STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K140	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Heart Health Services Llc	3313 S 7TH STREET, TERRE HAUTE, IN, 47802

(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: 05/09/2024-05/10/2024 & 05/13/2024-05/14/2024 Active Census: 43 At this Emergency Preparedness survey, Golden Hearts Health Services LLC was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR completed on 05/20/2024 by A4.	E0000	POCaccepted on 05-28-2024 E0000 GoldenHeart Health Services is submitting the following POC issued by ISDH and /or CMSas it is required to do by applicable state and federal regulations. Thesubmission of this POC is not intended as an admission, does not constitute anadmission by and should not be construed as an admission by Golden Heart HealthService that the findings and allegation here in are accurate and truerepresentation of quality of care and services provided to patients of theagency. Golden Heart Health Service desires this POC to consider our allegationof compliance. “The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is	

			correct and will notrecur. COMPLETION DATE: ON-GOING Teresa Johnson, RN-Administrator	
E0013	Development of EP Policies and Procedures 483.73(b) §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.	E0013	E0013 The Administrator is updating the Emergency Preparedness. Administrator will review and update the polices and procedures of the emergency preparedness program. The Emergency Preparedness program is on-going and reflects the complexity of the agency and need for the emergency preparedness program, priorities for patient and staff safety. Emergency preparedness program will be completed by__6/12/2024_____ The emergency preparedness program will be evaluated annually, and approval will be documented/recorded in Govern Body Minutes.	2024-06-12

	*Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the agency failed to develop and implement policies and procedures that align with the hazards identified within its risk assessment for 1 of 1 Emergency Preparedness Program review. Findings include:		The Administrator will update a risk assessment/hazard vulnerability analysis for the communities the agency serves for Terre Haute and Greenwood office. The analysis will inform the agency of the types of emergencies are at risk for. The analysis will be updated as needed and annually. Date completed__6/12/24_____ The Administrator will update / review the agency policies and procedures for the emergency and preparedness program which will be based on risk assessment and communication plan. The emergency preparedness program policies and procedures must address management of medical and	

	A policy titled "Emergency Preparedness Management Policy" was provided by the Administrator on 05/13/2024. The policy indicated that the agency would analyze emergencies and develop and maintain a written plan describing the process, readiness, and ability to implement it. A review of the Emergency Preparedness Plan for 2023 and 2024 failed to evidence policies and procedures for the following identified hazards within the risk assessment: tornadoes, severe thunderstorms, snowfall, external flooding, and Epidemics. Additional emergency events identified in the risk assessment included the following: blizzards, ice storms, earthquakes, temperature extremes, drought, wildfires, dam inundation, and chemical, biological, nuclear, and explosives. During an interview on 05/13/2024 at 1:20 PM, the Administrator stated she could not find any policies aligning with the agency's identified hazards for 2023 and 2024. The		non-medical emergencies, and policies must align with agencies with hazard identified within the risk assessment (on-going) It is the Administrator's responsibility for updating the Emergency preparedness program and monitoring these corrective actions to ensure this deficiency is corrected and will not recur.	

	Administrator stated the former Administrator had deleted information from the computer and that papers were everywhere. The Administrator stated she was left to clean up a mess.			
E0036	EP Training and Testing 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the	E0036	E0036 Administrator and /or Director of Nursing must develop andmaintain testing and training, and orientation including tabletop, communityexercise or emergency event for staff of the emergency preparedness programbased on risk assessment, policies, and procedures; the testing and trainingmust be reviewed and updated every two years, which meets the requirements forevacuation drills and training. Documentation of training and testing will bemaintained by the Administrator. (on-going) Administrator in-service staff of emergency preparednessplan that the agency will conduct tabletop and actual drills	2024-06-12

	this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the agency failed to maintain documentation of its training and testing program for emergency preparedness, as set forth in the emergency plan for 1 of 1 Emergency Preparedness Program review. Findings include:		annually and asneeded. Date Completed__6/12/24_____ _ The administrator and/or Director of nursing will maintainemergency preparedness information with patients of the agency in admission redfolder content in patients' homes. The emergency preparedness information inred folders will be updated per Director of Nursing and/or RN staff, with anychanges made to the patient's status in the red folder content. (on-going) The administrator will be responsible for monitoringtesting, training, orientation for staff and patients, and patient 'emergencyinformation updated in red folder content.	

	1. A 2023 "Emergency Preparedness Plan" was provided by the Administrator on 05/10/2024. The plan indicated that the agency would conduct tabletop and actual drills quarterly or as needed. 2. An undated policy titled "Emergency Preparedness Management Policy" was provided by the Administrator on 05/13/2024. The policy indicated that staff members were supposed to participate in an annual desktop drill. 3. A review of the agency's 2023 and 2024 Emergency Binder on 05/13/2024 failed to evidence that the staff completed a tabletop exercise, community exercise, or emergency event for 2023 and 2024. Additionally, the agency failed to provide policies and procedures based on the identified hazards within the risk assessment and failed to evidence staff training related to the agency's policies and procedures that align with the agency's identified hazards. 4. During an interview on 05/13/2024 at 1:20 PM, the Administrator stated she could			

	with the agency's identified hazards for 2023 and 2024. The Administrator stated the former administrator had deleted information from the computer or hid the 2023 tabletop exercise in a file somewhere. The Administrator stated she was left to clean up a mess.			
E0039	EP Testing Requirements 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next	E0039	E0039- Administrator and/or Director of Nursing must conducttesting, training and orientation for requirements pertaining to the annualemergency preparedness program with documentation of training provided.(on-going) Administrator and/or Director of Nursing must conductexercise to test the Emergency preparedness plan by including full scaleexercise or community- based exercise if accessible per policy. If not accessible, then agency basedfunctional exercise will be conducted annually. The exercises will be conducted	2024-06-12

	facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:		alternating years of a full-scaleexercise and a functional exercise and analyzed responses will be documented.(on-going) Date Completed__6/12/24_____ The administrator is responsible for monitoring testing,training, and orientation of the emergency preparedness program includingdocumentation for these corrective actions to ensure this deficiency iscorrected and will not recur.	

	(A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.			

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]

(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:

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

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

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

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following:

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

(B) A mock disaster drill; or

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

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

*[For PACE at §460.84(d):]

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

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

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

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

	(B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge			

	an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on record review and interview, the agency failed to conduct and document the analysis of all tabletop drills, emergency events, and the agency response to the analysis for 1 of 1 Emergency Preparedness Programs. Findings include: A 2023 "Emergency Preparedness Plan" was provided by the Administrator on 05/10/2024. The plan indicated the agency would conduct tabletop exercises and actual drills quarterly or as needed. The plan did not address the analysis of all tabletop exercises, drills, emergency events, the agency's response to the analysis, and what lessons were learned. A review of the Emergency Preparedness Binder failed to provide evidence staff attended a tabletop exercise or community-based exercise for 2023. During an interview on			

	05/13/2024 at 1:20 PM, the Administrator stated she started four months ago and just started working on the Emergency Preparedness program. She stated that the former Administrator probably hid the 2023 tabletop exercise in a file somewhere.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: 05/09/2024 to 05/14/2024 12-Month Unduplicated Skilled Admissions: 5 Extended survey announced: 05/13/2024 During this Federal Recertification Survey, Golden Heart Health Services was found to be out of compliance with Conditions of Participation §484.45 Reporting of OASIS Information, §484.60 Care planning, coordination of services, and quality of care.; §484.80 Home health aide services.	G0000	POC accepted on 05-28-2024 G0000 Golden Heart Health Services is submitting the following POC issued by ISDH and /or CMS as it is required to do by applicable state and federal regulations. The submission of this POC is not intended as an admission, does not constitute an admission by and should not be construed as an admission by Golden Heart Health Service that the findings and allegation here in are accurate and true representation of quality of care and services provided to patients of the agency. Golden Heart Health Service desires this POC to consider our allegation of compliance. “The Administrator will be responsible for monitoring these corrective actions to	

	Based on the Condition-level deficiencies during the 05/14/2024 survey, your HHA was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 05/13/2024. 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 programs for a period of two years beginning 05/14/2024 and continuing through May 13, 2026. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.		ensure that this deficiency is correct and will not recur. COMPLETION DATE: ON-GOING Teresa Johnson, RN-Administrator	
G0370	Reporting OASIS information 484.45 Condition of participation: HHAs must electronically report all OASIS data collected in accordance with §484.55. Based on record review and interview, the agency failed to transmit OASIS information for	G0370	G0370- Administrator in-service Director of Nursing on transmissionof Oasis. Administrator provided Director of Nursing with Oasis Guidance	2024-06-12

	all skilled Medicaid patients utilizing federally funded health plans not meeting the transmittal requirements and failed to submit OASIS (Outcome Assessment Information Set) within 30 days of assessment completion (See tag G372) The cumulative effect of this systemic problem resulted in the home health agency to be out of compliance with the Condition of Participation of 42 CFR 484.45, Reporting of OASIS information. Findings include: 1. A policy titled "Encoding and Reporting OASIS Data" indicated but was not limited to " ... The agency will electronically report all OASIS data ... transmit assessment data on all skilled (Medicare and Medicaid) clients receiving services from Agency ... " 2. A policy titled "Transfer Policy" indicated but was not limited to " ... The Transfer		manualE 2024, Oasis Timepoints with instructions how to review and complete, andprovide a tracking form. Date Completed: 5/20/24 Director of Nursing is to complete all Oasis transmissionsand documentation (on-going) Director of Nursing is to complete all inactive	

	OASIS will be conducted within 48 hours of (or knowledge of) transfer to another home health or higher level of care facility … " 3. A review of an agency document titled " OASIS (a comprehensive assessment designed to collect information related to a home care recipient's demographic, clinical, functional, and service needs) Agency Final Validation." The document was for the reporting period of the year to date, which indicated that Inactive Patients #1 had a section titled "RFA (Reason For Assessment) listed as 05, indicating other follow-up OASIS assessments were submitted on 02/01/2024. The agency validations failed to report transfer submissions for Patients #1 and #7 Medicaid skilled patients utilizing federally funded health plans. 4. A review of the inactive clinical record for Patient #1, discharge date 08/29/2023, contained a plan of care for the recertification period of 07/04/2023 to 10/11/2023. The plan of care indicated Patient #1 received Skilled Nursing 11		completion, including Oasis past the scheduled timepoints, including prior to Director of Nursing services stated in correctiveaction. DateCompleted_6/12/24___ Director of Nursing to complete all start of care,recertifications, resumptions, follow-up, transfer to an inpatient facility,and discharge from agency oasis transmission, and final validation to bemonitored. (on-going) The administrator will be	

	hours a day for 7 days a week to provide total care for nutritional and medication management per gastronomy tube (a tube inserted into the stomach to provide liquid nutrition and medication), blood sugar management, oral suctioning, bladder and incontinence care, repositioning, transfers with a Hoyer, and assessments. A review of physician-signed orders indicated on 08/26/2024, Patient #1's Home Health Agency (HHA) services were placed on due hospitalization. An order dated 08/29/2024, revealed Patient #1 was discharged due to death. A review of the comprehensive reassessment dated 08/16/2023 indicated the OASIS Assessment reason, Other follow-up for the certification period 07/14/2023 to 09/11/2023. The narrative indicated a resumption of care assessment completed after a hospital stay from 07/29/2023 to 08/13/2023 for coughing and respiratory distress. The record failed to evidence a transfer OASIS was completed for 08-26-2023. During an interview on		responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	05/09/2024 at 3:22 PM, when queried regarding the transfer OASIS location in the clinical record, the Administrator indicated that the only OASIS in Patient #1's chart is the other follow-up OASIS. The Administrator stated, "Someone didn't do it." 5. A review of the inactive clinical record for Patient #7, discharge date 01-22-2024, contained a plan of care for the recertification period of 11/21/2023 to 01/19/2024. The plan of care indicated that Patient ##7 received Skilled Nursing 1 hour a day for 2 days a week for ileostomy (a surgical opening that connects the ileum to the abdominal wall for stool to leave the body) and hearing aid maintenance due to disease processes that hinder the patient from completing these skills. A review of physician-signed orders indicated on 01/22/2024 that Patient #7 may be discharged from Golden Heart Health Services due to hospital admission at the end of their recertification, and the Power of Attorney was notified.			

