STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K097	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
4U HOME HEALTH INC	8770 GUION ROAD SUITE K1 , INDIANAPOLIS, Indiana, 46268

(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 CFR 484.102. Survey Dates: 05-20-2024, 05-21-2024, and 05-22-2024 Active Census: 18 At this Emergency Preparedness survey, 4U Home Health Inc. was found to be out of compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102. QR completed by Area 3 on 5-29-2024.	E0000		
E0001	Establishment of the Emergency Program (EP) CFR(s): 484.102 §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	E0001		

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

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E0001	Continued from page 1 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 program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure an Emergency Preparedness Program was in place; the agency failed to evidence an Emergency Preparedness Plan had been developed, maintained, reviewed and updated every two(2) years (E0004), failed to evidence a risk assessment had been conducted (E0006), failed to address patient population, the types of services the agency had the ability to provide in an emergency, continuity of operations, delegation of authority and succession plans (E0007), failed to evidence a process for cooperation and collaboration with local tribal, regional, State and Federal emergency preparedness officials' efforts to to maintain an integrated response during an disaster or emergency situation (E0009), failed to evidence policies and procedures based on the emergency plan were reviewed and updated at least every two(2) years (E0017), failed to evidence procedures to inform State/Local officials regarding homebound patients in need of evacuation from their residences at any time due to an emergency, based on the patient's medical, psychiatric condition, and home environment (E0019), failed to evidence procedures to follow up with on-duty staff and patients to determine services needed during an emergency, and for informing the State and local officials of any on-duty staff or patients they are unable to contact (E0021), failed to evidence a process or procedure to secure and maintain availability of records during an emergency (E0023), failed to evidence use of volunteers or other emergency staffing to address surge needs during an emergency (E0024), failed to evidence an emergency communication plan (E0029), failed to evidence names and contact information for staff, entities providing services under arrangement, patients' physicians, other agencies, and volunteers	E0001		

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E0001	Continued from page 2 (E0030), failed to evidence emergency officials' contact information: Federal, State, tribal, regional, and local emergency preparedness staff, and other sources of assistance (E0031), failed to evidence a method for sharing information and medical documentation for patients, with other health providers to maintain the continuity of care (E0033), failed to evidence a means of providing information about the agency's needs during an emergency and its ability to provide assistance during to the authority having jurisdiction, the Incident Command Center, or designee (E0034), failed to evidence Emergency Preparedness Testing and Training were conducted based on the emergency preparedness plan, risk assessment, policies and procedures, and communication plan (E0036), failed to evidence an Emergency Preparedness Training Program (E0037), and failed to evidence an Emergency Preparedness Testing Program (E0039). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition /Emergency Preparedness, requirement for Medicare Participating Providers and Suppliers, for Home Health Agencies /at /42 CFR 484.102. Findings include: On 05-20-2024 at 9:50 AM the Emergency Preparedness (EP) program was requested from the agency. On 05-21-2024 at 1:20 PM, the EP program was again requested from the agency. On 05-21-2024 at 3:03 PM the Administrator, Alternate Administrator, and Administrative Personnel 5 indicated the agency had no formal EP program in place.	E0001		
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-licensure survey of Home Health Provider. Survey Dates: 05-20-2024, 05-21-2024, and 05-22-2024. 12-Month Unduplicated Skilled Admission: one (1) The survey was fully extended and announced to the Administrator on 05-21-2024 at 4:01 PM. During this Federal Recertification Survey, 4U Home Health Inc., was found to be out of compliance with Conditions of Participation 484.64 Quality Assurance Performance Improvement, and 484.102 Emergency Preparedness.	G0000		

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G0000	Continued from page 3 Based on the Condition-level deficiencies during the 05-22-2024 survey, your Home Health Agency was subject to an extended survey pursuant to section 1891 (c)(2)(D) of the Social Security Act on 05-22-2024. 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 period of two years beginning 05-22-2024 and continuing through 05-20-2026. This deficiency report reflects State findings cited in accordance with 410 IAC 17. Refer to State Findings form for additional State findings. QR completed by Area 3 on 5-29-2024.	G0000		
G0528	Health, psychosocial, functional, cognition CFR(s): 484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure the comprehensive assessment included relevant past medical history, all active health and medical problems, and the patient's psychosocial status in 5 of 5 active records reviewed. (Patients #1, 2, 3, 4, and 7) Findings include: 1. A review of a policy dated 09/30/2013 titled 'Ongoing Assessment CLIN2022' revealed, " … 2. … the clinician will reassess the patient for: f. Bowel sounds … k. Patient and family /caregiver support … m. Compliance to treatment and/or medications … 6. The physician will be notified … treatment/interventions that require physician approval." A review of a policy dated 09/30/2013 titled 'Reassessment/Recertification CLIN2023' revealed, " … 3. The update of the comprehensive assessment must at a minimum, include: a. Completion of all follow-up date items of OASIS and any changes in patient status b. Drug regiment review of all medications … ". 2. A review of the clinical record for Patient #3 revealed a document titled, 'OASIS-E Recertification signed by the Clinical Manager dated 04/13/2024 at 2:30 PM for the certification period of 04/14/2024 through	G0528		

