STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157573	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMERICAN HOME HEALTH SERVICES INC	7895 BROADWAY AVENUE, SUITE G-A, MERRILLVILLE, IN, 46410

(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 The Indiana Department of Health conducted an Emergency Preparedness survey, conducted in accordance with 42 CFR §484.102, for a Home Health Provider and Suppliers. Survey Dates: January 6, 7, 8, and 9, 2025 Census: 16 During this Emergency Preparedness survey, American Home Health Services was found to be in compliance with Conditions of Participation at 42 CFR §484.102: Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E0000		
G0000	INITIAL COMMENTS This visit was for Federal	G0000		

	Recertification and State Re-Licensure survey of a Home Health Provider. Survey Dates: January 6, 7, 8, and 9, 2025 Unduplicated Skilled Admissions for the last 12 Months: **27** This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. During this Federal Recertification Survey, American Home Health Services, was found to be out of compliance with Conditions of Participation at 42 CFR 484.60 Care Planning, Coordination of Services, and Quality of Care, 484.65 Quality assessment/performance improvement, and 484.70 Infection Prevention and Control. Based on the Condition-level deficiencies during the January 09, 2025 survey, American Home Health Services, was subject to an extended survey on January 07, 2025 at 4:00 PM, pursuant to section 1891(c)(2)(D) of the Social			

	Security Act. 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 1/9/2025 and continuing through January 08, 2025. Abbreviations used in report: Home Health Aide [HHA], Clinical Manager [CM], Registered Nurse [RN], Plan of Care [POC], Start of Care [SOC], Occupational Therapist [OT], Skilled Nurse [SN], and Physical Therapist [PT]. QR by Area 2 on 01/23/2025			
G0434	Participate in care 484.50(c)(4)(i,ii,iii,iv,v,vi,vii,viii) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to-- (i) Completion of all assessments; (ii) The care to be furnished, based on the comprehensive assessment; (iii) Establishing and revising the plan of care; (iv) The disciplines that will furnish the care;	G0434	The clinical manager called for an emergencymeeting of all personnel on 01-10-2025 and held an in-service regarding thePolicy and Procedure on Voluntary informed consent ***(exhibit #1);*** emphasized to admitting staff (SNand PT) that when admitting and signing any form of consent, for patients whohave any sign or symptom of confusion, the representative or surrogate shall berequired to	2025-01-30

	(v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; (vii) Any factors that could impact treatment effectiveness; and (viii) Any changes in the care to be furnished. Based on record reviews and interviews, the agency failed to ensure the rights of the patients including consent in advance of and during treatment in 4 of 6 active clinical records reviewed (Patients #1, 4, 5, 8). Findings include: # The agency policy titled "Voluntary Informed Consent" indicated patients are involved in decisions about care, treatments and services and a surrogate decision maker when the patient cannot participate in the decisions. #The clinical record for Patient #1 revealed an initial comprehensive assessment, completed on 11/1/2024 that indicated Patient was alert and forgetful with confusion in new and complex situations. The comprehensive assessment indicated Patient lived alone and depended on caregivers, including the primary caregiver, a family member. The clinical		sign and/or counter-sign, date, with the reason why therepresentative or surrogate is signing the consent. Start of care (SOC) documents were revised (***exhibit #3a to 3e***) to provide a space for the representative or surrogate to sign, date andstate reason he/she is signing. The Admission/Initial Visit Checklist ***(exhibit #4)*** was revised andapproved by the Governing Body on 01-24-2025 to include the item #2-Discussed and completed, signed & dated by patient and/or patientrepresentative as required: Admission Consent, Statement of Financial Liabilityof the services to be provided, Medicare Questionnaire, Consent to Treatment/MedicareQuestionnaire Completed with HIC Number and name same as in the Insurance Card,Patient's Rights and responsibilities, and Elected beneficiary Transferexecuted (If applicable). All old forms were shredded, SOC Book updated. Quality assurance shall be done at the time ofsubmission of SOC documents by the admitting personnel to ensure all pages are properlyfilled and completed- signed as required and dated using the revised Admission/InitialVisit Checklist ***(exhibit #4)*** to ensure completeness andcompliance. The Clinical Chart Review was revised andapproved by the Governing Body on 01-24-2025 to include the item #3-	