	A review of the comprehensive assessment completed in the clinical record for Patient #7 indicated that the last assessment was completed on 12/29/2023 and was a resumption of care assessment for the certification period of 11/12/112 to 01/19/2024. The record failed to evidence a transfer OASIS was completed for 08/26/2023. During an interview on 05/10/2024 at 2:11 PM, when queried regarding the transfer OASIS location in the clinical record, the Administrator indicated that it should have been done and wasn't.			
G0372	Encoding and transmitting OASIS 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary. Based on record review and interview, the agency failed to submit OASIS (Outcome Assessment Information Set) within 30 days of assessment completion for 1 of 2 inactive	G0372	G0372- Administrator in-service Director of Nursing and Nurses oncompletion of start of care, recertifications, resumption of care, within timepoints required for completion. RN nurses receive orientation that allpatient's assessments are to be completed within the required timeframe ofrecertification period open	2024-05-23

	records reviewed. (Patients: #1) Findings Include: 1. A policy titled "Encoding and Reporting OASIS Data" indicated but was not limited to, " ... Agency will encode and electronically transmit each completed OASIS assessment to the CMS system within 30 days of completing the assessment of the client ... " 2. A review of an agency document titled " OASIS (a comprehensive assessment designed to collect information related to a home care recipient's demographic, clinical, functional, and service needs) Agency Final Validation." The document was for the reporting period of the year to date, which indicated that Inactive Patients #1 had a section titled "RFA (Reason For Assessment) listed as 05, indicating other follow-up OASIS assessments were submitted on 02/01/2024 and the M0090 date (date of completion) of 02-08-2023 with message -3330 indicating record submitted late; more than 30 days after the M0090 date of the record.		window, patients are to be called per Nurses andprovide patients with a time and date of arrival and document discussion. Startof care is to be completed within 48 hours. Director of Nursing to review allRN assessment and chart review after completion of work, then send to physicianor allowed practitioner for signature. Completed date:5/23/24	

	3. A review of the inactive clinical record for Patient #1, discharge date 08/29/2023, contained a comprehensive reassessment dated 08/16/2023. The OASIS Assessment reason was for Other follow-up for the certification period 07/14/2023 to 09/11/2023. The narrative indicated a resumption of care assessment completed after a hospital stay from 07/29/2023 to 08/13/2023 for coughing and respiratory distress. During an interview on 05/09/2024 at 3:22 PM, when queried regarding the submissions of OASIS, the Administrator indicated that the Director of Clinical was to review and submit the OASIS within 30 days of the date of completion.			
G0414	HHA administrator contact information 484.50(a)(1)(ii) (ii) Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints. Based on record review and interview, the agency failed to	G0414	G0414- The administrator and/or Director of Nursing ensured allcurrent patients were given written notice of whom the Administrator andDirector of Nursing with name and contact	2024-06-12

	ensure all patients were provided with the correct and updated contact information for the administrator for 4 of 5 home visits conducted. (Patients: #4, 5, 8, and 9) Findings Include: 2. During a home visit on 05/10/2024 at 10:05 AM, the admission packet of Patient # 4 was reviewed and found not to have the Administrator's name and contact information. The agency failed to provide the patient and/or caregiver with updated agency contact information. An interview on 05/10/2024 at 10:05 AM, Patient #4 indicated they did not know who the Administrator was for the agency. 4. During an observation on 05/13/2024 at 10:50 AM, Patient #8's admission packet did not contain the Administrator's name and contact information. The agency failed to provide the patient and/or caregiver with updated agency contact information. During an interview on		information per mail. Datecompleted___6/12/24_____ The Administrator and Director of Nursing ensured all staffwere given written notice of whom the Administrator and Director of Nursingwith name and contact numbers per Alora mail and in-service. Datecompleted_6/12/24_____ Administrator and Director of Nursing in-services with allstaff informing of Administrator and Director of Nursing names and contactinformation. Date Completed_6/12/24___ Director of Nursing and/or designee updated current	

	05/13/2024 at 11:40 AM, Patient #8 indicated they did not know who the agency's Administrator was or how to file a complaint with the agency. 1. A policy titled "Client/Family Grievance Policy" indicated but was not limited to "All clients admitted to the Agency will be informed of their right to voice grievances to the agency ... Clients will be presented with the Agency ... correct Contact numbers ... " 2. During a home visit at Patient #5's residence on 05/10/2024 at 10:45 AM, when queried regarding the agency folder, Patient #5 provided a red folder for review. A review of the red folder contained Golden Heart Health Services admission documents but failed to have the administrator's contact information. Patient #5 confirmed they did not know who the Administrator was or how to contact them. During an interview on 05/10/2024, at 11:00 AM, the Home Health Aide (HHA) 3, the caregiver for Patient #5, indicated they were unaware of the contact information for the		patientsupdated red folder contents including Administrator and Director of Nursingnames and contact information, Plan of care, medication profile, medicationinteractions, allergy list, Braden scale, correct contact information, GoldenHeart Health Services calendar contains schedules. Datecompleted_6/12/24_____ Director Of Nursingand/or Nurse will document current patients received updated red folder contentincluding Administrator and Director of Nursing names and contact information.Date Completed__6/12/24____ Administrator and Director of Nursing in-serviced staff toview red folder content in all current patients' homes. Any patient who doesn'thave/can't find their folder a new one will be	

	Administrator and only knew the scheduler, Admin 1. 3. During a home visit at Patient #9's residence on 05/13/2024 at 10:37 AM, when queried regarding the agency information, Patient #9 obtained a red folder from their dresser drawer. A review of the red folder contained Golden Heart Health Services admission documents and listed the current Administrator as Former Employee 7, the agency's previous Administrator. During an interview on 05/13/2024 at 10:53 AM, the Registered Nurse (RN) 1 confirmed Patient #9's folder indicated Former Employee 7 as the current Administrator. RN 1 stated, "That is old and needs to be updated."		originaland current documents. Nurses will document in chart if Admin folder waspresent and if not that a new one was provided to patient. DateCompleted___6/12/24_____ and (on-going). The Director of Nursing will be responsible for monitoringthese corrective actions to ensure that this deficiency is corrected and willnot recur.	
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 agency failed to provide services as ordered on the plan of care (POC) for 4 of 7	G0436	G0436- Administrator and Director of Nursing in-service staff onrequirements for patients, all services ordered by physician or allowedpractitioner in the plan of care.	2024-06-12

	active record reviews. (Patient #2, #3, #6, #8) Findings include: 6. A review of Patient #3's record, start of care (SOC) dated 01/22/2024, certification period 01/22/2024 to 03/21/2024, included a POC with orders for skilled nursing services 1 hour a day, one day a week for 26 weeks for medication box fill. The agency failed to provide skilled nursing services from 01/22/2024 to 03/05/2024 and failed to document a reason why. 7.A review of Patient #8's record, the start of care (SOC) dated 01/05/2024, certification period 01/05/2024 to 03/04/2024 included a POC with orders for Home Health Aide (HHA) services 6 hours a day, four days a week for 26 weeks. The agency failed to document why HHA services were not provided from 01/05/2024 to 02/15/2024 and failed to provide HHA services from 02/15/2024 to 03/04/2024 due to staffing availability. A certification period from		Director of nursing/designee will audit all current patientcharts to ensure patients were receiving the services ordered by physician orallowed practitioner in the plan of care. Visit notes compared to plan of careto ensure frequency and tasks are provided as ordered on the plan of care. Thephysician and or allowed practitioner will be notified of any clarification oforders and documentation completed with the name spoken to regarding patients'care and document and changes in patients plan of care. Datecompleted_6/12/24_____ The Director of Nursing is to communicate to the scheduleron scheduled visits according to the frequency on the plan of care and trackingfrequencies of changes of frequencies. (on-going)	

	03/05/2024 to 05/03/2024 included a POC with orders for skilled nursing services 1 hour a week for 26 weeks for medication box fill and Home Health Aide (HHA) services 4 hours a day four days a week for 26 weeks. The agency failed to provide HHA services from 03/05/2024 to 03/13/2024 due to staff availability. 8. During an interview on 05/13/2024 at 1:35 PM, the Administrator indicated a late start in services is acceptable because family members are there to help the patient until the agency can start services. 1. A policy titled "Clinical Documentation" was provided by the Administrator on 05/10/2024. The policy states that if services are not provided as per the physician's order, the reason for missed visits must be documented and reported to the physician. 2. An undated document titled "Rights of the Client" was provided by the Administrator on 05/13/2024. The document indicated the patient should receive all services outlined in		The Director of Nursing will review the nursing scheduleweekly to ensure visits are scheduled as ordered frequency plan of care.(on-going) The administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	comprehensive assessment. The agency was to document all problems and efforts made to resolve the problem in the patient record. 3. A review of Patient #2's record, start of care (SOC) dated 03/11/2024, certification period 03/11/2024 to 05/09/2024 included a plan of care (POC) with orders for home health aide (HHA) services 10 hours a day five days a week. The agency failed to aides services from 03/14/2024 to 04/07/2024. The agency failed to document a reason why HHA services were not provided. 4. A review of Patient #6's record, start of care (SOC) date 03/13/2024, certification period 03/13/2024 to 05/11/2024 included a POC with orders for HHA services 10 hours a day for six days a week, and skilled nursing services 1 hour a week every week for medication refill and assessment. The agency failed to provide services for March, April, and May 2024. 5. During an interview on 05/09/2024 at 12:30 PM, the Administrator stated they were waiting on payor approval for			

	Patient #2. The Administrator stated that no visits had been made for Patient #6 as they were waiting on payor approval. Due to this, the agency had to put HHA services on hold. The Administrator said the physician did not approve as the medication list for Patient #6 was incorrect. The Administrator was not able to provide a reason for the need for HHA services if Patient #6 could go without any services for three months.			
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 record review and interview, the agency failed to complete an initial assessment within 48 hours of a referral for 4 of 7 active record reviews. (Patient #2, #3, #6, #8)	G0514	G0514- Administrator in-service Director of Nursing and Nursingstaff on initial assessments to be completed within 48 hours of referral, or onthe physicians or allowed practitioner start date. DateCompleted__5/23/24_____ The administrator and/or	2024-05-23

