STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15K164	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APPLE TREE HOME HEALTH CARE SERVICES, LLC	5257 N TACOMA DR SUITE 4, INDIANAPOLIS, IN, 46220

(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: 03/17/2025 and 03/18/2025 Active Census: 23 At this Emergency Preparedness survey, Apple Tree Home Health Care Services, LLC was found to be out of compliance with Conditions of Participation Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 484.102 QR by A3 on 3-19-2025.	E0000		
E0001	Establishment of the Emergency Program (EP)	E0001	In order to correct this deficiency the agency has implemented the following: EOOO1 - The emergency preparedness plan has been created and reviewed by the governing body as of 03/25/2025. The Administrator will	2025-04-17

	483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following		ensure that this plan is reviewed every 2 years and in place at all times. E0004 - For this part of the deficiency, the Administrator has completed the agency's emergency Preparedness checklist, that utilizes an all hazards approach. This was completed on 03/25/2025. E0006 - emergency preparedness binder is in place with all of the agency's patients contacts and staff members contact information. Patient's schedules have also been added to this binder as well and the schedules will be replaced monthly in this binder. This is to ensure that all schedule information is up to date at all times. E0021, E0029, E0030, E0031 - The agency has updated the binder with all employees contact information, emergency contact information and schedule. Patient's physician contact numbers and information. Per the emergency Preparedness Policy, the calling plan is in place and all entities (in the home with each patient) contact information has been added to the binder and updated. Local agencies, state agencies, and federal agency information has been added to the binder and the admission folders of all active patients of the agency. The agency has also obtain a CB radio and land line phone for the office, just in case regular communication goes down, the office will have a way to communicate with state and federal agencies. The Administrator will ensure that the calling plan is reviewed annually and all pertinent information pertaining to staff and patient is updated as needed in the emergency preparedness binder. The EPP will be tested by 04/10/2025 and all federal and state agencies will be contacted by 04/17/2025 by Administrator.	

	elements: Based on record review and interview, the agency failed to ensure the comprehensive emergency preparedness program met all requirements to ensure the health, safety, and security needs of their staff and patient population for 1 of 1 agency (E0001); failed to ensure an emergency preparedness plan was in place and reviewed every 2 years at minimum (E0004); failed to ensure a facility based and community based risk assessment utilizing an all-hazards approach (E0006); failed to ensure the agency had a plan for subsistence needs for staff or patients, whether the evacuated or sheltered in place: failed to ensure access to a plan or a system / defined procedure to track the location of on-duty staff and sheltered patients under the agency's care during an emergency (E0021); failed to develop a communication plan to be reviewed/updated at least annually (E0029); failed to ensure that an emergency preparedness communication plan included all staffing addresses and phone numbers, entities providing services under arrangements, and patient physicians for all districts/territories that the agency provided services to (E0030); failed to include contact information for Federal, State, Regional, and Local emergency preparedness officers (E0031); failed to provide a primary and alternate means for communicating			

	with Federal, State, tribal, regional, and local emergency management agencies (E0032); failed to ensure the facility had a communication plan that is reviewed and updated at least every 2 years (E0034). The cumulative effect of these systematic problems resulted in the agency being out of compliance with the condition, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers for Home Health Agencies, at 42 CFR 484.102 Findings include: 1. A review of an undated agency's policy titled "Emergency Preparedness Management Policy," indicated but was not limited to, "POLICY Agency will have an identified plan in place to ensure the safety and well-being of clients and employees during periods of an emergency or disaster that disrupts agency services ... PURPOSE ... To establish guidelines for client care during periods of emergency or disaster ... Effectiveness of processes and systems will be reviewed regularly, but as least annually ... SAMPLE DISASTER PLAN ..." 2. Review an agency document titled "Agency Governing Body Meeting" dated 02/23/2025,			

	indicated but was not limited to, " ... New Business: Agenda Items: Agency program review and findings: Review of services ... Quality Indicators ... Evaluation of emergent care services, hospital admissions and readmissions ... Agency's performance across the spectrum ... Presence of an ongoing program for quality improvement ... Any findings of fraud or waster ... Complaint ... Infection control ... Reporting of possible illegal action by its employees ... Fiscal operation Agency budget Operational plans QAPI program ... Governing Body Findings: ... Action ..." The document failed to evidence the Emergency Preparedness Plan was reviewed. 3. Review of an undated agency documented titled "EMERGENCY PREPAREDNESS CHECKLIST," indicated but was not limited to, "Event, Probability, Risk, Preparedness, Total ... " The document failed to evidence the agency had completed the checklist.			