	consent document signed by Patient on 11/1/2024 that consented for treatment, release of medical information, financial responsibility, notice of rights and responsibilities, and advanced directives. The record failed to evidence a consent for treatment signed by Patient's health care representative. During an interview on 1/8/2025 at 9:50 AM, Administrator relayed Patient was alert to person and place only and primary caregiver and family member, Other D, was present on admission. Administrator revealed the consents were not signed by Other D. # The clinical record for Patient #8 revealed an initial comprehensive assessment, completed on 11/19/2024 that indicated Patient was alert to person place and time with forgetfulness and confusion with new and complex situations. The comprehensive assessment indicated Patient lives with a family member, Other A, who was also the primary caregiver for Patient. The record included an admission consent document		Admission / InitialVisit Checklist completed and signed, and item #4- SOC PART 1 & 2-signed/dated, attached to EHR ***(exhibit #5)***. It shall be the responsibility of the ClinicalManager/QA to monitor all consent forms for admission are properly filled outand completed to certify compliance at the time of submission using the revisedClinical Chart Revie at the time of initial chart review. Dissemination of information regarding the revised forms completed on01-30-2025. On01-10-2025, the clinical manager called for an emergency meeting of all personnel,and held an in-service regarding the Policy and Procedure on Voluntary InformedConsent ***(exhibit#1),*** Coordinationof Client Services ***(exhibit #6)***, Service on Hold ***(exhibit #7)***,and on Plan of Treatment ***(exhibit 8)***. ThePolicy on Voluntary Informed Consent discussed and emphasized on the special instructions #3 Clients will beinformed of any changes to	

	signed by Patient on 11/19/2024 that consented for treatment, release of medical information, financial responsibility, notice of rights and responsibilities, and advanced directives. The record failed to evidence a consent for treatment signed by Patient's health care representative. During an interview on 1/9/2025 at 10:00 AM, Administrator relayed Other A was present admission, Patient was not fully alert at all times and Other A allowed Patient to sign the consent. Administrator revealed the agency should have family sign consent if Patient was not fully alert. #During an interview on 1/8/2025 at 8:06 AM, HHA 1 relayed she was on vacation and unavailable from 12/20/2024 to 12/30/2024 and the Administrator was made aware weeks ahead. 410 IAC 17-12-3(b)(2)(D)(ii)(AA) 1. A clinical record review for Patient #4 evidenced a plan of care for the recertification period of 11/09/2024-01/07/2025 which		the Plan of treatment or of changes in theavailability of services; and #7 In the event the client refuses care ortreatment, the client will be informed of expected consequences of such actionand this will be documented in the client record. Policy and Procedure on Coordinationof Client Services was discussed; emphasized regarding the purpose of carecoordination of client services to ensure services are coordinated betweenmembers of the interdisciplinary team effectivelyas well as special instructions #7 which states that the primary careNurse or Therapist will assume responsibility for updating/ changing theTreatment plan and communicating changes to caregivers within 24 hoursfollowing the conference or changes. The physician will be contacted whenhis/her approval for that change is necessary and to alert physician to changesin client condition. Active records will be reviewed on an ongoing basis by theNursing Supervisor or designated Registered Nurse/Therapist. Inservicediscussed Policy and Procedure on Service on Hold	

	provide PT services 2 times a week for 6 weeks and HHA services 2 times a week for 8 weeks. A document titled "Physician Telephone/Verbal Order" signed by PT 1 on 11/16/2024 indicated the PT visit frequency was changed to 1 time a week for the next 8 weeks. Review failed to evidence the patient and caregiver were notified of the change in PT visit frequency. A missed visit note dated 11/16/2024 completed by PT 1 indicated the patient requested the PT visit be held for the day. A missed visit note dated 12/25/2024 completed by HHA 1 indicated the patient requested the HHA visits be held for the week. On 1/07/2025, at 3:15 PM, the patient's caregiver indicated he/she believed PT was supposed to be coming 2 times a week. The patient's caregiver indicated neither the caregiver nor the patient refused PT or HHA services. On 01/09/2025, at 3:45 PM, the CM indicated PT 1 was feeling ill the day of the scheduled PT visit on 11/16/2024 and there were no attempts to reschedule		was discussed. Emphasizedspecial instruction #1 which states that when services are suspended theClinical manager or designee will place the services "on hold" with a reasonidentified which will be included as a missed visit report. Missed Visit ReportForm was revised ***(exhibit #9)*** to include expected consequences ofthe missed visit, and emphasized to report to the clinical manager of anyanticipated miss visit or to the office or on-call phone any time 24/7 so ifpatient agrees, a substitute will be assigned in a timely manner. It was alsodiscussed possible strategies to prevent a miss visit by: scheduling visitsearly part of the week, and to as much as possible save Friday and Saturday ofeach week to give time to cover for all missed visits incurred during the earlypart of the week to avoid missed visits; another one, is to offer a substitute,and notify the office immediately to give time for the Clinical Manager to reassignpatient for the week. Electronic Health Record provider was requested therevision of the missed visit	

