STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157610	A. BUILDING B. WING	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOME HEALTH ANGELS LLC	117 N MAIN ST PO BOX 283, WINCHESTER, IN, 47394

(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: October 3, 4, 7, 8, 9, 2024 Active Census: 61 At this Emergency Preparedness survey, Home Health Angels was not found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102	E0000		
E0006	Plan Based on All Hazards Risk Assessment 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2),	E0006	Action Plan: Alternate Administrator will ensure that Administer, Alternate Administrator, and Director receive the necessary training and education related to	2024-11-07

	§460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk		Agency's Emergency Preparedness Plan, including strategies for addressing any identified emergency events from the risk assessment form. Alternate Administrator will supply Administrator, Alternate Administrator, and Director with training on EPP, and strategies for addressing identified emergency events from risk assessment form in person, by US Mail, and/or email. Inservice to be completed by 11/7/2024 Timeframe to be completed 11/7 2024 Implementation of EPP training on or before 11/7/2024 Means of tracking measurable indicators 100% completion of in-service by Administrator, Director and Alternate administrator verified by sign in sheet, name, credentials, and date of Inservice. Ongoing: EPP training including updating strategies to all newly appointed Administrators, Alternate Administrators, and Directors with most current revisions and additions to EPP and risk strategies. If significant changes all Administrators, Alternate Administrators, and Directors will receive training on revisions within 14 days of implementation. Party responsible for tracking and measuring indicators: Administrator, Director, Alternate Administrator.	

assessment, utilizing an all-hazards approach, including missing residents.

(2) Include strategies for addressing emergency events identified by the risk assessment.

*[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:

(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.

(2) Include strategies for addressing emergency events identified by the risk assessment.

Based on EP plan review and interview, the home health agency failed to ensure its EP plan included strategies for addressing emergency events identified by the risk assessment, which had the potential to affect all active patients and employees.

Findings include:

1. The review of the agency's Hazard and Vulnerability Assessment Tool, completed by Alternate Administrator on 1/04/24, indicated the agency identified the emergency events "Severe Thunderstorm … Snow Fall … Ice Storm … Temperature Extremes … Epidemic … Electrical Failure … HVAC

	probability of occurring. The emergency events "Drought ... Earthquake ... Transportation Failure ... Fuel Shortage ... Natural Gas Failure ... Water Failure ... Sewer Failure ... Fire Alarm Failure ... Communications Failure ... Medical Gas Failure ... Information Systems Failure ... Flood, Internal ... Supply Shortage ... Structural Damage ... Chemical Exposure ... Internal Spill ... Mass Casualty Incident ... Hostage Situation ... Civil Disturbance ... Labor Action ... Forensic Admission ...." were identified as having "moderate" or "low" probability of occurring. 2. The review of the agency's EP plan failed to evidence the agency had identified and documented strategies for addressing the above emergency events identified by the risk assessment as having a probability of occurring. 3. During an interview with Alternate Administrator on 10/09/24 beginning at 5:50 PM, she reported she last reviewed the agency's EP plan on 1/04/24, including updating the agency's hazard and			

	vulnerability risk assessment. Alternate Administrator reported the agency had not developed strategies for addressing emergency events identified by the risk assessment.			
E0030	Names and Contact Information 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	E0030	Action Plan: Alternate Administrator will ensure that all employees receive the necessary training and education related to Agency's Emergency Preparedness Plan, including updating EP communication plan including name and contact information for all patients and staff. Alternate Administrator will supply 100% of employees with training on EPP including updating EP communication plan with contact information for staff and patients. in person, by US Mail, and/or email. Inservice to be completed by 11/7/2024 Timeframe to be completed 11/7 2024 Implementation of EPP training on or before 11/7/2024 Means of tracking measurable indicators 100% completion of in-service by Administrator, Director and Alternate administrator verified by sign in sheet, name, credentials, and date of Inservice. Ongoing: EPP training including updating strategies to all newly appointed Administrators, Alternate Administrators, and Directors with most current revisions and additions to EPP and updating with current staff and patient contact information. If significant changes all Administrators,	2024-11-07

	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. *[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		Alternate Administrators, and Directors will receive training on revisions within 14 days of implementation. Party responsible for tracking and measuring indicators: Administrator, Director, Alternate Administrator.	

	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 EP plan review and interview, the home health agency failed to ensure its EP communication plan included name and contact information for all staff, which had the potential to affect all agency staff and patients. Findings include: 1. The review of the agency's EP binder evidenced a document titled "Associate List" dated 5/22/2020. The list failed to evidence contact information for COTA 1, RN 2, Office Assistant 4, and Speech Therapist 1. 2. During an interview with Alternate Administrator on 10/09/24 beginning at 5:50 PM, she reported she last reviewed the agency's EP plan on 1/04/24, however she had not reviewed and updated the communication plan to include all active employees.			
E0031	Emergency Officials Contact Information 483.73(c)(2)	E0031	Action Plan: Alternate Administrator will ensure that all employees receive the necessary training and education related to the Agency's Emergency Preparedness Plan, including updating Federal, State, and	2024-11-07

	§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 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 EP plan review and		Local emergency preparedness staff contact information. Alternate Administrator will supply Administrator, Alternate Administrator, and Director with training on EPP, including updating Federal, State, and Local emergency preparedness staff contact information in person, by US Mail, and/or email. Inservice to be completed by 11/7/2024 Timeframe to be completed 11/7 2024 Implementation of EPP training on or before 11/7/2024 Means of tracking measurable indicators 100% completion of in-service by all employees verified by sign in sheet, name, credentials, and date of Inservice. Ongoing: EPP training including updated federal, state, and local emergency preparedness staff contact information to all employes with most current revisions and additions to EPP and updating Federal, State, and Local emergency preparedness staff contact information. If significant changes all Administrators, Alternate Administrators, and Directors will receive training on revisions within 14 days of implementation. Party responsible for tracking and measuring indicators: Administrator, Director, Alternate Administrator.	

	interview, the home health agency failed to ensure its EP communication plan included contact information for Federal, State, and local emergency preparedness staff, which had the potential to affect all agency staff and patients. Findings include: 1. The review of the agency's EP binder evidenced a document titled "Indiana Public Health Preparedness District and District Healthcare Coalition Contacts," dated 08/2017. The EP communication plan failed to evidence contact information for current Federal, State, and local emergency preparedness staff. 2. During an interview with Alternate Administrator on 10/09/24 beginning at 5:50 PM, she reported she last reviewed the agency's EP plan on 1/04/24, however she had not reviewed and/or updated the communication plan to include current Federal, State, and local emergency preparedness staff.			
G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State	G0000		

	Re-Licensure survey of a Home Health Provider. Survey Dates: October 3, 4, 7, 8, 9, 2024 12-Month Unduplicated Skilled Admissions: 190 Survey was announced as fully extended on 10/07/24 at 3:08 PM. During this Federal Recertification Survey, Home Health Angels was found to be out of compliance with Conditions of Participation §484.60 Condition of participation: Care planning, coordination of services, and quality of care; §484.80 Condition of participation: Home health aide services and §484.105 Condition of participation: Organization and administration of services.			

	This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. Based on the Condition-level deficiencies during the 10/09/24 survey, your HHA was subject to a partial or extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 10/07/24. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency and/or competency evaluation program for a period of two years beginning October 9, 2024, and continuing through October 8, 2026.			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date.	G0514	Action Plan: Alternate Administrator will ensure all Registered Nurses receive the necessary training and education related to Initial Patient Assessments. Alternate Administrator will supply 100% RN staff with training and education relating to completing initial assessments in person, by US Mail, and/or email. Inservice over Initial Assessments will be completed by 11/7/2024	2024-11-07

	Based on record review and interview, the home health agency failed to conduct an initial assessment to determine the patient's immediate care and support needs within 48 hours of referral for 5 of 9 records reviewed (Patients #1, 5, 6, 7, 8, 9). Findings include: 2. Patient #1's clinical record evidenced a referral was received on 9/09/24 and RN 1 conducted a start of care visit on 9/12/24. The record failed to evidence the reason for delay in conducting an initial assessment. During an interview on 10/07/24 beginning at 12:35 PM, RN 1 was unsure of the delay in SOC. During an interview on 10/08/24 beginning at 2:45 PM, the Alternate Administrator relayed she was unsure of the delay in SOC and verified the clinical record was missing documentation of the delay. 3. Patient #5's clinical record evidenced a referral was received on 5/03/24 and RN 1		Timeframe to be completed by: 11/7/2024 Implementing of Initial Assessment training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Initial Assessment training and education will be provided to all new Registered Nurses with the most current revisions and additions to Initial Assessments. If any significant changes are made to Initial Assessments all Registered Nurses will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator.	

	on 5/06/24. The record failed to evidence the reason for delay in conducting an initial assessment. During an interview on 10/07/24 beginning at 12:55 PM, RN 1 was unsure of the delay in SOC. During an interview on 10/08/24 beginning at 2:45 PM, the Alternate Administrator relayed she was unsure of the delay in SOC and verified the clinical record was missing documentation of the delay. 4. Patient #6's clinical record evidenced a referral was received on 2/16/24 and RN 1 conducted a start of care visit on 3/18/24. The record failed to evidence the reason for delay in conducting an initial assessment. During an interview on 10/09/24 beginning at 9:50 AM, the Alternate Administrator relayed the home health agency was waiting on insurance authorization and verified the clinical record for Patient #6 did not include documentation that the patient or the assisted living facility was notified of the delay.			

	During an interview on 10/09/24 beginning at 10:12 AM, RN 1 was unsure of the delay in SOC and relayed the delay should have been documented in the clinical record for Patient #6. 5. Patient #7's clinical record evidenced a referral was received on 2/13/24 and RN 1 conducted a start of care visit on 3/18/24. The record failed to evidence the reason for delay in conducting an initial assessment. During an interview on 10/08/24 beginning at 3:24 PM, the Alternate Administrator relayed the home health agency was waiting on insurance authorization and verified the clinical record for Patient #7 did not include documentation that the patient or the assisted living facility was notified of the delay. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 was unsure of the delay in SOC and relayed the delay should have been documented in the clinical record for Patient #7.			

	410 IAC 17-14-1(a)(1)(A) Findings include: 1. Agency policy "Initial Patient Assessment" indicated a Registered Nurse (RN) should an initial assessment visit within 48 hours of referral or within 48 hours of the patient's return home. 6. Patient #8's clinical record evidenced a referral was received on 7/08/24 and RN 2 conducted a start of care visit on 7/12/24. The record failed to evidence the reason for delay in conducting an initial assessment. During an interview with Alternate Administrator on 10/08/24 beginning at 1:08 PM, she reported RN 2 was currently on leave from the agency.			
G0520	5 calendar days after start of care 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on record review and interview, the home health agency	G0520	Action Plan: Alternate Administrator will ensure all Registered Nurses, Physical Therapists, and Occupational Therapists receive the necessary training and education related to Comprehensive Patient Assessments. Alternate Administrator will supply 100% RN, PT, and OT staff with training and education	2024-11-07

	failed to conduct a comprehensive assessment which included an evaluation for all referred services within 5 days of the start of care for 2 of 3 records reviewed with SOC in the last 3 months (Patient #1 and 8). Findings include: 2. Patient #1's clinical record evidenced a referral was received for PT, OT and SN services on 9/09/24. RN 1 conducted a SOC visit on 9/12/24 and created a POC which failed to include the OT evaluate and treat order. The record evidenced an OT Evaluation was completed on 9/27/24, fifteen days after SOC, by OT 2. The record failed to evidence an order for the OT Evaluation. During an interview on 10/07/24 beginning at 12:35 PM, RN 1 relayed they didn't order the OT Evaluation at the SOC to allow Patient #1 time to improve from COVID-19 symptoms and she verified the clinical record failed to evidence documentation that the physician was notified of the delay in OT services. During an interview on		relating to comprehensive patient assessments in person, by US Mail, and/or email. Inservice over Comprehensive Patient Assessments will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementing of Initial Assessment training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses, Physical Therapists, and Occupational Therapist verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Comprehensive Patient Assessment training and education will be provided to all new Registered Nurses, Physical Therapists, and Occupational therapists with the most current revisions and additions to Comprehensive Patient Assessments. If any significant changes are made to Comprehensive Patient Assessments All Registered Nurses, Physical Therapists, and Occupational Therapists will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	10/07/24 beginning at 3:13 PM, OT 2 relayed they were unsure why the initial OT Evaluation was not ordered at SOC on 9/12/24. 1. Agency policy titled "Comprehensive Patient Assessment" indicated all patients were to have a comprehensive assessment completed within 5 calendar days of the start of care. 3. Patient #8's clinical record evidenced a referral was received on 7/08/24 for PT services on 7/08/24 and Patient's start of care date was 7/12/24. RN 2 conducted a start of care visit on 7/12/24 and created a plan of care which indicated PT was to evaluate and treat Patient. The record indicated on 7/22/24, Patient had not yet had a PT referral. Alternate Administrator obtained a second order for PT to evaluate and treat Patient. The record indicated on 7/23/24, Patient was discharged on 7/23/24 due to "expired at home." The record failed to evidence a PT evaluation had			

	Patient's discharge. During an interview with PT 1 on 10/09/24 beginning at 11:45 AM, he reported he had attempted multiple times to contact Patient, however Patient did not answer or return the calls. PT 1 reported on 7/23/24, he went to Patient's home to attempt to conduct the PT evaluation, and found the coroner and police were at Patient's home, as Patient was deceased. The record failed to evidence PT' 1's reported attempts to contact Patient nor attempted visit.			
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on record review and interview, the home health agency failed to ensure an accurate review of all medications for 2 of 2 active records reviewed who reside in an Assisted Living Facility (ALF) (Patient #6 and 7).	G0536	Action Plan: Alternate Administrator will ensure all Registered Nurses receive the necessary training and education related to Medication Profile and Reconciliation. Registered Nurses will review and update all current patient medication profile reconciliations during the current patients next home visit. All medication and updated by 11/7/2024. Alternate Administrator will supply 100% RN staff with training and education relating to Medication Profile and Reconciliation in person, by US Mail, and/or email.	2024-11-07

