STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K035	A. BUILDING B. WING	05/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRINITY HOME HEALTH CARE INC	3502 STELLHORN ROAD, FORT WAYNE, IN, 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR §484.102. Survey Dates: April 30, May 1, 2, 3, and 6, 2024. Current Census: 22 At this Emergency Preparedness survey, Trinity Home Health Care was not found in compliance with the Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102	E0000	Credible allegation of compliance by Lisa Hunter, Administrator This Plan of Correction is the agency's credibleallegation of compliance. Preparation and/or execution of this plan ofcorrection does not constitute admission or agreement by the provider of thetruth of the facts alleged or conclusions set forth in the statement ofdeficiencies. The plan of correction is prepared and/or executed solely becauseit is required by the provisions of federal and state law.	

E0001	Establishment of the Emergency Program (EP) 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness	E0001	The Governing Body established an Emergency Program (EP) committeeon May 20, 2024 to maintain a comprehensive emergency preparedness program(EPP), utilizing an all-hazards approach. The EP committee will review andupdate EP policies and procedures to maintain compliance with CFR(s): 484.102. The Governing Body will annually review the EPP and minutes of theEP committee to ensure 100% compliance with the following Tags: E009 (Local,State, Tribal Collaboration Process), E0019 (Homebound HHA/Hospice Inform EPOfficials, E0030 (Names and Contact Information), E0031 (Emergency OfficialsContact Information), E0033 (Methods for Sharing Information), E0034(Information on Occupancy/Needs, E0037 (EP Training Program), E0039 (TestingRequirements). A Home Health Agency Preparedness Assessment checklist will be theframework	2024-06-05

	program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: Based on record review and interview, the home health agency failed to ensure their emergency preparedness plan (EPP) included a process to collaborate and cooperate with local, tribal, regional, state, and federal emergency preparedness entities to maintain an integrated response in case of an emergency (Tag E0009); failed to ensure their emergency preparedness plan (EPP) included procedures of how to inform State and local emergency preparedness officials about homebound home care patients in need of evacuation from their residences due to an emergency (Tag E0019); failed to ensure the Emergency Preparedness Plan (EPP) included the physician's name and contact information for each patient (Tag E0030); failed to ensure the Emergency Preparedness Plan (EPP) included the contact information for Federal emergency preparedness staff (Tag E0031); failed to ensure the Emergency Preparedness Plan (EPP) included a method for sharing agency patient information and location of home health patients with other health providers to maintain continuity of care (Tag E0033); failed to ensure the Emergency Preparedness Plan (EPP) included a process for communicating the		process. The Administrator is responsible for monitoring the EmergencyProgram is in compliance with CFR(s): 484.102.	

	agency's capacity, needs, and ability to provide assistance, to the designated community officials (Tag E0034); failed to provide Emergency Preparedness policy and procedure training to all new and existing staff (Tag E0037); and failed to carry out exercises to test the emergency plan annually (Tag E0039). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment and resulted in the agency being found out of compliance with the condition 42 CFR 484.102 Emergency Preparedness.			
E0009	Local, State, Tribal Collaboration Process 483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:]	E0009	The EPP was updated to include arrangements with local and stateemergency preparedness officials. The process for cooperation and collaborationwith the identified officials is outlined in the EPP. The Governing Body will annually review the EPP and minutes of theEP committee to ensure 100% compliance with our local and state collaboration process.Tribal officials are not	2024-06-05

	(4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Based on record review and interview, the home health agency failed to ensure their emergency preparedness plan (EPP) included a process to collaborate and cooperate with local, tribal, regional, state, and federal emergency preparedness entities to maintain an integrated response in case of an emergency in 1 of 1 home health agency. Findings include: A record review of the agency's EPP failed to evidence arrangements or processes the agency had in place with local, tribal, regional, state, or federal EPP entities during an emergency. During an interview on 05/06/24 at 10:30 AM, when asked how the EPP identified		applicable to our location. The Administrator is responsible for monitoring the EmergencyProgram is in compliance with CFR(s): 484.102(a)(4).	