	Findings include: 3. A review of Patient #3's record, the start of care (SOC) date 01/22/2024, and certification period 01/22/2024 to 03/21/2024 included an unsigned referral dated 01/08/2024. The agency failed to complete the initial assessment within 48 hours of the referral. During an interview on 05/10/2024 at 1:00 PM, the Administrator indicated she was unable to find communication notes for reason of admission being delayed past 48 hours. 5. A review of Patient #8's record, start of care (SOC) date 01/25/2024, certification period 01/05/2024 to 03/04/2024 included a referral date 01/15/2024. The agency failed to complete the initial assessment within 48 hours of the referral. 1. A policy titled "Comprehensive Client Assessment" was provided by the Administrator on 05/10/2024. The policy		notifyphysician and or allowed practitioner for any reason assessment is delayed, thephysician and or allowed practitioner must be notified as evidenced bysupporting documentation. (on-going). The Director of Nursing will be responsible for monitoringthese corrective actions to ensure this deficiency is corrected and will notrecur.	

	assessment must be conducted within 48 hours of a referral. 2. A review of Patient #2's record, start of care (SOC) date 03/11/2024, certification period 03/13/2024 to 05/11/2024 included a referral date 02/29/2024. The agency failed to complete the initial assessment within 48 hours of the referral. 3. A review of Patient #6's record, SOC date 03/13/2024, certification period 03/13/2024 to 05/11/2024, included a referral date of 02/29/2024. The agency failed to complete the initial assessment within 48 hours of the referral.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the agency failed to ensure staff reviewed patient medications	G0536	G0536- Administrator in-service Director of Nursing and Nurses onneed to complete a review of all medication profiles, medication interaction,allergy list, medications over the counter, duplicate therapy, ineffective drugtherapy patients are currently using. Date completed. _5/23/24_____	2024-05-23

	during a home visit for 1 of 1 recertification observations with a nurse. (Clinical Supervisor) Findings include: 1. A policy titled "Medication Reconciliation" was provided by the Administrator on 05/10/2024. The policy indicated but was not limited to the nurse reviewing and reconciling all medications at each nursing visit and recertification (60 days). 2. During a home visit on 05/09/2024 at 3:00 PM, the Clinical Supervisor failed to review each medication bottle against the care plan/medication profile for Patient #2's 60-day recertification visit. The Clinical Supervisor reviewed the admission packet but could not locate the plan of care or medication/wound care list. The Clinical Supervisor stated that Entity 1 handles the wound treatment and medications. 3. During an interview on 05/10/2024 at 8:45 AM, the Administrator stated that the nurse was expected to compare each medication bottle against the medication profile or plan		Administrator in-service Director of Nursing and Nurses onneed of assessment to accurately reflect patient medications profiles,allergies, medication interactions for patient education and teaching. In thisin-service Nurses and Director of Nursing were provided proper technique incompleting medication set-ups for patients; including standard precautions ofinfection control, donning gloves, obtaining updated medication profiles fromphysicians or allowed practitioners, changes of drug therapy, education patienton proper disposal of expired medication or sharp objects including usedneedles, reporting any changes and documentation completion. Date completed.__5/23/24_____	

	of care at the time of recertification to ensure the patient received it correctly. 410 IAC 17-14-1(a)(1)(B)		The Director of Nursing will review all medication set-upsdocumentation after every skilled patient visit and every 14 days Supervisoryvisit for skilled patients to ensure documentation on patients, medication changes, patient education andteaching of medications, medication interactions and allergies. (on-going) The Director of Nursing and/or designee will complete every14 days a Supervisory visit to all skilled patients. Date completed(on-going)	

			The Director of Nursing will be responsible for monitoringthese corrective actions to ensure this deficiency is corrected and will notrecur.	
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 observation, record review, and interview, the agency failed to have a signed plan of care (POC) or a verbal POC order from the primary physician before providing services and treatments (See tag	G0570	G0570- Administrator in-serviced Director of Nursing and Nursesthat a physician or allowed practitioner's written or verbal order authorizingdisciplines, frequencies, services, treatment, medications order, and otherpatient specific orders must be obtained before services are provided. Datecompleted__5/23/24_____ The Director of Nursing and/or designee will complete chartaudits that physician or allowed practitioner's written or verbal orders wereobtained	2024-05-23

	teaching and education provided to a patient (See tag G574); failed to follow physician orders for setting up a weekly medication planner (See tag G580); failed to ensure the agency coordinated care with another agency that was providing care to a patient (See tag G608); failed to ensure the patient's visiting schedule was in the home (See tag G614); failed to provide a copy of written medication and treatment instruction was in the home (See tag G616); failed to ensure the patients failed to ensure staff reviewed patient medications during a home visit (See tag G618); and failed to provide the patient with contact information for the clinical manager (See tag G622). The cumulative effect of this systemic problem resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation of 42 CFR 484.60 Care planning, coordination of services, and		before care is provided to the patient. Date completed (on-going)_ Director of Nursing and/or designee will update patients'red folders with signed plan of care, calendar of frequencies, medicationprofile, medication interactions, allergy list, Braden scale; after theassessment completed per physician's or allowed practitioners' orders obtained.Assessment completed and sent to physician or allowed practitioners reviewsigned and returned to agency. (0n-going). The Director of Nursing will be responsible for monitoringthese corrective actions to ensure this deficiency is corrected and will notrecur.	

	quality of care.			
G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to have a signed plan of care (POC) or a verbal POC order from the primary physician before providing services and treatments to patients for 3 of 7 active patient record reviews. (Patient #3, #4, #8) Findings include: 1. An undated policy, titled "Physician/Allowed Non-Physician Practitioner (NNP) orders," indicated all medication, treatments, and services provided to patients	G0572	G0572- Administrator in-serviced Director of Nursing and Nursesthat a physician or allowed practitioner's written or verbal order authorizingdisciplines, frequencies, services, treatment, medications order, and otherpatient specific orders must be obtained before services are provided. Datecompleted__5/23/24_____ The Director of Nursing and/or designee will complete chartaudits that physician or allowed practitioner's written or verbal orders wereobtained before care is provided to the patient. Date completed (on-going)_	2024-05-23

	These orders may be received by phone or in writing and must be signed. 2. The record review for Patient #3, certification period 03/22/2024 to 05/20/2024, revealed patient care was provided to Patient #3 without a verbal order or physician-signed order on 03/27/2024. During an interview on 05/10/2024 at 1:00 PM, the Administrator indicated she understood the POC needs to be signed or a verbal order of services to be provided until POC is signed. The Administrator was unable to locate verbal orders, in Patient #3's chart, for visit provided on 03/27/2024. 3. The record review for Patient #4, certification period 03/23/2024 to 05/21/2024, revealed patient care was provided to Patient #4 without a verbal order or physician-signed order on 03/25/2024. 4. The record review for Patient #8, certification period 05/04/2024 to 07/02/2024,		Director of Nursing and/or designee will update patients'red folders with signed plan of care, calendar of frequencies, medicationprofile, medication interactions, allergy list, Braden scale; after theassessment completed per physician's or allowed practitioners' orders obtained.Assessment completed and sent to physician or allowed practitioners reviewsigned and returned to agency. (0n-going). The Director of Nursing will be responsible for monitoringthese corrective actions to ensure this deficiency is corrected and will notrecur.	

	provided to Patient #8 without a verbal order or physician-signed order for the following days: 05/07/2024, 05/08/2024, 05/09/2024. 5. During an interview on 05/14/2024 at 9:45 AM, the Administrator indicated that services are not provided without orders. Once orders are signed, the agency will start providing care to patients. 410 IAC 17-13-1(a)			
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	G0574- Administrator and Director of Nursing in-serviced Nurses onwhat is required in a plan of care with written and/or verbal orders from ofphysician or allowed practitioner, and the plan must be individualized. Theindividualized plan of care must include the following: 1. All pertinent diagnosis 2. The patient's mental, psychosocial, and cognitive	2024-05-23

	(xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to document teaching and education provided to a patient for 1 of 1 record reviews with known cellulitis (infection). (Patient #6) Findings include: A policy titled "Plan of Care" was provided by the Administrator on 05/10/2024. The policy indicates the plan of care includes providing instruction, education, and other appropriate items. A review of Patient #6's record, SOC date 03/13/2024, certification period 03/13/2024 to 05/11/2024, included a plan of care (POC) and clinical summary that indicated Patient		status 3. The types of services, supplies, and equipment requiredand/or present in the home. 4. The frequency and duration of visits to be made. 5. Prognosis 6.Rehabilitation potential 7. Functional limitations 8.Activities permitted 9. Activities permitted 10. Nutritional requirements 11. All medications and	

	scabbed chronic edema blisters to bilateral shins. The clinical summary indicated Patient #6 applies an antibiotic ointment daily and that the blisters heal but then overdoes it one day, and the blisters come back. The POC and clinical summary did not evidence the nurse provided instructions, teaching, or education regarding wound care and infection prevention. On 05/14/2024 at 12:30 PM, during an interview, the Administrator was questioned about the lack of specific intervention or education for the open areas on Patient #6's bilateral shins. After reviewing Patient #6's record, the Administrator stated that the patient had cellulitis. It was expected that the nurse would detail in the POC and clinical summary what was taught about wound care and infection prevention. The agency failed to document teaching and education for a patient with cellulitis. 410 17-13-1(a)(1)(D)(i-xiii)		treatments 12. Safety measures to protect from injuries 13. A description of the patient's risk for emergencydepartment visits and hospital readmissions and all interventions to addressthe underlying risk factors. 14. Patient and caregivers' education and training tofacilitate timely discharge patient-specific interventions and education; measurableoutcomes and goals identified by HHA and the patient 15. Information related to any advance directives	

			16. Any additional items HHA or physician or allowedpractitioner may choose to include. Administrator and Director of Nursing in-services includedreporting changes of patient's conditions, Patient teaching and education ofhandwashing, standard precautions to aid in prevention of infection, and woundcare. Documentation and physician or allowed practitioner to obtain written orverbal orders in addition to plan of care. The Director of Nursing will audit all current patient plansof care and comprehensive assessments to ensure they contain all requiredinformation and reflect needs based on their comprehensive assessment. Ifrequired information is missing a written or verbal order will be obtained forthe missing information. Date completed__5/23/24_____	

			The Director of Nursing will audit all plans of care weeklyto ensure they contain all required components and are individualized for thatpatient. The assessments completed will be reviewed to the plan of care toensure the information is accurate. (on-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on observation and record review the agency failed	G0580	G0580- Administrator and Director of Nursing in-serviced Nurses onfollowing orders of a physician or allowed practitioner and agency policy ofcorrectly filling medication	2024-05-23

	to follow physician orders for setting up weekly medication planner, affecting 1 of 1 observed medication set up. (Patient #8) An undated policy, titled "Medication Set Up Policy," indicated that the agency will set up medications as ordered by the physician; the nurse should ensure that he/she is correctly filling the medication planner. During an observation on 05/13/2024 at 10:50 AM, Registered Nurse (RN) 3 placed Aspirin (used for thinning blood) in the medication planner every day. The nurse failed to follow the order on the medication profile, which indicated Aspirin should be given twice per week. The record review for Patient #8, certification period 05/04/2024 to 07/02/2024, included a medication profile that indicated Aspirin is to be given twice weekly. The RN failed to correctly set up the medication planer as ordered by the physician. 410 IAC17-13-1(a)		planner. Date completed__5/13/24_and5/23/24_____ Director of Nursing to complete skilled Supervisory visitsof medication set-up every 14 days with completed documentation. (on-going) The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur	