	Findings include: 1. The undated agency policy "Medication Profile" indicated the medication profile shall be reviewed by a RN every sixty (60) days and updated whenever there is a change or discontinuation in medication. 2. Patient #6's clinical record evidenced a start of care (SOC) on 3/18/24 and included a POC and medication profile for the certification period 9/14/24 to 11/12/24. Clinical records were obtained from Entity G during the survey. Comparison of Entity G's current medication orders list and the home health agency's POC medication profile evidenced the following discrepancies: a) Ipratropium-Albuterol Inhalation Solution (used to treat COPD) 0.5-2.5 (3mg/3 milliliter (ml)) daily at bedtime was listed on Entity G's current medication list. The medication was not listed on the home health agency's medication profile. b) Ipratropium-Albuterol Inhalation Solution (used to treat shortness of		Inservice over Medication Profile and Reconciliation will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementing of Initial Assessment training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Medication Profile and Reconciliation training and education will be provided to all new Registered Nurses with the most current revisions and additions to Initial Assessments. If any significant changes are made to Medication Profile and Reconciliation all Registered Nurses will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	(3mg/3ml) every 6 hours as needed was listed on Entity G's current medication list. The medication was not listed on the home health agency's medication profile. c) Acetaminophen with Codeine Phosphate (used to treat pain) 300-30 milligram (mg) three times a day as needed was listed on the home health agency medication profile. The medication was not listed on Entity G's current medication list. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed they reconcile medications for Patient #6 during every recertification visit. 3. Patient #7's clinical record evidenced a start of care (SOC) on 3/18/24 and included a POC and medication profile for the certification period 9/14/24 to 11/12/24. Clinical records were obtained from Entity G during the survey. Comparison of Entity G's current medication orders list and the home health agency's POC medication profile evidenced the following discrepancies: a) Calcium carbonate (used to			

	treat indigestion) 500 mg tablet was listed on Entity G's current medication list as 2 tablets every 8 hours as needed. The home health agency's medication profile listed the medication as a 600 mg tablet with dosing of 2 tablets daily as needed. b) Cholecalciferol (used to treat Vitamin D deficiency) 50 microgram (mcg) 2000 units was listed on Entity G's current medication list as 50 mcg daily (2000 units). The home health agency's medication profile listed the medication as 5000 units daily. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed they reconcile medications for Patient #7 during every recertification visit. 4. During the entrance conference on 10/03/24 beginning at 9:58 AM, the Alternate Administrator relayed medications should be reconciled during every visit. 410 IAC 17-14-1(a)(1)(B)			
G0546	Last 5 days of every 60 days unless:	G0546	Action Plan: Alternate Administrator will ensure all	2024-11-07

	484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or (iii) Discharge and return to the same HHA during the 60-day episode. Based on record review and interview, the home health agency failed to ensure the therapy evaluation was completed within 5 days of the recertification for 4 of 4 active records reviewed with a therapy recertification (Patient #3, 4, 6 and 7). Findings include: 1. Patient #3's clinical record evidenced a SOC on 4/23/24 and a recertification period of 8/21/24 to 10/19/24. OT and PT Evaluations were completed on 8/24/24 by OT 2 and PT 1, three days after the recertification period began. The record failed to include the OT and PT recertification evaluations were performed within 5 days of the 8/21/24 recertification date. During an interview on 10/07/24 beginning at 2:04 PM, PT 1 relayed the PT evaluation		Registered Nurses, Physical Therapists, and Occupations Therapists receive the necessary training and education related to Patient Recertification. Alternate Administrator will supply 100% RN, PT, and OT staff with training and education relating to completing patient recertification in person, by US Mail, and/or email. Inservice over Patient Recertifications will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementing of Initial Assessment training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses, Physical Therapists, and Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Patient Recertification training and education will be provided to all new Registered Nurses, Physical Therapists, and Occupational Therapists with the most current revisions and additions to patient recertification. If any significant changes are made to Patient Recertifications all Registered Nurses, Physical Therapists, and Occupational Therapists will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	days of the recertification and he was unsure why the evaluation was late. During an interview on 10/07/24 beginning at 3:13 PM, OT 2 relayed OT recertification should be done every 60 days, and he was unsure if it was completed within that timeframe. 2. Patient #4's clinical record evidenced a SOC on 5/02/23 and a recertification period of 8/24/24 to 10/22/24. An OT Evaluation was completed on 8/17/24 by OT 2, seven days before recertification period began. The record failed to include an OT recertification evaluation was performed within 5 days of the 8/24/24 recertification date. During an interview on 10/07/24 beginning at 3:13 PM, OT 2 relayed OT recertification should be done every 60 days, and he was unsure why it was not completed within that timeframe. 3. Patient #6's clinical record evidenced a SOC on 3/18/24 and a recertification period of 9/14/24 to 11/12/24. An OT			

	9/07/24 by OT 2, seven days before recertification period began and a PT Evaluation was completed on 9/14/24 by PT 1, the first day of the recertification period. The record failed to include OT and PT recertification evaluations were performed within 5 days of the 9/14/24 recertification date. During an interview on 10/09/24 beginning at 10:36 AM, PT 1 relayed he was unsure why the evaluation was late. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed he the OT evaluation was done early because he usually only works on Saturday. 4. Patient #7's clinical record evidenced a SOC on 3/18/24 and a recertification period of 9/14/24 to 11/12/24. An OT Evaluation was completed on 8/31/24 by OT 2, fourteen days before the recertification period. The record failed to include the OT recertification evaluation was performed within 5 days of the 9/14/24 recertification date. During an interview on			

	AM, OT 2 relayed he completes the reevaluation visits when he is available, usually on Saturdays. 410 IAC 17-14-1(a)(1)(B)			
G0548	Within 48 hours of the patient's return 484.55(d)(2) Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician or allowed practitioner - ordered resumption date; Based on record review and interview, the home health agency failed to conduct a ROC re-evaluation for all services within 48 hours from a patient's return home after hospitalization for 1 of 2 records reviewed of a patient who was hospitalized (Patient #9). Findings include: 1. Agency policy "Comprehensive Patient Assessment" indicated when a client was admitted to an inpatient facility for more than 24 hours, a resumption of care assessment would be completed within 48 hours of the patient's discharge home. 2. Patient #9's clinical record	G0548	Action Plan: Alternate Administrator will ensure all Registered Nurses, Physical Therapists, and Occupations Therapists receive the necessary training and education related to Comprehensive Patient Assessments and resumption of care timeline for evaluations. Alternate Administrator will supply 100% RN, PT, and OT staff with training and education relating to completing patient recertification in person, by US Mail, and/or email. Inservice over Comprehensive Patient Assessments will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementing of Comprehensive Patient Assessment training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses, Physical Therapists, and Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Patient Recertification training and education will be provided to all new Registered Nurses, Physical Therapists, and Occupational Therapists with the most current revisions and additions to Comprehensive Patient Assessment. If any significant changes are made to Comprehensive Patient Assessment all Registered Nurses, Physical Therapists, and Occupational Therapists will receive training on revisions within 14 days of	2024-11-07

	evidenced a start of care date of 5/16/24. PT 2 and OT 2 conducted initial evaluations on 5/18/24 and documented Patient was to receive further therapy services. The record indicated Patient was hospitalized after admission to the home health agency. RN 1 conducted a nursing ROC visit on 5/23/24. The visit note indicated Patient was discharged from the hospital on 5/21/24. The record evidenced OT 2 conducted an OT ROC visit on 5/25/24, which was 4 days after Patient's hospital discharge. PT 2 conducted a PT ROC visit on 5/29/24, which was 8 days after Patient's hospital discharge. The record failed to evidence a reason the PT and OT ROC visits were delayed. 3. During an interview with PT 2 on 10/09/24 beginning at 10:39 AM, he reported if a patient was hospitalized, a ROC visit should be completed within 24-48 hours of their hospital discharge, unless the therapist was unavailable, or the patient requested a delayed visit. The therapist reported the reason for a delayed visit should be entered in the medical record PT 2 could not recall the reason		implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	Patient's ROC visit was delayed. 4. During an interview with OT 2 on 10/09/24 beginning at 11:52 PM, he reported if a patient was hospitalized, a ROC visit should be completed within 3 days of their hospital discharge. OT 2 could not recall the reason Patient's ROC visit was delayed.			
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the home health agency failed to ensure the plan of care was updated at recertification and failed to ensure the patient	G0570	Action Plan: Alternate Administrator will ensure all Registered Nurses, Physical Therapists, and Occupations Therapists receive the necessary training and education related to Patient Plan of Care Policy. Registered Nurses, PTs, and OT's will review all current patient plan of care and update using a clinical update order to include all the following information: verbal and/or written physician order for current service orders including frequency and duration along with care needs, all safety concerns and safety measure, all updated physician orders. All current patient records reviewed and all ordered services, safety measures, and updated physician orders are updated. Alternate Administrator will supply 100% RN, PT, and OT staff with training and education relating to Plan of Care in person, by US Mail, and/or email. Inservice over Patient of Care will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementing of Patient Plan of Care training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses, Physical Therapists, and Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Patient Plan of Care training and	2024-11-07

	received services as ordered (See G572); failed to ensure the POC included measures to address all safety concerns, frequency and duration of visits to be made, patient-specific interventions, and measurable outcomes and goals (See G574); failed to ensure all orders were recorded into the POC (See G576); failed to ensure services were provided only as ordered by a physician or allowed practitioner (See G580) failed to ensure the plan of care (POC) was reviewed with the physician at start of care (SOC) and/or recertification (See G588); failed to ensure the patient/caregiver was provided with written POC information including all treatments administered (See G618) and failed to provide the patient and/or caregiver with accurate clinical manager information (See G622). Findings include: The cumulative effect of these systemic problems had the potential to impact all 61 active patients which resulted in the agency being found out of compliance with the Condition of Participation 42 CFR 484.60 Care Planning, Coordination of Services and Quality of Care.		education will be provided to all new Registered Nurses, Physical Therapists, and Occupational Therapists with the most current revisions and additions to Patient Plan of Care. If any significant changes are made to Patient Plan Patient of Care all Registered Nurses, Physical Therapists, and Occupational Therapists will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the POC was updated at recertification for 4 of 4 active records reviewed with OT recertification (Patients #3, 4, 6, 7) and failed to ensure the patient received all PT and OT services as ordered in the plan of care for 1 of 1 discharged record reviewed where Patient received PT and OT services (Patient #9). Findings include: 3. Patient #3's clinical record evidenced a recertification POC for the certification period 8/21/24 to 10/19/24. The POC included orders for an OT re-evaluation and treat per OT POC. The record evidenced an	G0572	Action Plan: Alternate Administrator will ensure all Registered Nurses, Physical Therapists, and Occupations Therapists receive the necessary training and education related to Patient Plan of Care Policy, updating plan of care at recertification, ensuring patients are receiving ordered services. Alternate Administrator to review all current patient plan of care to ensure that all patients are receiving ordered services and that all services are placed on service member schedules. Alternate Administrator to work with scheduler to ensure all patients are being seen at the correct frequency and duration. All patient schedules have been updated with current orders as of 11/7/2024 Alternate Administrator will supply 100% RN, PT, and OT staff with training and education relating to Plan of Care, updating plan of care at recertification and ensuring patients are receiving services ordered in person, by US Mail, and/or email. Inservice over Patient of Care, updating plan of care at recertification and ensuring patients are receiving services ordered, will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024	2024-11-07

	on 8/24/24. The record failed to evidence an OT recertification POC was created and failed to include documentation of a verbal or written order for OT services to continue. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed they missed completing the recertification OT POC for Patient #3 and he did not collaborate with the physician after the 8/24/24 visit. 4. Patient #4's clinical record evidenced a recertification POC for the certification period 8/24/24 to 10/22/24. The POC included orders for an OT re-evaluation and treat per OT POC. The record evidenced an OT routine visit was completed on 8/17/24. The record failed to evidence an OT recertification POC was created and failed to include documentation of a verbal or written order for OT services to continue. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed they missed completing the recertification OT POC for Patient #4 and he did not collaborate with the physician after the 8/17/24 visit.		Implementing of Patient Plan of Care, updating plan of care at recertification and ensuring patients are receiving ordered services training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses, Physical Therapists, and Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Patient Plan of Care, training and education will be provided to all new Registered Nurses, Physical Therapists, and Occupational Therapists with the most current revisions and additions to Patient Plan of Care. If any significant changes are made to Patient Plan Patient of Care all Registered Nurses, Physical Therapists, and Occupational Therapists will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	5. Patient #6's clinical record evidenced a recertification POC for the certification period 9/14/24 to 11/12/24. The POC failed to include OT orders. The record evidenced an OT Routine visit was completed on 9/07/24. The record failed to evidence an OT recertification POC was created and failed to include documentation of a verbal or written order for OT services to continue. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed they missed completing the recertification OT POC for Patient #6 and he did not collaborate with the physician after the 9/07/24 visit. 6. Patient #7's clinical record evidenced a recertification POC for the certification period 9/14/24 to 11/12/24. The POC included orders for HHA visits 3 times a week for 8 weeks and an OT re-evaluation and treat per OT POC. The record failed to evidence HHA visits were completed the week of 9/08/24. The record evidenced an OT Routine visit was completed on 8/31/24. The record failed to			

	POC was created and failed to include documentation of a verbal or written order for OT services to continue. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 was unaware that Patient #7 did not receive HHA visits during the week of 9/08/24. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed they missed completing the recertification OT POC for Patient #6 and he did not collaborate with the physician after the 8/31/24 visit. 410 IAC 17-13-1(a) Findings include: 1. Agency Policy "Plan of Care" indicated all patients should have a written, individualized plan of care which was "periodically reviewed" by the ordering provider at least every 60 days. The revised plan of care should "reflect current information from the patient's updated comprehensive assessment and contain			

	patient's progress toward the measurable outcomes and goals ...." Services were to be provided as ordered by the physician. 2. Patient #9's clinical record indicated Patient was referred for physical therapy and occupational therapy services. On 5/25/24, OT 2 conducted an OT resumption of care re-evaluation. The therapist wrote an order for 2 OT visits per week for 4 weeks, effective 5/26/24. The record indicated only 1 OT visits was conducted the week of 5/26/24 – 6/02/24. On 5/29/24, PT 2 conducted a PT resumption of care re-evaluation. The therapist wrote an order for 1 PT visit per week for 4 weeks, effective 6/02/24. The record failed to evidence Patient received a PT visit the week of 6/24/24 – 6/30/24. On 7/06/24, PT 2 conducted a PT re-evaluation of Patient. PT 2 documented Patient was going to have a cardiac stent placed on 7/08/24, and "Patient needs continued PT to work on [his/her] strength and stability			

	Patient also needs monitored after the stent placement and will be re-evaluated next week for continued PT services." The therapist wrote an order for Patient to be re-evaluated for PT services effective 7/07/24. The record failed to evidence a PT re-evaluation of Patient was completed and failed to evidence Patient received further PT services. On 7/27/24, OT 2 conducted an OT re-evaluation of Patient. The therapist wrote an order for 1 OT visit per week for 4 weeks, effective 7/28/24. The record failed to evidence Patient received an OT visit the week of 7/28/24 – 8/03/24. On 8/24/24, OT 2 conducted an OT re-evaluation of Patient. The therapist wrote an order for 1 OT visit per week for 3 weeks, effective 8/25/24. The record failed to evidence Patient received an OT visit the week of 8/25/24 – 8/31/24. On 9/07/24, OT 2 conducted an OT re-evaluation of Patient. This was the first OT visit completed since Patient's previous OT re-evaluation on 8/24/24. OT 2 wrote an order for Patient to be			

discharged from OT services due to Patient meeting goals.