	take to collaborate with local, tribal, regional, state, and federal agencies during an emergency, the administrator indicated the federal entity contact information was missing in the EPP and indicated the audit nurse reached out to the local, tribal, regional, and state entities and had not received any responses.			
E0019	Homebound HHA/Hospice Inform EP Officials 418.113(b)(2) §418.113(b)(2), §460.84(b)(4), §484.102(b)(2) [(b) Policies and procedures. The [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. At a minimum, the policies and procedures must address the following:] *[For homebound Hospice at §418.113(b)(2), PACE at §460.84(b)(4), and HHAs at §484.102(b)(2):] The procedures to inform State and local emergency preparedness officials about [homebound Hospice, PACE or HHA] patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment. Based on record review and	E0019	Risk assessment levels from 1 to 3 have been assigned to 100% of ourpatients and added to the patient roster to help identify patients in need ofevacuation due to an emergency situation. Level 1 indicates homebound status.Our policy/process is first to contact the level 1 patients, prioritizing thosewithout a present caregiver in the home /and or their emergency contact viaphone to assess their current situation. If we are unable to make contact viaphone or logistics prevent us from knocking on their door, we will contact 911for level 1 patients in need of evacuation from their residences due to anemergency situation. Information will be relayed from the patient roster on thepatient’s medical and psychiatric condition, andthe	2024-06-05

	interview, the home health agency failed to ensure their emergency preparedness plan (EPP) included procedures of how to inform State and local emergency preparedness officials about homebound home care patients in need of evacuation from their residences due to an emergency in 1 of 1 home health agency. Findings include: A record review of the agency's EPP failed to evidence identification of patients who were homebound and failed to evidence the process for notifying the State and local emergency preparedness officials of patients in need of evacuation during an emergency. During an interview on 05/06/24 at 10:30 AM, when asked to see the patient list identifying homebound status, the administrator indicated a patient list with no identification of homebound status and indicated there were no procedures in the EPP to notify emergency preparedness officials about patient evacuation from homes.		home environment. We will follow suit with level 2 and level 3 patients,ensuring their safety. If able, communication notes will be made in real time.After the event, the EP committee will analyze the activation of the emergencyplan, documenting in the EPP. The Governing Body will annually review the EPP and minutes of theEP committee to ensure 100% compliance with local and state collaboration. The Administrator is responsible for monitoring the EmergencyProgram is in compliance with CFR's:484.102(b)(2).	
E0030	Names and Contact Information	E0030	The patient roster has been	2024-06-05

	483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers.		updated to include the physician’s name andcontact information for each patient. Nurses will update patient records asthis information changes. The Governing Body will annually review the EPP andminutes of the EP committee to ensure 100% compliance with names and contactinformation. The communication plan includes names and contact information forthe following: staff, entities providing services under arrangement, and patients’ physicians.Trinity does not utilize volunteers. The Administrator is responsible for monitoring the EmergencyProgram in compliance with CFR(s): 484.102(c)(1).	

	*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices.			

	*[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on record review and interview, the home health agency failed to ensure the Emergency Preparedness Plan (EPP) included the physician's name and contact information for each patient for 1 of 1 agency. Findings include: A review of the emergency binder failed to include the names and contact information for the physicians of the agency's Patients.			

	During an interview on 05/06/24 at 10:30 AM, when asked to see the physician's name and contact information for the agency's patient in the EPP, the administrator indicated they did not include that information in the EPP.			
E0031	Emergency Officials Contact Information 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification	E0031	Contact information for Federal emergency officials was corrected on05/06/24 in the EPP. The communication plan identifies contact information forFederal emergency preparedness staff and other sources of assistance. TheGoverning Body will annually review the EPP and minutes of the EP committee toensure 100% compliance with emergency officials contact information and updateas necessary. The Administrator is responsible for monitoring the emergency program is in compliance with CFR(s): 484.102(c)(2).	2024-06-05

	Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on record review and interview, the home health agency failed to ensure the Emergency Preparedness Plan (EPP) included the contact information for Federal emergency preparedness staff in 1 of 1 agency. Findings include: A record of the agency's EPP failed to evidence contact information for the Federal emergency preparedness staff. During an interview on 05/06/24 at 10:30 AM, when asked to see the Federal emergency preparedness staff in the agency EPP, the administrator indicated it was not in the EPP.			
E0033	Methods for Sharing Information	E0033	The EPP has been updated to	2024-06-05