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 observation, record review, and interview, the agency failed to ensure the agency coordinated care with another agency that was providing care for 3 of 7 active record reviews. (Patient #2, #4, #9) Findings include: 5. The record review for Patient #4, certification period 03/23/2024 to 05/21/2024, included a communication log with no documented communication between agency field staff, physician, or Entity 2 since the start of the certification period. During an interview on 05/10/2024 at 10:00 AM, HHA 2 indicated that patient #4 has been having issues with blood sugar levels every day; HHA 2 has verbally reported this to the agency and Entity 2 but has	G0608	G0608- Administrator in-service Director of Nursing and Nurses onrequirement to include in comprehensive assessment and on plan of care the nameof the agency/entity, type of services, and frequency. The nurses are tocontact those agencies and document coordination of care was completed andobtain any necessary documents deemed pertain to patient's care. Documentationis to include the name of agency, date, time, person spoke with, and what wasdiscussed. Data completed____5/23/24_____ TheUpdate Administrator and or nurse will review all currentpatient assessments to ensure if there is documentation of another healthcareentity/agency providing care it is listed on the plan of care. Alldocumentation	2024-06-12

	never documented this verbal communication in the patient's chart. During a home visit on 05/13/2024 at 8:55 AM, Patient #4 informed HHA 2 that their blood sugar was 79 before breakfast. The Clinical Supervisor indicated Patient #4's blood sugar is managed by Entity 2. Abnormal readings would be reported to the patient's primary physician if Home Health Aide (HHA) 2 reported abnormal readings to the agency; the registered nurse would report abnormal blood sugar levels to a physician at recertification, and supervisory visits, and a verbal report would be provided to Entity 2's nurse. She indicated the communication would be documented in the system under the patient's communication log. During an interview on 05/13/2024 at 9:40 AM, Person 8 indicated the agency has no communication binder at Entity 2. Person 8 indicated they have never received a report on a patient from the agency's HHA or Nurses; every few months, the nurse from the agency		completed___6/12/24_____ ___ Administrator and /or Director of Nursing in-service allstaff on communication Binders in all assisted living facilities, on reportingand coordination of care, including reporting to agency. (on-going) The Director of Nursing or designee will obtain thedocumentation from the communication binders weekly. Date completed,___6/12/24_____ - (on-going) The Administrator will be responsible for monitoring thesecorrective actions to	

	requests a medication list. During an interview on 05/13/2024 at 9:50 AM, The Clinical Supervisor indicated that the agency provides Entity 2 with a list of patients it is providing aide services to. During an interview on 05/13/2024 at 1:35 PM, the Administrator indicated staff should be reporting anything that is a concern to the physician. 1. A policy titled "Coordination of Client Services" was provided by the Program Director on 05/10/2024. The policy indicated that the agency was to coordinate care with all disciplines to ensure patient needs and goals were met. 2. During an observation on 05/09/2024 at 3:00 PM, the Clinical Supervisor assessed three of the six wounds to Patient #2's bilateral buttocks, sacral area, and mid-lower back. Patient #2 and the Clinical Supervisor stated that Entity 1 measures and provides the treatment for the wounds. The Clinical Supervisor stated that the patient doesn't like to have		ensure that this deficiency is corrected and will notrecur.	

	areas assessed. 3. A review of Patient #2's record, start of care (SOC) date 03/11/2024, certification period 03/13/2024 to 05/11/2024 included a plan of care (POC) and a clinical summary indicating Patient #2 had a sacral decubitus ulcer that was being cared for by Entity 1. The clinical summary indicated the Clinical Supervisor could not visualize the wound per the patient's request. The agency failed to evidence coordination between the agency and Entity 1 regarding the care, type of treatment/instructions, and progress toward healing for six wounds on the bilateral buttocks, sacral area, and mid-lower back since the SOC. 4. During an interview on 05/10/2024 at 2:30 PM, the Administrator stated that the nurse was expected to coordinate care with Entity 1 and assess all wounds at each nursing visit. The Administrator reviewed Patient #2's record and was made aware there was no coordination between the two agencies. The Administrator called Entity 1 requesting their wound documentation. Entity			

	1's nursing visit notes from 04/24/2024 to 05/08/2024 evidenced that Patient #2 had three stage II (open ulcer) wounds to the right buttock and both upper thighs and a stage III (exposed deep tissue and fat) wound to the coccyx (tailbone). Entity 1's visit notes did not evidence care coordination with the agency. The agency failed to coordinate wound care with Entity 1. 5. A review of the clinical record for Patient #9, who started care on 01/03/2024, revealed a plan of care for the recertification period of 05/02/2024 to 06/30/2024. The plan of care indicated that Patient #9's residence was listed at Entity 4, an assisted living facility. The plan of care contained a section titled " Coordination of Care" that revealed the primary care physician's name and indicated Entity 4 but failed to list the person with whom they coordinated care. A review of agency documents titled "Patient Communication Log," dated 01/03/2024 through 05/13/2024, indicated a message on 01/31/2024 entered by the Director of			

	Nursing. The message indicated a call was placed to Entity 4, and a message was left for a return call. The logs failed to evidence any further follow-up or coordination of care with the nursing staff of Entity 4. During an interview on 05/13/2024 at 11:10 AM, when queried about the nurse from Golden Heart Health Services coordinating care for Patient #9, Person 5, Entity 4's floor nurse for Patient #9, stated, " No, not that I am aware of. I don't recall them speaking to me regarding Patient #9."			
G0614	Visit schedule 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview, the agency failed to provide the patients and caregivers a visit schedule for the frequency of visits provided by the agency staff in 4 of 5 home visits conducted. (Patients: #4, 5, 8, and 9) Findings include:	G0614	G0614- The Administrator and Director of Nursing will provide andmaintain a monthly visit schedule for the frequency of visits to patients andcaregivers. Date completed___6/12/24_____	2024-06-12

	2. During a home visit on 05/10/2024 at 10:05 AM, the admission packet (red folder) of Patient # 4 was reviewed and found to have an agency calendar dated 04/2023. No current agency calendar was found in the patients' red folder or home. The agency failed to provide the patient and/or caregiver with an updated agency services calendar. 4. During a home visit on 05/13/2024 at 10:50 AM, Patient #8's admission packet (red folder) did not contain an agency calendar, and one was not found in the home. The agency failed to provide the patient and/or caregiver with an updated agency services calendar. 6. During an interview on 05/09/2024 at 9:25 AM, the administrator indicated that the admission packet (red folder) is usually placed on top of the refrigerator and should contain all documents related to the patient. The staff should review the red folder every visit and at recertification, and the red folders should be updated as needed.		Administrator in-serviced Director of Nursing which includedin the in-services of patient's rights to be informed in advance of care to beprovided with a frequency of visits scheduled. Datecompleted___5/23/24_____- Director of Nursing and /or designee to ensure red foldercontent is uploaded with a calendar content is updated with a calendar forfrequency of visits monthly. Director of Nursing and/ or designee is responsible forupdating all patient's red folders with documentation of completionon__6/12/24_____--and monthly thereafter (on-going).	

	7. During an interview on 05/13/2024 at 1:35 PM, the administration indicated the red folder should include a current plan of care, medication list, schedule, allergy list, and Braden score. 1. A review of an agency document titled "Right of the Client" indicated but was not limited to, "As a client of Golden Heart Health Services Home Health Agency (HHA), you have the following rights: ... be informed about ... in advance of, and during treatment ... The care to be furnished ... The disciplines that will furnish the care ...The frequency of visits ... " 2. During a home visit at Patient #5's residence on 05/10/2024 at 10:45 AM, a red folder was provided for review when queried regarding the agency folder. A review of the red folder contained Golden Heart Health Services admission documents but failed to include a schedule of agency staff's frequency of treatments. During an interview on 05/10/2024 at 1:33 PM, Registered Nurse (RN) 2		The Director of Nursing is responsible for monitoring thesecorrective actions to ensure the deficiency is corrected and will not recur.	

	confirmed they set up Patient #5's medications weekly, and the Patient has an HHA five days a week. RN 2 further indicated they were unaware that they needed to provide service schedule frequency of staff to Patient #9 and their caregivers. 3. During a home visit at Patient #9's residence on 05/13/2024 at 10:37 AM, when queried regarding the agency information, Patient #9 obtained a red folder from their dresser drawer. A review of the red folder contained Golden Heart Health Services admission documents but failed to include a schedule of agency staff's frequency of treatments. During an interview on 05/13/2024 at 10:53 AM, RN 1 confirmed the folder did not contain a schedule of the frequency of visits by agency staff and should be located in the front of the red folder.			
G0616	Patient medication schedule/instructions 484.60(e)(2) Patient medication schedule/instructions,	G0616	G0616- Administrator in-service	2024-05-23

	including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. Based on record review and interview, the agency failed to provide the patients with a medication schedule and instructions for 4 of 5 home visits. (Patients: #4, 5, 8, and 9) Findings include: 2. During a home visit on 05/10/2024 at 10:05 AM, the admission packet (red folder) of Patient # 4 was reviewed and found to have a medication profile dated 07/28/2022. No current documentation was found in the patient's red folder. The agency failed to provide the patient and/or caregiver with an updated medication schedule and instructions. 4. During a home visit on 05/13/2024 at 10:50 AM, Patient #8's admission packet (red folder) did not contain a medication profile. The agency failed to provide the patient and/or caregiver with an updated medication schedule and instructions. 6. During an interview on 05/09/2024 at 9:25 AM, the administrator indicated that the		toprovide patients with medication profiles, medication interactions, allergylist. The medication the mediation schedule is to include patient's name,medication name, dosage, and frequency, and name of agency/facilityadministering and scheduling medication set-ups. Datecompleted___5/23/24_____ The Director of Nursing is to monitor medication profilewith start of care, resumption of care, recertification, transfers, change ofdiscontinue of medications, (on-going).	

	admission packet (red folder) is normally placed on top of the refrigerator and should contain all documents related to the patient. The staff should review the red folder every visit and at recertification, and the red folders should be updated as needed. 7. During an interview on 05/13/2024 at 1:35 PM, the Administration indicated the red folder should include a current plan of care, medication list, schedule, allergy list, and Braden score. 1. A policy titled “Medication Profile” indicated but was not limited to “ … The Medication Profile shall be reviewed by a Registered Nurse every sixty (60) days and updated whenever there is a change or discontinuation in medication … Medication profiles created through electronic point of care documentation systems will have a copy in the client records, and the client’s home if the agency is setting up or managing the medication administration … ” 2. During a home visit at Patient #5’s residence on 05/10/2024 at		The Director of Nursing will audit Nurses notes with eachNurses visit to ensure documentation of update medication profile with teachingand education to patients.. The Director of Nursing will be responsible for monitoringthese corrective actions to ensure that this deficiency is correct and will notrecur.	