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G0528	Continued from page 4 06/12/2024 which revealed Allergies was left blank, functional limitations of endurance, hearing, incontinence and ambulation, Advance Care Plan/Directives left blank, Supportive Assistance – Community Agencies/Social Service Screening was left blank, Endocrine indicated Patient #3 was a diabetic, diabetic management was controlled by diet, and patient was independent with glucometer (a device used to check blood sugars) use, Cardiovascular indicated Patient #1 had 1+ pitting edema (a finger pressed on the swollen leg leaves an indentation and indentation disappears within 10 seconds and is a sign of right-sided heart failure) to both legs, dizziness and occasional chest pain, SN was to instruct on measures to detect and alleviate edema and Patient #3 would understand symptoms of cardiac complications and when to call 911 by (left blank) Gastrointestinal (GI) assessment indicated the patient had GERD (Gastroesophageal reflux disease which occurs when stomach acid repeatedly flows back into the tube [esophagus] connecting your mouth and stomach), indicated the last BM was 04/13/2024 and all other areas were blank, Musculoskeletal indicated Patient #3 has impaired mobility ambulates with use of a walker, had joint pain in legs, weakness, poor balance and joint stiffness, Fall Assessment was left blank, Timed up and Go Findings was left blank, Supplies/DME was left blank, and coordination of care was left blank. The OASIS-E Recertification failed to identify how often the glucometer was to be used, failed to identify blood sugar ranges, failed to indicate how chest pain was relieved, failed to perform a GI assessment, failed to conduct a fall assessment, and failed to identify supplies required. 3. A review of the clinical record for Patient #4 revealed a document titled, 'OASIS-E Recertification signed by the Clinical Manager dated 04/22/2024 at 9:09 AM for the certification period of 04/25/2024 through 06/23/2024 which revealed Supportive Assistance – Community Agencies/Social Service Screening was left blank, Endocrine indicated Patient #4 was a diabetic, diabetic management was controlled by diet and an oral hypoglycemic, and patient was independent with glucometer (a device used to check blood sugars) use, Cardiovascular indicated Patient #1 had 1+ pitting edema (a finger pressed on the swollen leg leaves an indentation and indentation disappears within 10 seconds and is a sign of right-sided heart failure), dizziness, and occasional chest pain, SN was to instruct on measures to detect and alleviate edema, Gastrointestinal (GI) assessment indicated the patient had GERD (Gastroesophageal reflux disease which occurs	G0528		

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G0528	Continued from page 5 when stomach acid repeatedly flows back into the tube [esophagus] connecting your mouth and stomach), indicated the last BM was 04/22/2024 and had constipation, all other areas were blank, and the Fall Assessment was left blank, Supplies/DME (Durable Medical Equipment) was left blank, and the Coordination of Care was left blank The OASIS-E Recertification failed to identify allergies, indicate how often the glucometer was to be used, identify blood sugar ranges, indicate which leg(s) were affected by the edema, indicate how chest pain was relieved, and failed to perform a GI assessment, failed to conduct a fall assessment, and failed to identify supplies required. 4. A review of the clinical record for Patient #7 revealed a document titled, 'OASIS-E Recertification signed by the Clinical Manager dated 05/01/2024 at 9:09 AM for the certification period of 05/05/2024 through 07/03/2024 which revealed Allergies were left blank, Supportive Assistance – Community Agencies/Social Service Screening was left blank, Gastrointestinal (GI) assessment indicated the patient's last BM was 05/01/2024 and had constipation, all other areas were blank, Musculoskeletal indicated Patient #7 had limited range of motion, used a walker, had joint pain and stiffness, weakness and poor balance, the Fall Assessment was left blank, and Supplies/Durable Medical Equipment (DME) was left blank. The OASIS-E Recertification for Patient #7 failed to identify if had allergies or had any Supportive Assistance - Community Agencies, failed to complete the GI assessment, the Fall assessment, and Supplies/DM. 5. On 05/22/2024 at 10 AM, the Alternate Clinical Supervisor indicated the Administrator would call them if information needed to be corrected or if they missed any items on the documents they submitted. On 05/22/2024 at 3:06 PM the Clinical Supervisor expects a complete head-to-toe assessment completed on each visit, with special attention to specific details, and document all findings. On 05/22/2024 at 12:20 the Administrator indicated they expect the assessments to be completed and accurate. 6. Review of the clinical record for Patient #1 contained an 'OASIS-E Recertification' dated 04-29-2024 for the certification period of 05-02-2024 to 06-30-2024. This comprehensive assessment evidenced	G0528		