	483.73(c)(4)-(6) §403.748(c)(4)-(6), §416.54(c)(4)-(6), §418.113(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §441.184(c)(4)-(6), §460.84(c)(4)-(6), §482.15(c)(4)-(6), §483.73(c)(4)-(6), §483.475(c)(4)-(6), §484.102(c)(4)-(5), §485.68(c)(4), §485.542(c)(4)-(6), §485.625(c)(4)-(6), §485.727(c)(4), §485.920(c)(4)-(6), §491.12(c)(4), §494.62(c)(4)-(6). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4).		include a method for sharinginformation, medical documentation, and location for patients under Trinity's care, asnecessary, with other health providers to maintain the continuity of care. Theorder of method is phone, secure fax, or email. The means is the patientinformation sheet, which includes general condition and location of thepatient. The Governing Body will annually review the EPP and minutes of the EPcommittee to ensure 100% compliance with methods for sharing information. The Administrator is responsible for monitoring the emergency planis in compliance with CFR(s): 484.102(c)(4)-(5).	

	*[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). Based on record review and interview, the home health agency failed to ensure the Emergency Preparedness Plan (EPP) included a method for sharing agency patient information and the location of home health patients with other health providers to maintain continuity of care and for 1 of 1 agency. Findings include: A record review of the agency's EPP failed to evidence the method to share patient information and patient location with other health providers to maintain continuity of care. During an interview on 05/06/24 at 10:30 AM, the administrator indicated the EPP was missing the process to share patient medical			

	information and patient location with other health providers.			
E0034	Information on Occupancy/Needs 483.73(c)(7) §403.748(c)(7), §416.54(c)(7), §418.113(c)(7) §441.184(c)(7), §482.15(c)(7), §460.84(c)(7), §483.73(c)(7), §483.475(c)(7), §484.102(c)(6), §485.68(c)(5), §485.68(c)(5), §485.727(c)(5), §485.542(c)(7), §485.625(c)(7), §485.920(c)(7), §491.12(c)(5), §494.62(c)(7). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113(c):] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.	E0034	The process for providing information about communicating Trinity's capacity,needs, and ability to provide assistance to designated officials has been addedto Trinity's EPP. Using Trinity's establishedphone tree; available staff, needs, and abilities are identified. Trinity isthen able to report any available staff via phone and respond to what theirrequests are pertaining to available staff. Requests are varied. May beanything from nurses needed for triage at the Community Center to anyone having4-wheel drive vehicles. The Governing Body will annually review the EPP and minutes of theEP committee to ensure 100% compliance with the agency's communicationplan. The Administrator is responsible	2024-06-05

	Based on record review and interview, the home health agency failed to ensure the Emergency Preparedness Plan (EPP) included a process for communicating the agency's capacity, needs, and ability to provide assistance, to the designated community officials for 1 of 1 agency. Findings include: A record review of the agency's EPP failed to evidence a process to communicate the capacity, needs, and the ability to provide assistance to designated officials. During an interview on 05/06/24 at 10:30 AM, the administrator indicated the EPP was missing the process to communicate their capacity, needs, and ability to provide assistance.		planis in compliance with CFR(s): 484.102(c)(6).	

E0037	EP Training Program 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency	E0037	All current employees were in-serviced on Trinity's EmergencyPreparedness policy and procedures. New employees will be oriented to theemergency management plan during the orientation process. Thereafter, emergencypreparedness training will occur at least every 2 years for all employees. The agency will maintain documentation of all emergency preparednesstraining and demonstrate staff knowledge of emergency procedures. The training hasbeen added to the orientation checklist. HR will conduct personnel recordreviews quarterly using the agency's audit form. If the emergency preparedness policies and procedures aresignificantly updated, training will be conducted on the updated policies andprocedures to all staff and documented accordingly.	2024-06-05

	procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants,		The Governing Body will annually review the EPP and minutes of theEP committee to ensure 100% compliance with the EP Training Program. Thisincludes initial training in emergency preparedness policies and procedures toall new and existing staff and individuals providing services underarrangement, consistent with their expected roles. Trinity does not utilizedvolunteers. The Administrator is responsible for monitoring the EmergencyProgram is in compliance with CFR(s): 484.102(d)(1).	

	roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific			

	emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			

	Based on record review and interview, the home health agency failed to provide Emergency Preparedness policy and procedure training to all new and existing staff for 1 of 1 agency. Findings include: A review of an agency policy titled "Emergency Preparedness Management Policy" indicated all staff members will be oriented to the emergency management plan. A review of an agency document titled "Client Safety/First Aid/Emergency Procedures" included staff procedures for provision of first aid and what to do for patients with do not resuscitate status. This training document content failed to evidence emergency preparedness policy and procedure training. During an interview on 05/06/24 at 11:45 AM, when asked to see the emergency preparedness training provided to new and existing staff, the administrator provided a copy of a document titled "Client Safety/First Aid/Emergency Procedures".			

