician for POC orders. 5. Patient #11's clinical record evidenced a SOC on 1/08/19 and included a recertification POC for certification period 8/09/24 to 10/07/24. The record failed to evidence documentation of a verbal or written order for the recertification POC. During an interview on 8/20/24 beginning at 1:11 PM, RN 4 indicated they did not document a verbal order for the recertification POC and relayed the recertification POC is faxed to the physician for signature after the Clinical Manager approves it. 410 IAC 17-13-1(a) and 410 IAC 17-13-1(a)(2)		**patients will be completed by 09/22/24.** **5. The education for all staff will be completed by 9/22/24.**	
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	G0590	**G0590** **1. How are we going to correct the deficiency?** **The agency will provide in-service education to all**	2024-09-22

	achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to alert the attending physician for changes in the plan of care (POC) for 1 of 1 patient with a change in home health aide (HHA) frequencies (Patient #9). Findings include: 1. Patient #9's clinical record included POC for certification period 8/14/24 to 10/12/24 with orders for HHA visits 5 times a week for 8 weeks and then 1 time a week for 1 week. The clinical record for Patient #9 evidenced the last HHA visit was performed on 7/24/24. The record failed to evidence HHA visits have been made this certification period and failed to evidence collaboration with the attending physician for orders to discontinue HHA services.		**clinical staff regarding the need to collaborate with the physician/provider after or during comprehensive assessment (Initial/SOC, ROC, or Recertification) to obtain verbal orders for the new plan of care being created. The RN will document conversation with physician/provider or office staff outlining review of the new Plan of Care. Documentation of received 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 from recurring in the future by performing an audit on 100% of all new SOC, ROC's, and recertifications for documentation of collaboration by the RN with the physician/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 clinical staff about how**	

	2. During an interview on 8/19/24 beginning at 12:26 PM, the Clinical Manager confirmed Patient #9 was still an active patient and relayed the insurance prior authorization had expired as of 7/24/24 and they did not collaborate with the attending physician to alter the POC. 410 IAC 17-13-1(a)(2)		**collaboration should occur and be documented for new Plans of Care, ROC's and Recerts. Documentation for this education will be kept in the staff's personnel file.** **3. The DON will be responsible for ensuring the above audits and education are completed.** **4. The audits for 100% of patients will be completed by 09/22/24.** **5. The education for all staff will be completed by**	
G0608	Coordinate care delivery 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 home health agency failed to conduct and document coordination of care with the patient and/or caregiver regarding delays in the initiation of services for 5 of 5 records reviewed of patients listed on the agency's active patient list but who had not received services (Patients #15, 16, 17, 18, 19).	G0608	**G0608** **1. How are we going to correct the deficiency?** **The agency will correct this deficiency by reviewing their current process for accepting patients into care who will require prior authorizations. The agency will make sure they have a completed referral before scheduling an admission visit. At that admission visit, the RN will notify the patient and/or legal representative of the**	2024-09-22

	Findings include: 1. The review of Patient #15's clinical record evidenced Registered Nurse (RN) 3 conducted an initial assessment visit on 7/18/24 and Patient signed admission consents, including a "Consent for Treatment," during this visit. The record failed to evidence Patient had received any services from the agency nor had agency staff communicated with Patient and/or their caregiver regarding the delay in initiation of services. 2. The review of Patient #16's clinical record evidenced RN 2 conducted an initial assessment visit on 7/30/24 and Person 13, guardian for Patient, signed admission consents, including a "Consent for Treatment," during the visit. A plan of care indicated Patient's start of care was 7/27/24 with an initial certification period of 8/19/24 – 10/17/24. The plan of care evidenced skilled nursing and home health aide orders, effective 7/30/24 and 7/31/24, which included an order for home health visits to be conducted 8 hours per day, 7 days per week. The record failed		**process to obtain prior auth. The RN will have the documentation completed within 5 days and fax the Plan of Care to be signed by the MD so the PA can be submitted. The agency will contact the patient at a minimum of two times a week to update them on the PA process. The agency will audit all current patients and update any patients who are still waiting for their prior authorization. They will document these communications in the patient's clinical chart. The agency will follow up with the insurance company on any PA that has been submitted greater than 7 days for an update and document that conversation. All charts will be audited and all patients who are waiting for a PA will be contacted, and documentation will occur by 9/22/24.** **2. The agency will prevent this from occurring in the future by following the above process for any new patient who requires a PA**	