	the visit with another PT. 2. A clinical record review for Patient #5 evidenced a plan of care for the recertification period 09/22/2024-11/20/2024 which indicated the agency was to provide PT services 2 times a week for 8 weeks. A signed physician order dated 10/5/2024 and signed by PT 1 indicated the PT frequency was changed to 1 time a week for 8 weeks and failed to evidence the patient/caregiver were informed of the change in the PT frequency. On 01/08/2025, at 5:55 PM, the patient's caregiver indicated he/she was unaware why the PT visit frequency was changed and indicated PT 1 just started coming 1 time a week. On 01/09/2025, at 10:30 AM, PT 1 indicated the office was supposed to have notified the patient about the change in PT frequency. On 01/09/2025, beginning at 2:36 PM, the CM indicated there was no documentation the agency notified the patient of the change in PT frequency.		report form, waiting for the completion of therevision of the forms in their system. On 01-24-2025, the Clinical Manager contacted allpatients and their representative/surrogates via phone and discussed thatmissed visits are not tolerated by the agency, and substitutes are available incase the visiting staff will not be able to complete the visit/s for the week. Electronic Health Record provider was requested therevision of the missed visit report form, waiting for the completion of therevision of the forms in their system. On 01-24-2025, the Clinical Manager contacted allpatients and their representative/surrogates via phone and discussed thatmissed visits are not tolerated by the agency, and substitutes are available incase the visiting staff will not be able to complete the visit/s for the week. It will be the responsibility of the Clinical Manager/QAto	

			to discuss expected consequences of amissed visit, and all patients and/or representative understand the effects andconsequences to patient care, goals and the plan of treatment by properlyfilling out/ completing the revised missed visit form. ThePolicy and Procedure on Plan of Treatment discussed; emphasized purpose of theplan of treatment which is to provide guidelines for agency staff to develop aplan of treatment individualized to meet specific identified needs, and to reflect client's ability to make choices andactively participate in establishing and following the plan designated toattain personal health goals, and that any changes to the plan of treatment shouldbe coordinated to the patient and/or representative as stated in the specialinstruction #7. For compliance, skilled nursing (SN) visit notes ***(exhibit#10)*** and physical therapy (PT) visit notes ***(exhibit #11)*** wererevised and approved by the Governing Body on 01-24-2025 to includecoordination of care	

			of treatment such as in thecase of PT change in visit frequency.The patient and/or representative has the right to know the change in thefrequency, and all disciplines involved in the care; and physician shall alsobe notified as stated in the special instructions #10 which states that a Verbal/telephoneorders shall be obtained from the client's physician for changes in the Plan oftreatment. Electronic HealthRecord (EHR) provider was requested the revision of the SN and PT skilled notes,waiting for the completion of the revision of the forms in the system. For compliance, the Clinical Chart Review Form wasrevised and approved by the Governing Body on 01-24-2025 to include on Items: B.16-POCchanges coordinated: pt/ representative, MD & disciplines, G.5-Compliant to frequency, updated asneeded in EMR & 485 (POC), H.3- Compliant to frequency, updated as neededin EMR & 485 (POC), H.5- Care Coordinated re: Eval, q 21 days, change inPOT, I.8- Q POC Deviation:	

			patient&/representative, disciplines & MD ***(exhibit #12).*** Disseminationof information regarding the revised forms completed on 01-30-2025. It will be the responsibility of the Clinical Manager/QAto ensure compliance by utilizing the Clinical Chart Review Form for all patientsduring monthly chart audit.	
G0460	Patient refuses services 484.50(d)(4) The patient refuses services, or elects to be transferred or discharged; Based on record review and interview the agency failed to evidence they educated patients, who declined services and requested to discharged form home health services, on the risks and potential adverse outcomes that may result from the discontinuation of services in 1 of 1 closed clinical record reviewed with a discharge per patient request (Patient #7). Findings include: The clinical record for Patient #7 revealed an initial	G0460	On 01-10-2025, the Clinical Manager called for an emergency meeting ofall personnel and held an in-service regarding the Policy and Procedure onClient Discharge Process ***(exhibit #13)***.During the discussion, emphasized the purpose of the discharge planning toassure timely collaboration with the physician, client, family and otherdisciplines to initiate plan for discharge from the agency. It is also statedin the special instructions #5 that ADischarge Plan shall be developed that is documented in writing and includesall written/verbal instruction regarding the client's ongoing care needs andavailable resources provided	2025-01-30