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 required community-based or individual, 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	E0039	Trinity's Emergency Preparedness ManagementPolicy has been updated to include exercises to test the EP which will beconducted annually. Participation in a community based full-scale exercise willoccur every 2 years. If a community based full-scale exercise is not available,an annual individual, facility-based functional exercise will be conducted bythe agency. An additional tabletop exercise will be conducted opposite the yearthe full-scale exercises are conducted. A facilitator will be designated tolead a group discussion on a clinically-relevant emergency scenario. Analysisof such will be included in documentation of all drills, tabletop exercises,and emergency events to be included in the EP binder. The Allen County Homeland Security Planning Coordinator is our resource for locating community-based exercises available. The EPcommittee will schedule all exercises and employees who will be participants. The Governing Body will annually review the minutes of the EPcommittee to ensure 100% compliance with EP	2024-06-05

	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: (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		Testing Requirements. The EP committee will analyze the response to and maintaindocumentation of all drills, tabletop exercises, and emergency events, andrevise the agency’s emergency plan as needed. The Administrator is responsible for monitoring the Emergency Planis in compliance with CFR(s): 484.102(d)(2).	

	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			

	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 accessible, conduct an annual individual, 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			

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 participate in a full-scale community-based or

	years to test the emergency plan. Findings include: A review of an agency policy titled "Emergency Preparedness Management Policy" indicated agency staff members will participate in an annual desktop drill to determine the effectiveness and efficiency of the current plan. A review of the agency's emergency preparedness binder failed to evidence a full-scale community-based or facility-based exercise in the last 2 years. A review of an emergency preparedness team meeting, dated 04/27/23, indicated the agency conducted a fire drill for a kitchen fire on 05/12/22. During an interview on 05/06/24 at 11:45 AM, when asked when and what testing of the emergency plan had occurred, the administrator indicated the last testing done was a fire drill on 05/12/22 and was not an actual event.			
G0000	INITIAL COMMENTS	G0000		

	This visit was for a Federal Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: 4/30, 5/1, 5/2, 5/3, and 5/6/2024 12 Month Unduplicated Skilled Admissions: 9 Survey was fully extended on 05/2/2024. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings.			

G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on record review, and interview, the agency failed to ensure the comprehensive assessment was updated to include the patient's current condition for 1 of 3 active patients with only skilled nurse services (Patient #1). Findings include: 1. A review of the policy on reassessment indicated the assessment should be updated based on improvement or decline in the patient's condition. 2. A review of the clinical record for Patient #1 included a recertification assessment completed by the Director of Nursing (DON) on 4/1/2024. The reassessment indicated wound care was completed and the patient removed the soiled dressing. Wounds 1 (right leg) and 2 (left leg) were identified	G0544	All clinical charts have been updated to include the patient's currentcondition. The Administrator in-serviced the nursing staff on the policies andprocedures for updating comprehensive assessments; to ensure the comprehensiveassessment is being updated to include the patient's currentcondition. If there is a major decline or improvement in the patient's conditionthis must be documented regardless when the comprehensive assessment is due. After the assessment is completed, the nurse will manually reviewagainst the new Plan of Care to ensure 100% accuracy. This will correct theerror of outdated information being carried over to the new assessment form inthe electronic system. Charts will be audited quarterly for quality assuranceand ongoing compliance. The Director of Nursing is responsible for monitoring compliance withupdate of the comprehensive assessment CFR(s): 484.55(d).	2024-06-05

	as unstageable (unable to determine the depth of the wound), with a small amount of thin, clear drainage of the right leg, and a moderate amount of thin, clear drainage for the left leg. Additionally, the left leg was noted to have macerated skin (skin damage due to excessive moisture) surrounding the wound. The reassessment also indicated there were no wounds or open areas. During an interview on 4/30/2024 at 3:15 PM, the DON indicated the patient did not have wounds on the date of the reassessment. When asked how someone would know if Patient #1 had wounds, the DON indicated there were no wound measurements so there were no active wounds. The DON was unable to identify when the wounds were healed. The Administrator indicated the electronic system did not always save updated information. The Administrator indicated the reassessment failed to indicate the patient's status or whether there was improvement or decline.			