	10:45 AM, when queried regarding the agency folder with the medication list, Patient #5 provided a red folder for review. Patient #5's red folder contained admission documents from Golden Heart Health Services. A review of the documents failed to evidence a medication list. When queried regarding a medication list and who sets up their medication, Patient #5 indicated the nurse comes once a week and sets up their medications, and they did not leave a medication list. During an interview on 05/10/2024 at 1:33 PM, Registered Nurse (RN) 2 confirmed they set up Patient #5's medications weekly. RN 2 further indicated they brought a medication list with them to set up Patient #5's medications, and they were not aware that they needed to provide a medication list to Patient #9 and their caregiver. 3. During a home visit at Patient #9's residence on 05/13/2024 at 10:37 AM, when queried regarding the agency information, Patient #9 obtained a red folder from their dresser drawer. A review of the			

	red folder contained admission documents from Golden Heart Health Services. A review of the documents failed to evidence a medication list. Patient #9 indicated they were not given one regarding a medication list when queried. During an interview on 05/13/2024 at 10:53 AM, RN 1 confirmed the folder did not contain a medication list and that the medication list should be located in the front of the red folder.			
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review, and interview, the agency failed to ensure the patient received a current copy of medication and treatment instructions for 5 of 7 active record reviews. (Patients #2, #4, #5, #8, #9) Findings include: 4. During a home visit on	G0618	G0618- Administrator in-service Director of Nursing and NursesCNA/HHA on contents of red folders in patients' home which include medicationprofile with instructions information. The in-services included theinstructions that the red folder containing plan of care, medication profile,medication interactions, Braden scale, allergy list, aide Docs., patientfrequency visit schedule is to be reviewed every visit and	2024-06-12

	05/10/2024 at 10:05 AM, the admission packet (red folder) of Patient # 4 was reviewed and found to have a medication profile dated 07/28/2022, a calendar dated 04/2023 and a plan of care for the certification period of 03/29/2023 to 05/27/2023 and an aide plan of care dated 01/06/2022. No current documentation was found in the patients' red folder. The agency failed to provide the patient and/or caregiver with updated medication and instruction information. 6. During a home visit on 05/13/2024 at 10:50 AM, Patient #8's admission packet (red folder) did not contain a plan of care and medication list. The agency failed to provide the patient and/or caregiver with current medication and treatment instructions. 1. A policy titled "Medication Profile" was provided by the Administrator on 05/10/2024. The policy indicated that the agency was to provide the patient with a copy of the medication profile. 2. An undated document in the		noted for updateinformation. Staff informed that in red folders if note needed documentation instructedto report to the agency. Date completed__5/23/24_____ Director of Nursing and/or designee updated red foldercontent containing plan of care, medication profile, medication interactions,allergy list, Braden scale to each patient home. Datecompleted_6/12/24_____ The Director of Nursing will be responsible for monitoringthese corrective actions to ensure that this deficiency is corrected and willnot recur.	

	admission packet titled "Rights of the Client" was provided by the Administrator on 05/13/2024. The document indicated the patient has the right to be informed about care being furnished, the plan of care, and access to their information. 3. During a home visit observation on 05/09/2024 at 3:00 PM, the Clinical Supervisor reviewed Patient #2's admission packet. The packet did not contain written instructions on medications and treatments. The Clinical Supervisor stated that the agency was responsible for the aide services, and Entity 1 was responsible for the medications and treatment list for the patient. The agency failed to provide the patient with written medication/treatment instructions. 4. During an interview on 05/13/2024 at 1:43 PM, the Administrator stated that the red admission folders in the home should contain the plan of care and medication list. The agency failed to provide a copy of written instructions to the patient that included any			

	treatments to be administered by the agency personnel or personnel acting on behalf of the agency. 5. During a home visit at Patient #5's residence on 05/10/2024 at 10:45 AM, when queried regarding the agency folder with the plan of care, Patient #5 provided a red folder for review. Patient #5's red folder contained admission documents from Golden Heart Health Services. A review of the documents failed to evidence a plan of care or treatments being provided by agency staff. During an interview on 05/10/2024 at 1:33 PM, Registered Nurse (RN) 2 confirmed they set up Patient #5's medications weekly, and the Patient has an HHA five days a week. RN 2 further indicated they were not aware that they needed to provide a plan of care with the treatments being provided by agency staff to Patient #9 and their caregiver. 6. During a home visit at Patient #9's residence on 05/13/2024 at 10:37 AM, when queried			

	information, Patient #9 obtained a red folder from their dresser drawer. A review of the red folder contained admission documents from Golden Heart Health Services. A review of the documents failed to provide evidence of a plan of care or treatments provided by agency staff. Patient #9 indicated they were not given one. During an interview on 05/13/2024 at 10:53 AM, RN 1 confirmed that the folder did not contain a plan of care with treatments by agency staff and that the plan of care should be located in the front of the red folder.			
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. Based on record review and interview, the agency failed to ensure all patients were provided with a copy of written instructions outlining the name and contact information of the home health clinical manager/director of nursing for 2 of 5 home visits conducted. (Patients: #5 and 9)	G0622	G0622- Director of Nursing and or/designee will ensure all currentpatients know the name of Clinical manager and contact information. Nurses willbe instructed to document the patient was notified. Date Completed__6/12/24_____	2024-06-12

	Findings Include: 1. A policy titled "Client/Caregiver Education" indicated but was not limited to "Clients and their caregivers will be provided with the information necessary ... To assure the client has adequate information to communicate effectively with the agency representatives and other health providers ... " 2. During a home visit at Patient #5's residence on 05/10/2024 at 10:45 AM, when queried regarding the agency folder, Patient #5 provided a red folder for review. A review of the red folder contained Golden Heart Health Services admission documents but failed to have the contact information of the Clinical Manager. Patient #5 confirmed they did not know who the Clinical Manager was or how to contact them. 3. During a home visit at Patient #9's residence on 05/13/2024 at 10:37 AM, when queried regarding the agency information, Patient #9 obtained a red folder from their dresser drawer. A review of the red folder contained Golden Heart Health Services admission		The Director of Nursing will create a tracking log to ensureall current patients receive the documentation. Datecompleted__6/12/24_____ _____ The Director of Nursing will ensure at any time if there isa change in the clinical manager thepatient will be provided with a form notifying who the clinical manager is andcontact information. Date completed (on-going)	

	documents and listed the Director of Nursing with the current Administrator's name. During an interview on 05/13/2024 at 10:53 AM, Registered Nurse (RN) 1 confirmed that Patient #9's folder contained a document that indicated the current Administrator was listed as the Director of Nursing. RN 1 stated, "That is old and needs to be updated."		The Administrator in-serviced caregivers on patient'sclinical manager with contact information to communicate with the with theagency representative and this information on aide doc. Date completed. ___6/12/24_____ The Director of Nursing is responsible for monitoring andapplying updates as needed for these corrective actions to ensure that thisdeficiency is corrected and will not recur.	
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality	G0658	G0658- The Administrator and Director of Nursing are updating theQAPI program and will reflect the complexity of the agency and services forquality improvement, priorities for improved quality care and patient safety.The QAPI will be completed by___6/12/24_____ and will include measurableindicators to	2024-06-12

	improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the agency failed to implement a performance improvement project for 2023 and 2024 for 1 of 1 quality performance improvement projects (QAPI) review. Findings include: A policy titled "Quality Assessment and Performance Improvement (QAPI)" was provided by the Administrator on 05/14/2024. The policy indicated that the agency must conduct a performance improvement project(s) annually, document the reason for conducting the project, and measure progress achieved. The governing body was responsible for ensuring an ongoing program for quality improvement and patient safety was defined, implemented, and maintained.		improve outcomes. The QAPI program will be evaluated monthly, andall findings will be reported to the owner. The owner's input and approval willbe documented in the QAPI program and will be recorded in the board meetingminutes. The Administrator will develop a PIP program related to agency policyfor QAPI and approval of the governing body. The following items will be corrected by 6/12/24: 1. Obtain governing body approval for the frequency anddetail of data collection 2. Document the agency had considered the incidence,prevalence, and severity of problems to select indicators and performanceimprovement efforts	

	A review of the 2023 and 2024 QAPI programs failed to evidence that a performance improvement project (PIP) was developed, ongoing, or completed for those years. A review of the Governing Body meeting minutes dated 11/24/2024 and 01/31/2024 failed to evidence approval of a PIP project or the frequency and detail of the data collected. During an interview on 05/14/2024 at 12:00 PM, the Administrator stated she had not implemented a PIP for this year and was unsure where the former Administrator placed any 2023 PIPs. 410 IAC 17-12-2(a)		3. Use data derived from OASIS assessments to monitorservices and quality of care 4. Ensure performance improvement activities documentedcorrection of identified problems related to the health and safety of patients 5. measure and trackand analyze adverse patient's events and implement actions to prevent adverseevents. 6. Measure and track performance improvement projects todetermine if improvement occurred and was sustained 7. ensure the QAPI -performance Improvement program includesat least 1 performance improvement project, either in development or ongoing,that is based on the agency's QAPI program activities and data obtained	

			throughtracking information, measuring, and analyzing high risk, high volume, andproblem prone areas. The Administrator will be responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	
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 the clinical staff followed the agency's policies for infection control practices with bag technique and hand hygiene in 4 of 5 home visit observations. (Employees:	G0682	G0682- The Administrator and /or Director of Nursing willin-service all Nurses on proper standard precautions to include bag technique,to aid in prevention of transmissions of infections and communicable disease.All Nurses are required to demonstrate proper bad technique. Datecompleted__5/23/24_____ _____	2024-06-12

	RN 3, HHA 2, 3, and 4) Findings Include: 5. During an observation on 05/13/2024 at 8:55 AM, HHA (Home Health Aide) 2 did not perform hand hygiene before gloving twice while providing personal care to Patient #4. The HHA failed to maintain infection control during the home visit for patient #4. 6. During an observation on 05/13/2024 at 10:50 AM, RN 3 placed her nursing bag directly on Patient #8 chair without a barrier. RN 3 provided medication setup for patients but did not use hand hygiene or gloves prior to touching the medication. After RN 3 provided care to the patient, she removed gloves but did not perform hand hygiene, then continued to touch items throughout the home and prepared food for Patient # 8. RN 3 washed hands at the kitchen sink for less than 20 seconds before removing food from the microwave and placing the soup bowl with a napkin on the uncleaned rollator seat for the patient to eat. The HHA		The administrator and /or Director of Nursing will bein-service observing aide for bag technique, handwashing and donning gloveswhen present for Supervisory visit, if aide is present at time of visit. DateCompleted__6/12/24_____ _ Administrator and/ or Director of Nursing will providein-service aids on bag technique, hand washing and donning gloves to aid inprevention of infections and communicable disease. Aides are required todemonstrate bag technique, hand washing, and donning gloves. Datecompleted__6/12/24_____ __	

	failed to maintain infection control during the home visit for patient #8. During an interview on 05/13/2024, the Administrator indicated she had instructed staff to place the drape down before placing the bag on the surface, and all equipment needs to be wiped off before being placed back in the bag. 1. A policy titled "Nursing Bag" indicated but was not limited to " ... The inside of the bag and its contents are considered clean. Therefore: Handwashing must occur before entering the bag ... All items removed from the bag should be cleaned before returning to the bag ... When in a client's home, place a waterproof disposable barrier on a clean and dry surface then place the bag down on the barrier ... " 2. A policy titled "Infection Prevention/Control" indicated but was not limited to, " ... To reduce the risk of transmission of microbes from both recognized and unrecognized sources of infection ... Hands are washed if contaminated with blood or body fluid,		The Administrator and/ or Director of Nursing willin-service all staff yearly and upon hire on proper bag technique, handwashing,and donning gloves; and are required to demonstrate. (on-going) The Administrator and/ or Director of Nursing will in-service all staff on proper standardprecautions to include proper hygiene, when to glove/change gloves andinfection control practices. Staff are required to demonstrate techniques. Datecompleted__6/12/24_____ _____ The Director of Nursing is responsible for monitoring thesecorrective actions to ensure that this deficiency is corrected and will notrecur.	