	9/26/2024 and an initial POC for dates 9/26/2024 to 11/24/2024 for RN visits once a week for 9 weeks and PT to evaluate and treat. The clinical record included discharge comprehensive assessment documentation dated 11/8/2024 that indicated Patient discharge was per family/patient request and a verbal physician's order to discharge Patient per Patient request dated 11/8/2024 and signed by the physician 11/15/2024. The clinical record failed to evidence Patient communication regarding when nor why services were being declined nor education provided to Patient regarding the risks and potential adverse outcomes related to missed visits or an early discharge from home health services. During an interview on 1/8/2025 beginning at 9:50 AM, Administrator relayed the clinical record for Patient #7 did not include education documentation for specific risks or outcomes due to an early discharge.		to the client and family. The Transfer/DischargeSummary Form was revised and approved by the Governing Body on 01-24-2025 toinclude discussion of the risks and potential adverse outcomes that may result from thediscontinuation of services ***(exhibit #14)***in the event the client's requests discharge or declines further visit to makesure risks and consequences of discharge with goals not met are discussed with patientand/or representative. Electronic Health Record provider was requested therevision of the Transfer/Discharge Summary form on 01-09-2025, waiting for thecompletion of the revision of the forms in their system. The Clinical RecordReview was revised and approved by the Governing body on 01-24-2025 to includeitem K.3- Patient/rep& Md notified 15-day prior to DC re: the DC plan, and K.4- DC Summarycompleted, discussed, sent to MD. Dissemination of information regarding the revised forms completedon 01-30-2025.	

			It shall be theresponsibility of the Clinical manager to assure compliance by making sure theTransfer/Discharge Summary Form is properly completed to include patient and/orrepresentative education on possible risks and outcomes due to an earlydischarge is documented when performing monthly chart audit and when doing thefinal chart audit prior to closing the case.	
G0464	Advise the patient of discharge for cause 484.50(d)(5)(i) (i) Advise the patient, representative (if any), the physician(s) or allowed practitioner(s), issuing orders for the home health plan of care, and the patient's 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 (if any) that a discharge for cause is being considered; Based on record review and interviews the agency failed to evidence the patient or their designated decision maker was advised that discharge was imminent in 1 of 1 closed clinical record with the Patient discharged with goals being met (Patient #6). Findings include: The clinical record for Patient #6 revealed an initial SOC comprehensive assessment dated 8/30/2023 and a POC dated 8/24/2024 to 10/22/2024 that included orders for RN visits once a week. The clinical record included a verbal order	G0464	On01-10-2025, theClinical Manager called for an emergency meeting of all personnel and held anin-service regarding the Policy and Procedure on Client Discharge Process ***(exhibit #13)***. Emphasized thepurpose of a discharge plan to assure collaboration with the physician, client,family and other disciplines in planning for discharge from the agency. Asstated in the special instructions #3, The physician will be involved in thedischarge plan and specific ongoing care needs will be identified and addressedas part of the plan. All disciplines were educated that a 15-day notice isrequired to notify not only all disciplines, patient/or PCG but also thephysician about the plan for discharge. ClinicalChart Review Form was revised and approved by the Governing Body on 01-24-2025	2025-01-30

	dated 10/22/2024 indicating Patient may be discharged, signed by the physician 11/15/2024. The patient was discharged on 10/22/2024. During an interview on 1/8/2024 starting at 3:47 PM, Administrator relayed the 'Notice of Medicare Non-Coverage' document, signed by the 10/2/2024, was a notification of discharge. Administrator revealed the clinical record did not include a 15-day notice that discharge was being considered to the physician. IAC 410 17-12-2(i)		toinclude: K.3- Patient/rep& Md notified 15-day prior to DC regarding the DC plan ***(exhibit. 15).*** Disseminationof information regarding the revised forms completed on 01-30-2025. It will be theresponsibility of the Clinical Manager/QA to ensure compliance by utilizing theClinical Chart Review Form during monthly chart audit.	
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 agency failed to ensure the comprehensive assessment included a review of all medications for potential adverse effects and drug reactions in 5 of 6	G0536	On 01-10-2025, the Clinical Manager called for an emergency meeting ofall personnel and held an in-service regarding the Policy and Procedure on MedicationProfile ***(exhibit #16),*** and Medication Management ***(exhibit #17)***.It was discussed that medication profile shall include all prescription andnon-prescription including regularly scheduled medications and those takenintermittently or	2025-01-30

	active clinical records reviewed. (Patient #2, 3, 4, 5, 8) The findings include: 5. The clinical record for Patient #2 revealed an initial comprehensive assessment, completed on 10/23/2024 by RN 2, that revealed Patient's medications included aluminum hydroxide, cholecalciferol, oxycodone, enzalutamide, and gabapentin. The review of the drug regimen in the electronic medical record failed to evidence significant drug interactions nor significant side effects. On Drugs.com, a review of interactions indicated aluminum hydroxide and cholecalciferol may potentially cause a major interaction such as aluminum toxicity that may cause bone pain, fracture, weakness, seizures, and coma. Drugs.com indicated oxycodone and enzalutamide may potentially cause the oxycodone (a narcotic pain reliever) to be less effective and the medications may cause a life-threatening heart rhythm, and oxycodone and gabapentin may potentially cause an interaction such as respiratory distress. The clinical record		as needed. The profile will be reviewed and updated as neededto reflect current medications the client is taking, one of the purposes ofwhich is to identify possible ineffective drug therapy, adverse reactions,significant side effects, drug allergies, and contraindicated medications.Special instructions #1 states that at the time of admission, the admissionprofessional shall check all medications the client may be taking to identifypossible ineffective drug therapy or adverse reactions, significant sideeffects, drug allergies, and contraindicated medication, and shall clinicianshall promptly report any identified problems to the physician. During thediscussion about the Medication Management, discussion was emphasized that theagency's medication management system thatsupports client safety and improves quality of care treatment and services byreducing practice variation, errors and misuse of medications. Identified and establishedmechanism to identify and report potential and actual errors, and a process	