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G0528	Continued from page 6 'Allergies' were left blank, 'Vital Sign Parameters' had been left blank for 'Fasting Blood Sugars' and 'Random Blood Sugars'. Diagnoses included but were not limited to: 'Impaired glucose tolerance' to (also known as borderline diabetes and prediabetes, sharing the same characteristics of elevated blood glucose levels that need to be watched but aren't quite high enough to constitute a diabetes diagnosis). 'Advanced Care Planning/Directives' left blank. 'Supportive Assistance/Community Agencies/Social Service Screening' left blank. 'Ability of Client to Handle Finances' was marked 'needs assistance' the 'Comments' section left blank, and Names of Organizations Providing Assistance was left blank. 'Pain Scale' indicated the patient's pain level was 5 out of 10 during the assessment, 'Clients Pain Goal' was left blank. 'Endocrine' section contained the following: 'WNL (within normal limits)' box was not marked, 'Is client diabetic?' box was marked 'No'. Diabetic Management: Diet, Oral, Exercise, Insulin were all left blank, 'Is caregiver independent with glucometer use?' left blank. 'Does patient have any of the following?': Polyuria (body urinates more than usual and passes excessive or abnormally large amounts of urine each time you urinate), Polydipsia (excessive thirst), Polyphagia (a feeling of extreme, insatiable hunger), Neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), Retinopathy (diabetic retinopathy is caused by damage to the blood vessels in the tissue at the back of the eye (retina)) and Thyroid problems (a general term for a medical condition that keeps your thyroid from making the right amount of hormones), were left blank and the Fall Assessment was left blank. The comprehensive assessment failed to identify allergies, parameters for blood glucose levels, advanced care planning and psychosocial concerns/barriers, patient's acceptable pain level, failed to complete an endocrinological assessment and failed to complete a fall assessment. 7. Review of the clinical record for Patient #2 contained an 'OASIS-E Recertification' dated 04-30-2024 for the certification period of 05-05-2024 to 07-03-2024. This comprehensive assessment evidenced 'Allergies' were left blank. Diagnoses included but were not limited to: unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and heart failure (the heart cannot pump (systolic) or fill (diastolic) adequately, symptoms include shortness of breath, fatigue, swollen legs, and rapid heartbeat). 'Advanced Care	G0528		

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G0528	Continued from page 7 Planning/Directives' left blank. 'Supportive Assistance/Community Agencies/Social Service Screening', left blank. 'Pain Scale' indicated the patient's pain level was 3 out of 10 during the assessment, 'Client's Pain Goal' was left blank The Fall Assessment was left blank. DME (Durable Medical Equipment) was left blank. The comprehensive assessment failed to identify allergies, advanced care planning and psychosocial concerns/barriers, patient's acceptable pain level, fall assessment, and medical supplies. 8. On 05-21-2024 at 3:24 PM, when queried as to incomplete and inaccurate documentation on the comprehensive assessments and plans of care, the Clinical Manager indicated, "I try to fill out everything" on the OASIS. 410 IAC 17-14-1(a)(1)(B)	G0528		
G0536	A review of all current medications CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure a review of all medications 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 in 3 of 5 active record reviews. (Patients #2, #3, and #4) Findings include: 1. A review of a policy dated 09/30/2013 titled 'Medication Profile CLIN2028' revealed "… Medication profiles will be updated for each change to reflect current medications, new, and/or discontinued medications. … 2. A drug regimen review will be performed at the time of admission when updates to the comprehensive assessments are performed …"	G0536		

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G0536	Continued from page 8 A review of a policy dated 09/30/2013 titled 'Medication Monitoring CLIN2043' revealed, "… Ongoing patient mediation monitoring will use a collaborative approach between clinicians, physicians, … 1. The clinician will assess the effect of medications on the patient … 2. The clinical effect of medications will be assessed … Review of the information … will be shared by the clinician with appropriate physicians … 7. Deviations from taking medications as ordered will be documented in clinical notes and the physician … will be notified." 2. A review of the clinical record for Patient #3 revealed a document titled, 'HOME HEALTH CERTIFICATION AND PLAN OF CARE' for the certification period of 04/14/2024 through 06/12/2024, signed by the Clinical Supervisor, dated 04/15/2024, which evidenced the following diagnoses but not limited to Osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), Type 2 Diabetes Mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel, this long-term condition results in too much sugar circulating in the blood), diabetic neuropathy (impact on muscle weakness and loss of reflex), Hypertension (high blood pressure), Tinnitus (a ringing sound, but some hear other types of sounds, such as roaring or buzzing), Left Ear, and Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), and evidenced the following medications but not limited to Bethanechol (It can treat urinary and bladder problems by emptying the bladder and increasing urination) 10 milligrams by mouth daily, Dicyclomine (relaxes the muscles of your stomach and bowel, which reduces cramping) 10 milligrams take 1 tablet by mouth daily, Famotidine (used to treat ulcers, gastroesophageal reflux disease, and conditions that cause excess stomach acid. It can also treat heartburn caused by acid indigestion) 20 milligrams take 1 tablet by mouth daily, Gabapentin (treat nerve pain) 100 mg 1 capsule by mouth 1 time a day, and Loratadine (used to treat allergies symptoms) 10 mg 1 tablet 1 time a day. A review of a document titled 'Medication List' dated 05/22/2024 from Person G, a Registered Nurse at Entity D, the provider for Patient #3 revealed the following medications but not limited to Carafate (used to treat and prevent ulcers in the intestines)1 gram take 1 tablet twice a day by mouth, Donepezil (treat symptoms of Alzheimer's, like confusion and memory loss) 5 mg 1 tablet by mouth every day, Ezetimibe (used to lower	G0536		