	410 IAC 17 – 14 – 1(a1B)			
G0592	Revised plan of care 484.60(c)(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care. Based on record review and interview, the home health agency failed to ensure the revised plan of care (POC) was up-to-date and supported by the recertification comprehensive assessment for 1 of 2 active records reviewed of patients that resided in their home (Patient #4). Findings include: 1. A review of an agency policy titled “Plan of Care” indicated the POC is based on the comprehensive assessment and developed to meet individualized needs and will include all pertinent diagnoses, medications, and safety measures. 2. A review of the clinical	G0592	The Administrator reviewed and in-serviced the nurses on thepolicies and procedures for Plan of Care (POC). Nurses were educated on theinstructions for the revised plan of care, supported by the recertificationcomprehensive assessment. All clinical charts will be audited to ensure current Plans of Careare up-to-date with pertinent diagnoses, medications, and safety measures,supported by the current comprehensive assessment.	2024-06-05

	record of Patient #4, start of care date 01/03/20, included a recertification comprehensive assessment completed on 04/08/24 by the director of nursing that indicated a primary diagnosis of quadriplegia (paralysis of all limbs and body from the neck down) and safety measures for the following precautions: bleeding, oxygen, seizure, fall, infection control, and aspiration. A review of a medication list indicated the order date of 10/16/23 for the following medications: Cefdinir (antibiotic) capsule twice daily for 5 days, Levofloxacin (antibiotic) tablet daily for 5 days, Vancomycin (antibiotic) capsules twice daily for 7 days, and Clotrimazole (to treat skin infection) cream twice daily for 21 days. The medication list included the discontinue date of 10/21/23 for Cefdinir and Levofloxacin, the discontinue date of 10/23/23 for Vancomycin, and the discontinue date of 11/06/23 for Clotrimazole cream. A review of the POC for certification period 04/11/24 – 06/09/24, included the		When nurses DC meds in the medical record system they will nowmanually correct the Plan of Care simultaneously and notify the physician. Thiswill correct the error of conflicting information on the Plan of Care andComprehensive Assessment in the electronic system. Charts will be auditedquarterly for quality assurance and ongoing compliance. The Director of Nursing is responsible for ensuring compliance withthe revised Plan of Care CFR(s): 484.60(c)(2).	

following active medications: Baclofen Pump (a device that delivers a muscle relaxant to the fluid in the spinal canal) continuous by mouth, Cefdinir capsule two times a day for 5 days, Levofloxacin tablet daily for 5 days, Vancomycin capsules two times a day for 7 days, and Clotrimazole cream two times a day for 21 days. The revised POC failed to evidence the diagnosis of quadriplegia, failed to evidence safety measures for the following precautions: bleeding, oxygen, seizure, and aspiration, failed to evidence the correct administration route of Baclofen pump, and failed to evidence current medications.

3. During an interview on 05/02/24 at 3:30 PM, when asked why a quadriplegia diagnosis was not included in the POC, the director of nursing indicated Patient #4 had both quadriplegia and paraplegia as diagnoses and indicated quadriplegia was not in the POC. When asked what the route of administration for Baclofen was, the director of nursing indicated the baclofen pump was surgically installed and the by mouth route is

	incorrect. When asked why the medications Cefdinir, Levofloxacin, Vancomycin, and Clotrimazole were active in the current POC, the director of nursing indicated these medications had been discontinued and should not be in the current POC. During an interview on 05/03/24 at 11:25 AM, when asked to be shown where the following safety precautions which included bleeding, oxygen, seizure, and aspiration, could be found in the POC, the director of nursing indicated they were not in the POC.			
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects.	G0658	The Administrator in-serviced the Quality Assurance and PerformanceImprovement (QAPI) committee on the policies and procedures for performanceimprovement projects (PIP). Designated staff has been assigned to maintainingminutes/documentation on the PIP. Datafrom Quality Assurance audits helps inform the agency on distinct	2024-06-05