	failed to evidence medication interactions with the medication review in the electronic medical record nor education provided to Patient regarding interactions. During an interview on 01/09/2025 at 11:00 AM, Administrator revealed the EMR has issues with medication reconciliation and the interactions were not provided. Administrator failed to provide documentation Patient was educated regarding potential interactions. 6. The clinical record for Patient #8 revealed an initial comprehensive assessment, dated 11/19/2024 revealed Patient's medication list that included hydrocodone, aripiprazole, ondansetron, and escitalopram. The review of the drug regimen failed to evidence significant drug interactions nor significant side effects. On Drugs.com, a review of interactions indicated hydrocodone and aripiprazole may potentially cause a major interaction that included profound sedation and ondansetron and escitalopram		toimprove systems and performance in the area of medication administration and managementto reduce errors and improve quality of care and promote safety. Medications in the home are reviewed with theclient/family to determine current medications and client understanding of themedications indication/actions and side effects to include possible druginteractions. Drug interactions is patient specific, and it shall include overthe counter medications that clients take on an as needed basis must bereviewed for potential side effects or adverse effects related to prescriptionmedications they are taking. It was unfortunate that during the survey, there was an ongoing Electronic Health Record provider update. Copy of the notice letterfor the update was provided to the surveyors during the survey. Drug regimenreview where we derive the information was not updated on time for thesurveyors to view and was unable to access the complete drug regimen despiteseveral attempts, there were no drug interactions downloaded. Several attemptswere made to follow up availability of the Drug regimen Feature of the EHR butit took longer than expected for them to complete the update. To prevent thisincident from recurring, a hard copy shall be downloaded, and shall be attachedto patient's clinical record under treatment plan for easy access, and a copyshall also be provided to SN	

	may potentially cause a major interaction that may lead to confusion, hallucinations, seizures (convulsions), and changes to vitals signs. The EMR failed to evidence medication interactions with the medication review nor the education, provided to Patient, regarding possible interactions. During an interview on 1/9/2025 at 11:00 AM, Administrator revealed the EMT was not providing the interactions during the medication reconciliation. The administrator failed to provide documentation that Patient was educated regarding interactions. 410 IAC 17-14-1(a)(1)(B) 1. A clinical record review for Patient #4 evidenced POCs for certification period 09/10/2024-11/08/2024 and 11/09/2024-01/07/2025 which indicated the patient's medications included: aspirin (for pain or to thin the blood), chlorthalidone (reduces the amount of water in the body), metformin (lowers blood sugar), albuterol (opens the airway), levothyroxine (treats underacting thyroid), and		teachingtool. Drug regimen for all patients were downloaded for all patients anddistributed to SN, and at the same time copies were attached to all patients' health records. Disseminationof information regarding the revised forms completed on 01-30-2025. Clinical Chart Review Form was revised andapproved by the Governing Body on 01-24-2025 to include: E.3- Drug Regimencompleted/attached to chart, copy provided to SN ***(exhibit #18)***. TheClinical Manager/QA shall be responsible to monitor the agency's compliance byutilizing the updated Clinical Chart Review Form during monthlychart audit.	

formoterol (relaxes air passages).

A review on www.drugs.com indicated 25 drug interactions with the patient's medications to include 15 moderate drug interactions including interactions between levothyroxine and metformin leading to decreased ability to lower blood sugar and aspirin and chlorthalidone, aspirin and albuterol, and aspirin and formoterol leading to decreased levels of potassium.

A SOC comprehensive assessment dated 9/10/2024 completed by the CM failed to identify the drug interactions, and the recertification comprehensive assessment completed by RN 1 on 11/06/2024 indicated issues were identified during the drug review but failed to evidence what the issues were.

On 1/7/2024, at 3:37 PM, RN 1 indicated the patient had no potential drug interactions.

2. A clinical record review for Patient #3 evidenced a POC for initial certification period 11/21/2024-01/19/2025 which

medications included, but were not limited to, ibuprofen (for fever or pain) and lisinopril (for high blood pressure).

A review on www.drugs.com indicated 11 drug interactions to include 1 serious interaction between ibuprofen and lisinopril which inhibited the effectiveness of lowering the blood pressure.

A SOC comprehensive assessment dated 12/11/2024 completed by RN 2 indicated issues were identified during the drug review but failed to evidence what the issues were. The clinical record failed to evidence any drug interactions.