	to evidence Patient had received any services from the agency nor had agency staff communicated with Person 13 regarding the delay in initiation of services. During an interview with Person 13 on 8/21/24 beginning at 12:44 PM, the guardian reported he/she had not received any status updates on Patient's initiation of services. 3. The review of Patient #17's clinical record evidenced RN 1 conducted an initial assessment visit on 6/06/24 and Patient signed admission consents, included a "Consent for Treatment," during the visit. A plan of care indicated a start of care date of 5/29/24 and initial certification period of 5/29/24 – 7/27/24. The plan of care evidenced skilled nursing and home health aide orders, effective 6/06/24, which included orders for skilled nursing visits to be conducted once every other week "for medication box set up, [vital signs], pulse [oximeter reading], assessment and education" and home health aide visits to be conducted 3 hours per day, 7 days per week. The record failed		**to be obtained. All staff involved in the PA process will be educated and the requirement for communication with the patients and with the insurance companies and the requirement for documentation in the chart. All staff involved in the PA process will be educated on this process and moving forward all new staff involved in the PA process will be educated on this process during onboarding. The administrator will follow all new patients requiring a PA and ensure that the updates with the patients and the insurance companies are being completed and being documented.** **3. The administrator will ensure the audits and the communications are completed and documented.** **4. The audits for current patients will be completed by 9/22/24.** **5. The education for all**	

	to evidence Patient had received any services from the agency nor had agency staff communicated with Patient and/or their caregiver regarding the delay in initiation of services. During an interview with Person 18, caregiver for Patient #17, on 8/20/24 beginning at 3:20 PM, the caregiver reported he/she had not received any status updates on Patient's initiation of services. 4. The review of Patient #18's clinical record evidenced a verbal order for a home health evaluation was obtained by Administrator on 8/02/24. RN 4 conducted an initial assessment visit on 8/08/24 and Patient signed admission consents, including a "Consent for Treatment," during the visit. A plan of care indicated a start of care date of 8/01/24 and initial certification period of 8/01/24 – 9/29/24. The plan of care evidenced skilled nursing and home health aide orders, effective 8/08/24, which included orders for skilled nursing visits to be conducted once every other week for "medication set up, assessment,		**9/22/24.**	

	vital signs, pulse [oximeter reading], and education" and home health aide visits to be conducted 6 hours per day, 7 days per week. The record failed to evidence Patient had received any services from the agency nor had agency staff communicated with Patient and/or their caregiver regarding the delay in initiation of services. During an interview with Patient and Person 17, caregiver for Patient #18, on 8/21/24 beginning at 12:57 PM, Patient and their caregiver reported they had not received any status updates on Patient's initiation of services. 5. The review of Patient #19's clinical record evidenced RN 2 conducted an initial assessment visit on 8/02/24 and Person 16, caregiver for Patient, signed admission consents, including a "Consent for Treatment," during the visit. A plan of care indicated a start of care date of 7/12/24 and initial certification period of 8/19/24 – 10/17/24. The plan of care evidenced skilled nursing and home health aide orders, effective 7/12/24, which included orders for home			

	health aide visits to be conducted 6 hours per day, 7 days per week. The record failed to evidence Patient had received any further services from the agency nor had agency staff communicated with Patient and/or their caregiver regarding the delay in initiation of services. During an interview with Person 16 on 8/20/24 beginning at 2:50 PM, the caregiver reported they had not received any status updates on Patient's initiation of services. 6. During an interview with Administrator on 8/20/24 beginning at 1:37 PM, she reported she oversaw the admission process. Administrator reported Patients #15, 16, 17, 18, and 19 had not received services yet as the agency was still in the admission process. Administrator reported office staff, including Scheduler 10, would call patients and/or their caregivers "about once a week" to give status updates regarding their initiation of services, however staff did not document this communication.			

	7. During an interview with Scheduler 10 on 8/20/24 beginning at 4:27 PM, she reported she did not routinely contact patients or families to give status updates on their initiation of services. 410 IAC 17-12-2(g)			
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 home health agency failed to document actions aimed at performance improvement and an evaluation of success resulting from performance improvement actions, which had the potential to affect all active patients. Findings include: The review of the agency's quality assessment and performance improvement (QAPI) committee documentation evidenced a meeting was held on 8/05/24. The committee documentation	G0656	**G0656** **1. The agency will review current PIP's that they have designate for their QAPI Program. The agency will review 484.65 and 410 IAC 17-12-2(a) They will document this as a part of their QAPI meetings. They will review documentation and data for all current PIP's and determine if they need to continue because the goals have not been met or if they can be discontinued due to goals being met. Any PIP that needs to continue, they will document education and efforts undertaken to facilitate this PIP.** **2. The agency will prevent**	2024-09-22

	meeting documented since the agency's last survey completed on 7/08/24. Review of the meeting minutes from 8/05/24 indicated a performance improvement project (PIP) regarding patient "ER/hospitalization" was to continue. The minutes failed to evidence further documentation related to the PIP, including actions taken for performance improvement nor an evaluation of the success resulting from PIP actions. The QAPI meeting minutes also failed to evidence documentation of any additional PIPs the committee had developed. During an interview with Administrator on 8/23/24 beginning at 2:37 PM, she reported the agency's current PIPs initiated prior to the current survey included "falls, hospitalizations, ER visits, infections ...." Administrator reported Clinical Manager was responsible for developing the PIP related to hospitalizations. The review of an undated document titled "Performance Improvement Project (PIP) Hospitalizations" failed to evidence if identified PIP actions		**future by placing quarterly QAPI meetings on the calendar. They will audit the QAPI meeting minutes every 6 months to ensure that the QAPI team is following 484.65.** **The agency will provide education to all new staff regarding the QAPI condition and the importance of it in the home health agency. This will happen during onboarding.** **3. The Administrator and/or DON will be responsible for ensuring the QAPI meetings and education are completed.** **4. The QAPI meeting and all education will be completed by 9/22/24.**	