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G0536	Continued from page 9 high cholesterol levels) 10 mg take 1 tablet by mouth every day, and furosemide (treat fluid retention [edema] and swelling caused by congestive heart failure, liver disease, kidney disease, and other medical conditions) 20 mg take 1 tablet by mouth every day. The Plan of Care for Patient #3 failed to evidence the following medications from Entity D Carafate, Donepezil, Ezetimibe, and Furosemide. 3. A review of the clinical record for Patient #4 revealed a document titled, 'HOME HEALTH CERTIFICATION AND PLAN OF CARE' for the certification period of 04/24/2024 through 06/23/2024, signed by the Clinical Supervisor, dated 04/22/2024, which evidenced the following diagnoses but not limited to Inflammatory polyarthropathy (causes inflammation in bone joints), gout (a type of arthritis that causes pain and swelling in your joints) bursitis (a painful condition that affects the small, fluid-filled sacs called bursae that cushion the bones, tendons, and muscles near your joints), other specified peripheral vascular diseases (the reduced circulation of blood to a body part due to narrowed or blocked blood vessels), and hypertension (high blood pressure), and evidenced the following medications but not limited to, Hydralazine (a vasodilator that works by relaxing the muscles in your blood vessels to help them dilate [widen]) 50 milligram (mg) orally to take 1 tablet when diastolic blood pressure (the pressure when your heart relaxes and fills with blood) is greater than 180, Icosapent Ethyl (taken along with certain medicines statins [a group of medicines that can help lower the level of low-density lipoprotein cholesterol in the blood], to reduce the risk of a heart attack) 1 gram orally, take 2 capsules 2 times a day, and Lidocaine 5% topical cream (helps to prevent pain) apply on affected areas 2 times a day. On 05/21/22 at 10:53 a medication list provided from Person C, an Registered Nurse for Person B, the Attending Physician at Entity A, a physician's office for Patient #4 evidenced the following medications but not limited to Allopurinol (used to prevent or lower high uric acid levels in the blood, a high uric acid level can cause gout or gouty arthritis [joint pain and inflammation]) 300 mg tablet by mouth every day, Aspirin (stops the production of certain natural substances that cause fever, pain, swelling, and blood clots) 81 mg take1 by mouth daily, B Complex vitamins (Vitamin B complex includes B1, B2, B3, B5, B6, B7, B9, and B12 which play an important role in cell metabolism and red blood cells) take 1 by mouth daily, Dicyclomine (relaxes the muscles of your stomach and bowel, which	G0536		

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G0536	Continued from page 10 reduces cramping) 20 mg tablet, take one daily before meals and at bedtime, Furosemide (diuretic used to treat fluid retention [edema] in people with congestive heart failure) 40 mg take 1 tablet daily, Isosorbide mononitrate (relaxes the blood vessels and increasing the supply of blood and oxygen to the heart while reducing its workload) 30 mg take 1 tablet daily, Pantoprazole (reduces the acid in stomach) 40 mg take one tablet by mouth every morning, Polyethylene glycol (a medication that is used in the management and treatment of constipation) 17 grams by mouth daily, Prednisone (treats many diseases and conditions, especially those associated with inflammation) 5 mg tablet take 1 tablet by mouth every day, Tramadol (an opioid medicine used for the short-term relief of moderate to severe pain) 50 mg tablet take 1 tablet every 6 (six) hours as needed. A review of the agency's Plan of Care for Patient #4 failed to evidence the following medications from the attending physician's office: Allopurinol, Aspirin, B Complex Vitamins, Dicyclomine, Pantoprazole, Polyethylene glycol, Prednisone, and Tramadol. 4. On 05/21/2024 at 10:07 AM Person C, a Registered Nurse at Entity A for Person B, the attending physician for Patient #3 indicated the agency should review all the medications with Person E Patient #3 is receiving. On 05/21/2024 at 3:24 PM the Clinical Supervisor indicated they would contact Person B to update the medications. On 05/22/2024 at 1:05 PM the Clinical Supervisor indicated they would contact Person E to update the medications. On 05-22-2024 at 2:27 PM, the Alternate Administrator indicated the agency would be reviewing all patients and would be verifying medications. On 05/22/2024 at 12:12 PM the Administrator indicated the Clinical Supervisor needs to reach out to the physicians and complete a medication review. 5. Review of the clinical record for Patient #2 revealed a document titled, 'HOME HEALTH CERTIFICATION AND PLAN OF CARE' for the certification period of 05-05-2024 through 07-03-2024, signed by the Clinical	G0536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K097	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2024

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G0536	Continued from page 11 Supervisor, dated 04-30-2024, with diagnoses which included but were not limited to: transient ischemic attack (a stroke that lasts only a few minutes, occurs when the blood supply to part of the brain is briefly interrupted), unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and heart failure(the heart cannot pump (systolic) or fill (diastolic) adequately, symptoms include shortness of breath, fatigue, swollen legs, and rapid heartbeat). The medication list for Patient #2 evidenced Eliquis (an anticoagulant medication used to treat and prevent blood clots and strokes in people with nonvalvular atrial fibrillation). The medication list failed to evidence Nitroglycerin (a medication which prevents and treats chest pain by relaxing blood vessels). In a section titled 'Safety Measures', 'Anticoagulant Precautions' was left blank. 'Orders for Discipline and Treatments' indicated, "SN (skilled nurse) to instruct patient when he s(he) starts feeling chest pain, tightness, or squeezing in the chest to take nitroglycerin. Patient may take nitroglycerin one time every 5 minutes. If no relief after 3 doses, call 911". 6. On 05-21-2024 at 3:05 PM, when queried as to when anticoagulant precautions should be in place for a patient, the Clinical Supervisor indicated this would be done for a patient on aspirin or other blood thinners, and would provide corresponding education. On 05-22-2024 at 10:21 AM, Person O of Doctor N's office indicated Nitroglycerin was not on Patient #2's medication list. On 05-22-2024 at 12:51 PM, when queried as to why Nitroglycerin did not appear on Patient #2's medication list, the Clinical Supervisor indicated the patient takes this medication very rarely, but the medication should have been listed. 410 IAC 17-14-1(a)(1)(B)	G0536		
G0574	Plan of care must include the following CFR(s): 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;	G0574		