During an interview with PT 2 on 10/09/24 beginning at 10:39 AM, he reported if an ordered visit was not conducted, he would contact Patient's ordering provider and document the reason for the missed visit in the record.

During a follow-up interview with PT 2 on 10/09/24 beginning at 11:45 AM, he reported he did not obtain a new order for Patient's PT services to resume after his/her cardiac stent was placed. PT 2 could not recall the reason a new order was not obtained, or the reason Patient's PT services failed to continue.

During an interview with OT 2 on 10/09/24 beginning at 11:52 PM, he reported if an ordered visit was not conducted, he would notify Patient's nurse and send a written order to the provider. When queried on the reason for Patient's missed visits, OT 2 stated Certified Occupational Therapy Assistant (COTA) 1 was responsible for conducting these visits.

During an interview with COTA

	1 on 10/09/24 beginning at 12:20 PM, she reported if a patient's visit was unable to be conducted, she would send a missed visit order to the patient's provider. COTA 1 reported Patient's OT visits would occasionally be missed due to Patient not being available. The therapy assistant reported she would document her attempts to schedule Patient's visits in the record, however the record failed to evidence these attempts and failed to evidence Patient's physician was notified of the missed visits. During an interview with Patient #9 on 10/09/24 beginning at 10:58 AM, he/she reported they were hoping his/her therapy services would not be stopped, as he/she would have liked to continue working on their endurance and balance.			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses;	G0574	Action Plan: Alternate Administrator will ensure all Registered Nurses, Physical Therapists, and Occupations Therapists receive the necessary training and education related to Patient Plan of Care Policy, updating plan of care to ensure	2024-11-07

	(ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on observation, record review, and interview, the home health agency failed to ensure the POC included measures to address all safety concerns, frequency and duration of visits to be made, patient-specific interventions, and measurable outcomes and goals, for 9 of 9 full records reviewed (Patients #1, 2, 3, 4, 5, 6, 7, 8, 9) and 1 of 4 focused records reviewed (Patient #4).		that plan includes measures to address all safety concerns, patient specific interventions, measurable outcomes for all goals, and frequency and duration of visits to be made. The Alternate Administrator will review all current patient plans of care to ensure that all safety concerns and safety measures are on the Plan of Care. Any POC found out of compliance will have a clinical update order completed and update the patient physician with corrections to the plan of care for physician signature and approval. Clinical staff educated on how to write a clinical update for any omissions to the plan of care. All patients cited charts reviewed and corrected for safety measures and concerns Alternate Administrator will supply 100% RN, PT, and OT staff with training and education relating to Plan of Care, updating plan of care at recertification and ensuring that plan of care includes measures to address all safety concerns, patient specific interventions, measurable outcomes for all patient goals, and frequency and duration of visits to be made , in person, by US Mail, and/or email. Inservice over Patient of Care, updating plan of care to ensure that plan includes measures to address all safety concerns, patient specific interventions, measurable outcomes for all goals, and frequency and duration of visits to be made, will be completed by 11/7/2024	

	Findings include: 2. Patient #1's clinical record included a SOC assessment completed on 9/12/24 by RN 1. The assessment indicated the Patient was a risk for falls and the medication profile evidenced the patient was taking an anticoagulant. The POC for Patient #1 for the certification period of 9/12/24 to 11/10/24, created by RN 1, failed to evidence safety measures to address patient's risk for falls and anticoagulant precautions and failed to include interventions for SN goals. During an interview on 10/07/24 beginning at 12:35 PM, RN 1 relayed the POC for Patient #1 should have included fall safety measures and bleeding precautions and she verified the POC failed to include interventions for nursing goals. 3. Patient #2's clinical record included a SOC assessment completed on 9/25/24 by RN 1. The assessment indicated the Patient was a risk for falls and the medication profile evidenced the patient was		Timeframe to be completed by: 11/7/2024 Implementing of Patient Plan of Care, updating plan of care to ensure that plan includes measures to address all safety concerns, patient specific interventions, measurable outcomes for all goals, and frequency and duration of visits to be made training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses, Physical Therapists, and Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Patient Plan of Care, training and education will be provided to all new Registered Nurses, Physical Therapists, and Occupational Therapists with the most current revisions and additions to Plan of Care. If any significant changes are made to Patient of Care all Registered Nurses, Physical Therapists, and Occupational Therapists will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	POC for Patient #2 for the certification period of 9/25/24 to 11/23/24, created by RN 1, failed to evidence safety measures to address patient's risk for falls and anticoagulant precautions and failed to include interventions for SN goals. During an interview on 10/07/24 beginning at 12:42 PM, RN 1 relayed the POC for Patient #2 should have included fall safety measures and bleeding precautions and she verified the POC failed to include interventions for nursing goals. 4. Patient #3's clinical record included a recertification assessment completed on 8/16/24 by RN 1. The assessment indicated the Patient was a risk for falls and the medication profile evidenced the patient was taking an anticoagulant. The recertification POC for Patient #3 for the certification period of 8/21/24 to 10/19/24, created by RN 1, failed to evidence safety measures to address patient's risk for falls and anticoagulant precautions and failed to include interventions for SN			

goals.

During an interview on 10/07/24 beginning at 12:47 PM, RN 1 relayed the POC for Patient #3 should have included fall safety measures and bleeding precautions and she verified the POC failed to include interventions for nursing goals.

5. Patient #4's clinical record included a recertification assessment completed on 8/22/24 by RN 1. The assessment indicated the Patient was a risk for falls and the medication profile evidenced the patient was taking an anticoagulant. The recertification POC for Patient #4 for the certification period of 8/24/24 to 10/22/24, created by RN 1, failed to evidence safety measures to address patient's risk for falls and anticoagulant precautions and failed to include interventions for SN goals.

During an interview on 10/07/24 beginning at 12:51 PM, RN 1 relayed the POC for Patient #4 should have included fall safety measures and

	verified the POC failed to include interventions for nursing goals. 6. Patient #5's clinical record evidenced an admission diagnosis of Type 2 Diabetes Mellitus and included a ROC assessment completed on 9/02/24 by RN 1. The ROC assessment indicated the Patient was a risk for falls and the medication profile evidenced the patient was taking diabetic medications. The recertification POC for Patient #5 for the certification period of 9/03/24 to 11/01/24, created by RN 1, failed to evidence safety measures to address patient's risk for falls and diabetic precautions and failed to include interventions for SN goals. During an interview on 10/07/24 beginning at 12:55 PM, RN 1 relayed the POC for Patient #5 should have included fall safety measures and diabetic precautions and she verified the POC failed to include interventions for nursing goals. 7. Patient #6's clinical record			

	assessment completed on 9/09/24 by RN 1. The assessment indicated the Patient was a risk for falls. The recertification POC for Patient #6 for the certification period of 9/14/24 to 11/12/24, created by RN 1, failed to evidence safety measures to address patient's risk for falls and failed to include interventions for SN goals. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed the POC for Patient #6 should have included fall safety measures and she verified the POC failed to include interventions for nursing goals.			

	8. Patient #7's clinical record included a recertification assessment completed on 9/09/24 by RN 1. The assessment indicated the Patient was a risk for falls. The recertification POC for Patient #7 for the certification period of 9/14/24 to 11/12/24, created by RN 1, failed to include all DME ordered for the patient, failed to evidence safety measures to address patient's risk for falls and failed to include interventions for SN goals. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed the POC for Patient #7 should have included fall safety measures and she verified the POC failed to include all DME ordered for the patient and failed to include interventions for nursing goals. 410 IAC 17-13-1(a)(1)(C) 1. Agency policy "Plan of Care" indicated each patient should have an individualized, written plan of care which must include "… the frequency and duration of visits to be made … all medications and treatments … safety measures to protect			

	against injury … patient-specific interventions … measurable outcomes and goals ….” 9. Patient #8’s clinical record included a start of care assessment completed on 7/12/24 by RN 2. The assessment indicated Patient was a risk for falls. Patient’s plan of care for the initial certification period of 7/12/24 – 9/09/24, created by RN 2, failed to evidence safety measures to address patient’s risk for falls. During an interview with Alternate Administrator on 10/08/24 beginning at 1:08 PM, she reported RN 2 was currently on leave from the agency. 10. Patient #9’s clinical record included a recertification visit conducted on 7/10/24 by RN 1. The assessment indicated Patient was at risk for falls. Patient’s plan of care for the recertification period of 7/15/24 – 9/12/24, created by RN 1, failed to evidence safety measures to address Patient’s risk for falls. The POC indicated Patient’s medications included Clopidogrel (a blood thinner used to decrease a patient’s risk			

	of heart attack and/or stroke). The POC failed to evidence safety measures to address Patient's increased risk for bleeding with use of this medication. The POC indicated the nursing goals included Patient's pain would be "controlled" throughout the certification period. The POC failed to evidence an individualized, measurable goal for Patient's pain. During an interview with RN 1 on 10/09/24 beginning at 10:12 AM, she reported she was unaware the plan of care should include safety measures to address a patient's risk for falls and/or bleeding. When queried how she would measure the goal "[Patient's] pain will be controlled," she reported she would ask a patient if their pain was controlled, what their pain "numbers" were, and if pharmacological interventions were "controlling" pain.			
G0576	All orders recorded in plan of care 484.60(a)(3)	G0576	Action Plan: Alternate Administrator will ensure all Registered Nurses, Physical Therapists, and Occupations	2024-11-07

	All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the home health agency failed to ensure all orders were recorded into the POC for 1 of 1 active wound clinic patient (Patient #5). Findings include: 1. Patient #5's clinical record included updated wound care treatment orders received from Entity M dated 10/01/24. The clinical record failed to include the updated wound care orders effective 10/01/24. 2. During an interview on 10/09/24 beginning at 9:50 AM, the Alternate Administrator relayed all outside orders are sent to the RN who should be updating the POC immediately. 3. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed she updates orders as soon as she received them and after looking through her inbox, she relayed she had not received the updated 10/01/24 orders from the home health agency fax.		Therapists receive the necessary training and education related to Patient Plan of Care Policy, updating plan of care at recertification, ensuring patients are receiving ordered services and treatments, ensuring all orders are on plan of care. The alternate administrator and office assistant will review all current patients' most current plan of care and ensure that all ordered services and treatment are in the patient plan of care. Office assistant will upload all new orders to the patient EMR after RN reviews and notes the orders. All patients cited charts reviewed and corrected. Alternate Administrator will supply 100% RN, PT, and OT staff with training and education relating to Plan of Care, updating plan of care at recertification and ensuring patients are receiving services and treatments ordered, and ensuring all orders are on the plan of care in person, by US Mail, and/or email. Inservice over Patient of Care, updating plan of care at recertification and ensuring patients are receiving services ordered, will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementing of Patient Plan of Care, updating plan of care at recertification and ensuring patients are receiving ordered services training: on or before 11/7/2024	

			Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses, Physical Therapists, and Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Patient Plan of Care, training and education will be provided to all new Registered Nurses, Physical Therapists, and Occupational Therapists with the most current revisions and additions to Patient Plan of Care. If any significant changes are made to Patient Plan Patient of Care all Registered Nurses, Physical Therapists, and Occupational Therapists will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to ensure services were provided only as ordered by a physician or allowed practitioner for 6 of 7 active patient records reviewed (Patient #1, 3, 4, 5, 6 and 7). Findings include: 1. The undated agency policy "Physician Orders" indicated all medications, treatments and	G0580	Action Plan: Alternate Administrator will ensure all licensed staff (RN, PT, OT, MSW) receive the necessary training and education related to Physician Orders Policy, ensuring that all medications, treatments, and services provided to patients are ordered by a physician. Alternate Administrator reviewed all current patient and all records updated as necessary for complete and accurate physician orders. Alternate Administrator will supply 100% licensed staff with training and education relating to Physican Orders, ensuring that all medications, treatments and services provided to patients are ordered by physician, in person, by US Mail, and/or email. Inservice over Physican Orders, ensuring that	2024-11-07

	must be ordered by a physician and when the nurse or therapist receives a verbal order from the physician, he/she shall write the order as given and then read the order back to the physician verifying that the person receiving the order heard it correctly and interpreted the order correctly. 2. Patient #1's clinical record included a POC for certification period 9/12/24 to 11/10/24 with orders for SN visit frequencies of 1 visit every week effective 9/15/24 and a PT visit frequency of 1 visit for Eval and treat effective 9/12/24. The record evidenced SN visits were performed on 9/16/24 and 9/23/24 and PT visits were performed on 9/18/24, 9/24/24 and 9/26/24. The clinical record for Patient #1 failed to include a verbal or signed written order for the SN and PT frequencies was obtained prior to the above visits performed. During an interview on 10/07/24 beginning at 12:35 PM, RN 1 relayed they thought they spoke with the physician during the SOC and she faxed the POC to the physician for signature. The clinical record for		all medications, treatments and services provided to patients are ordered by physician, will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementing of Physican Orders, ensuring that all medications, treatments and services provided to patients are ordered by physician training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all licensed staff verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Physician orders, training and education will be provided to all new licensed staff with the most current revisions and additions to Physician Orders. If any significant changes are made to Physician all licensed staff will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	Patient #1 failed to include documentation of collaboration with the physician for SOC orders. During an interview on 10/07/24 beginning at 2:04 PM, PT 1 verified the clinical record for Patient #1 did not include any documentation with the physician and they did not create a verbal order for the PT POC and frequencies. 3. Patient #3's clinical record included a recertification POC for certification period 8/21/24 to 10/19/24 with orders for an OT visit for Eval and treat. The record evidenced an OT evaluation visit was completed on 8/24/24 and OT visit was performed on 8/28/24. The clinical record for Patient #3 failed to include a verbal or signed written order for the OT frequencies was obtained prior to the above visits performed. During an interview on 10/07/24 beginning at 3:13 PM, OT 2 relayed he there were no changes in Patient #3's needs and he faxed the OT frequency order to the physician for signature. 4. Patient #4's clinical record			

	included a recertification period of 8/24/24 to 10/22/24 with orders for SN visit 1 time a week for 8 weeks and PT and OT visit frequencies of 1 visit for Eval and treat. The record evidenced SN visits were performed on 8/28/24, 9/05/24, 9/12/24 and 9/18/24. PT visits were performed on 8/29/14, 9/04/24 and 9/11/24 and OT visits were performed on 8/29/14, 9/05/24, 9/14/24 and 9/19/24. The clinical record for Patient #4 failed to include a verbal or signed written order for the SN, PT and OT frequencies was obtained prior to the above visits performed. During an interview on 10/07/24 beginning at 12:51 PM, RN 1 relayed the POC for Patient #4 was faxed to physician for signature and a verbal order was not received. During an interview on 10/07/24 beginning at 2:04 PM, PT 1 verified the clinical record for Patient #4 did not include any documentation with the physician and they did not create a verbal order for the PT POC and frequencies. PT 2 relayed the PT recertification			

physician.