	immediately after gloves are removed, between client contacts, and when indicated to prevent the transfer of microorganisms between other clients or the environment ... " 3. During a home visit at Patient #5's residence on 05/10/2024 at 10:45 AM, observed HHA 3 assist Patient #5 with breakfast. The HHA went to the kitchen sink, performed hand washing, used their bare hand to turn the faucet off, obtained a paper towel, dried their hands, discarded the paper towel in the trash receptacle, and obtained gloves from their bag. The HHA used their clean hand to touch the dirty faucet to turn the water off and failed to re-wash their hands before reaching into their clean bag to obtain gloves. HHA 3 donned gloves and cooked the bacon for Patient #5. HHA 3 removed their gloves, discarded them into the trash receptacle, obtained new gloves from their bag, and donned the new gloves. The HHA failed to perform hand hygiene after removing their gloves and getting new gloves out of their clean bag. HHA 3 cooked			

	Patient #5 scrambled eggs, removed their gloves, washed their hands at the kitchen sink, turned off the kitchen sink faucet with their bare hands, obtained a paper towel, and dried their hands. HHA 3 failed to use a paper towel to turn the faucet off and failed to rewash their hands after touching the dirty faucet. During an interview on 05/10/2024 at 11:37 AM, when queried regarding hand hygiene and infection control, HHA 3 indicated they should have used the paper towel to turn the water off. HHA 3 further confirmed hand hygiene is to be done anytime gloves are removed. 4. During a home visit at Patient #9's residence on 05/13/2024 at 10:37 AM, observed HHA 4 obtain a thermal scan temperature on Patient #9. The HHA entered the residence of Patient #9, placed their bag on the floor, and went to the sink to wash their hands. HHA 4 failed to place a barrier on a clean, dry surface and placed their bag on the barrier. The HHA obtained a paper towel, turned off the water, reached			

	into their bag, obtained clean gloves, and discarded the paper towel in the trash receptacle. HHA 4 obtained the thermal scan thermometer out of their bag, took Patient #9's temperature, and placed the thermometer back in their bag. HHA 4 failed to clean the thermometer before placing it back in the clean bag. HHA 4 reviewed Patient #9's needs and placed their gloved hands in the scrub pockets. Afterward, the HHA picked up their bag with their gloved hands and left the residence. HHA 4 failed to remove their gloves and perform hand hygiene. During an interview on 05/13/2024 at 11:17 AM, when queried about what they saw during the visit with Patient #9 and HHA 4, the branch office Registered Nurse (RN) 1, who observed the visit, indicated that HHA 4 should not have placed their bag on the floor. RN 1 further indicated that the gloved hands were in their scrub pant pockets and that they did not perform hand hygiene.			

G0750	Home health aide services 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Based on observation, record review, and interview, the agency failed to ensure all Home Health Aides provided hands-on personal care as ordered per the plan of care (see Tag G802); the agency failed to ensure the Registered Nurse (RN) completed Home Health Aide Supervisory visits every 14 days (see tag G808), and failed to ensure the RN accurately documented supervisory visits. (see tag G818). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality of care in a safe environment for the Condition of Participation 42 CFR 484.80: Home health aide services.	G0750	G0750- Administrator in-service Director of Nursing and Nurses areto complete home health aide supervisory visits every 14 days for patientsreceiving a skilled service from the agency, every 60 days for patientsnon-skilled, twice a year for shared visit. Date completed__5/23/24_____ Administrator in-serviced Director of Nursing and Nursesthat all Supervisory visits must include the Nurse observing aides, if presentduring the visit; proper standard precautions, hand hygiene, donning gloves,hands on personal care as ordered from physician or allowed practitioner perthe patients plan of care. Nurses are to complete documentation of visits. DateCompleted___5/23/24 and on-going_____	2024-05-23

			The Director of Nursing and/or Rn will complete every 14days supervisory visit to all patients receiving a skilled visit per agency.(on-going) The Director of Nursing will be responsible for monitoringall Supervisory visits and documentation for completion to ensure thisdeficiency is corrected and will not recur.	
G0802	Duties of a HH aide 484.80(g)(3) The duties of a home health aide include: (i) The provision of hands-on personal care; (ii) The performance of simple procedures as an extension of therapy or nursing services; (iii) Assistance in ambulation or exercises; and (iv) Assistance in administering medications ordinarily self-administered. Based on observation, record review, and interview, the agency failed to ensure all Home Health Aides (HHA) provided assistance with Activities of Daily Living (ADLS), including bathing, showering assistance, assistance	G0802	G0802- Administrator and Director of Nursing in-service CNAs/HHA onrequirement for patients to receive all services ordered per physician orallowed practitioner in the plan of car. The aides instructed that it is arequirement they must provide hands -on personal care. If a patient refuseshands- on personal care aide is notify the Director of Nursing and the agency'soffice. Aides instructed they cannot complete	2024-06-12

	with dressings, hair care, oral care, skin care, and nail care (hands-on care), as ordered per the plan of care for 2 of 5 active records reviewed of patients who received HHA services. (Patients: #5 and #9) Findings Include: 410 IAC 17-14-1(h)(1)-(14) 1. A policy titled "Home Health Aide Supervision" indicated but was not limited to " ... ensure that aides furnish care in a safe and effective manner, including but not limited to the following elements: Following the client's plan of care for completion of tasks assigned to a home health aide by the registered nurse ... " 2. During a home visit at Patient #5's residence on 05/10/2024 at 10:45 AM, observed HHA 3 assist Patient #5 with breakfast. Patient #5 indicated they ride bikes, do laundry, clean the bed sheets, cook together, and play dominos. During an interview on 05/10/2024 at 11:00 AM, HHA 3 confirmed that Patient #5 does not let them do hands-on care. Patient #5 does all her personal care herself. When asked if the		housekeeping tasks only. DateCompleted_6/12/24_____ - Administrator and Director of Nursing in-service CAN/HHA ona patient's plan of care. Agency's contact number and Name of Director ofNursing with contact number. Date Completed__6/12/24_____ Administrator in-serviced Director of Nurse and Nurses if apatent is refusing hands- on personal care they are to communicate with patientfor reasoning of refusal of personal care and notify physician or allowedpractitioner. If a patient does not want personal hands-on care the Nurse mustdiscuss discharge with patient and physician or allowed practitioner ashousekeeping/homemaker tasks only, is not permitted	

	HHA made the nurse aware, they indicated they made the office scheduler, Admin 1, aware. 3. A review of the clinical record for Patient #5, start of care 05-09-2023, contained an agency document electronically signed by RN 2 and dated 04/04/2024, titled "Aide Plan of Care." The aide care plan indicated a frequency of 3 hours a day for 5 days a week for HHA services. The section titled "Assignment" indicated the HHA was to do the following each visit: obtain temperature, hair care, skin care, mouth/denture care, foot care, nail care, dressing, make the bed, light housekeeping (bedroom, bathroom, kitchen), clean equipment, take out the trash, prepare a meal, encourage fluids, personal care, shower, sponge bath in a chair, toileting/hygiene, and assist with walker ambulation. The HHA was assigned to shampoo, light housekeeping, bed linen change, dust, sweep, and vacuum weekly. A review of the documents titled "Aide Visit Note-Daily" dated 04/08, 04/09, 04/10,		under Medicaid PA. Nursesare to document in patient's charts. Date completed__5/23/24_____ The Director of Nursing schedules supervisory visits withpatients to evaluate patients' plan of care and services ordered per physicianor allowed practitioner. (on-going) The Director of Nursing will be responsible for monitoringthese corrective actions to ensure this deficiency is corrected and will notrecur.	

	04/11, 04/12, 04/15, 04/16, 04/17, 04/18, and 04/19/2024 failed to evidence any hands-on personal care had been provided by HHA 3. Only companionship, meal prep, and housekeeping duties were provided. During an interview on 05/10/2024 at 1:33 PM, when queried regarding HHA 3 and what personal care they provided for Patient #5, RN 2 indicated they had met HHA. RN 2 further indicated the HHA prepared meals and played games with Patient #5. RN 2 further indicated they get confused with the agency's Prior Authorization and Waiver sides. 4. During a home visit at Patient #9's residence on 05/13/2024 at 10:37 AM, observed HHA 4 obtain a thermal scan temperature on Patient #9. The HHA asked Patient #9 if they could assist with showering or oral care. Patient #9 indicated they completed all that themselves and went to the dining room for meals. Patient #9 further indicated they shower in the evening. When			

	what the HHA did for them when they came, Patient #9 said they do my laundry and occasionally change my bed. During an interview on 05/13/2024 at 11:05 AM, HHA 4 indicated that Patient #9 was not their usual patient, and they were filling in. HHA 4 further revealed that when they see clients and the plan of care is not correct, they make the scheduler, Admin 1, aware. HHA 4 confirmed that this Patient needs personal care, not HHA services. 5. A review of the clinical record for Patient #9, start of care 01-03-2024, contained an agency document electronically signed by RN 4 and dated 05/01/2024, titled "Aide Plan of Care." The aide care plan indicated a frequency of 4 hours a day for 5 days a week for HHA services. The section titled "Assignment" indicated the HHA was to do the following each visit: obtain temperature, hair care, skin care, mouth/denture care, foot care, nail care, dressing, make the bed, light housekeeping (bedroom, bathroom, kitchen), clean equipment, dust, sweep,			

	vacuum take out the trash, prepare a meal, encourage fluids, feeding, personal care, shower, sponge bath in a chair, check for pressure points, toileting/hygiene, and assist with cane ambulation. The HHA was assigned to shampoo and light laundry weekly. A review of the documents titled "Aide Visit Note-Daily" dated 03/20, 3/22, 3/25, 03/28/, 03/29, 04/01, 04/05, 04/08, 04/12, 04/15, 04/19, 04/22, 04/26, 04/29, 05/03 and 05/13/2024 failed to evidence that HHA 3 had provided any hands-on personal care. Only companionship and housekeeping duties were provided. During an interview on 05/13/2024 at 12:34 PM, when queried regarding the hands-on care for Patient #9 and observed hands-on care from the HHA, RN 4 indicated they had not done a shared visit with the HHA. RN 4 further confirmed if the HHA is not providing hands-on care, they should be on the personal care side, not the home health side. When queried if the HHA had			

	HHA care plan on no hands-on care being provided, they stated, "No, never contacted me."			
G0808	Onsite supervisory visit every 14 days 484.80(h)(1)(i) (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services (A) 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 paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section. Based on record review and interview, the agency failed to ensure the Registered Nurse (RN) completed Home Health Aide Supervisory visits for patients who received skilled services every 14 days for 2 of 2 clinical records reviewed. (Patient: #5 and #8) Findings Include: 1. A policy titled "Home Health	G0808	G0808- Administrator in-service Director of Nursing and Nurses areto complete home health aide supervisory visits every 14 days for patientsreceiving a skilled service from the agency, every 60 days for patientsnon-skilled, twice a year for shared visit. Date completed__5/23/24_____ Administrator in-serviced Director of Nursing and Nursesthat all Supervisory visits must include the Nurse observing aides, if presentduring the visit; proper standard precautions, hand hygiene, donning gloves,hands on personal care as ordered from physician or allowed practitioner perthe patients plan	2024-05-23

	was not limited to, " ... Supervisory visits of Home Health Aides shall be according to the following frequency: A. When skilled services are being provided to a client. A Registered Nurse/therapist must make a supervisory visit to the client's residence no less frequently than every 14 days ... " 2. A review of the clinical record for Patient #5, start of care 10/09/2023, contained a plan of care for the recertification period 04/06/2024 to 06/04/2024. The plan of care contained orders for the following: Skilled Nursing 1 day a week for a medication refill, vital signs, sugar checks every 60 days for recertification and supervisory visits; HHA services for 3 hours a day for 5 days a week for Activities of Daily Living (ADLS) and Instrumental Activities of Daily Living (IADLS). A review of the documents titled "Aide Visit Note-Daily" revealed patient #5 received HHA visits for the following: A. The week of 3/31/2024 to 04/06/2024 HHA 4 completed		of care. Nurses are to complete documentation of visits. DateCompleted___5/23/24 and on-going_____ The Director of Nursing and/or Rn will complete every 14days supervisory visit to all patients receiving a skilled visit per agency.(on-going) The Director of Nursing will be responsible for monitoringall Supervisory visits and documentation for completion to ensure thisdeficiency is corrected and will not recur.	