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G0574	Continued from page 12 (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure the Plan of Care included all pertinent diagnoses, the types of supplies, treatments, and all medications were included in 4 of 5 active records reviewed. Patients #1, 2, 3, and 4) Findings include: 1. Review of an agency document revised December 2014, titled 'Plan of Care 700' stated, "PROCEDURE … 3. The 485, which includes the following Plan of Care elements, is developed in consultation with staff, client, physician and other providers involved in the client's care and will serve as the initial plan of care: Clients' primary and secondary	G0574		

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G0574	Continued from page 13 diagnoses/problems, food or drug allergies … safety measures to protect against injury … medications and treatments … specific procedures treatments … supplies and equipment required … other appropriate items such as precautions and contraindications … 4. The care plan is reviewed and/or revised, with physician participation at least every 60 days …" 2. A review of the clinical record for Patient #1 revealed a document titled, 'HOME HEALTH CERTIFICATION AND PLAN OF CARE' for the certification period of 05-02-2024 through 06-30-2024, signed by the Clinical Supervisor, dated 04-29-2024, with a diagnosis which included but was not limited to: impaired glucose tolerance (also known as borderline diabetes and prediabetes, all share the same characteristics of elevated blood glucose levels that need to be watched but aren't quite high enough to constitute a diabetes diagnosis) and failed to evidenced data for Advanced Directives, data for Caregiver Status, data for Psychosocial Status, and data for Hospitalization Risk. The Plan of Care failed to evidence vital sign parameters had been determined for 'Fasting Blood Sugars' and 'Random Blood Sugars', failing to indicate when to call the doctor for orders on readings outside the acceptable range. 3. A review of the clinical record for Patient #2 revealed a document titled, 'HOME HEALTH CERTIFICATION AND PLAN OF CARE' for the certification period of 05-05-2024 through 07-03-2024, signed by the Clinical Supervisor, dated 04-30-2024, with diagnoses which included but were not limited to: transient ischemic attack (a stroke that lasts only a few minutes, occurs when the blood supply to part of the brain is briefly interrupted), unspecified atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and heart failure(the heart cannot pump (systolic) or fill (diastolic) adequately, symptoms include shortness of breath, fatigue, swollen legs, and rapid heartbeat). Nursing interventions included: "SN (skilled nurse) to instruct patient when he s(he) starts feeling chest pain, tightness, or squeezing I the chest to take nitroglycerin. Patient may take nitroglycerin one time every 5 minutes. If no relief after 3 doses, call 911". The medication list failed to evidence Nitroglycerin (medication which prevents and treats chest pain by relaxing blood vessels) had been included. 4. On 05-21-2024 at 3:24 PM, when queried as to incomplete and/or inaccurate documentation on the comprehensive assessments and plans of care, the Clinical Supervisor indicated, "I try to fill out	G0574		

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G0574	Continued from page 14 everything" on the OASIS. 5. On 05-22-2024 at 9:55 AM, Person M of Doctor I's office indicated Patient #1 had a diagnosis of Diabetes. On 05-22-2024 at 10:21 AM, Person O of Doctor N's office indicated Nitroglycerin was not on Patient #2's medication list. 6. A review of the clinical record for Patient #3 revealed a document titled, 'OASIS-E Recertification signed by the Clinical Supervisor dated 04/13/2024 at 2:30 PM for the certification period of 04/14/2024 through 06/12/2024 which revealed Endocrine indicated Patient #3 was a diabetic, diabetic management was controlled by diet, and the patient was independent with glucometer (a device used to check blood sugars) use. A review of the clinical record for Patient #3 revealed a document titled, 'HOME HEALTH CERTIFICATION AND PLAN OF CARE' for the certification period of 04/14/2024 through 06/12/2024, signed by the Clinical Supervisor, dated 04/15/2024, which evidenced the following diagnoses but not limited to Type 2 Diabetes Mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel, this long-term condition results in too much sugar circulating in the blood) diabetic neuropathy (impact on muscle weakness and loss of reflex) and Dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), evidenced there was no data for Advanced Directives, no data for Caregiver Status, no data for Psychosocial Status, and no data for Hospitalization Risk. The Plan of Care for Patient #3 failed to evidence of how often blood sugars were to be taken or blood sugar ranges and failed to evidence of advanced directives, Psychosocial status, or caregiver status. 7. A review of the clinical record for Patient #4 revealed a document titled, 'OASIS-E Recertification signed by the Clinical Supervisor dated 04/22/2024 at 9:09 AM for the certification period of 04/25/2024 through 06/23/2024 which revealed functional limitations of endurance, hearing, incontinence and ambulation, Supportive Assistance – Community Agencies/Social Service Screening was left blank, Endocrine indicated Patient #4 was a diabetic, diabetic management was controlled by diet and an oral	G0574		