During an interview on 10/07/24 beginning at 3:13 PM, OT 2 relayed he faxed the OT frequency order to the physician for signature.

5. Patient #5's clinical record evidenced a ROC on 9/02/24 and a recertification period of 9/03/24 to 11/01/24 with orders for SN visits 2 times a week for 1 week and them 3 times a week for 8 weeks. The record evidenced a SN visit was performed on 9/03/24. The clinical record for Patient #5 failed to include a verbal or signed written order for the SN frequencies was obtained prior to the above visit performed.

During an interview on 10/07/24 beginning at 12:55 PM, RN 1 relayed she was unsure if she collaborated with the physician for Patient #5's ROC orders and the clinical record did not include any documentation.

6. Patient #6's clinical record evidenced a recertification POC for 9/14/24 to 11/12/24 with orders for SN visit frequencies of 1 visit every month; PT visit

	treat per PT POC and OT visit frequency of 1 visit for Eval and treat per OT POC. The record evidenced an OT was performed on 9/15/24 and HHA visits were performed on 9/17/24, 9/18/24, 9/19/24, 9/24/24, 9/25/24, 9/26/24, 10/01/24, 10/02/24 and 10/03/24 without orders. The clinical record for Patient #6 failed to include a verbal or signed written order for the POC frequencies was obtained prior to the above visits performed and failed to include documentation with the physician regarding the OT frequency orders. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed they did not collaborate with the physician for Patient #6's recertification POC and the POC was just faxed to the physician for signature. She was unsure why the HHA frequencies were not on the POC. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed he did not collaborate with the physician for the recertification, and he			

	faxed the OT frequency order to the physician for signature. 7. Patient #7's clinical record evidenced a recertification period of 9/14/24 to 11/12/24 with orders for SN visit frequencies of 1 visit every month; OT visit frequency of 1 visit for Eval and treat per OT POC and HHA visit 3 times a week for 7 weeks. The record evidenced an OT visit was performed on 9/21/24 and HHA visits were performed on 9/17/24, 9/18/24 and 9/19/24. The clinical record for Patient #7 failed to include a verbal or signed written order for the POC frequencies was obtained prior to the above visits performed and failed to include documentation with the physician regarding the OT frequency orders. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed they did not collaborate with the physician for Patient #7's recertification POC and the POC was just faxed to the physician for signature. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed he did not			

	collaborate with the physician for the recertification, and he faxed the OT frequency order to the physician for signature. 410 IAC 17-13-1(a)			
G0618	Treatments and therapy services 484.60(e)(3) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services. Based on observation, record review, and interview, the home health agency failed to ensure the patient/caregiver was provided with written POC information including all treatments administered by the agency for 3 of 3 home visits observed (Patient #1, 2, and 3). Findings include: 1. Patient #1's clinical record evidenced a SOC on 9/12/24. During a home visit observation with Patient #1 on 10/03/24 beginning at 3:27 PM, the home health agency's folder was reviewed and failed to evidence the home health agency had provided Patient #1 a copy of	G0618	Action Plan: Alternate Administrator will provide RN case manager with written copy of patient/clients most current Plan of Care to be delivered to patient/client via home visit to be placed in home folders. Current patient plan of care will be delivered to patient homes and placed in admission home folder at next home visit. All new admissions will receive a written Plan of Care with admission packet when completed to be delivered by RN case manager via home visit. Time frame to be completed: 100% of agencies' current patients will receive a written copy of their plan of care by 11/7/2024. New admissions will receive a copy of the written plan of care when a signed copy is available from the physician. Implementation: on or before 11/7/2024, all of the current home patients will have a copy of the current plan of care delivered via home visit. Ongoing: All patients will receive a written copy of plan of care with admission and with each recertification/resumption of care after signature obtained Means of tracking measurable indicators: Will be confirmed when new patient information packet is ready to be delivered to patient homes.	2024-11-07

	the current POC and treatment orders. 2. Patient #2's clinical record evidenced a SOC on 9/25/24. During a home visit observation with Patient #2 on 10/04/24 beginning at 8:50 AM, the home health agency's folder was reviewed and failed to evidence the home health agency had provided Patient #2 a copy of the current POC and treatment orders. 3. Patient #3's clinical record evidenced a SOC on 4/23/24. During a home visit observation with Patient #3 on 10/04/24 beginning at 1:03 PM, the home health agency's folder was reviewed and failed to evidence the home health agency had provided Patient #3 a copy of the current recertification POC and treatment orders. 4. During an interview on 10/08/24 beginning at 1:49 PM, the Alternate Administrator relayed the patient should be given a copy of the POC at the next visit after the POC has been created.		Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administration, and Office Manager.	
G0622	Name/contact information of clinical manager	G0622	Action Plan: Alternate	2024-10-17

	484.60(e)(5) Name and contact information of the HHA clinical manager. Based on observation, document review and interview, the home health agency failed to provide the patient and/or caregiver with accurate clinical manager information for 3 of 3 active patients with home visit observations (Patient #1, 2 and 3). Findings include: 1. During a home visit observation with Patient #1 on 10/03/24 beginning at 3:27 PM, the home health agency's folder was reviewed and failed to evidence the correct name and contact information of the clinical manager. 2. During a home visit observation with Patient #2 on 10/04/24 beginning at 8:50 AM, the home health agency's folder was reviewed and failed to evidence the correct name and contact information of the clinical manager. 3. During a home visit observation with Patient #3 on 10/04/24 beginning at 1:03 PM,		Administrator will ensure that 100% of new patient home folders have the name of the current Clinical Director and contact number listed. Current patients/clients' folders will be updated with current clinical directors' name and contact information via home visits. Current folders will be reviewed and updated if necessary, at the next home visit and all patient home folders to be updated at any change in staffing Time frame to be completed: All new patient folders and current patient/client home folders will have the clinical manager's name and contact number by 11/7/2024. Completed on: 10/17/2024 100% of current patients home folders have been updated with Clinical Director name and contact information. Ongoing: Patient home folders will be monitored at each patient home visit for name of clinical manager, if missing clinical directors name and number shall be added to folder. Means of tracking and measuring indicators: Will be confirmed when new patient folder is developed at admission. Party responsible for tracking and measuring indicators: Alternate Administrator, Office Manager.	

	was reviewed and failed to evidence the correct name and contact information of the clinical manager. 4. During an interview on 10/08/24 beginning at 8:23 AM, the Clinical Manager (person who was identified during the entrance conference as the Clinical Manager) relayed that she was just a consultant for the home health agency. She stated she was not the Clinical Manager and was not involved in the daily operations of the agency. 5. During an interview on 10/08/24 beginning at 1:49 PM, the Alternate Administrator verified the clinical manager listed in the home folder was inaccurate and indicated the agency folder in the patient's home should be corrected to include the current clinical manager's name and contact information.			

G0642	Program scope 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. Based on record review and interview, the agency failed to measure, document improvement actions and track quality indicators for 1 of 1 agency. Findings include: 1. The agency policy "Quality Assurance Performance Improvement-QAPI", last revised 11/2018, indicated the program will be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. The HHA will measure, analyze, and track	G0642	The Alternate Administrator will ensure that the necessary training and education relating to Quality Assurance Performance-QAPI be provided to all agency employees. Alternate Administrator will supply 100% of all agency employees with training and education related to Quality Assurance Performance-QAPI policy in person, by US mail, and/or email. Inservice over Quality Assurance Performance-QAPI to be completed by 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all agency employees verified by sign-in sheet with name, signature, credentials and date of in-service. Ongoing: Alternate Administrator will provide Quality Assurance Performance-QAPI training to all newly hired employees with the must current revisions and additions, if any significant change is made to policy all agency employees will receive training within 14 days of implementation. Party responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator.	2024-11-07

	adverse patient events, and other aspects of performance that enable the HHA to assess processes of care. 2. The agency's QAPI binder, weekly whiteboard meeting notes and Governing Body minutes from the last 12 months were reviewed. The QAPI binder failed to include any data for measuring, improving or tracking quality indicators. 3. During an interview on 10/09/24 beginning at 12:40 PM, the Alternate Administrator relayed the agency does not keep QAPI meeting minutes and they were unsure if the agency was tracking any quality indicators. 4. During an interview on 10/09/24 beginning at 5:06 PM, the Administrator relayed the agency is always looking at QAPI items, however, the agency does not keep any meeting minutes of this. 410 IAC 17-12-2(a)			
G0644	Program data	G0644	The Alternate Administrator will ensure that the necessary training and education relating	2024-11-07

	484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and interview, the agency failed to ensure the Governing Body approved the frequency and detail of the data collection of the QAPI program for 1 of 1 agency. Findings include: 1. The agency policy "Quality Assurance Performance Improvement-QAPI", last revised 11/2018, indicated the program will be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. The HHA will		to Quality Assurance Performance-QAPI be provided to all agency employees and governing body Alternate Administrator will supply 100% of all agency employees and governing body with training and education related to Quality Assurance Performance-QAPI policy in person, by US mail, and/or email. Inservice over Quality Assurance Performance-QAPI to be completed by 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all agency employees and governing verified by sign-in sheet with name, signature, credentials and date of in-service. Ongoing: Alternate Administrator will provide Quality Assurance Performance-QAPI training to all newly hired employees with the must current revisions and additions, if any significant change is made to policy all agency employees and governing body will receive training within 14 days of implementation. Employees assigned to QAPI will meet on a weekly basis to monthly basis to discuss, verify measurable outcomes, implement changes, with the governing body and minutes will be recorded in QAPI binder. All changes to QAPI program to be approved by the governing body. Party responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator.	

quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care.

2. The agency's QAPI binder, weekly whiteboard meeting notes and Governing Body minutes from the last 12 months were reviewed. The QAPI binder failed to include meeting minutes and failed to evidence documentation of the frequency and detail of the data collection approved by the Governing Body.

During an interview on 10/09/24 beginning at 12:40 PM, the Alternate Administrator relayed the agency does not keep QAPI meeting minutes and therefore the governing body has not approved the QAPI program.

During an interview on 10/09/24 beginning at 5:06 PM, the Administrator relayed the agency does not keep any QAPI meeting minutes and therefore, the governing body has not approved any QAPI information.

410 IAC 17-12-2(a)

G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure employees followed standards of practice for hand hygiene and bag technique to reduce the spread of infections for 2 of 3 home visit observations (Patients #2 and 3). Findings include: 1. The undated agency policy "Handwashing/Hand Hygiene" indicated hand hygiene should be performed between tasks on the same patient, after removing gloves and after touching objects that are potentially contaminated. 2. The undated agency policy "Infection Control" indicated the home health agency will follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.	G0682	Action Plan: Alternate Administrator will ensure all employees receive the necessary training and education relating to infection control and bag technique. The Alternate Administrator will supply 100% agency staff with training on infection control and bag technique in person, by US Mail, and/or email. Inservice to be completed by: 11/7/2024 Time frame to be completed: 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all staff verified by sign-in sheets with employee name, signature, credentials, and date of in-service. Ongoing: Infection control and bag technique education will be provided to all new employees with most current revisions and additions, if any significant changes to the infection control and bag technique policy all staff will receive training within 14 days of implementation Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator.	2024-11-07

	hand hygiene and use of personal protective equipment. 3. The undated policy "Healthcare Bag Technique for Home Health Care Clinicians" indicated staff is to wash their hands if you need to re-enter the home care bag for additional supplies during patient care. To never reach into the bag with gloved hands, to remove gloves and clean hands first, utilize the antiseptic wipes or alcohol pads to clean your equipment, lay them in your clean area, to dry, prior to returning them to the bag, then wash your hands, and repack and close the healthcare bag. 4. During a home visit observation conducted with Patient #2 and COTA 1 on 10/04/24 beginning at 8:50 AM, COTA 1 was observed wearing gloves while performing an assessment and therapy exercises during the entire session with Patient #2. COTA 1 was also observed to cleanse the vitals equipment and return cleaned items to their equipment bag immediately without allowing to air dry, while wearing the same gloves. COTA 1 failed to change gloves			

	or perform hand hygiene during the visit. During an interview on 10/07/24 beginning at 3:48 PM, COTA 1 relayed hand hygiene should have been performed before, during and after the patient session and gloves should have been changed in between patients and if soiled. 5. During a home visit observation conducted with Patient #3 and RN 1 on 10/07/24 beginning at 1:03 PM, RN 1 used the vitals equipment to obtain vital signs on Patient #3 and then sat the items on a paper towel on the table. RN 1 was observed cleaning the vitals equipment with a bleach wipe. RN 1 then sat the clean vitals equipment back on the dirty towel to air dry. During an interview on 10/07/24 beginning at 1:57 PM, RN 1 relayed the clean vitals equipment should have been placed on a clean barrier to air dry. During an interview on 10/07/24 beginning at 2:08 PM, the Alternate Administrator relayed all cleaned vitals			

	placed on a clean barrier to air dry. 410 IAC 17-12-1(m)			
G0708	Development and evaluation of plan of care 484.75(b)(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); Based on observation, record review and interview, the OT failed to ensure a recertification OT POC was created for 4 of 4 patients who received OT services with a recertification period (Patient #3, 4, 6 and 7). Findings include: 1. The undated agency policy "Plan of Care" indicated each patient must receive home health services that are written in an individualized plan of care which is established, periodically reviewed, and signed by a doctor and all patient care orders, including verbal orders, must be recorded in the plan of care. The plan of care must be reviewed and revised by the physician who is responsible for the home health	G0708	Action Plan: Alternate Administrator will ensure all Occupational Therapists receive the necessary training and education related to Patient Plan of Care Policy, recertification plan of care (Care Needs). All current patients reviewed and alternate administrator and scheduler ensured all patients are scheduled for recertification evaluations in the last five days of current certification period Alternate Administrator will supply 100% OT staff with training and education relating to Plan of Care, recertification plan of care (Care Needs) in person, by US Mail, and/or email. Inservice over Plan of Care, recertification plan of care (Care Needs), will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementing of Patient Plan of Care, recertification plan of care (Care Needs) training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Patient Plan of Care, training and education will be provided to all new Occupational Therapists with the most current revisions and additions to Patient Plan of Care.	2024-11-07

	frequently as the patient's condition or needs require, but no less frequently than once every 60 days. 2. Patient #3's clinical record evidenced a SOC on 4/23/24 and included a recertification POC for the certification period 8/21/24 to 10/19/24. The POC included orders for an OT re-evaluation and treat per OT POC. The record evidenced OT Routine visits were completed on 8/10/24 and 8/24/24. The record failed to evidence an OT recertification POC was created and failed to include documentation of a verbal or written order for OT services to continue. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed they missed completing the recertification OT POC for Patient #3. 3. Patient #4's clinical record evidenced a SOC on 5/02/23 and included a recertification POC for the certification period 8/24/24 to 10/22/24. The POC included orders for an OT re-evaluation and treat per OT POC. The record evidenced an		If any significant changes are made to Patient Plan Patient of Care all Occupational Therapists will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	on 8/17/24. The record failed to evidence an OT recertification POC was created and failed to include documentation of a verbal or written order for OT services to continue. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed they missed completing the recertification OT POC for Patient #4. 4. Patient #6's clinical record evidenced a SOC on 3/18/24 and included a recertification POC for the certification period 9/14/24 to 11/12/24. The record evidenced an OT Routine visit was completed on 9/07/24. The record failed to evidence an OT recertification POC was created and failed to include documentation of a verbal or written order for OT services to continue. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed they missed completing the recertification OT POC for Patient #6. 5. Patient #7's clinical record evidenced a SOC on 3/18/24 and included a recertification POC for the certification period 9/14/24 to 11/12/24. The			

	record evidenced an OT Routine visit was completed on 8/31/24. The record failed to evidence an OT recertification POC was created and failed to include documentation of a verbal or written order for OT services to continue. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed they missed completing the recertification OT POC for Patient #6. 410 IAC 17-14-1(b)			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the home health agency failed to ensure all OT visit note documentation was completed accurately for 4 of 4 active patient records reviewed who have received OT services for at least 30 days (Patient's #3, 4, 6 and 7). Findings include: 1. Patient #3's clinical record included documentation of OT Supervisory visits completed on	G0716	Action Plan: Alt Administrator will ensure that employees receive the necessary training and educational tools needed related to preparing clinical notes/supervisory visits. RNs, PTs, and OTs were given paper supervisory visit forms to use if patient does not have adequate cellular service in the home to complete electronic supervisory visit. The Alternate Administrator will supply 100% Clinical staff with training in relation to preparing clinical notes/supervisory visits in person, by U.S. Mail, and/or by email. Therapist to do supervisory visit with each therapy eval. Paper form to given to clinical staff to utilize if EMR version unavailable to clinician at time of supervisory visit. All supervisory visits placed on clinical staff schedule. Time frame to be completed 11/7/2024 Implementation: 11/7/2024	2024-11-07