	04/04, and 04/05/2024. B. The week of 04/07/2024 to 04/13/2024 HHA 3 completed visits on 04/08, 04/09, 04/10, 04/11, and 04/12/2024. C. The week of 04/14/2024 to 04/20/2024 HHA 3 completed visits on 04/15, 04/16, 04/17, 04/18, and 04/19/2024. A review of a signed physician order dated 04/19/2024 indicated a verbal order to place Golden Heart Health Services HHA and SN services on Hold from 04/22/2024 to 05/08/2024 because Patient #5 was going to Florida on vacation with their family. A review of "Supervisory Visit Note" documents revealed HHA supervisory visits documented by RN 2 on 04/10/2024 and RN 4 on 02/01/2024. The record failed to evidence that the RN completed HHA supervisory visits every 14 days. During an interview on 05/10/2024 at 1:33 PM, RN 2 indicated that they completed Patient #5's HHA supervisory visits every 60 days. RN 2 further revealed that they get confused by the timelines of			

	documentation and services for care provided by an HHA under Medicaid prior authorization versus an Attendant under the Medicaid waiver program.			
G0818	HH aide supervision elements 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on observation, record review, and interview, the agency failed to ensure the Registered Nurse (RN) documentation during supervisory visits accurately reflected the care that was being provided to the patient by the Home Health Aide (HHA) for 2 of 5 active records reviewed. (Patients: #5, and 9)	G0818	G0818 Administrator in-service Director of Nursing and Nurses onadequate documentation during supervisory visit, the documentation is toreflect the care ordered per physician or allowed practitioner of the plan ofcare. The care provided must ensure the aides conduct care in a safe andeffective manner. Date completed__5/23/24_____ Administrator in-service Director of Nursing and Nursessupervisory visit must include observing aides completing hands – personal careof the services ordered per physician or allowed practitioner; Nurses are tomonitor the aide for following patient's plan of care, appear competent whenproviding services, adheres to standard	2024-06-12

	Findings Include: 410 IAC 17-14-1(n) 1. A policy titled "Home Health Aide Supervision" indicated but was not limited to " ...Home health aide supervision ensure that aides furnish care in a safe and effective manner, including but not limited to the following elements: Following the client's plan of care for completion of tasks assigned to a home health aide by the registered nurse ... " 2. A review of the clinical record for Patient #5, who started care on 05-09-2023, contained agency documents titled "Supervisory Visit Note" dated 04/03/2024 and 11/08/2023. These documents indicated the following: the aide was not present during the visits, reported to work as scheduled, followed the care plan, appeared competent when providing services, used proper body mechanics, adhered to the dress code, adhered to standard precautions, reports client needs/conditions to supervisor in a timely manner, adheres to patient rights, patient/family satisfied with the clinician, good personal grooming habits, and		precautions per agency policy, reportpatient's needs/conditions to supervisor in a timely manner, adheres to dresscode, adheres to patient; rights, use proper body mechanics, good personalgrooming habits, and if family and patient are satisfied with care. The nurseis to document all patients' visits and if there is any refusal of personalcare from the patient the Director of Nursing notified, which the Director ofNursing will notify the physician or allowed practitioner. A nurse is to reportany findings that an aide is not completing according to the patient's plan ofcare or agency policies and report to the Director of Nursing. Datecompleted_____5/23/24___ _____	

	demonstrated open communication. The supervisory visit failed to answer the home health aide's performance accurately, as evidenced by the following: A review of the plan of care for the recertification period of 04/06/2024 to 06/04/2024 revealed orders for discipline and treatment for Skilled Nursing 1 day a week for med refill and HHA 5 hours a day, 5 days a week for Activities of Daily Living (ADLS)/Instrumental Activities of Daily Living (IADLS). Review of an agency document electronically signed by RN 2 and dated 04/04/2024, titled "Aide Plan of Care." The aide care plan indicated a frequency for 3 hours a day for 5 days a week for HHA services. The section titled "Assignment" indicated the HHA was to do the following each visit: obtain temperature, hair care, skin care, mouth/denture care, foot care, nail care, dressing, make the bed, light housekeeping (bedroom, bathroom, kitchen), clean equipment, take out the trash, prepare the meal, encourage fluids, personal care, shower, sponge bath in a chair,		Administrator and Director of Nursing in-service CNA/HHA onrequirements for patients to receive all services ordered by physician orallowed practitioner and components of expectations of supervisory visit. DateCompleted_6/12/24_____ __ It is the Director of Nursing responsibility for monitoringthese corrective actions to ensure that this deficiency is corrected and willnot recur.	

	toileting/hygiene, and assist with walker ambulation. The HHA was assigned to shampoo, light housekeeping, bed linen change, dust, sweep, and vacuum weekly. A review of agency documents titled "Supervisory Visit Note" dated 04/03/2024 and 11/08/202 indicated that the aide was not present during the visit, followed the care plan, and demonstrated open communication. A review of the documents titled "Aide Visit Note-Daily" dated 04/08, 04/09, 04/10, 04/11, 04/12, 04/15, 04/16, 04/17, 04/18, and 04/19/2024 failed to evidence any hands-on personal care had been provided by HHA 3. Only companionship, meal prep, and housekeeping duties were provided. During an interview on 05/10/2024 at 11:00 AM, HHA 3 confirmed that Patient #5 does not let them do hands-on care. Patient #5 does all her care herself. When asked if the HHA made the nurse aware, they indicated they made the office scheduler, Admin 1, aware.			

	3. A review of the clinical record for Patient #9, the start of care 01-03-2024, contained agency documents titled "Supervisory Visit Note" dated 03/27/2024 and 02/29/2024. These documents indicated the following: the aide was not present during the visits, followed the care plan, appeared competent when providing services, used proper body mechanics, adhered to the dress code, adhered to standard precautions, reported client needs/conditions to the supervisor in a timely manner, adheres to patient rights, patient/family satisfied with the clinician, and demonstrated open communication. The supervisory visit failed to answer the home health aide's performance accurately, as evidenced by the following: A review of the plan of care for the recertification period of 05/02/2024 to 06/30/2024 revealed orders for discipline and treatment for a Skilled Nurse for supervisory visits every 60 days and HHA 4 hours a day, 5 days a week to provide assist with personal care and assistance with ADLs.			

	A review of an agency document electronically signed by RN 4 and dated 05/01/2024, titled "Aide Plan of Care." The aide care plan indicated a frequency for 4 hours a day for 5 days a week for HHA services. The section titled "Assignment" indicated the HHA was to do the following each visit: obtain temperature, hair care, skin care, mouth/denture care, foot care, nail care, dressing, make the bed, light housekeeping (bedroom, bathroom, kitchen), clean equipment, dust, sweep, vacuum take out the trash, prepare the meal, encourage fluids, feeding, personal care, shower, sponge bath in a chair, check for pressure points, toileting/hygiene, and assist with cane ambulation. The HHA was assigned to shampoo and light laundry weekly. A review of the documents titled "Aide Visit Note-Daily" dated 03/20, 3/22, 3/25, 03/28/, 03/29, 04/01, 04/05, 04/08, 04/12, 04/15, 04/19, 04/22, 04/26, 04/29, 05/03 and 05/13/2024 failed to evidence that HHA 3 had provided any hands-on personal care. Only companionship and housekeeping duties were			

	provided. During an interview on 05/13/2024 at 12:34 PM, when queried regarding the hands-on care for Patient #9 and observed hands-on care from the HHA, RN 4 indicated they had not done a shared visit with the HHA. RN 4 further confirmed if the HHA is not providing hands-on care, they should be on the personal care side, not the home health side. When queried if the HHA had contacted them regarding the HHA care plan on no hands-on care being provided, they stated, “No, never contacted me.”			
G0978	Must have a written agreement 484.105(e)(2)(i-iv) An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been: (i) Denied Medicare or Medicaid enrollment; (ii) Been excluded or terminated from any federal health care program or Medicaid;	G0978	G0978- Administrator is tocommunicate to any new potential patient’s referral source, to the patient, andphysician or allowed practitioner if the potential patient has any otheragency, with an organization, or with an individual providing services and /orwill remain providing services to the potential patient	2024-06-12

	(iii) Had its Medicare or Medicaid billing privileges revoked; or (iv) Been debarred from participating in any government program. Based on record review and interview, the agency failed to have a written agreement or contract with the primary Home Health agency for 2 of 2 patient records reviewed who received care from another entity. (Patient #2, #4) Findings include: 4. During a home visit on 05/13/2024 at 8:55 AM, The Clinical Supervisor indicated that their agency provides aide services for Patient #4, and Entity 2 managed the patient's medication and blood sugar. During an interview on 05/13/2024 at 1:35 PM, the Administrator stated that the agency has no contract with Entity 2 to determine the services being provided. 1. A policy titled "Coordination of Client Services" was provided by the Administrator on 05/10/2024. The policy indicated all disciplines that provide care directly or under arrangement will integrate services. The staff must		and/or current patient.Date completed_6/12/24_____ The administrator will obtain a written and signed agreementfrom another agency, organization, or individual of potential patients. Thewritten and signed agreement must contain the services provided to thepotential patients and frequencies. The agreement must state that the agency,organization, or individual proving services under agreement may not have been:denied Medicare or Medicaid enrollment, been excluded or terminated from anyfederal health care program or Medicaid, had Medicare or Medicaid billingprivileges revoked, been debarred from participating in any government program;prior to admission for services to Golden Heart Health services. Documentationof this agreement will be placed in the patient's chart. Datecompleted___6/12/24 and on-going	

	document coordination activities. 2. During an interview on 05/09/2024 at 3:00 PM, the Clinical Supervisor stated that Entity 1 provides wound care for Patient #2's wounds, and our agency provides aide services. 3. During an interview on 05/10/2024 at 1:19 PM, the Administrator stated that the agency does not have a contract or agreement with Entity 1. She stated that Entity 1 did not have the aide staffing for Patient #2, which was why the agency provided aide services. The Administrator stated that the agency has its plan of care separate from Entity 1. The agency failed to have a written agreement/contract with Entity 1 and failed to work from a single plan of care for Patient #2.		Administrator to notify physician or allowed practitioner ofcoordination of care. Director of Nursing to notify Nurses and staff ofcoordination of care. Nurses are to communicate with coordination of care anddocument. Date Completed: 6/12/24 and on-going The Administratorwill be responsible for monitoring this corrective action to ensure thisdeficiency is corrected and will not recur.	
G1012	Required items in clinical record	G1012	G1012-	2024-06-12