On 01/09/2025, at 10:59 AM, RN 2 indicated the electronic health record (EHR) program checked the drug interactions and was not sure where the drug interactions were found in the clinical record. RN 2 indicated she was not sure what the patient's drug interactions were.

3. A clinical record review for Patient #5 evidenced a POC for a recertification period 11/21/2024-01/19/2025 which indicated the patient's

	medications included, but were not limited to, Tramadol (for pain), escitalopram (antidepressant), albuterol, and melatonin (for sleep). A review on www.drugs.com indicated 8 drug interactions to include albuterol and Tramadol and Tramadol and melatonin which increased drowsiness and between escitalopram and albuterol causing an abnormal heart rhythm. A recertification comprehensive assessment dated 11/29/2024 completed by RN 2 failed to evidence the drugs were reviewed and what the drug interactions were. The clinical record failed to evidence any drug interactions. On 01/09/2025, beginning at 2:36 PM, the CM indicated the drug review was not documented at the time of the comprehensive assessment.			

	4. On 1/8/2024, at 12:30 PM, the CM indicated the drug interactions were to be checked by the EHR program at time of comprehensive assessments and indicated none of the drug interactions were identified in the clinical records.			
G0538	Primary caregiver(s), if any 484.55(c)(6)(i,ii) The patient's primary caregiver(s), if any, and other available supports, including their: (i) Willingness and ability to provide care, and (ii) Availability and schedules; Based on record review and interview, the agency failed to ensure the comprehensive assessment included the assessment of the availability, ability, and willingness of the primary caregiver to provide care in 2 of 2 active clinical records reviewed assessed to be bedbound. (Patient #1 and 3) The findings include: 2. The clinical record for Patient #1 revealed an initial comprehensive assessment, completed on 11/1/2024 that	G0538	On 01-10-2025, the Clinical Manager called for an emergency meeting ofall personnel and held an in-service regarding the Policy and Procedure onComprehensive Client Assessment ***(exhibit 19)***. The policy statesthat a thorough, well-organized, comprehensive and accurate assessment,consistent with the client's immediate needs will be completed for all clientsin a timely manner. All skilled Medicare and Medicaid clients will have comprehensiveassessments with OASIS data sets specific to mandated time points. Theassessment identifies facilitating factors and possible barriers to clientreaching his or her goals including presenting problems. The depth	2025-01-30

	forgetful with confusion in new and complex situations, bedfast and unable to position self, and required assistance to bathe, groom, dress, toilet, and transfer. The comprehensive assessment indicated Patient had two pressure wounds, was incontinent of bowel, used a urinary catheter to eliminate urine, lived alone and depended on caregivers, including the primary caregiver, a secondary caregiver and paid care seven days a week from 8:00 AM to 11:00 AM and 4:00 PM to 7:00 PM; the availability of assistance was noted as occasional and short term. The comprehensive assessment failed to evidence the availability, ability and willingness of primary and secondary caregivers nor services provided by paid caregivers. During an interview on 1/8/2025 at 9:50 AM, Administrator relayed the hours of the paid caregiver are documented, not the services they provide nor availability of the primary and secondary caregivers. 1.A clinical record review for Patient #3 evidenced a SOC		andfrequency of ongoing assessments will depend on client needs, goals, and thecare treatment and services provided. Completion of the agency comprehensiveassessment tool with OASIS will include: clinical record items, demographicsand client history, living arrangement, respiratory status, supportiveassistance, elimination status, sensory status, integumentary status, neuro/emotional/behavioralstatus, activities of daily living, medications, equipment management, emergentcare data, items collected at inpatient facility admission and discharge, and nutritionalstatus are all assessed. In the initial assessment of Patient #3,the friend was identified as the PCG able and willing to assist with ADLs andIADLs ***(exhibit #20),*** performwound care as evidenced in the Oasis page 12 ***(exhibit #21)***, discussedprescribed diet-cardiac heart healthy soft bite-sized mildly thick liquid diet***(exhibit #22)***, the patient need for caregivers from Entity	

	comprehensive assessment dated 12/11/2024 completed by RN 2 which indicated the patient was bedbound and unable to reposition self, forgetful, dependent for personal care and feeding, dependent for medication administration, required thickened liquids due to difficulty swallowing, incontinent of bowel and bladder, had pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (some skin loss or damage involving the top-most skin layers) to the right and left buttocks, and lived alone with some assistance during the day and evening for personal care from Entity F. The SOC comprehensive assessment failed to evidence the assessment of the primary caregiver on the ability and willingness to provide medication management/administration, wound care in the absence of the skilled nurse, feeding, turning every 2 hours, and incontinent care in absence of the paid caregivers from Entity F.		admission as evidenced in Oasis page 20 ***(exhibit#23)***copies of which were provided to the surveyors during the surveyperiod. To ensure these important items areaddressed: assessment of the primary caregiver on theirability and willingness to provide medication management/administration, skin/woundcare in the absence of the skilled nurse, feeding, turning schedule-every 2hours, and incontinent/perineal care, the Clinical Chart Review Form wasrevised ***(exhibit#24)*** toinclude I.7- IdentifiedPCG to help: meds/wound/feeding/incontinent care, and theAdmission/ Initial Visit Checklist ***(exhibit #25)*** wasrevised and approved by GB on 01-24-2025 to include item 11.c- Identified PCG/CGwho are willing and able to provide assistance with medication, skin/woundcare, incontinent/perineal care, food prep/feeding. The admitting personnelwill be responsible filling out and completing the Admission/Initial during theadmission process, and is submitted together with the rest of the	