	4. Review of an undated agency document titled "Apple Tree Home Health Care Services, LLC," indicated but was not limited to, "Type of Event, Severity Classification, Rank ... Name and title of person completing HVA ..." The document failed to evidence the agency had completed the hazard vulnerability assessment. 5. Review of an undated agency document titled "EMERGENCY MANAGEMENT AGENCY," evidenced contact information for different counties. The document failed to evidence the information was reviewed and up to date. 6. During an interview on 03/17/2025 at 10:53 AM the Administrator indicated policies have not been updated, and the policies need to be implemented. 7. During an interview on 03/17/2025 at 4:00 PM, the Administrator indicated they were unaware the Emergency Preparedness Plan needs to be reviewed and approved annually. When queried about			

	the all hazards vulnerability assessment, the Administrator indicated the assessment has not been completed yet. When queried about the communication plan, the Administrator indicated the communication plan is embedded in the Emergency Preparedness Policy that is undated.			
G0000	INITIAL COMMENTS This visit was a Post-Condition revisit for a home health agency recertification and re-licensure survey conducted on 01/27/2025. Survey Dates: 03/17/2025 and 03/18/2025 12-Month Unduplicated Skilled Admissions: 3 During the post-condition revisit survey Apple Tree Home Health Care Services, LLC remained out of compliance with two previously cited	G0000		

	standard-level deficiencies, and one previously cited deficiency. One previously cited condition and seven previously cited standard-level deficiencies were corrected. The agency remained out of compliance with Condition of Participation 484.65 Quality Assessment and Performance Improvement. Apple Tree Home Health Services, LLC was found to be in compliance with Condition of Participation 484.60 Care planning, coordination, and quality of care. Apple Tree Home Health Care Services, LLC continues to be precluded from providing its own home health aide training and competency evaluation program for a period of 2 years beginning 01/27/2025 to 01/26/2027. Abbreviations: HHA Home Health Aide RN Registered Nurse LPN Licensed Practical Nurse			

	DON Director of Nursing POC Plan of Care SOC Start of care SN Skilled Nursing QAPI Quality Assessment and Performance Improvement DME Durable Medical Equipment QR by A3 on 3-19-2025.			
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.	G0572	For this deficiency the agency has began to do calendar chart audits for each certification. Start back from October 2024 to present. All patient will have calendars which will help the agency ensure that what is in the system is being worked and if missed visits are needed that they are caught in a timely manner. The Administrator has also retrained all direct care staff on the importance of contacting the office when a visit will be missed so that we can inform the physicians of this missed visit. As of 04/17/2025 1/3 of the patients charts will been audited with calendar audits from 10/2024 to present. The agency will be current as of 100% by 04/25/2025. To ensure this deficiency does not occur again The Administrator will review calendars weekly.	2025-04-17

	Based on record review and interview, the agency failed to ensure patients received the frequency of services listed in the POC for 1 of 1 active clinical record reviewed with SN services only. (Patient #5) Findings Include: 1. A policy titled "Plan of Care" indicated but was not limited to, " ... Home care services are furnished under the supervision and direction of the client's physician/allowed non-physician practitioner (NPP) ..." 2. A review of Patient #5's clinical record evidenced a POC with a SOC of 03/13/2021 and a certification period from 02/21/2025 to 04/21/2025. The POC included the following diagnoses: Convulsions (uncontrolled jerking), constipation, reduction deformities of the brain, tracheostomy (a surgical procedure to create an opening in the front of the neck to open the airway and allow the individual to breath) status, Severe intellectual disabilities,			