	(1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on record review and interview, the home health agency failed to ensure the Quality Assurance and Performance Improvement (QAPI) committee had initiated and documented a performance improvement project (PIP) which was approved by the Governing Body which had the potential to affect all agency patients and staff. Findings include: A review of the agency QAPI documentation failed to evidence the agency had initiated or documented PIP(s). During an interview on 05/03/24 at 1:50 PM, when asked to see the Performance Improvement Projects the agency was currently working on, the administrator indicated they had discussed staffing. When asked to see the documentation of the discussions, the administrator indicated the discussions had		improvementprojects that will be conducted annually. The Governing Body will approveprojects recommended that have the potential to affect all agency patients andstaff. The Governing Body will review the PIP documentation annually. On May 20, 2024 the Governing Body reviewed and approved a PIPproject on agency staffing. The Administrator is responsible for monitoring compliance withPerformance improvement projects CFR(s): 484.65(d)(1)(2).	

	just been written down as notes and not as a documented report. On 05/03/24 at 2:25 PM the administrator provided a copy of agency documents titled "Performance Improvement for 2024 and 2023". When asked if the documents had been put together after the 1:50 PM discussion about PIPs, the administrator indicated yes.			
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 nurses followed appropriate hand hygiene during wound care for 1 of 1 registered nurse (RN) observation of wound care at a home visit (RN 1). Findings include: 1. A review of the infection prevention policy indicated the agency followed standard precautions and the Centers for	G0682	The Administrator in-serviced all nurses on Trinity's InfectionPrevention policy. Nurses were educated on proper hand hygiene followingstandard precautions using training materials from the Centers for DiseaseControl and Prevention (CDC). A documented return demonstration was completedwith each nurse. All new nurses will complete this training in the orientationprocess and will be documented in their personnel record. The Director of Nursing is responsible for monitoring infectionprevention in compliance with CFR(s): 484.70(a).	2024-06-05

	Disease Control and Prevention (CDC). 2. A review of the CDC Hand Hygiene training materials, available at https:// www.cdc.gov/ handhygiene/ training/ interactiveEducation/, indicated hand hygiene, by use of soap and water hand wash or the use of an alcohol-based hand rub, is required before donning gloves and after removing gloves. 3. A home visit observation of wound care occurred on 5/1/2024 at 11:20 AM, with Patient #3 and RN 1. During the visit, RN 1 pulled down Patient's brief to inspect for sores. RN 1 removed the gloves and failed to complete hand hygiene prior to donning new gloves. RN 1 then removed the dressing from the Patient's wounds. After washing the Patient's wound areas, RN 1 donned new gloves but failed to complete hand hygiene. RN 1 then applied antibiotic ointment to the wounds. RN 1 removed gloves, used hand sanitizer, waved hands in the air, and then donned new gloves. RN 1 applied a new dressing, donned new gloves with no hand hygiene, and wrapped the			

wounds with gauze. RN 1 removed gloves, rubbed hands on scrub pants, and put on new gloves, and stated it was difficult to get new gloves on when their hands were sweaty.

4. During an interview on 5/1/2024 at 2:55 PM, RN 1 indicated hand washing was required prior to starting wound care, after removing the dressing, and after completing the wound care. RN 1 indicated hand hygiene with hand sanitizer occurred when moving between sections of providing wound care and before changing into new gloves. When asked about waving hands after using hand sanitizer, RN 1 indicated they wanted to dry their hands. RN 1 then indicated that waving hands contaminated gloves and should not have been done. When asked about rubbing hands on scrubs because their hands were sweaty, RN 1 indicated they were unaware they did this, and it should not have been done. RN 1 indicated they were nervous.

	410 IAC 17 – 12 – 1(m)			
G0768	Competency evaluation 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. Based on record review and interview, the agency failed to ensure there was a skills competency evaluation prior to providing patient care for 1 of 2	G0768	The Administrator reviewed the agency's policy andprocedures on competency assessment with all office staff. Prior to providingindependent patient care all HHAs and CNAs will complete a skills competencyevaluation. A qualified supervisor/preceptor will document the satisfactorydemonstration of skills using the agency's skillsassessment checklist. Upon completion the preceptor will notify scheduling tonote this in the employee's electronic personnel information. Thissystem change will ensure qualified staff being scheduled. HR will auditpersonnel records quarterly using the agency's audit form toensure 100% compliance. The Director of Nursing is responsible for monitoring the competencyevaluation in compliance with 410 IAC 17 – 12 – 1(m).	2024-06-05