	had been enacted and failed to evidence an evaluation of success resulting from the identified improvement actions. During an interview with Clinical Manager on 8/23/24 beginning at 4:35 PM, she reported the agency's hospitalization PIP was initiated on 6/28/24. When queried on what was reviewed regarding this PIP during the 8/05/24 QAPI committee meeting, Clinical Manager stated she did not remember and she had "just turned in" the PIP documentation to Administrator. During a follow-up interview with Administrator on 8/23/24 beginning at 4:40 PM, she reported the agency had no documentation for its PIPs related to falls or infections.			
G0708	Development and evaluation of plan of care 484.75(b)(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); Based on record review and interview, the registered nurse (RN) failed to ensure the plan of	G0708	**G0708** 1.How are we going to correct this deficiency? Theagency will audit 100% of patients charts who have been admitted within last 90days to determine that all	2024-09-22

	care (POC) was created and reviewed with the physician for 1 of 1 patient record reviewed with a new start of care (SOC) (Patient #13). Findings include: 1. The agency policy "Care Plan" indicated to ensure that a patient's needs are met adequately and appropriately, a care plan is started upon initiation of service by the RN, based upon the plan of treatment and an assessment of the patient's needs, resources, family and environment. 2. Patient #13's clinical record evidenced a SOC on 8/15/24. The record failed to evidence a POC for the certification period 8/15/24 to 10/13/24 was created at SOC. 3. During an interview on 8/21/24 beginning at 11:43 AM, the Clinical Manager relayed the POC should have been created after the comprehensive assessment was performed during the SOC. 4. During an interview on 8/21/24 beginning at 1:56 PM, RN 1 relayed they were still working on the POC for Patient		documentation has been completed within the timeframe that agency policy dictates. Any deficiencies found will be addressed by contacting the physician and documented in a communication note and/or corrected within an interim order given verbally by the physician and then faxed for signature. Any orders obtained will be placed in patient's chart. **2. The agency will prevent this from recurring in the future by auditing 100% of all SOC's to ensure 100% of documentation is being completed on time. If this is not being completed timely, the administrator will notify the DON and they will meet with the RN responsible for developing the POC. They will review and document the conversation as to why the POC was not completed in a timely manner. If education is found to not be effective, the RN will be placed on a performance improvement plan.** **3. The Director of Nursing**	

	#13 and it was still in progress. 410 IAC 17-14-1(a)(1)(C)		**will provide all education regarding timely initiation of care. The Administrator will ensure that all audits are completed.** **4. All education will be performed by 9/22/24.** **5. All audits will be performed by 9/22/24.**	
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the registered nurse (RN) failed to ensure all skilled nurse (SN) visit note documentation was completed in a timely manner for 1 of 1 active patient records reviewed with a new start of care (SOC) (Patient #13). Findings include: 1. Patient #13's clinical record evidenced a SOC on 8/15/24. The SN comprehensive assessment visit note created on 8/15/24 was not completed and signed during record review on 8/20/24. RN 1 failed to complete the SN visit note. 2. During an interview on	G0716	**G0716** **1. How are we going to correct the deficiency?** **The agency will audit 100% of patient charts who have been admitted within the last `90 days to determine that all documentation has been completed within the time frame that agency policy dictates.** **Education will be provided to all staff regarding agency policy for timely documentation completion. All education will be completed by 9/22/24.**	2024-09-22

	8/20/24 beginning t 2:10 PM, the Administrator relayed the SN visit notes should be completed within 24 hours of the visit. 3. During an interview on 8/21/24 beginning at 1:44 PM, the Clinical Manager relayed the SN visit notes should be completed within 24 hours and the OASIS assessment note should be completed within 72 hours. 4. During an interview on 8/21/24 beginning at 1:56 PM, RN 1 relayed they had started the 8/15/24 SN visit note for Patient #13, however, they were still working on it. 410 IAC 17-14-1(a)(1)(E)		**2. How are you going to prevent the deficiency from recurring in the future, even if it has already been corrected?** **We will prevent this from recurring in the future by educating all new staff regarding agency policy for timely documentation. We will monitor and audit 100% of all new SOC's for timely documentation completion. If education is found to not be effective, the RN will be placed on a performance improvement plan.** **Our Director of Nursing will oversee all audits for timely documentation and will oversee all education provided.** **3. All education will be performed by 9/22/24.** **4. All audits will be**	
N0000	Initial Comments This was a Post-Condition Revisit for a State Re-Licensure	N0000		

	survey of a Home Health Provider. Survey Dates: August 19, 20, 21, 23, 2024 12-Month Unduplicated Skilled Admissions: 33			

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	9/18/2024 11:03:26 AM