	feeding difficulties, and a cystostomy (a surgical opening to create an opening in the bladder for urine to expel from the body into a collection bag). The POC evidenced the patient received SN services eight hours a day, seven days a week for the certification period. Review of the SN visit notes evidenced the following: During the week of 03/02/2025 through 03/08/2025, evidenced SN visits were conducted on 03/03, 03/04, 03/05, 03/06, and 03/07/2025. The record failed to evidence SN visit notes on 03/02 and 03/08/2025. During the week of 03/09/2025 through 03/15/2025, evidenced SN visits were conducted on 03/10, 03/11, 03/12, 03/13, and 03/14/2025. The record failed to evidence SN visit notes on 03/09 and 03/15/2025. Attempted to call LPN 1 on			

	PM, left voicemail both times. The call was not returned. During an interview with the Clinical Manager on 03/18/2025 at 3:17 PM, they indicated if LPN 1 was unable to make a visit to provide care for Patient #5, they indicated Person 7, the patient's relative and caregiver, provided care for the patient. They indicated LPN 1 was supposed to inform the office of the missed visits and the physician would be notified through fax. During an interview with the Administrator on 03/18/2025 at 4:29 PM, they indicated Patient #5's clinical record failed to evidence missed visit notes or communication to the physician regarding the visits. They explained if there were no dates listed in the clinical record, the visit had not been completed and the physician was not notified. They indicated they had not audited the chart. 3. During an interview with the			

	Administrator on 03/18/2025 at 1:15 PM and 4:00 PM, they were requested to reach out to their staff to inform them of interviews needed. The Administrator indicated they sent out a text message to their staff to inform them of the interviews needed. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for	G0574	To correct this deficiency, all patients DME and supplies are being reviewed and updated in our system. The clinical manager is going through each patient and making sure all DME and supplies are updated accordingly. The administrator is reviewing all DME for each patient and will be going to each patients house to make sure all DME is listed. This will be completed in stages, 1/3 of the patients will be completed By 04/17/2025. with the remaining ones being completed by 04/25/2025. The Administrator will visit 1/3 of patients home by 04/17/2025, with 100% being seen by 04/25/2025. To ensure that this deficiency does not occur again, the administrator will review all DME with the clinical manager and on a monthly basis, and the administrator and clinical manager will train all direct care staff on what DME are in the home so that they can also update the clinical manager when a patient receives any new DME supplies.	2025-04-17

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 agency failed to ensure the plan of care was individualized and included all necessary elements including advanced directive, DME, interventions for skilled nursing services, parameters to notify the physician of INR (International Normalized Ratio, blood test that measures how long it takes for a person's blood to clot), correct enteral feeding rate, relevant diagnoses, goals, and frequency of services to be provided for 1 of 3 focused active clinical records reviewed (Patient # 6) and 5 of 7 active clinical records reviewed. (Patients # 2, 3, 4, 5, and 11)

Findings Include:

1. A review of an agency's policy titled "PLAN OF CARE," indicated but was not limited to, " ... The Plan of Care should be completed in full to include:

	... frequency ... of all visits/ services ... need for / presence of home medical equipment and assistive devices ... specific dietary or nutritional requirements ... medical supplies and equipment ... treatment goals ... other appropriate items ..." 2. Review of the clinical record for Patient #2 revealed a document titled "Home Health Certification and Plan of Care" with a SOC date of 12/18/2023 for the certification period of 02/10/2025 through 04/10/2025 signed by the DON. The POC evidenced Patient #3 has a diffuse TBI (Traumatic Brain Injury, injury to the brain caused by an external force), cramp and spasm, other irregular eye movement, and Circadian rhythm sleep disorder (a sleep disorder that occurs when the body's internal clock is out of sync with a person's body). The POC subsection titled "Advanced Directive" evidenced "there is no data for this section". The POC subsection titled "Psychosocial Status" evidenced "Community Resources Providing Assistance:			