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G0574	Continued from page 15 hypoglycemic, and the patient was independent with glucometer (a device used to check blood sugars) use, that the skilled nursing was to assess Patient #4's ability to manage diabetic disease process and be free from signs and symptoms of hypo/hyperglycemia. A review of the clinical record for Patient #4 revealed a document titled, 'HOME HEALTH CERTIFICATION AND PLAN OF CARE' for the certification period of 04/24/2024 through 06/23/2024, signed by the Clinical Supervisor, dated 04/22/2024, which evidenced the following diagnoses Inflammatory Polyarthropathy (causes inflammation in bone joints), Gout (a type of arthritis that causes pain and swelling in your joints) Bursitis (a painful condition that affects the small, fluid-filled sacs called bursae that cushion the bones, tendons, and muscles near your joints), other specified Peripheral Vascular Diseases (the reduced circulation of blood to a body part due to narrowed or blocked blood vessels), Hypertension (high blood pressure), Iron Deficiency anemias (when your body doesn't have enough iron to make red blood cells), asthma (a condition in which a person's airways become inflamed, narrow and swell, and produce extra mucus, which makes it difficult to breathe), and Retained Cholelithiasis following cholecystectomy (dropped or slipped gallstones are common during a laparoscopic cholecystectomy [the removal of the gallbladder through a small incision] and can occur when gallstones are inadvertently spilled into the peritoneal cavity), evidenced there was no data for Advanced Directives, no data for Caregiver Status, no data for Psychosocial Status, and no data for Hospitalization Risk. The Plan of Care failed to evidence a diagnosis of Diabetes and failed to identify an oral glycemic, how often Patient #4 should be checking blood sugars and failed to identify ranges for blood sugars. 8. On 05/22/2024 at 1:05 the Clinical Supervisor indicated they would contact Person E, the attending physician for Patient #3 and Person B, the attending physician for Patient #4 to update the medications, get accurate orders for blood sugar testing, and start reporting blood sugars to the physicians and indicated they would have done so if the physicians had asked them. 410 IAC 17-13-1(a)(1)(B) 410 IAC 17-13-1(a)(1)(C)	G0574		

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G0574	Continued from page 16 410 IAC 17-13-1(a)(1)(D)(i-xiii)	G0574		
G0584	Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. This ELEMENT is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure verbal orders were obtained upon the recertification of patients for the continuing need of home care services in 5 of 5 active clinical record reviews. (Patients #1, 2, 3, 4, and 7) Findings include: 1. A review of a policy dated 09/30/2013 titled, 'Reassessment/Recertification CLIN2023' revealed " ... 8. After the reassessment is conducted ... the case will be reviewed for need of continuation, change of orders ... This may take the form of the new Plan of Care. 9. The physician will be contacted to verify the continued need for care and his/her agreement with the continued plan of care. 10. An interim order to continue home care services will be prepared and sent to the physician ... 11. The updated plan of care will be prepared and sent to the physician for review and signature ... " 2. A review of the clinical record for Patient #3 revealed a document titled, 'OASIS-E Recertification signed by the Clinical Supervisor dated 04/13/2024 at 2:30 PM for the certification period of 04/14/2024 through 06/12/2024 which evidenced coordination of care was left blank.	G0584		

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G0584	Continued from page 17 The OASIS-E Recertification failed to evidence coordination of care with Person E, the attending physician for Patient #3, and the clinical record failed to evidence a verbal order was obtained for the continuing need for Home Care Services. 3. A review of the clinical record for Patient #4 revealed a document titled, 'OASIS-E Recertification signed by the Clinical Supervisor dated 04/22/2024 at 9:09 AM for the certification period of 04/25/2024 through 06/23/2024 which revealed the Coordination of Care was left blank. The OASIS-E Recertification failed to evidence coordination of care with Person B, the attending physician for Patient #4, and the clinical record failed to evidence a verbal order for the continuing need for Home Care Services. 4. A review of the clinical record for Patient #7 revealed a document titled, 'OASIS-E Recertification signed by the Clinical Supervisor dated 05/01/2024 at 9:09 AM for the certification period of 05/05/2024 through 07/03/2024 which evidenced the Coordination of Care was left blank. The OASIS recertification failed to evidence coordination of care occurred with Person 8, the attending Physician for Patient #7, and failed to evidence a verbal order for the continuing need for Home Care Services. 5. On 05/21/2024 at 10:07 AM, Person C from Entity A for Person B, the attending physician for Patient #4 indicated the agency does not call for orders, and occasionally will fax the 485 or the Plan of Care for the physician's signature. On 05/21/2024 at 11:53 AM, Person G from Entity D for Person E, the attending physician for Patient #3 indicated the agency does not call for orders and they don't get verbal updates from the agency. On 05/22/2024 at 10:10 AM, the Alternate Clinical Supervisor indicated they do not call the physicians after assessments are completed, they complete the Plan of Care, then will call the physician's office to inform them they are sending it over to be signed by the physician and to return. On 05/22/2024 at 3:16 the Clinical Supervisor indicated sometimes they call the physicians for a verbal order for the recertification but mostly will send a message,	G0584		