	8/11/24 and 8/25/24. OT 2 failed to complete the OT Supervisory visits during the OT visits on 8/10/24 and 8/24/24 and the clinical record failed to include documentation of the date discrepancies. 2. Patient #4's clinical record included documentation of an OT Supervisory visit completed on 8/18/24. OT 2 failed to complete the OT Supervisory visit during the OT visit on 8/17/24 and the clinical record failed to include documentation of the date discrepancy. 3. Patient #6's clinical record included documentation of an OT Supervisory visit completed on 8/25/24. OT 2 failed to complete the OT Supervisory visit during the OT visit on 8/24/24 and the clinical record failed to include documentation of the date discrepancy. 4. Patient #7's clinical record included documentation of an OT Supervisory visit completed on 9/02/24. OT 2 failed to complete the OT Supervisory visit during the OT visit on 8/31/24 and the clinical record failed to include documentation of the date discrepancy.		Means of tracking measurable indicators: 100% completion of in-service by all staff verified by sign-in sheets with name, signature, credentials, and date of inservice. Verification of adherence to requirements will be monitored weekly with timesheet verification during visit verification process on an ongoing basis Party responsible for tracking and measuring indicators: Administrator/Director, Alt Admin/Director	

	5. During an interview on 10/07/24 beginning at 3:13 PM, OT 2 relayed he had forgot to document the OT Supervisory visits during the OT visits and he was unable to backdate the supervisory visit notes to reflect the actual visit date. 410 IAC 17-14-1(c)(5)			
G0718	Communication with physicians 484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care; Based on record review and interview, the home health agency failed to ensure the PT POC was reviewed with the attending physician and/or a verbal or written order was obtained prior to visits being performed for 5 of 5 active patient records reviewed who received PT services (Patient #1, 2, 3, 4 and 6) and failed to ensure the OT collaborated with the attending physician and/or a verbal or written order was obtained prior to visits being performed for 6 of 6 active patient records reviewed who received OT services (Patient #1, 2, 3, 4, 6 and 7).	G0718	Action Plan: Alternate Administrator will ensure all Occupational Therapists and Physical Therapists receive the necessary training and education related to Patient Plan of Care Policy, recertification plan of care (Care Needs) and collaboration of care needs with patient specific physician. Alternate administrator reviewed all current patient charts and educated staff on collaborating with MD after eval and obtaining verbal order for plan of care. Alternate Administrator will supply 100% OT and PT staff with training and education relating to Plan of Care, recertification plan of care (Care Needs), and collaboration with physician for patient specific care needs in person, by US Mail, and/or email. Inservice over Plan of Care, recertification plan of care (Care Needs), and collaboration with physician, will be completed by 11/7/2024	2024-11-07

	Findings include: 1. The undated agency policy "Plan of Care" indicated each patient must receive home health services that are written in an individualized plan of care which is established, periodically reviewed, and signed by a doctor and all patient care orders, including verbal orders, must be recorded in the plan of care. The plan of care must be reviewed and revised by the physician who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days. 2. Patient #1's clinical record evidenced a SOC on 9/12/24. A PT Evaluation was completed on 9/18/24 by PT 1 and an OT Evaluation was completed on 9/27/24 by OT 2. The record failed to include documentation with the physician and failed to include documentation of a verbal or written order for the PT and OT POC's and frequency orders. During an interview on		Timeframe to be completed by: 11/7/2024 Implementing of Patient Plan of Care, recertification plan of care (Care Needs), MD collaboration training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Physical Therapist and Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Patient Plan of Care, training and education will be provided to all new Occupational Therapists with the most current revisions and additions to Patient Plan of Care. If any significant changes are made to Patient Plan Patient of Care all Physical Therapists and Occupational Therapists will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	PT 1 verified the clinical record for Patient #1 did not include any documentation with the physician and they did not create a verbal order for the PT POC and frequencies. During an interview on 10/07/24 beginning at 3:13 PM, OT 2 relayed he only collaborated with the physician if there were questions, and he faxed the OT POC to the physician for signature. 3. Patient #2's clinical record evidenced a SOC on 9/25/24. An OT Evaluation was completed on 9/26/24 by OT 2 and a PT Evaluation was completed on 9/27/24 by PT 1. The record failed to include documentation with the physician and failed to include documentation of a verbal or written order for the OT and PT POC's and frequency orders. During an interview on 10/07/24 beginning at 2:04 PM, PT 1 verified the clinical record for Patient #2 did not include any documentation with the physician and they did not create a verbal order for the PT POC and frequencies. PT 2 relayed they faxed the PT POC			

	to the physician a couple days after the evaluation visit. During an interview on 10/07/24 beginning at 3:13 PM, OT 2 relayed he only collaborated with the physician if there were questions, and he faxed the OT POC to the physician for signature. 4. Patient #3's clinical record evidenced a SOC on 4/23/24 and a recertification period of 8/21/24 to 10/19/24. OT and PT Evaluations were completed on 8/24/24 by OT 2 and PT 1. The record failed to include documentation with the physician and failed to include documentation of a verbal or written order for the OT and PT POC's and frequency orders. During an interview on 10/07/24 beginning at 2:04 PM, PT 1 verified the clinical record for Patient #3 did not include any documentation with the physician and they did not create a verbal order for the PT POC and frequencies. PT 2 relayed the PT recertification orders were faxed to the physician. During an interview on 10/07/24 beginning at 3:13 PM,			

	OT 2 relayed he there were no changes in Patient #3's needs and he faxed the OT frequency order to the physician for signature. 5. Patient #4's clinical record evidenced a SOC on 5/02/23 and a recertification period of 8/24/24 to 10/22/24. An OT Evaluation was completed on 8/17/24 by OT 2 and a PT Evaluation was completed on 8/21/24 by PT 1. The record failed to include documentation with the physician and failed to include documentation of a verbal or written order for the OT and PT POC's and frequency orders. During an interview on 10/07/24 beginning at 2:04 PM, PT 1 verified the clinical record for Patient #4 did not include any documentation with the physician and they did not create a verbal order for the PT POC and frequencies. PT 2 relayed the PT recertification orders were faxed to the physician. During an interview on 10/07/24 beginning at 3:13 PM, OT 2 relayed he faxed the OT			

physician for signature.

6. Patient #6's clinical record evidenced a SOC on 3/18/24 and a recertification period of 9/14/24 to 11/12/24. An OT Evaluation was completed on 9/07/24 by OT 2 and a PT Evaluation was completed on 9/14/24 by PT 1. The record failed to include documentation with the physician and failed to include documentation of a verbal or written order for the OT and PT POC's and frequency orders.

During an interview on 10/09/24 beginning at 10:36 AM, PT 1 relayed he thought he collaborated with the physician, however, the clinical record for Patient #6 did not include any documentation with the physician. PT 2 relayed the PT recertification orders were faxed to the physician.

During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed he did not collaborate with the physician for the recertification, and he faxed the OT frequency order to the physician for signature.

7. Patient #7's clinical record

	and a recertification period of 9/14/24 to 11/12/24. An OT Evaluation was completed on 8/31/24 by OT 2. The record failed to include documentation with the physician and failed to include documentation of a verbal or written order for the OT frequency orders. During an interview on 10/09/24 beginning at 11:51 AM, OT 2 relayed he did not collaborate with the physician for the recertification, and he faxed the OT frequency order to the physician for signature. 410 IAC 17-14-1(a)(1)(G)			
G0750	Home health aide services 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Based on record review and interview, the home health agency failed to ensure the HHA was currently certified to provide home health services (See G754); failed to ensure the HHA provided services as ordered in the HHA	G0750	Action Plan: Alternate Administrator will ensure that all Home Health Aides are currently licensed to provide services, home health aides provide services as ordered in the home health aide care plan, and that home health aides receive supervisory visits every 14 days per policy. Alternate Administrator reviewed all current patient schedules and updated the schedules to include supervisory visit on scheduled date Alternate Administer will supply 100% of home	2024-11-07

	POC (See G800) and failed to ensure the RN supervised the HHA every 14 days (See Tag G808). Findings include: The cumulative effect of these systemic problems had the potential to impact all 61 active patients which resulted in the agency being found out of compliance with the Condition of Participation 42 CFR 484.80 Home health aide services.		health aides and Registered Nurses with education and training related to home health aide plan of care and home health aide supervisory visits. Alternate Administer will update associate compliance and run associate compliance reports monthly to ensure all home health aides are licensed to provide services. Alternate Administer will provide 100% of all licensed staff on Policy for Staff to Maintain Licensure. All training will be provided in person, by US Mail, and/or email. Timeframe to be completed: 11/7/2024. Implementation: on or before 11/7/2024 Means of tracking measurable indicators: Alternate Administrator will run an employee compliance report monthly to ensure all licensed staff licenses are current and active. 100% completion of in-services by all licensed staff verified by sign-in sheet with name, signature, credentials, and date of Inservice. Ongoing: Alternate Administrator will update employee compliance in EMR when copy of renewed license received by employee. Training and education on Home Health Aide Plan of Care, Home Health Aide Supervisory visits, and Policy for Staff to Maintain Licensure to all newly hired employees, if any significant changes in policies all staff will receive training within 14 days of implementation. Party Responsible for tracking and Measuring indicators: Administrator/Director, Alternate Administrator.	
G0754	A qualified HH aide successfully completed: 484.80(a)(1)(i-iv) A qualified home health aide is a person who has successfully completed: (i) A training and competency evaluation program as specified in paragraphs (b) and (c) respectively of this section; or (ii) A competency evaluation program that meets the requirements of paragraph (c) of	G0754	Action Plan: Alternate Administrator will provide 100% of home health aides with training and education on how to renew and when to renew home health aide certifications. Alternate Administrator will update home health aide employee compliance record in EMR and run reports monthly to ensure all licenses and	2024-11-07

	this section; or (iii) A nurse aide training and competency evaluation program approved by the state as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the state nurse aide registry; or (iv) The requirements of a state licensure program that meets the provisions of paragraphs (b) and (c) of this section. Based on personnel file review, policy review, and interview, the home health agency failed to ensure the HHA was currently certified to provide home health services for 1 of 1 HHA personnel file reviewed (HHA 1), which had the potential to affect 12 of 12 patients who received services during the time frame the aide was not certified (Patients #6, 7, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20). Findings include: 1. Agency policy "Competency Evaluation of Home Care Staff" indicated employees should be "licensed, registered, or certified as required by law, policy, or standards of practice." 2. A list of current agency employees indicated HHA 1 was the only current HHA employed by the agency. 3. HHA 1's personnel file indicated a hire date of 4/02/19. She was trained by the agency		certifications are current. Alternate Administrator will supply100% of home health aides with in-service relating to maintaining home health aide certifications in person, by US Mail, and/or by email. Timeframe to be completed: 11/7/2024 Inservice to be completed by: 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service verified by in-service sign-in sheet with name, signature, credentials, and date of in-service. Ongoing: Alternate Administrator will provide education and training to any newly hired home health aides on how to renew and when to renew licenses/certificates, if any significant changes to policy all home health aides will receive training within 14 days of implementation.	