	On 01/09/2025, at 12:10 PM, the CM indicated the SOC comprehensive assessment did not include the assessment of the willingness, ability, and availability of the primary caregiver to provide all patient care needs based on assessment.		admissiondocuments. Disseminationof information regarding the revised forms completed on 01-30-2025. The Clinical Manager will be responsible in monitoring to ensurecompliance by utilizing the revised Clinical Chart Review Form during the initial chart audit, and monthly thereafter.	
G0544	Update of the comprehensive assessment 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- Based on record review and interviews, the agency failed to ensure the comprehensive assessment was updated and revised as frequently as the patient's conditions warrants due to a major decline or improvement in the patient's health status in 1 of 2 active clinical records reviewed with wounds (Patients #1) and in 1 of 2 active clinical records reviewed with falls (Patient #5). Findings include: # The agency policy titled	G0544	On 01-10-2025,the ClinicalManager called for an emergency meeting of all personnel, and provided anin-service regarding the Policy and Procedure on Client Reassessment/Update of Comprehensive Assessment ***(exhibit 26)***,and Wound Assessment ***(exhibit #27).*** The policy on Client Reassessment/Update of ComprehensiveAssessment states that the Comprehensive Assessment will beupdated and revised as often as the client's condition warrants due to majordecline or improvement in health status. The assessment will include OASIS datacollection for all skilled clients. Reassessments must be done at least: Recertification-every second calendar month beginning with start of care (within last 5 days	2025-01-30

	Comprehensive Assessment" indicated the comprehensive assessment would be updated and revised with significant changes that occur in the patient's condition or diagnoses. # The clinical record of Patient #1 included an initial comprehensive assessment, completed on 11/1/2024 by Administrator, that indicated Patient had two stage 2 pressure ulcers (partial thickness wounds) on the left buttock. The RN documentation of a visit on 11/14/2024 indicated Patient had new blisters to the left thigh and the RN documentation of a visits on 11/19/2024 included the assessment of blisters as open, no longer fluid filled. The RN documentation of the physical assessment on 12/3/2024 revealed the wounds to the left buttock and the blisters to the left thigh were healed. The RN documentation on 12/9/2024 included an assessment of a new blister on the right thigh. The clinical record failed to evidence a comprehensive reassessment for healed wounds nor new wounds.		ofthe episode, including day 60); Resumption of Care- within 48 hours of (orknowledge of) client return home from hospital admission of more than 24 hoursfor any reason other than diagnostic testing; Discharge and transfers- within48 hours of (or knowledge of) discharge or transfer. Purposes of which is toidentify decline or improvement in health status, modify the plan of treatmentand document changes that may affect care and reimbursement, and to verifyappropriate use of home care services and determine eligibility for Medicarebenefit as applicable. Emphasized during the discussion are the other instanceswhen a reassessment needs to be done based on special instructions #2 whensignificant changes occur in their condition, & #3 when significant changesoccur in their diagnosis. Wound Care policy was also discussed and emphasizedspecial instructions #4- Documentation of wounds stating that: a-all wounds shouldbe properly documented on the SN notes- SN note page 2 ***(exhibit #28)***,c- all changes in wound condition shall be	

	During an interview on 1/8/2025 beginning at 9:50 AM, Administrator relayed the comprehensive assessment should be updated every 60 days and as needed, including if new wounds were found. 410 IAC 17-14-1(a)(1)(B) 1. A clinical record review for Patient #5 evidenced a communication note dated 11/16/2024 which indicated the patient fell and hit his/her head. The communication note dated 11/17/2024 indicated the patient was transferred to the emergency department (ED) for evaluation. A communication note dated 01/03/2024 indicated the patient fell and sustained a bruise to the face. The clinical record failed to evidence a revised comprehensive assessment for the change in condition related to the falls and ED transfer since the last comprehensive assessment on 11/19/2024. On 01/09/2025, at 3:07 PM, the CM indicated a change in condition was defined as a patient with falls and indicated the agency did not complete a revised comprehensive		reported to the physician and documentationwill include the individual whom the nurse spoke to; what orders were provided;d- All changes in care shall be documented, along with notification of the RNcase manager, Clinical Manager and/orothers care when needed. It was reported during the survey that formajor sudden change in condition (SCIC), patients are usually sent to theemergency room for further evaluation and are usually admitted for further treatment,a transfer OASIS is then completed; and when discharged back home, a Resumptionof care OASIS is being completed. With patient #5 diagnosis includes Z91.81History of Falling. She fell on 11-16-2024, was ordered to go to the nearestemergency room for further evaluation and treatment since it was reported aquarter-sized bump tender to touch sustained after hitting her forehead on thefloor while seated at the bedside trying to reach for an object that fell onthe floor. Records provided	