	Entity 14, a waiver service company". The POC subsection titled "DME & Supplies" included, "Motorized Wheelchair, Hospital Bed, Tub/Shower Bench, Hoyer lift, Chux/Underpads, Exam gloves, non-sterilized gloves". During a home visit on 03/18/2025 at 9:00 AM, HHA 4 was observed providing care for Patient #2. Patient #2 was observed to have briefs and a stand machine. The POC failed to evidence if Patient #2 has an Advanced Directive, Entity #14, a waiver service company, no longer provides services, and DME: briefs and stand machine. During an interview on 03/18/2025 at 3:18 PM, the DON indicated Patient #2 is a full code (medical term used to describe someone's consent to receive all medical interventions in the event the individual's heart stops or the individual			

	about Entity 14, a waiver service company, the Administrator indicated Patient #2 no longer uses Entity 14 and should not be listed on the POC. When queried about Patient #2's DME, the DON indicated Patient #2 does have a stand machine and briefs could be added to the POC. 3. Review of the clinical record for Patient #3 revealed a document titled "2025 Recertification" dated 03/17/2025 and signed by the DON. The document indicated but was not limited to, " ... SN every 30 days, weekly ... No skilled services needed ..." The document failed to evidence Patient #3 has a need for SN services and what SN services are provided. Review of the clinical record for Patient #3 revealed a document titled "Home Health Certification and Plan of Care" with a SOC date of 09/23/2024			

	03/22/2025 through 05/20/2025 signed by the DON. The POC evidenced, but was not limited to Patient #3 has Atrial Fibrillation (quivering or irregular heart beat), Gastro-esophageal reflux disease (condition where acidic gastric fluid flows backward into the esophagus, resulting in heartburn), chronic kidney disease (condition where the kidneys slowly lose their ability to filter waste products and excess fluid from the blood), pure hypercholesterolemia (high levels of cholesterol in the blood), and obstructive sleep apnea (sleep disorder that occurs when the upper airway is blocked during sleep, causing breathing to be interrupted). The POC subsection titled "Orders for Discipline and Treatment," included but was not limited to, SN frequency every 30 days, and weekly, SN to instruct client to wear proper footwear when ambulating, SN to instruct client to use prescribed assistive device when ambulating, SN to instruct client to change positions slowly, SN to instruct the Client to remove clutter from client's path, SN to instruct the client to contact agency to report any fall.			

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 agency failed to provide services as ordered by the physician for 1 of 2 active records reviewed with patients receiving SN services and HHA services (Patient #3). Findings Include: 1. A review of an agency's policy titled "Physician/Non-Physician Practitioner (NPP) Orders," indicated but was not limited to, "POLICY All medications, treatments and services provided to clients must be ordered by a physician/allowed non-physician practitioner (NPP) ... All medications and treatments, that are part of the client's plan of care, must be ordered by the physician/allowed non-physician practitioner (NPP) ..." 2. Review of the clinical record	G0580	To correct this deficiency all patients will have a POC audit done to ensure that the information being sent to the physician/Non-Physician Practitioner is correct. All POC from October 2024 to present are being reviewed with the audit and the Clinical Manager will be correcting all POC as needed. As of 04/17/2025 1/3 of the POC from 10/2024 will be corrected and reviewed, with 100% being reviewed (and corrected as needed) by 04/30/2025. To ensure this deficiency does not happen again, the Administrator will make sure all POC will be audited within 5- 10 days of completion.	2025-04-17

	for Patient #3 revealed a document titled "Home Health Certification and Plan of Care" with a SOC date of 09/23/2024 for the certification period of 03/22/2025 through 05/20/2025 signed by the DON. The POC evidenced, but was not limited to, Patient #3 would receive HHA 6 hours a day, 7 days a week for 9 weeks and SN every 30 days and weekly. Review of the clinical record for Patient #3 revealed a document titled "PHYSICIAN ORDER" dated 03/17/2025 and signed by the DON. The document evidenced but was not limited to, a verbal order was received "to continue HHA services for this certification period ... HHA to assist with personal care, incontinent care, and ADL's per POC under supervision of an RN ..." The clinical record failed to evidence an order from a physician to provide SN services weekly.			