	by the State of Indiana on 6/04/19. The expiration date for the aide's certification was 6/04/23. The file failed to evidence an active certification for HHA 1. 4. Review of the State of Indiana's license and certification verification website, www.mylicense.IN.gov, on 10/09/24 evidenced the employee's home health aide certification had expired on 6/04/23. The website failed to evidence HHA 1's certification was renewed until 10/08/24. 5. A list of patients who received home health aide services from HHA 1 between 6/05/23 – 10/07/24 evidenced 12 patients received HHA services from the aide while she was not certified. These included Patients #6, 7, 11, 12, 13, 14, 15, 16, 17, 18, 19, and 20. 6. During an interview with HHA 1 on 10/09/24 beginning at 4:39 PM, she reported she was unaware her home health aide certification had expired on 6/04/23. 7. During an interview with Alternate Administrator on 10/09/24 beginning at 4:45 PM,			

	she reported staff were responsible for ensuring their license and/or certification was kept up to date. 410 IAC 17-14-1(l)(1)(B)			
G0800	Services provided by HH aide 484.80(g)(2) A home health aide provides services that are: (i) Ordered by the physician or allowed practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training. Based on record review and interview, the home health agency failed to ensure the HHA provided services as ordered in the HHA POC for 5 of 5 patient records reviewed who have received HHA services for at least 2 weeks (Patient #6, 7, 11, 12 and 13). Findings include: 1. The undated policy "Home Health Aide Care Plan" indicated the HHA cannot be responsible for performing any procedure that is not assigned	G0800	Action Plan: Alternate Administrator will provide 100% of Home Health Aides with training and education relating to Home Health Aide Care Plan Alternate Administrator will supply 100% of Home Health Aides with in-service relating to home health aide services and home health aide care plans, documentation, and job duties in person, by US mail, and/or email. Inservice to be completed by 11/7/2024 Timeframe to be completed: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service verified by in-service sign-in sheet with name, signature, credentials, and date of in-service Ongoing: Alternate administrator will provide training and education to all newly hired home health aides with the most current revisions and additions related to home health aide job duties, home health aide documentation, home health aide care plans and home health aide services. Any significant changes to policy all home health aides will receive training and education within 14 days of implementation. Party Responsible for tracking measurable indicators: Administrator/Director, Alternate Administrator	2024-11-07

	beyond his/her ability. 2. Patient #6's clinical record for certification period 9/14/24 to 11/12/24 included a HHA care plan which indicated Patient #6 was to receive HHA visits 3 times a week. The aide care plan indicated the patient was to receive a shower/bath every visit. The HHA visit notes for 9/18/24, 9/25/24 and 10/02/24 failed to include Patient #6 receiving a shower/bath during the HHA visits. HHA 1 failed to document the reason for not bathing Patient # during the HHA visits. The HHA visit note for 10/03/24 indicated HHA 1 trimmed Patient #6's hair. HHA 1 failed to document the reason for not bathing Patient #6 during the HHA visits and failed to follow the HHA care plan. During an interview on 10/09/24 beginning at 9:38 AM, HHA 1 relayed they are not a licensed beautician and shouldn't have trimmed Patient #6's hair and she relayed she only gives Patient #6 a shower on her assigned assisted living facility (ALF) shower days. During an interview on			

	the Alternate Administrator relayed the HHA should be documenting if a shower has not been given on the aide visit note and the HHA should not be cutting a patient's hair when she is not licensed. 3. Patient #7's clinical record for certification period 9/14/24 to 11/12/24 included a HHA care plan which indicated Patient #7 was to receive HHA visits 3 times a week. The aide care plan indicated the patient was to receive a shower/bath every visit. The HHA visit notes for 9/17/24, 9/18/24, 9/19/24, 9/24/24, 9/25/24, 9/26/24, 10/01/24, 10/02/24 and 10/03/24 failed to include Patient #7 receiving a shower/bath during the HHA visits. HHA 1 failed to document the reason for not bathing Patient #7 during the HHA visits. During an interview on 10/09/24 beginning at 9:38 AM, HHA 1 relayed Patient #7 prefers to bathe in the evening and the ALF staff give the patient the shower. 4. Patient #11's clinical record for certification period 8/28/24			

	to 10/26/24 included a HHA care plan which indicated Patient #11 was to receive HHA visits 2 times a week. The HHA visit notes for 8/12/24, 8/16/24, 8/19/24, 8/23/24, 8/26/24, 8/30/24, 9/02/24, 9/06/24, 9/09/24, 9/16/24, 9/20/24, 9/23/24, 9/30/24 and 10/04/24 indicated HHA 1 took Patient #11 to the gym, park and shopping. HHA 1 failed to follow the aide care plan and HHA scope of practice. During an interview on 10/09/24 beginning at 9:38 AM, HHA 1 relayed Patient #11's parents allow her to transport the patient to activities and to get snacks. During an interview on 10/09/24 beginning at 9:50 AM, the Alternate Administrator relayed they were unsure if transporting a patient was an allowable HHA activity. 5. Patient #12's clinical record for certification period 8/16/24 to 10/14/24 included a HHA care plan which indicated Patient #12 was to receive HHA visits 3 times a week. The aide care plan indicated the patient was to receive a shower 1 time			

	a week and partial bath the other visits of the week. The HHA visit notes for 8/13/24, 8/14/24, 8/15/24, 8/20/24, 8/21/24, 8/22/24, 8/27/24, 8/28/24, 8/29/24, 9/03/24, 9/04/24, 9/05/24, 9/10/24, 9/11/24, 9/12/24, 9/17/24, 9/18/24, 9/19/24, 9/24/24, 9/25/24, 9/26/24, 10/01/24, 10/02/24 and 10/03/24 failed to include Patient #12 receiving a shower/partial bath during the HHA visits. HHA 1 failed to document the reason for not bathing Patient #12 during the HHA visits. During an interview on 10/09/24 beginning at 9:38 AM, HHA 1 relayed Patient #12 prefers to bathe in the evening and the ALF staff give the patient the shower. 6. Patient #13's clinical record for certification period 9/10/24 to 11/08/24 included a POC and aide care plan which indicated Patient #13 was to receive HHA visits 3 times a week. HHA visits were performed on 9/10/24, 9/11/24, 9/12/24, 9/17/24, 9/18/24, 9/19/24, 9/24/24, 9/25/24, 9/26/24, 10/01/24, 10/02/24 and 10/05/24. The			

	9/10/24 to 11/08/24 failed to include orders for HHA visits. During an interview on 10/09/24 beginning at 9:50 AM, the Alternate Administrator relayed the HHA frequencies should have been listed on the POC. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed the HHA frequencies should be on the POC and she was unsure why they were missing. 7. During an interview on 10/09/24 beginning at 9:50 AM, the Alternate Administrator relayed the HHA should be documenting if the HHA is offering the shower and the reason it was not given.			
G0808	Onsite supervisory visit every 14 days 484.80(h)(1)(i) (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services (A) A registered nurse or other appropriate skilled professional who is familiar with the	G0808	Action Plan: Alternate Administrator will ensure all Registered Nurses receive the necessary training and education on Home Health Aide Supervision. Alternate Adminstrator reviewed all current home health aide patients and added supervisory visit note to the schedule date. Registered Nurses educated	2024-11-07

	patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section. Based on record review and interview, the home health agency failed to ensure the RN supervised the HHA every 14 days for 2 of 2 active clinical records reviewed of patients receiving skilled services and HHA services (Patient #6 and 7). Findings include: 1. The undated agency policy "Home Health Aide Supervision" indicated when skilled services are being provided to a patient, a RN/Therapist must make a supervisory visit to the patient's residence at least every fourteen (14) days to assess relationships and determine whether goals are being met. 2. Patient #6's clinical record included a POC for the certification period 9/14/24 to 11/12/24 and included orders for SN, PT, OT and HHA services. The record evidenced the RN performed HHA		that Home Health Aide supervisory visits are to be done every 14 days and that note will appear on their schedules The Alternate Administrator will supply 100% of all Registered Nurses training and education on Home Health Aide Supervision in person, by US Mail, and/or email. Inservice over Home Health Aide Supervision will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementation: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Home Health Aide Supervision training and education will be provided to all new Registered Nurses with the most current revisions and additions to policy. If any significant changes are made to Home Health Aide Supervision, Registered Nurses will receive training on revisions within 14 days of implementation. Verification of home health aide supervisory visits will be completed bi-weekly with timesheet/payroll audit. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	supervisory visits on 7/11/24 and 9/09/24. The clinical record failed to evidence RN 1 performed HHA supervisory visits every 14 days. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed HHA supervisory visits should be done every 30 days. When queued, she stated she did not perform HHA supervisory visits for Patient #6 every 14 days. 3. Patient #7's clinical record included a POC for the certification period 9/14/24 to 11/12/24 and included orders for SN, OT and HHA services. The record evidenced the RN performed HHA supervisory visits on 7/11/24 and 9/09/24. The clinical record failed to evidence RN 1 performed HHA supervisory visits every 14 days. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed HHA supervisory visits should be done every 30 days. When queued, she stated she did not perform HHA supervisory visits for Patient #7 every 14 days. 4. During an interview on 10/09/24 beginning at 9:50 AM,			

	the Alternate Administrator relayed supervisory visits should be done every 30 days. 410 IAC 17-14-1(h)			
G0940	Organization and administration of services 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. Based on record review and interview, the agency failed to ensure the Administrator was managing the day-to-day operations of the agency (see G948)*;* failed to ensure a clinical manager was available during operating hours (See G950); failed to ensure the Clinical Manager was involved in daily activities of the agency (See G958); and failed to ensure the Clinical Manager was involved in the operations /	G0940	Action Plan: Alternate Administrator will ensure Administrator, Director of Clinical Services, and Governing body receive training and education on company policies titled: Clinical Supervision, and Governing Body. Alternate Administrator will supply 100% of Administrator, Director of Clinical Services, and Governing body with Inservice on Clinical Supervision and Governing Body in-service in person, by US Mail, and/or by email by 11/7/2024 Implementation: 11/7/2024 Timeframe to be completed: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by Administrator, Director of Clinical Services, and Governing body verified via sign-in sheet with employee name, signature, credentials, and date of in-service. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	2024-11-07

	agency (See Findings below). Findings include: 1. The undated agency policy "Clinical Supervision" indicated the Director of Nursing/Nursing Supervisor shall be responsible for the quality of care provided and supervision of all staff providing therapeutic services. He/she will also be responsible for organizing and directing the Agency's ongoing functions and nursing leaders shall coordinate the day-to-day operation of the organization and work with the Administrator. 2. The undated agency policy "Governing Body" indicated the duties and responsibilities of the Governing Body shall include adopting and periodically reviewing and approving administrative and personnel policies, patient care policies and procedures, bylaws as required, the annual operating budget and capital expenditure plan; overseeing the management and fiscal affairs of the agency, this shall include organizational operations; define the corporate structure and clearly indicate lines of authority. This policy indicated Heather Myers was			

	appointed as the Administrator and Director of Nursing on 11/09/08. 3. Review of the home health agency organizational chart evidenced Admin 3 as the Clinical Manager of the agency. 4. Review of CMS provider details, last updated on 4/27/23, evidenced Admin 3 as the Clinical Manager of the agency. 5. Review of the Governing Body minutes, dated 12/15/23, failed to evidence Admin 3 was appointed as the Clinical Manager effective 4/07/23. 6. During an interview on 10/08/24 beginning at 8:23 AM, Admin 3 (who is listed as the Clinical Manager) relayed she was only available as a consultant. She also relayed she was unsure who the current clinical staff were at this time as she was not involved in the daily activities of the agency. She also relayed that she tried to check in with the agency at least once a year and has not provided any consulting services to the agency in over a year. Admin 3 stated Admin 2 was the Administrator and			

	health agency. 7. During an interview on 10/09/24 beginning at 5:06 PM, Admin 1 (who is listed as the Administrator of the agency) relayed she was the only member of the Governing Body and Admin 2 was the current Administrator and Clinical Manager of the agency and Admin 2 was responsible for the day-to-day activities and overseeing patient care. 8. The cumulative effect of these problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation 42 CFR 484.105 Organization and Administration of Services.			
G0948	Responsible for all day-to-day operations 484.105(b)(1)(ii) (ii) Be responsible for all day-to-day operations of the HHA; Based on record review and interview, the agency failed to ensure the Administrator was responsible for the day-to-day operations of the agency for 1 of 1	G0948	Action Plan: Current Administrator to initiate staff change notification to the Indiana State Department of Health to add current Alternate Administrator to become Administrator/Director of Clinical Services. The Current Director of Clinical services to become Alternate administrator upon approval of the request by	2024-11-07

	agency. Findings include: 1. During the entrance conference on 10/03/24 beginning at 9:58 AM, the Alternate Administrator listed Admin 1 as the Administrator of the home health agency. Review of the form CMS 1572, completed by the Alternate Administrator on 10/04/24 evidenced Admin 1 listed as the Administrator. The home health agency failed to have an Administrator that was responsible for the day-to-day operations of the agency. 2. During an interview on 10/04/24 beginning at 3:48 PM, COTA 1 relayed Admin 1 was the Administrator of the agency. 3. During an interview on 10/08/24 beginning at 8:23 AM, Admin 3 (who is listed as the Clinical Manager) relayed she thought Admin 2 was the Administrator of the agency. 4. During an interview on 10/09/24 beginning at 5:06 PM, Admin 1 (who is listed as the		the State Department of Health, to ensure that the Administrator is available to the agency for the day-to-day operations of the agency. Current Alternate Administrator to update job descriptions in employee files when positions are approved by the State, update corporate organizational chart, and update patient information packets to reflect changes to staffing. Alternate Administrator to update current employees of administrative changes upon approval from the State Department of health. Implementation: 11/5/2024 Timeframe to be completed by: 11/7/2024 or upon approval of the State Board of Health Means of tracking measurable indicators: Monitor email and US mail correspondence for approval letter for State Department of Health. Party Responsible for tracking and measuring indicators: Administrator/Governing Body	

	Administrator of the agency) relayed Admin 2 was the current Administrator of the agency. 410 IAC 17-12-1(c)(1)			
G0950	Ensure clinical manager is available 484.105(b)(1)(iii) (iii) Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours; Based on record review and interview the Administrator failed to ensure a clinical manager was available during operating hours for 1 of 1 home health agency surveyed. Findings include: 1. During the entrance conference on 10/03/24 beginning at 9:58 AM, the Alternate Administrator listed Admin 3 as the Clinical Manager of the home health agency. Review of CMS provider details, last updated on 4/27/23, evidenced Admin 3 as the Clinical Manager of the agency. Review of the home health agency organizational chart	G0950	Action Plan: Current Administrator to initiate staff change notification to the Indiana State Department of Health to add current Alternate Administrator to become Administrator/Director of Clinical Services. Director of Clinical services to become Alternate administrator upon approval of the request by the State Department of Health, to ensure that the Clinical Manager is available to the home health agency during operating hours. Current Alternate Administrator to update job descriptions in employee files when positions are approved by the State, update corporate organizational chart, and update patient information packets to reflect changes to staffing. Alternate Administrator to update current employees of administrative changes upon approval from the State Department of health. Implementation: 11/5/2024 Timeframe to be completed by: 11/7/2024 or upon approval of the State Board of Health Means of tracking measurable indicators: Monitor email and US mail correspondence for approval letter for State Department of Health.	2024-11-07

	Clinical Manager of the agency. 2. During an interview on 10/07/24 beginning at 12:58 PM, RN 1 relayed they were unsure when the Clinical Manager (Admin 3) was available. 3. During an interview on 10/08/24 beginning at 8:23 AM, Admin 3 (who is listed as the Clinical Manager) relayed she was only available as a consultant, and she thought Admin 2 was the Clinical Manager of the agency. 4. During an interview on 10/09/24 beginning at 5:06 PM, Admin 1 (who is listed as the Administrator of the agency) relayed Admin 2 was the current Clinical Manager of the agency. 410 IAC 17-12-1(d)		Party Responsible for tracking and measuring indicators: Administrator/Governing Body	
G0958	Clinical manager 484.105(c) Standard: Clinical manager. One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following-- Based on record review and	G0958	Action Plan: Current Administrator to initiate staff change notification to the Indiana State Department of Health to add current Alternate Administrator to become Administrator/Director of Clinical Services to ensure that clinical manager is available to the agency for to oversee all	2024-11-07

	interview the agency failed to ensure the Clinical Manager was involved in daily activities of the agency for 1 of 1 home health agency surveyed. Findings include: 1. During the entrance conference on 10/03/24 beginning at 9:58 AM, the Alternate Administrator listed Admin 3 as the Clinical Manager of the home health agency. Review of CMS provider details, last updated on 4/27/23, evidenced Admin 3 as the Clinical Manager of the agency. Review of the home health agency organizational chart evidenced Admin 3 as the Clinical Manager of the agency. 2. During an interview on 10/08/24 beginning at 8:23 AM, Admin 3 (who is listed as the Clinical Manager) relayed she was only available as a consultant, and she thought Admin 2 was the Clinical Manager of the agency. She also relayed she was unsure who the current clinical staff were at this time as she was not involved in the daily activities of the agency.		patient care services and personnel, and to be involved with the daily operations of the agency. Current Director of Clinical services to become Alternate administrator upon approval of the request by the State Department of Health. Current Alternate Administrator to update job descriptions in employee files when positions are approved by the State, update corporate organizational chart, and update patient information packets to reflect changes to staffing. Alternate Administrator to update current employees of administrative changes upon approval from the State Department of health. Implementation: 11/5/2024 Timeframe to be completed by: 11/7/2024 or upon approval of the State Board of Health Means of tracking measurable indicators: Monitor email and US mail correspondence for approval letter for State Department of Health. Party Responsible for tracking and measuring indicators: Administrator/Governing Body	