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G0584	Continued from page 18 and verbal orders are not obtained for the continuing need for Home Care Services. 6. Review of the clinical record for Patient #1 contained an 'OASIS-E Recertification' signed by the Clinical Supervisor, was dated 04-29-2024 for the certification period of 05-02-2024 to 06-30-2024. The section titled 'Coordination of Care:' evidenced the following: "Conferenced with MD (Medical Doctor), SN (Skilled Nurse) ... HHA (Home Health Aide) ... Name: ... Regarding: ..." were all left blank. On 05-22-2024 at 9:55 AM, Person M with Doctor I's office indicated did not receive calls from the agency regarding Patient #1. Further indicated, "I am the one who would have received calls". Indicated received faxes, but received no calls for verbal orders, no requests for provider visit notes, nor updated medication lists have been charted or documented. 7. Review of the clinical record for Patient #2 contained an 'OASIS-E Recertification' signed by the Clinical Supervisor, was dated 04-30-2024 for the certification period of 05-05-2024 to 07-03-2024. The section titled 'Coordination of Care:' evidenced the following: "Conferenced with MD (Medical Doctor), SN (Skilled Nurse) ... HHA (Home Health Aide) ... Name: ... Regarding: ..." were all left blank. On 05-22-2024 at 10:21 AM, Person O with Doctor N's office indicated received Patient #2 's plan of care for signature, but indicated did not receive calls from the agency regarding Patient #2 for verbal orders or updated medication lists, going back as far as November 2023. 401 IAC 17-14-1(a)(H)	G0584		
G0640	Quality assessment/performance improvement CFR(s): 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital	G0640		

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G0640	Continued from page 19 admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. This CONDITION is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure a Quality Assurance Performance Improvement (QAPI) program was established and maintained: the agency failed to evidence they had measured. analyzed, and tracked quality indicators including adverse events and other aspects of performance which enable the Home Health agency to assess processes of care, Home Health services, and operations (G0642), failed to evidence quality indicator data were used to design a QAPI program (G0644), failed to evidence the agency had identified any high risk, high volume, problem-prone areas nor had devised associated performance improvement activities to address same (G0646), failed to evidence tracking of any adverse patient events, analysis of causes, nor implementation of preventative causes (G0654), failed to evidence performance improvement plans had sustained improvements (G0656), and the governing body failed to be responsible for the implementation, operations, and ongoing activities of a QAPI program(G0660). The cumulative effect of these systemic problems resulted in the agency being found out of compliance with the condition, /Quality Assessment Performance Improvement requirements for Medicare Participating Providers and Suppliers, for Home Health Agencies /at /42 CFR 484.65. Findings include: On 05-20-2024 at 9:50 AM the Quality Assurance Performance Improvement (QAPI) program was requested from the agency. On 05-20-2024 at 3:16 PM the agency was reminded the QAPI program had been requested. On 05-21-2024 at 1:20 PM the QAPI program was again requested from the agency. On 05-21-2024 at 3:03 PM the Administrator, Alternate Administrator, and Administrative Personnel 5 indicated the agency had no formal QAPI program in place.	G0640		
G0682	Infection Prevention	G0682		

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G0682	Continued from page 20 CFR(s): 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. This STANDARD is NOT MET as evidenced by: Based on observation, record review and interview the agency failed to ensure infection control measures, hand hygiene, and personnel protective equipment (PPE) usage, were appropriately performed in 2 of 3 home visits observed. (Clinical Supervisor and Home Health Aide (HHA)1) Findings include: 1. Review of an agency document, 'reviewed' 01-07-2015, titled 'Standard Precautions ADM2045' stated, "PURPOSE To reduce the risk of exposure to and transmission of infections when caring for patients … PROCEDURE … Personal Protective Equipment 1. Gloves: … gloves are to be worn when: i. There is actual or potential contact with blood or other potentially infectious materials … iii. Touching contaminated items or surfaces … xiii. Handling soiled linens … c. Gloves are to be changed: i. in between tasks on the same patient, ii. During changing or cleaning of an incontinent patient …" Review of an agency document 'reviewed' 01-07-2015, titled 'Hand Hygiene ADM2047' stated, "… Hand Washing with Soap and Water … 4. Use a dry disposable towel to shut off the faucet …" Review of an agency document, 'reviewed' 01-07-2015, titled 'Bag Technique ADM 2054' stated, "PURPOSE To describe the procedure for maintaining a clean nursing bag and preventing cross contamination … Bag Technique 1. The bag will place the bag on a clean surface in the car and in the home … 4. The bag will contain a designated clean and dirty area. The clean area contains unused or cleaned supplies/equipment, and the dirty area is designated for contaminated materials (i.e. used equipment, etc.) … 7. If paper towels/newspaper have been used as a protective barrier for bag placement the patient's home, they will be discarded …" 2. On 05-21-2024 at 10:00 AM, during a home visit for	G0682		