	During an interview on 03/18/2025 at 3:02 PM, LPN 2 indicated they were at their other job and to call back at 3:45 PM. During an interview on 03/18/2025 at 4:05 PM, the DON confirmed Patient #3 receives SN services, which include a medication box set up and assistance with notifying the physician of the INR (International Normalized Ratio, blood test that measures how long it takes for a person's blood to clot) result. The Administrator confirmed that a verbal order is necessary in order to provide the SN services. On 03/18/2025 at 4:15 PM, a call was made to LPN 2. The call was sent to voicemail, and a message was left requesting a call back. The call was not returned. 410 IAC 17-13-1(a)			

G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the agency failed to ensure patients received the frequency of services listed in the POC for 1 of 1 active clinical record reviewed with SN services only. (Patient #5) Findings Include: 1. A policy titled "Plan of Care" indicated but was not limited to, " ... Home care services are furnished under the supervision and direction of the client's physician/allowed non-physician practitioner (NPP) ..." 2. A review of Patient #5's clinical record evidenced a POC with a SOC of 03/13/2021 and a certification period from 02/21/2025 to 04/21/2025. The POC included the following	G0590	to correct this deficiency going forward, the agency will reviewing all visits that are completed in the system on a daily basis as well as a weekly basis. The direct care staff have been instructed again through training to inform the office of any visits that are not on their schedule (or any visits that are missed) for any reason immediately. The Administrator will be reviewing all patients schedule on a weekly basis to ensure this deficiency does not occur again.	2025-04-17

	(uncontrolled jerking), constipation, reduction deformities of the brain, tracheostomy (a surgical procedure to create an opening in the front of the neck to open the airway and allow the individual to breath) status, Severe intellectual disabilities, feeding difficulties, and a cystostomy (a surgical opening to create an opening in the bladder for urine to expel from the body into a collection bag). The POC evidenced the patient received SN services eight hours a day, seven days a week for the certification period. Review of the SN visit notes evidenced the following: During the week of 03/02/2025 through 03/08/2025, evidenced SN visits were conducted on 03/03, 03/04, 03/05, 03/06, and 03/07/2025. The record failed to evidence SN visit notes on 03/02 and 03/08/2025. During the week of 03/09/2025			

	SN visits were conducted on 03/10, 03/11, 03/12, 03/13, and 03/14/2025. The record failed to evidence SN visit notes on 03/09 and 03/15/2025. Attempted to call LPN 1 on 03/18/2025 at 1:02 PM and 3:57 PM, left voicemail both times. The call was not returned. During an interview with the Clinical Manager on 03/18/2025 at 3:17 PM, they indicated if LPN 1 was unable to make a visit to provide care for Patient #5, they indicated Person 7, the patient's relative and caregiver, provided care for the patient. They indicated LPN 1 was supposed to inform the office of the missed visits and the physician would be notified through fax. During an interview with the Administrator on 03/18/2025 at 4:29 PM, they indicated Patient #5's clinical record failed to evidence missed visit notes or communication to the physician			

	explained if there were no dates listed in the clinical record, the visit had not been completed and the physician was not notified. They indicated they had not audited the chart. During an interview with the Administrator on 03/18/2025 at 1:15 PM and 4:00 PM, they were requested to reach out to their staff to inform them of interviews needed. The Administrator indicated they sent out a text message to their staff to inform them of the interviews needed. 410 IAC 17-13-1(a)(2)			
G0640	Quality assessment/performance improvement 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or	G0640	For this deficiency the agency has implemented a QAPI program. On 03/25/2025 the board was introduced again (by the administrator) with the QAPI audit tools that will be used to gather information pertaining to the quality of care the agency currently provides. On 03/25/2025, the administrator held the QAPI meeting with QAPI team members where high-risk/problems areas were identified and PIP have started to be put into place. 1/3 of the the PIP and identified risk will be completed by 04/18/2025. For each problem area identified, the administrator assigned a member to be responsible for ensuring that the expected outcome is met. The expected outcome compliance was set according to federal and state regulations. All charts will be audited utilizing audits created and chosen to assist the agency with staying in	2025-04-17

	arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. Based on record review and interview, the agency failed to provide evidence to show measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care (G642), failed to utilize quality indicator data, including measures derived from OASIS to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement, and have the frequency and detail of the data collection approved by the HHA's governing body (G644), failed to document the agency had considered the incidence, prevalence, and high-risk/problem-prone areas to select indicators and identify performance improvement projects (G646), failed to take action at performance improvement and measure its success and track performance to ensure that improvements are sustained (G656), failed to document the reasons for conducting these projects, and the measurable progress achieved on these projects (G658), failed to evidence		compliance with the QAPI program put in place. The Administrator will ensure that 1/2 audits are performed by 04/18/2025, with the reamining of corrections being completed by 04/30/2025. The team will meet quarterly to review findings. It will be the responsibility of the administrator 'to review all chart audits, and any errors found will be addressed and corrected. On 03/28/2025 the administrator met with the board to review the QAPI meeting notes and all audit tools again. Board agreed with meeting notes and audit tools. The administrator will meet with the board quarterly to review quarterly findings.	

	governing body oversight of an ongoing QAPI program for Quality improvement and patient safety is defined, implemented, and maintained with the potential to affect all 23 active patients (G660). The cumulative effect of these systemic problems resulted in the agency's inability to ensure patients received appropriate services which could result in the agency not providing quality health care, thus resulting in non-compliance with Condition of Participation CFR 484.65 Quality Assessment/Performance Improvement. Findings Include: 1. A review of an agency's policy titled "QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT (QAPI)," indicated but was not limited to, " ... Agency will develop, implement, evaluate, and maintain an effective, ongoing agency wide, data driven QAPI program ... The agency will maintain documentary evidence of its QAPI program ... The agency's governing body must ensure that the program reflects the complexity of its organization and services ...			

	and focuses on indicators related to improved outcomes ... The program will be capable of showing measurable improvement in indicators that will improve health outcomes, client safety, and quality of care ... will identify, measure, analyze, and track quality indicators ... include client adverse events, and other relevant data to assess processes of care, services, and operations ... frequency and detail of the data collection must be approved by the governing body ... will establish timelines for review to measure success and establish ongoing activities to sustain the success ... agency must document the quality improvement projects undertaken, the reasons for conducting these projects and the measurable progress achieved on these projects ... The governing body is responsible for ensuring ... An ongoing program for quality improvement and patient safety is defined, implemented, and maintained ... agency wide assessment and performance improvement efforts address priorities for improved quality of care and client safety ... All			

	improvement actions will be evaluated for effectiveness ..." 2. A review of a document titled "Agency Governing Body Meeting" dated 02/23/2025 revealed the Governing body approved all of the agency's audit tools. The Governing Body meeting minutes failed to evidence the agency approved and discussed quality improvement or performance improvement plans. 3. A review of the QAPI binder failed to evidence QAPI meeting minutes. The binder revealed undated POC audits for Patients #11, #12, and #14 and staff audits for the Clinical Manager, HHA 2, and HHA 3. A review of the QAPI binder evidenced blank QAPI audit and data tools. 4. During an interview with the Administrator on 03/18/2025 at 4:36 PM, they revealed they had			

	agency had no QAPI meeting recently. They explained they had not completed a performance improvement plan for the agency and planned to do it at a later date. They indicated they were working on making corrections in the clinical records first and then would focus on QAPI.			
N0000	Initial Comments This visit was for a Post Condition Revisit for a State Re-licensure survey of a Home Health Provider. Survey Dates: 03/17/2025 and 03/18/2025 12-Month Unduplicated Skilled Admissions: 3 QR completed by A3 on 3-21-2025.	N0000		