	4. During an interview on 10/09/24 beginning at 5:06 PM, Admin 1 (who is listed as the Administrator of the agency) relayed Admin 2 was the current Clinical Manager of the agency and was responsible for the day-to-day activities. 410 IAC 17-12-1(d)			
G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, See Tag G940	G0960	Action Plan: Current Administrator to initiate staff change notification to the Indiana State Department of Health to add current Alternate Administrator to become Administrator/Director of Clinical Services. Current Director of Clinical services to become Alternate administrator upon approval of the request by the State Department of Health. Current Alternate Administrator to update job descriptions in employee files when positions are approved by the State, update corporate organizational chart, and update patient information packets to reflect changes to staffing. Alternate Administrator to update current employees of administrative changes upon approval from the State Department of health. Implementation: 11/5/2024 Timeframe to be completed by: 11/7/2024 or upon approval of the State Board of Health Means of tracking measurable indicators: Monitor email and US mail correspondence for approval letter for State Department of Health.	2024-11-07

			Party Responsible for tracking and measuring indicators: Administrator/Governing Body	
G0962	Coordinate patient care 484.105(c)(2) Coordinating patient care, See Tag G940	G0962	Action Plan: Current Administrator to initiate staff change notification to the Indiana State Department of Health to add current Alternate Administrator to become Administrator/Director of Clinical Services to ensure that coordination of patient care, coordination of referrals, ensure that patient needs are continually assessed, and assure that development, implementation, and updates are completed to the patient plan of care. Current Director of Clinical services to become Alternate administrator upon approval of the request by the State Department of Health. Current Alternate Administrator to update job descriptions in employee files when positions are approved by the State, update corporate organizational chart, and update patient information packets to reflect changes to staffing. Alternate Administrator to update current employees of administrative changes upon approval from the State Department of health. Implementation: 11/5/2024 Timeframe to be completed by: 11/7/2024 or upon approval of the State Board of Health Means of tracking measurable indicators: Monitor email and US mail correspondence for approval letter for State Department of Health. Party Responsible for tracking and measuring	2024-11-07

			indicators: Administrator/Governing Body	
G0964	Coordinate referrals; 484.105(c)(3) Coordinating referrals, See Tag G940	G0964	Action Plan: Current Administrator to initiate staff change notification to the Indiana State Department of Health to add current Alternate Administrator to become Administrator/Director of Clinical Services. Current Director of Clinical services to become Alternate administrator upon approval of the request by the State Department of Health. Current Alternate Administrator to update job descriptions in employee files when positions are approved by the State, update corporate organizational chart, and update patient information packets to reflect changes to staffing. Alternate Administrator to update current employees of administrative changes upon approval from the State Department of health. Implementation: 11/5/2024 Timeframe to be completed by: 11/7/2024 or upon approval of the State Board of Health Means of tracking measurable indicators: Monitor email and US mail correspondence for approval letter for State Department of Health. Party Responsible for tracking and measuring indicators: Administrator/Governing Body	2024-11-07
G0966	Assure patient needs are continually assessed 484.105(c)(4)	G0966	Action Plan: Current Administrator to initiate staff change notification to the Indiana State Department of Health to add current Alternate Administrator to become	2024-11-07

	Assuring that patient needs are continually assessed, and See Tag G940		Administrator/Director of Clinical Services. Current Director of Clinical services to become Alternate administrator upon approval of the request by the State Department of Health. Current Alternate Administrator to update job descriptions in employee files when positions are approved by the State, update corporate organizational chart, and update patient information packets to reflect changes to staffing. Alternate Administrator to update current employees of administrative changes upon approval from the State Department of health. Implementation: 11/5/2024 Timeframe to be completed by: 11/7/2024 or upon approval of the State Board of Health Means of tracking measurable indicators: Monitor email and US mail correspondence for approval letter for State Department of Health. Party Responsible for tracking and measuring indicators: Administrator/Governing Body	
G0968	Assure implementation of plan of care 484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care. See Tag G940	G0968	Action Plan: Current Administrator to initiate staff change notification to the Indiana State Department of Health to add current Alternate Administrator to become Administrator/Director of Clinical Services. Current Director of Clinical services to become Alternate administrator upon approval of the request by the State Department of Health. Current Alternate Administrator to update job descriptions in employee files when positions are approved by the State, update corporate	2024-11-07

			organizational chart, and update patient information packets to reflect changes to staffing. Alternate Administrator to update current employees of administrative changes upon approval from the State Department of health. Implementation: 11/5/2024 Timeframe to be completed by: 11/7/2024 or upon approval of the State Board of Health Means of tracking measurable indicators: Monitor email and US mail correspondence for approval letter for State Department of Health. Party Responsible for tracking and measuring indicators: Administrator/Governing Body	
G1020	Contact info for primary care practitioner 484.110(a)(5) Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA; and Based upon record review and interview, the home health agency failed to ensure the accuracy of the correct attending physician for 2 of 11 records reviewed (Patient #5 and 11). Findings include: 1. Patient #5's clinical record included a POC for the certification period of 9/03/24 to 11/01/24 which indicated the patient's attending physician was Physician L. Physician L's	G1020	Action Plan: Alternate Administrator to contact EMR system to fix issue with wrong MD pulling onto patient Plan of Care after the physician had been removed from patient EMR The Alternate Administrator will verify that all current and active patients/clients have the correct physician identified on their plan of care. Implemented: 11/7/2024 Timeframe to be completed: 11/7/2024 Means of tracking measurable indicators: Registered Nurse, PT, and OT to verify that the correct physician is on plan of care prior to approving plan of care. The Alternate Administrator will review all patients that need a new plan of care weekly and ensure that the correct physician is listed in their EMR. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator, Office Assistant.	2024-11-07

	the POC and Physician P signed the POC. During an interview on 10/07/24 beginning at 12:55 PM, RN 1 relayed she was unsure why the POC had Physician L listed as the attending physician. 2. Patient #11's clinical record included a POC for the certification period of 8/28/24 to 10/26/24 which indicated the patient's attending physician was Physician L. Physician L's name was marked through on the POC and the POC was signed by another practitioner (unable to read). During an interview on 10/07/24 beginning at 12:55 PM, RN 1 relayed she was unsure why the POC had Physician L listed as the attending physician. She relayed the POC was faxed to Physician P for approval. 3. A telephone call was placed to Physician P's office on 10/07/24 at 11:55 AM to attempt to verify the attending physician for Patient #5 and 11 with no return call received. 4. During an interview on			

	10/08/24 beginning at 12:12 PM, the Alternate Administrator was unsure why the electronic medical record (EMR) system was pulling Physician L's name to the POC's. She relayed she would contact the EMR system to inquire about this. 410 IAC 17-15-1(a)(2)			
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: October 3, 4, 7, 8, 9, 2024 12-month Unduplicated Skilled Admissions: 190	N0000		

N0440	Home health agency administration/management 410 IAC 17-12-1(a) Rule 12 Sec. 1(a) Organization, services furnished, administrative control, and lines of authority for the delegation of responsibility down to the patient care level shall be: (1) clearly set forth in writing; and (2) readily identifiable. Based on record review and interview, the home health agency's organizational chart failed to include lines of authority for delegating responsibility to the patient care level for 1 of 1 agency. Findings include: 1. The review of the organizational chart evidenced the organizational structure of the agency, from the Owner to the Clinical Staff. The organizational chart failed to include the patient level.	N0440	Action Plan: Alternate Administrator to update organizational chart to include lines of authority and to add patient level to the bottom of the organizational chart. 100% of all copies of organizational charts will be updated to include lines of authority and to add patient level to bottom of the organizational chart. Implemented: 10/14/2024 Completed on: 10/14/2024 Means of tracking measurable indicators and Ongoing measures: Alternate Administrator will verify organizational chart accuracy yearly and with any position changes.	2024-10-14

	2. During an interview on 10/07/24, the Alternate Administrator confirmed the patient is missing from the organization chart and relayed the patient should be at the bottom of the chart.			
N0447	Home health agency administration/management 410 IAC 17-12-1(c)(4) Rule 12 Sec. 1(c)(4) The administrator, who may also be the supervising physician or registered nurse required by subsection (d), shall do the following: (4) Ensure the accuracy of public information materials and activities. Based on observation, document review and interview, the Administrator failed to ensure the information materials provided were accurate for the public for 1 of 1 Home Health Agency. Findings include: 1. Patient #1's clinical record evidenced a SOC on 9/12/24. During a home visit observation with Patient #1 on 10/03/24 beginning at 3:27 PM, the home	N0447	Action Plan: Alternate Administrator will ensure that 100% of new patient home folders have the name of the current Clinical Director and contact number listed. Current patients/clients' folders will be updated with current clinical directors' name and contact information and updated admission packet with correct agency operating hours via home visits. Old admission packets with incorrect operating business hours will be discarded. Time frame to be completed: All new patient folders and current patient/client home folders will have the clinical manager's name and contact number and updated operating hours by 11/7/2024. Completed on: 10/17/2024 100% of current patients home folders have been updated with Clinical Director name and contact information and updated operating hours. Ongoing: Patient home folders will be monitored at each patient home visit for name of clinical manager, if missing clinical directors name and number shall be added to folder. Admission paperwork to be monitored to ensure correct operating hours are noted in	2024-10-17

	health agency's folder was reviewed and evidenced the incorrect name of the home health agency's Clinical Manager. The folder also evidenced the agency's office hours listed with 3 different operating times. 2. Patient #2's clinical record evidenced a SOC on 9/25/24. During a home visit observation with Patient #2 on 10/04/24 beginning at 8:50 AM, the home health agency's folder was reviewed and evidenced the incorrect name of the home health agency's Clinical Manager. The folder also evidenced the agency's office hours listed with 3 different operating times. 3. Patient #3's clinical record evidenced a SOC on 4/23/24. During a home visit observation with Patient #3 on 10/04/24 beginning at 1:03 PM, the home health agency's folder was reviewed and evidenced the incorrect name of the home health agency's Clinical Manager. The folder also evidenced the agency's office hours listed with 3 different operating times.		packet. Means of tracking and measuring indicators: Will be confirmed when new patient folder is developed at admission. Party responsible for tracking and measuring indicators: Alternate Administrator, Office Manager	

	4. During an interview on 10/08/24 beginning at 1:49 PM, the Alternate Administrator relayed the patient folder and handouts should contain the current contact information and agency operating hours.			
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following: (1) Receipt of job description. (2) Qualifications. (3) A copy of an employee's national/expanded criminal history background check pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations.	N0458	Action Plan: Agency will utilize the EMR Program to record and track all employee evaluations and expiration dates, upload signed job descriptions and ensure criminal background checks are completed. Expiration dates data input into EMR will be facilitated by Alternate Administrator and Office Manager. Time Frames: Training of Office Manager completed by Crystal Hackler RN, Alt Admin on: 10/15/2024 Implementation: on or before 11/7/2024; completion of 100% of employees' data input into EMR achieved 11/7/2024. 100% of overdue evaluations completed by 11/7/2024 by Admin/Alt. Means of tracking measurable indicators: Reports will be run in the EMR on a monthly basis to review 100% of the employees who require an employee evaluation for the following month by personnel as directed by the Administrator. These employees will be notified in person, by email or by phone call and/or text message of the requirement as directed by the Administrator and will track and report to Administrator r/t the completion of the requirement by the employees. If an employee does not comply with the arrangement, or attendance, of an evaluation meeting, the Administrator and employee will	2024-11-07

	Based on personnel file review and interview, the home health agency failed to ensure personnel files included a signed job description for all roles, a national/expanded criminal history background check, a copy of the employee's current certification, and annual performance evaluations, for 5 of 10 active personnel files reviewed (Administrator, Clinical Manager, LPN) 1, RN 1, and HHA 1) and 1 of 1 persons included on the active employee list without a title (Person H). Findings include: 1. The review of agency policy "Competency Evaluation of Home Care Staff" indicated "when agency staff are assigned to new areas or procedures, training and return demonstrations or other observed evidence of competency will be documented." Annual performance evaluations were to be conducted to "address competencies in areas of essential function." 2. The review of Administrator's personnel file indicated a hire date of 1/01/13. The file failed to evidence an annual		be notified, and the employee will be suspended from work until evaluation is completed. Upon hire all signed job descriptions will be uploaded to EMR and also placed in the employee file. Criminal background dates to be uploaded into EMR, and criminal background to be filed in employee record. Any employee that changes positions in the company will have a newly signed job description and if needed an updated background check. Party Responsible for tracking measures: Administrator/Alternate Administrator	

since 2022.

3. The review of Clinical Manager's personnel file indicated a hire date of 3/03/2015. The file failed to evidence an annual evaluation had been conducted since 2019.

4. The review of Alternate Clinical Manager's personnel file evidenced a hire date of 11/15/19. The file failed to evidence a signed job description for the employee's role as alternate clinical manager.

The review of an agency letter, received by the state agency on 11/30/20, evidenced Alternate Clinical Manager was elected to the position effective 11/05/2020.

5. HHA 1's personnel file indicated a hire date of 4/02/19. She was trained by the agency and issued a HHA certification by the State of Indiana on 6/04/19. The expiration date for the aide's certification was 6/04/23. The file failed to evidence a copy of HHA 1's active certification.

Review of the State of Indiana's

	verification website, www.mylicense.IN.gov, on 10/09/24 evidenced the employee's home health aide certification had expired on 6/04/23. The website failed to evidence HHA 1's certification was renewed until 10/08/24. 6. The review of LPN 1's personnel file indicated a hire date of 7/05/2016. The file failed to evidence an annual evaluation had been conducted since 2022. 7. The review of Office Assistant 1's personnel file indicated a hire date of 9/03/21. The employee had been hired as Cat Lounge Manager. The file failed to evidence a signed job description and orientation to the employee's current role as Office Assistant. 8. The review of the agency's active employee list evidenced Person H was listed with no job title.			