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(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
G0682	Continued from page 21 Patient #1, the Clinical Supervisor (the nurse providing care for this visit) was observed preparing to refill the patient's pillbox. The nurse went to the patient's bathroom sink, washed hands with soap and water, and shut off the faucet with her bare right hand. When filling the pillbox, the nurse donned gloves, and retrieved medication bottles from the patient's china cabinet, set them on a dining table which was covered with tablecloth, several placemats, and paperwork. The bottles were then opened, held with the right gloved hand, and the contents were poured into the left gloved hand. The appropriate number of pills required were picked out of the left gloved hand with the right hand and were then placed into individual slots of the pillbox. Excess tablets/capsules were poured back into the bottles from the left gloved hand. Later the nurse removed vital sign equipment from the nursing bag and placed them on the same dining table without a barrier, sanitized each item with a disposable sanitizing wipe, and then placed each item back onto the surface of the dining table, still without a barrier. At the end of the visit the nurse removed an electronic device and stylus from her purse, these were not sanitized before being handed to the patient, were not sanitized after the patient's use, and both were placed back into the nurse's purse. 3. On 05-21-2024 at 10:30 AM, when queried as to how hand washing should occur, the Clinical Supervisor indicated should have used a paper towel to shut off the handle. When queried as to how medications should be removed from bottles and transferred into the pillbox, indicated should have poured medications into the bottle's lid and then placed them into the pillbox. When queried as to when and how vital sign equipment should be sanitized, indicated a barrier would have been good to utilize. And when queried as to how and when the device and stylus should be sanitized, indicated her phone gets sanitized after leaving, when the visit is done. 4. On 05/21/2024 at 8 AM during a home observation visit with HHA 1 at Patient #4's residence, HHA 1 donned gloves and assisted Patient #4 into the bathroom. Patient #4 sat on the toilet, HHA 1 assisted Patient #4 with the removal of their Depends (adult diaper), then assisted Patient #4 into the shower onto the shower chair. HHA 1 turned the water on, adjusted the temperature, used the shower head, rinsed Patient 4, then washed their back, under right, then left arm. Patient #4 stood, HHA 1 began washing Patient 4's peri area (washing the genitals and anal area), then washed both lower extremities, then rinsed Patient #4, took a towel off the bathroom door rack, assisted Patient #4	G0682		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K097	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2024

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G0682	Continued from page 22 with drying, reached into the vanity under the sink for a clean depends and assisted Patient #4 with putting them on. Patient #4 indicated for HHA 1 to use a bottle of pink liquid, called Arthritis and Sports Penetrating Heat Rub, and rubbed it on Patient #4's back, and under their left breast. HHA 1 took a robe out of Patient #4's closet and assisted with putting it on, then combed Patient #4's hair. HHA 1 went to the bathroom and began cleaning the bathroom, Patient #4's phone rang, HHA 1 answered it, then handed the phone to Patient #4, and resumed cleaning the shower and placing towels and wash rags outside on the drying rack. HHA 1 returned to the kitchen doffed their gloves, turned the water on, washed their hands, then turned the water off with their bare hands. HHA 1 failed to perform hand hygiene before donning gloves, failed to change their gloves appropriately and perform hand hygiene while performing care, and failed to perform hand hygiene at the end of the care. 5. On 05/21/2024 at 8:45 HHA 1 indicated they always clean the handles on the faucet with antiseptic wipes and realized they should have changed their gloves more often. On 05/21/2024 at 04/15/2024 the Administrator and Alternate Administrator indicated the HHA should have used a paper towel to turn the water off when performing hand hygiene. 410 IAC 17-12-1(m)	G0682		
G0988	Institutional planning CFR(s): 484.105(h) Standard: Institutional planning. The HHA, under the direction of the governing body, prepares an overall plan and a budget that includes an annual operating budget and capital expenditure plan. (1) Annual operating budget. There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. However, it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense. (2) Capital expenditure plan.	G0988		

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G0988	Continued from page 23 (i) There is a capital expenditure plan for at least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than $600,000 for items that would under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time, but are components of an overall plan or patient care objective, are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds. (ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health Services Block Grant) or title XVIII (Medicare) or title XIX (Medicaid) of the Social Security Act, the plan specifies the following: (A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. (B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations. (C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency. (3) Preparation of plan and budget. The overall plan	G0988		

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G0988	Continued from page 24 and budget is prepared under the direction of the governing body of the HHA by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the HHA. (4) Annual review of plan and budget. The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (i)(3) of this section under the direction of the governing body of the HHA. This STANDARD is NOT MET as evidenced by: Based on record review and interview the agency failed to ensure an annual budget was prepared and reviewed, along with a expenditure plan in 1 of 1 agency. Findings include: A review of a policy dated 12/08/2014 titled 'Organizational Planning ADM4001' revealed " ... The written strategic plan will be developed and approved by the Governing Body at least every three (3) years ... 1. Annually, the organization's leadership will plan for home care/service delivery by: a. Allocating resources through the budgeting process b. Directing planning activities through an annual review and evaluation of the strategic plan ... ". A review of a policy dated 09/30/2013 titled 'Administrative Qualifications and Responsibilities ADM1005' revealed " ... i. Managing operations in accordance with established fiscal parameters j. Program planning, development, implementation, and oversight ... ". A review of the Governing Body minutes from 01/14/2023 and 01/06/2024 evidenced there was no discussion and approval of the agency's budget or expenditure plan with the Administrator, the Alternate Administrator, and the Administrative Staff 5 signatures for both meetings. On 05/22/2024 at 9:08 AM, when queried regarding the agency's budget and expenditure plan, Administrative Staff 5 indicated there was not a budget, and asked were we supposed to present the agency's budget to ourselves. On 05/22/2024 at 9:10 AM, the Administrator indicated there was not a budge and didn't realize they needed to present one to the Governing Body.	G0988		

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G0988	Continued from page 25 410 IAC 17-12-1(b)(3)	G0988		