	records reviewed (HHA #2). Findings include: 1. A review of the policy on competency assessment indicated a skills assessment checklist "... will be used by the supervisor/ preceptor to document the completion of satisfactory demonstration of skills." 2. A review of the policy on delegation of nursing tasks to an aide included the need for the registered nurse to assess the skill of the aide assigned to perform the task by the return demonstration of the nursing tasks. 3. A review of the personnel record for HHA #2 indicated the agency hired them on 11/21/2023. The record failed to include a skills competency assessment. 4. During an interview on 5/3/2024 at 5:15 PM, the Administrator indicated there was no skills competency in HHA #2's personnel record. The Administrator indicated their practice was to complete a skills competency with HHAs or CNAs prior to providing independent			

	patient care. 410 IAC 17 – 14 – 1(l)(1)(A)			
G0804	Aides are members of interdisciplinary team 484.80(g)(4) Home health aides must be members of the interdisciplinary team, must report changes in the patient's condition to a registered nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures. Based on observation, record review and interview the agency failed to ensure the home health aide (HHA) reported changes in patient status to the registered nurse (RN) for 1 of 1 home visit for HHA observation. (HHA 1) Findings include: 1. A review of a policy on home health aide services identified the aide's responsibility to observe and report the patient's condition to the RN. 2. An observation of HHA care for Patient #2 occurred on 5/1/2024 at 10:10 AM. HHA 1 provided care to the patient as surveyor and Director of Nursing (DON) arrived. During the observation, HHA 1 indicated Patient 2's respiratory	G0804	All staff will be in-serviced on the agency's Home HealthAide Services policy and procedures. Home health aides are members of theinterdisciplinary team, responsible for observing and reporting changes inpatient status to the RN for documentation in the patient's chart in atimely manner. If unreported changes are discovered either before the nextscheduled supervisory visit or at the visit, the HHA will be counseledaccordingly and must repeat the in-service training. New hires are oriented tothe agency's Home Health Aide Services policyduring the orientation process. Charts will be audited quarterly for qualityassurance and ongoing 100% compliance. The Director of Nursing is responsible for monitoring compliance withAides being members of the interdisciplinary team CFR(s): 484.80(g)(4).	2024-06-05

	status had changed on 4/26 or 4/27/2024. HHA 1 indicated Patient #2 went to see Person C, (the patient's primary care provider) on 4/30/2024 and received a diagnosis of bronchitis. Two prescriptions were ordered but the patient did not start them due to family concerns about side effects. The DON indicated they were not aware of the symptoms, medical visit, or new prescriptions prior to the home visit. The DON indicated Patient #2 had a diagnosis of chronic obstructive pulmonary disease (COPD; lung diseases that obstruct the airflow from the lungs) and had several hospitalizations related to COPD. During an interview at the time of the home visit, HHA 1 indicated they would notify the RN if there were changes in the patient, such as new or recurring symptoms. When asked, HHA 1 first indicated they did not notify the RN and the change in symptoms should have been reported. HHA 1 then said they did not notify the RN because it was Saturday. HHA indicated they knew how			

	and on weekends and had done that previously. HHA 1 indicated they were going to notify the Alternate DON, Patient #2's regular nurse. 3. The record review for Patient #2 failed to evidence documentation HHA 1 notified the office or an RN of Patient #2's symptoms. During an interview on 5/1/2024 at 3:15 PM, the DON indicated they were not aware of the patient's symptoms, visit to the doctor, or new medications. The DON indicated there was no documentation in the chart and they were waiting for a return call from the Alternate DON to determine if HHA 1 contacted them. Two voicemail messages left for the Alternate DON (on 5/2 and 5/3/2024) were not returned by survey exit.			
G1024	Authentication 484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and	G1024	The Administrator reviewed the clinical documentation policy withthe Director of Nursing. Documentation of service is documented on the day ofservice and incorporated into the clinical record within 7 days	2024-06-05

	timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interview, the agency failed to ensure skilled nurse visit notes were completed within 7 days of the date of service for 3 of 5 active patient records reviewed (Patients #3, 4, and 5) and 2 of 2 discharge patient records (Patients #6 and 7). Findings include: X. A review of the clinical documentation policy indicated the documentation of service was to be documented the day of the service and incorporated into the clinical record within 7 days of the date of service. X. A review of the clinical record for Patient #3 evidenced visit notes by the Director of Nursing (DON). The visit notes for 3/15, 3/21, 3/22, 3/25, 3/27, and 3/28/2024 were in pending status. During an interview on 5/2/2024 at 9:30 AM, the DON indicated their notes for Patient #3 were incomplete as they no longer had a registered nurse in the office to approve the notes. X. A review of the clinical		of the date ofservice. A systemic change allowing the primary author of the documentation toreview and approve the entry alleviates previous confusion on approval of thedocumentation. All patient records were reviewed to ensure skilled nurse visitnotes were completed and authenticated. Charts will be audited quarterly forquality assurance and ongoing 100% compliance. The Director of Nursing is responsible for ensuring compliance withauthentication of clinical documentation in a timely manner CFR(s): 484.110(b).	

	record for Patient #7 evidenced visit notes completed by the DON. On 5/3/2024, the visit notes for 11/10, 11/15, 11/20, and 11/22/2023 were in pending status, though Patient #7 was discharged on 11/23/2023. During an interview on 5/2/2024 at 9 AM, the DON indicated the notes were pending as there was no nurse to approve them. The DON indicated they did not know if they could approve their own notes. X. During an interview on 4/30/2024 at 9:45 AM, the Administrator indicated visit notes were considered completed after a registered nurse reviewed and approved the notes. Notes which were not completed or approved were considered pending notes. 410 IAC 17 – 15 – 1(a)(7) A review of the clinical record of Patient #4 for certification period 04/11/24 – 06/09/24 included orders for a skilled nurse to make daily visits seven days a week. Record review included agency			

	documents titled "Care Note Report" completed by the director of nursing on dates: 04/16/24, 04/17/24, 04/18/24, 04/19/24, and 04/22/24 that evidenced the status of the documents as pending. A review of the clinical record of Patient #5 for certification period 04/01/24 – 05/30/24 included orders for a skilled nurse to make one visit a month. Record review included an agency document titled "Care Note Report" completed by the director of nursing on 04/12/24 that evidenced the status of the document as pending. A review of the clinical record of Patient #6 for certification period 03/04/24 – 05/02/24 included orders for a skilled nurse to make one visit a day for up to 4 days a week. Record review included agency documents titled "Care Note Report" completed by the director of nursing on dates: 03/15/24, 03/22/24, 03/25/24, and 03/27/24 that evidenced the status of the documents as pending.			

	During an interview on 05/03/24 at 3:20 PM, when asked what pending status means in the skilled nurse care note reports, the director of nursing indicated it means the document is ready to be reviewed by a registered nurse.			
N0000	Initial Comments This visit was for a State Re-Licensure survey of a Home Health Provider. Survey Dates: 4/30, 5/1, 5/2, 5/3, and 5/6/2024 12 Month Unduplicated Skilled Admissions: 9 Survey was fully extended on 05/2/2024	N0000		
N9999	Final Observations	N9999	Allcurrent HHAs will receive state approved dementia training. This training willbe added as one of Trinity's specialty in-services during the orientationprocess and will be added to the orientation	2024-06-05

	Based on record review and interview, the home health agency failed to provide approved dementia training to home health aides (HHA) providing care to patients with diagnosis of dementia, alzheimer's or a related cognitive disorder in 1 of 1 agency. Findings include: 1. A review of the clinical record of Patient #8 included a plan of care for certification period 04/25/24 – 06/23/24 that indicated a diagnosis included, but not limited to, dementia and included orders for a HHA to make one visit a day for five days a week. Record review evidenced HHA 4 was assigned to provide care to Patient #8. 2. A review of HHA personnel records failed to evidence the agency provided HHA 4 with approved state dementia training. 3. During an interview on 05/03/24 at 3:55 PM, when asked to see the approved		checklist. HR will conductpersonnel record reviews quarterly using the agency's audit form to ensure 100%compliance. The Director of Nursing is responsible for monitoring thispractice.	

	provided to the HHAs, the administrator indicated did not know what that training was.			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided.For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility.If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lisa Hunter	Administrator	5/27/2024 10:21:20 AM