	During an interview with Alternate Administrator on 10/08/24, she reported Person H was a silent partner in the home health agency and did not have a job title nor a personnel file. 9. During an interview with Alternate Administrator on 10/09/24 beginning at 4:05 PM, she reported the following: a. Alternate Administrator was responsible for conducting annual performance evaluations. b. The agency's cat lounge had closed effective 9/01/24. Alternate Administrator was unsure of what the Office Assistant 1's current job description was or if the employee had any training for their current role. c. Person H attended the agency's administrative weekly meetings, during which patients' protected health information was discussed. Alternate Administrator reported Person H did not a national background check.			

N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must: (A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3).	N0464	Action Plan: Agency will utilize the EMR Program to record and track all employee evaluations and expiration dates, upload signed job descriptions and ensure criminal background checks are completed. Expiration dates data input into EMR will be facilitated by Alternate Administrator and Office Manager. Time Frames: Training of Office Manager completed by Crystal Hackler RN, Alt Admin on: 10/15/2024 Implementation: on or before 11/7/2024; completion of 100% of employees' data input into EMR achieved 11/7/2024. 100% of overdue evaluations completed by 11/7/2024 by Admin/Alt. Means of tracking measurable indicators: Reports will be run in the EMR on a monthly basis to review 100% of the employees who require an employee evaluation for the following month by personnel as directed by the Administrator. These employees will be notified in person, by email or by phone call and/or text message of the requirement as directed by the Administrator and will track and report to Administrator r/t the completion of the requirement by the employees. If an employee does not comply with the arrangement, or attendance, of an evaluation meeting, the Administrator and employee will be notified, and the employee will be suspended from work until evaluation is completed. Upon hire all signed job descriptions will be uploaded to EMR and also placed in the employee file. Criminal background dates to be uploaded into EMR, and criminal background to be filed in employee record. Any employee that changes positions in the company will have a newly signed job description and if needed an updated background check. Party Responsible for tracking measures:	2024-11-07

	(5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on personnel file review and interview, the home health agency failed to conduct annual tuberculosis screenings for 4 of 7 personnel files reviewed of employees who provided direct patient care (Employees C, D, F, H). Findings include: 1. The review of agency policy "Tuberculosis (TB, a respiratory infection) Evaluation Policy" indicated the agency would "ensure all persons providing care on behalf of the agency who will have direct patient contact are evaluated for tuberculosis on hire and annually thereafter." The policy indicated healthcare facilities		Administrator/Alternate Administrator	

	TB screening" for employees "at increased occupational risk for TB exposure … Facilities should work with their state and local health departments to make these decisions …." 2. The review of Employee C's personnel file indicated their job duties included direct patient care. The employee's personnel health file evidenced the employee had not had an annual TB screening conducted since 2022. 3. The review of Employee D's personnel file indicated their job duties included direct patient care. The employee's personnel health file evidenced the employee had not had an annual TB screening conducted since 2022. 4. The review of Employee F's personnel file indicated their job duties included direct patient care. The employee's personnel health file evidenced the employee had not had an annual TB screening conducted since 2022. 5. The review of Employee H's personnel file indicated their job duties included direct			

	personnel health file evidenced the employee had not had an annual TB screening conducted since 2022. 6. During an interview with Alternate Administrator on 10/09/24 beginning at 2:57 PM, she reported the agency had adopted the Center for Disease Control and Prevention (CDC)'s national standard for TB testing and screening of healthcare workers. Alternate Administrator reported employees who provided direct patient care would be tested for TB on hire and would complete TB screenings annually.			
N0543	Scope of Services 410 IAC 17-14-1(a)(1)(D) Rule 14 Sec. 1(a) (1)(D) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (D) Initiate appropriate preventive and rehabilitative nursing procedures. Based on record review and interview, the registered nurse failed to include all referred services on the POC for 1 of 2 active records reviewed with a	N0543	Action Plan: Alternate Administrator will ensure all Registered Nurses, Physical Therapists, and Occupations Therapists receive the necessary training and education related to Patient Plan of Care Policy, ensuring all ordered services are put on the plan of care, , ensuring collaboration with the MD with any refusal of ordered services or patient request for delays, obtaining new orders for services, updating plan of care at recertification, ensuring patients are receiving ordered	2024-11-07

	SOC in the past 30 days (Patient #1). Findings include: 1. Patient #1's clinical record evidenced a referral was received for PT, OT and SN services on 9/09/24. RN 1 conducted a SOC visit on 9/12/24 and created a POC which failed to include the OT evaluate and treat order. The record evidenced an OT Evaluation was completed on 9/27/24, fifteen days after SOC, by OT 2. The record failed to evidence an order for the OT Evaluation. During an interview on 10/07/24 beginning at 12:35 PM, RN 1 relayed they didn't order the OT Evaluation at the SOC to allow Patient #1 time to improve from COVID-19 symptoms and she verified the clinical record failed to evidence documentation that the physician was notified of the delay in OT services. During an interview on 10/07/24 beginning at 3:13 PM, OT 2 relayed they were unsure why the initial OT Evaluation was not ordered at SOC on		services. Alternate Administrator will supply 100% RN, PT, and OT staff with training and education relating to Plan of Care, updating plan of care at recertification and ensuring patients are receiving services ordered in person, by US Mail, and/or email. Inservice over Patient of Care, updating plan of care at recertification and ensuring patients are receiving services ordered, will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementing of Patient Plan of Care, updating plan of care at recertification and ensuring patients are receiving ordered services training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses, Physical Therapists, and Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Patient Plan of Care, training and education will be provided to all new Registered Nurses, Physical Therapists, and Occupational Therapists with the most current revisions and additions to Patient Plan of Care. If any significant changes are made to Patient Plan Patient of Care all Registered Nurses, Physical Therapists, and Occupational Therapists will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	

	9/12/24.			
N0547	Scope of Services 410 IAC 17-14-1(a)(1)(H) Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, licensed advanced practice registered nurse, licensed physician assistant, dentist, chiropractor, podiatrist, or optometrist orders (oral and written). Based on record review and interview, the RN failed to ensure all orders were recorded into the POC for 1 of 1 active wound clinic patient (Patient #5). Findings include: 1. Patient #5's clinical record included updated wound care treatment orders received from Entity M dated 10/01/24. The clinical record failed to include	N0547	Action Plan: Alternate Administrator will ensure all Registered Nurses, Physical Therapists, and Occupations Therapists receive the necessary training and education related to Patient Plan of Care Policy, updating plan of care at recertification, ensuring patients are receiving ordered services and treatments. The alternate administrator and office assistant will review all current patients' most current plan of care and ensure that all ordered services and treatment are in the patient plan of care. Office assistant will upload all new orders to the patient EMR after RN reviews and notes the orders. All patients cited charts reviewed and corrected. Alternate Administrator will supply 100% RN, PT, and OT staff with training and education relating to Plan of Care, updating plan of care at recertification and ensuring patients are receiving services ordered in person, by US Mail, and/or email. Inservice over Patient of Care, updating plan of care at recertification and ensuring patients are receiving services and treatments as ordered, will be completed by 11/7/2024 Timeframe to be completed by: 11/7/2024 Implementing of Patient Plan of Care, updating plan of care at recertification and ensuring patients are receiving ordered	2024-11-07

	the updated wound care orders effective 10/01/24. 2. During an interview on 10/09/24 beginning at 9:50 AM, the Alternate Administrator relayed all outside orders are sent to the RN who should be updating the POC immediately. 3. During an interview on 10/09/24 beginning at 10:12 AM, RN 1 relayed she updates orders as soon as she received them and after looking through her inbox, she relayed she had not received the updated 10/01/24 orders from the home health agency fax.		services training: on or before 11/7/2024 Means of tracking measurable indicators: 100% completion of in-service by all Registered Nurses, Physical Therapists, and Occupational Therapists verified by sign in sheet with employee name, signature, credentials, and date of in-service. Ongoing: Patient Plan of Care, training and education will be provided to all new Registered Nurses, Physical Therapists, and Occupational Therapists with the most current revisions and additions to Patient Plan of Care. If any significant changes are made to Patient Plan Patient of Care all Registered Nurses, Physical Therapists, and Occupational Therapists will receive training on revisions within 14 days of implementation. Party Responsible for tracking and measuring indicators: Administrator/Director, Alternate Administrator	
N9999	Final Observations Authority IC 16-27-1.5-5 "Approved dementia training for home health aides" Sec. 5 (a) This section applies to a registered home health aide who: (1) is employed as a home health aide; and (2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder. (b) As used in this section, "approved dementia training" refers to a dementia training program: (1) for use in training home health aides in the care of individuals described in subsection (a)(2); and (2) that has been approved by the state	N9999	Alternate Administrator will provide 100% of home health aides with dementia training information through home health agency in-service provided, recognized by the Indiana Association for Home and Hospice Care (IAHHC), RCTC Learn. Alternate administrator will ensure all home health aides have log in information to access in-service provider. Alternate administrator will ensure 100% of home health aides receive an in-service over required	2024-11-07

department under subsection (f).

(c) Not later than sixty (60) days after the date on which a home health aide is initially hired to care for an individual with Alzheimer's disease, dementia, or a related cognitive disorder, the home health aide shall complete at least six (6) hours of approved dementia training.

(d) Before December 31 of each year, a home health aide who has been employed as a home health aide for at least one (1) year shall complete at least three (3) hours of approved dementia training.

(e) A home health aide who:

(1) has received the training required by subsections (c) and (d);

(2) has been employed as a home health aide for at least twenty-four (24) consecutive months; and

(3) is hired by a home health agency; is not required to repeat the training required by this section.

(f) The state department shall do the following:

(1) Identify and approve each dementia training program that meets the following requirements:

(A) The dementia training program includes education concerning the following:

(i) The nature of Alzheimer's disease, dementia, and other related cognitive disorders.

(ii) Current best practices for caring for and treating individuals with dementia.

(iii) Guidelines for the assessment and care of an individual with dementia.

(iv) Procedures for providing patient centered quality care.

(v) The daily activities of individuals with dementia.

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

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

dementia training and education and how to access RCTC Learning modules.

Implementation: 11/7/2024

Timeframe to be completed: on or before 11/7/2024

Means of tracking measurable indicators: 100% of in-services by home health aides verified by Inservice sign-in sheet with name, credentials, signature, and date of in-service. 100% RCTC dementia learning modules to be verified through the RCTC leaning site via certificate of completion.

Ongoing: All home health aides will receive the required 6 hours of initial dementia training, and the required 3 hours of yearly dementia training while employed with home health agency. Dementia in-services will be assigned through RCTC learn and tracked by Alternate Administrator/Director for timely completion. Administrator and home health aide will be notified of any home health aide found out of compliance with mandated dementia training will be suspended until completion of required in-services.

Party Responsible for tracking and measuring indicators: Administrator/Alternate Administrator, Director of Clinical Services

(B) The dementia training program:

(i) must be culturally competent; and

(ii) may be provided online.

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

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

(h) An entity that provides approved dementia training shall provide to each home health aide who successfully completes the training a certificate of completion.

(i) A home health aide:

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

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

As added by P.L.44-2022, SEC.1.

Authority IC 16-27-1.5-6 "Conditions required to administer gastrointestinal and jejunostomy tube feedings; training"

Sec. 6 (a) A registered home health aide may administer gastrointestinal and jejunostomy tube feedings to a specific patient only if the following conditions are met:

(1) The registered home health aide has completed the training curriculum described in subsection (b).

(2) A registered nurse, providing registered nursing under IC 25-23-1-1.1(b)(6), either:

(A) supervises the registered home health aide in administering the gastrointestinal and jejunostomy tube feedings; or

(B) delegates responsibility for administering the gastrointestinal and jejunostomy tube

based on the registered nurse's assessment of the registered home health aide's competency to administer gastrointestinal and jejunostomy tube feedings.

(3) The home health agency that the registered home health aide is employed with:

(A) allows the registered home health aide to administer gastrointestinal and jejunostomy tube feedings;

(B) establishes a procedure for:

(i) the delegation of the administration of gastrointestinal and jejunostomy tube feedings from a registered nurse to a registered home health aide that includes patient specific clinical parameters based on the registered nurse's assessment of the patient and the registered home health aide's competency to administer the gastrointestinal and jejunostomy tube feedings; and

(ii) the assessment by the registered nurse of the patient specific clinical parameters;

(C) retains documentation that the registered home health aide has completed the training curriculum described in subsection (b); and

(D) notifies each patient requiring gastrointestinal and jejunostomy tube feedings upon admission that the home health aide agency may allow registered home health aides to administer gastrointestinal and jejunostomy tube feedings.

(b) Training curriculum for home health aides to administer gastrointestinal and jejunostomy tube feedings must:

(1) be approved by the state department; and

(2) include the following concerning the administration of gastrointestinal and jejunostomy tube feedings:

(A) At least four (4) hours and not more than eight (8) hours of classroom training.

(B) At least two (2) hours and not more than four (4) hours of practical training.

(C) A written and practical examination administered by the trainer.

(c) A registered home health aide may not

	administer gastrointestinal and jejunostomy tube feedings until the home health aide has successfully: (1) completed the curriculum described in subsection (b); and (2) passed the examinations described in subsection (b)(2)(C). (d) The state department may require a registered home health aide who administers gastrointestinal and jejunostomy tube feedings under this section to annually complete not more than one (1) hour of in service training specific to the administration of gastrointestinal and jejunostomy tube feedings. (e) Before January 1, 2024, the state department must approve at least one (1) training curriculum described in subsection (b). As added by P.L.117-2023, SEC.6. Based on personnel file review, clinical review, and interview, the home health agency failed to ensure the HHA completed the required dementia training prior to providing care to a patient diagnosed with dementia and annually thereafter for 1 of 1 personnel file reviewed of a home health aide, which had the potential to			

affect 2 of 2 active patients who received HHA services and had a diagnosis of dementia (Patients #10, 11).

Findings include:

1. A list of current agency employees indicated HHA 1 was the only current HHA employed by the agency.

2. HHA 1's personnel file indicated a hire date of 4/02/19. The file indicated the employee had completed 1 hour of dementia training in 2022 and 2.6 hours of dementia training in 2023. The file failed to evidence the aide had received the required 6 hours of initial dementia training nor the 3 hours of annual dementia training.

3. Patient #10's clinical record indicated a start of care date of 2/20/24. Patient had a diagnosis of dementia and received home health aide services from HHA 1.

	4. Patient #11's clinical record indicated a start of care date of 4/29/13. Patient had a diagnosis of dementia and was currently receiving home health aide services from HHA 1. 5. During an interview with HHA 1 on 10/09/24 beginning at 4:39 PM, she reported she had completed on-line training related to care of a patient with dementia through the agency's online training platform. HHA 1 was unsure of the number of training hours she completed. She stated she still needed to complete the required training for 2024.			

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
Crystal Hackler	RN, Alternate Administrator	11/22/2024 4:25:20 PM