	484.110(a)(1) The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician or allowed practitioner orders; Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment accurately reflected the patient's status at the time of the home visit for 1 of 1 home visit observations with a known wound. (Patient #2) Findings include: 1. A policy titled "Comprehensive Client Assessment" was provided by the Administrator on 05/10/2024. The policy indicated that the comprehensive assessment must accurately reflect the patient's current health status. The comprehensive assessment must address the patient's progress toward goals identified by the patient and agency. 2. During an observation on 05/09/2024 at 3:00 PM, the Clinical Supervisor asked the Certified Nurse Assistant (CNA) 1 to remove three of the six		Administrator in-service Director of Nursing and Nursingstaff on the plan of care, which is based on a comprehensive assessment; thatall patients are to receive. Comprehensive assessment is to include patients'health, psychosocial, and cognitive assessment, and accuracy specific to eachpatient. The comprehensive assessment is to have collaboration with thephysician or allowed practitioner, other agencies providing care to thepatient, clients to develop a comprehensive plan of care. It is a requirementthat all documentation is completed pertaining to a comprehensive assessment.Date completed__5/23/24_____ Administrator in-service Director of Nursing and Nurses onrequirement to include in comprehensive assessment and on plan of care the nameof all	

	dressings found on Patient #2's bilateral buttocks, sacrum, and mid-lower back. She then asked CNA 1 what stage the wounds were, to which she replied I don't know. CNA told the Clinical Supervisor that the wounds were getting better and that the dressings were due to be changed the next day by Entity 1's nurse. CNA 1 reapplied 2 of the dressings soiled with brown/bloody drainage to the left buttock but did not reapply the gauze dressing to the sacral area. Patient #2 and the Clinical Supervisor stated Entity 1 measures and provide the treatment for the wounds. At that time, the Clinical Supervisor stated the patient didn't like it when the dressings were removed and didn't always allow our agency to assess the areas. The Clinical Supervisor did not provide any education on turning and repositioning or applying clean dressings. 3. A review of Patient #2's record, start of care (SOC) date 03/11/2024, certification period 03/11/2024 to 05/11/2024, included a plan of care and a comprehensive assessment dated 03/11/2024, which failed		patient is receiving services from. Needto include name of agency/entity, type of services and frequency. The nurse isto contact those agencies and document coordination of care was completed andobtain, if possible, any printable documentation pertaining to patients plan ofcare. Documentation to include the name of agency, person spoke with and whatdiscussed. Date Completed_5/23/24____ Director of Nursing will audit all comprehensive assessmentsdone weekly to ensure completion and accuracy reflects the patient's health,psychosocial, functional, cognitive information, and documentation ofcoordination of care. Date COMPLETED__6/12/24 and on-going _ The Administratorwill be responsible for monitoring these corrective actions to ensure that thisdeficiency is corrected and will not recur.	

	to evidence coordination between the agency and Entity 1 regarding the care, type of wound treatment/instructions, and progress toward healing for six wounds on the bilateral buttocks, sacral area, and mid-lower back that was observed at the home visit. A review of the non-Oasis document dated 03/14/2024 indicated a wound on the sacral area with no measurements, assessment, staging, or treatment. The non-Oasis indicated the patient refused a wound assessment but did not explain why. The agency failed to educate the patient regarding assessing a wound and failed to indicate if wound care was managed by another Entity. A review of the non-Oasis document dated 04/22/2024 indicated a wound on the sacral area with no measurements, assessment, staging, or treatment. The non-Oasis indicated the patient refused a wound assessment because the dresses had just been changed. The note indicated Entity 1 was providing wound care three			

	to assess a wound(s) and coordinate care with Entity 1 regarding a wound(s). A review of the Braden Scale (a tool used to predict bed sores) dated 03/14/2024 indicated a mild risk for skin breakdown and, on 04/22/2024, an increased moderate risk. The agency failed to prevent an increased risk of skin breakdown and failed to accurately reflect the care provided during the home visit in relation to what was documented in Patient #2's comprehensive assessment and non-Oasis assessment. 4. During an interview on 05/09/2024 at 12:30 PM, the Administrator stated that the nurse should assess the wounds during each nursing visit and coordinate care with the other Entity that provides care. On 05/10/2024 at 8:45 AM, the Administrator was made aware there was no coordination of care with Entity 1 documented. At 2:30 PM the Administrator reviewed Patient #2's chart and stated she would call Entity 1 for a copy of their wound documentation. Upon review of			

	dated 04/24/2024, 05/01/2024, and 05/08/2024, evidenced that Patient #2 had three stage II wounds to the right buttock and both upper thighs and a stage III wound to the coccyx (tailbone). Entity 1's visit notes did not evidence care coordination with the agency. The agency failed to coordinate wound care with Entity 1. 410 IAC 17-15-1(a)(1)(7)			
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: 05/09/2024-05/10/2024 & 05/13/2024-05/14/2024 12-month Unduplicated Skilled Admissions: 5	N0000	POC accepted on 05-28-2024 N0000 Golden Heart Health Services is submitting the following POC issued by ISDH and /or CMS as it is required to do by applicable state and federal regulations. The submission of this POC is not intended as an admission, does not constitute an admission by and should not be construed as an admission by Golden Heart Health Service that the findings and allegation here in are accurate and true representation of quality of care and services provided to patients of the agency. Golden Heart Health Service desires this	

			of compliance. "The Administrator will be responsible for monitoring these corrective actions to ensure that this deficiency is correct and will not recur. COMPLETION DATE: ON-GOING Teresa Johnson, RN-Administrator	
N9999	Final Observations IC 16-27-1.5-5 Sec. 5. (a) This section applies to a registered home health aide who: (1) is employed as a home health aide; and (2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related	N9999	N9999 The Administrator will submit an application for Home HealthAide Dementia training program that was created by Indiana Association for Homeand Hospice Corporation, to ensure Golden Heart Health Services dementiaprogram and training are conducted under an approved program by the Indianadepartment of Health. The home health aide dementia training programapplication was emailed To the Indiana Department of Health as instructed on05/28/2024	2024-06-12

	cognitive disorder. (b) As used in this section, "approved dementia training" refers to a dementia training program: (1) for use in training home health aides in the care of individuals described in subsection (a)(2); and (2) that has been approved by the state department under subsection (f). (c) Not later than sixty (60) days after the date on which a home health aide is initially hired to care for an individual with Alzheimer's disease, dementia, or a related cognitive disorder, the home health aide shall complete at least six (6) hours of approved dementia training. (d) Before December 31 of each year, a home health aide who has been employed as a home health aide for at least one (1) year shall complete at least three (3) hours of approved dementia training. (e) A home health aide who: (1) has received the training required by subsections (c) and		The Director of Nursing/ and or RN will complete at least(6) hours of approved Dementia training to Golden Heart Health Servicesstaff initially hired within 60 daysafter the date of hire, and (3) hours of approved dementia training for employees employed for at least (1) yearwith Golden Heart Health services. The Administrator / and or designee will review all individuals hire dates andemployee files for approved Home Health Aide Dementia Training Program within30 days but up to 60 days for completion. The Administrator will be responsible for monitoring thecorrective actions to ensure that the deficiency is corrected and will notreoccur after the approval of the Home Health Aide dementia training, pendingapproval: application sent to the Indiana Department of Health HCBC division on5/28/24.	

	(d); (2) has been employed as a home health aide for at least twenty-four (24) consecutive months; and (3) is hired by a home health agency; is not required to repeat the training required by this section. (f) The state department shall do the following: (1) Identify and approve each dementia training program that meets the following requirements: (A) The dementia training program includes education concerning the following: (i) The nature of Alzheimer's disease, dementia, and other related cognitive disorders. (ii) Current best practices for caring for and treating individuals with dementia. (iii) Guidelines for the assessment and care of an individual with dementia.			

(iv) Procedures for providing patient-centered quality care.

(v) The daily activities of individuals with dementia.

(vi) Dementia-related behaviors, communication, and positive intervention.

(vii) The role of an individual's family in caring for an individual with dementia.

(B) The dementia training program:

(i) must be culturally competent; and

(ii) may be provided online.

(2) Establish and implement a process for state department approval of a dementia training program.

(g) To the extent allowed by 42 CFR 484.80, the hours of approved dementia training completed under this section satisfies an equivalent number of hours of the home health aide training required by 42 CFR 484.80.

(h) An entity that provides approved dementia training shall provide to each home

health aide who successfully completes the training a certificate of completion.

(i) A home health aide:

(1) is responsible for maintaining the home health aide's certificate of completion; and

(2) may use the certificate of completion as proof of compliance with this section.

This LICENSURE REQUIREMENT is NOT MET as evidenced by:

Based on record review and interview, the agency failed to ensure the agency dementia program and training were conducted under an approved program by the Indiana Department of Health (IDOH) for 1 of 1 dementia program review with the potential to affect all 34 active home health aides. (HHAs #1, #2, #5)

Findings include:

1. According to Indiana Code 16-27-1.5-5, the Indiana Department of Health must approve the agency's dementia training program under

	subsection f. 2. A review of the https://rctclearn.net/ website failed to indicate the agency dementia program was approved by IDOH or conducted under an approved program such as Indiana Association for Home & Hospice Care (IAHHC) or Comfort at Home Healthcare, INC. 3. A review of home health aide (HHA) 1's record evidenced a Certificate of Completion for Approaching Care for Dementia dated 01/09/2024, approved by the Washington State Department of Social and Health Services (DSHS). The agency failed to ensure the dementia program and training were conducted under an approved program by IDOH. 4. A review of home health aide (HHA) 2's record evidenced a Certificate of Completion for Approaching Care for Dementia dated 01/02/2024, approved by the Washington State Department of Social and Health Services (DSHS). The agency failed to ensure the dementia program and training were conducted under an			

	approved program by IDOH. 5. A review of home health aide (HHA) 5's record evidenced a Certificate of Completion for Approaching Care for Dementia dated 11/03/2023, approved by the Washington State Department of Social and Health Services (DSHS). The agency failed to ensure the dementia program and training were conducted under an approved program by IDOH. 6. During an interview on 05/14/2024 at 3:10 PM, the Administrator was asked if IDOH approved the agency's dementia program. The Administrator was unsure and mentioned needing to contact the owner for confirmation. The Administrator could not provide evidence of IDOH's approval for the dementia training program. The agency failed to ensure the dementia program and training were conducted under an approved program by IDOH, affecting all 34 active HHAs.			

TERESA	JOHNSON	6/11/2024 11:25:59 AM