	assessment because the electronic health record did not have the option to complete a revised comprehensive assessment.		to surveyors, showed CT scan of the head revealedno evidence of intracranial hemorrhage. Patient was then discharged home sameday with a diagnosis of R29.6- Repeated Falls. Since the time of the fall waswithin the 5-day window for recertification, recertification Oasis thencompleted on 11-19-2024 as planned and requested by patient and PCG. In the case of patient #1, patientdiagnoses at SOC include Pressure Ulcer stage 2 on left buttock: x 2 measuringapproximately 1 cm x 1 cm x 0.1 cm, and 1.5 cm x 1 cm x 0.1 cm. On 11-14-2024,SN documented new blisters that popped out x 2 to the left thigh fromirritation, as per patient & PCG, caused by the velcro used by theurologist office to anchor his IFC; both blisters #1 & #2 measure - 1.0 cmin circumferences, intact, no drainage with pink wound bed, no signs ofinfection. Pressures ulcers to left buttocks decreased in sized measuring: #1- 0.6cmx 0.7 cm x 0.1 cm & #2- 0.8cm x 0.9 cm x 0.1 cm with no signs of infection,no drainage noted with redness around the wounds blanchable.	

			Reported on12-3-2024 all wounds over left buttocks and left thigh healed completelywithout complications, however, on 12-09-2024, integumentary assessment includeda new fluid filled blister about 1 cm in diameter over the right upper thigh; patientand PCG instructed measures to promote skin integrity and prevent skinbreakdown: to turn to sides at frequent intervals at least q 1-2 hours to keeppressure off from areas with bony prominences, to keep perineal area clean anddry, and eating healthy with adequate hydration, and use of ZINC OXIDE CREAM toreddened areas of the skin; to protect fragile skin by being extra careful whenmoving around, and importance of daily inspection and to promptly report toSN/MD for immediate intervention. The Clinical Chart Review Form ***(exhibit#29)*** was revised and approved by GB on 01-24-2025 to include SCIC underitem entitled Oasis Data Collected-item #2- SOC, ROC, RECER, **SCIC,**DC- in a timely manner; #3- Data collected – complete,	

			accurate& relevant;and item F.10- Wound Assessment/measurement/care specified- on SN note ***(exhibit#30).*** The Clinical Manager notified all SN to utilize the skilled notespage 2 to document wounds. It will be the responsibility of theclinical manager/QA to monitor compliance by using the revised Clinical ChartReview during monthly chart audit to assure that the major sudden change ofcondition shall be immediately captured by collecting appropriate SCIC OASIS ina timely manner, and wounds are properly documented on the SN note page 2**.** Disseminationof information regarding the revised forms completed on 01-30-2025.	
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	G0570	On01-10-2025, the Clinical Manager called for an emergency meeting of all Staff, andprovided an in-service regarding the Policy and Procedure on Admission Policy ***(exhibit#31)***and Coordination of Client Care ***(exhibit #6)***. The AdmissionPolicy states that	2025-01-30

	residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review, and interview, the agency failed to ensure: the needs of the patient were met (See G0570); the plan of care was reviewed by the physician, individualized and followed by all agency staff (See G0572); the plan of care included all required information / elements for the treatment of the patient (See G0574); all treatments provided by agency staff were ordered by a physician (See G0580); physicians were promptly notified of a change in the patient's condition (See G0590); the agency failed to evidence coordination of care for all services provided to the patient (See G0606). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care. A deficient practice citation was also evidenced at this standard as		clients are accepted for treatment in the home on the basisof reasonable criteria and under the expectation that the client's medical,nursing, and social needs can be met adequately by the Agency in the client'splace of residence. Special instructions#3 states that Services for a clientreceiving Skilled Nursing, Therapy, or Home Health Aide services must follow awritten Plan of treatment established and periodically reviewed by a doctor ofmedicine, osteopathy, or podiatric medicine. The written Plan of treatmentshall be reviewed at least every 60 days by that physician or their designee;and #5 states that reasonable expectation shall consider whether the agency'spersonnel and resources are adequate and suitable for providing the servicesthe client requires, the attitudes of client/caregiver toward care at home, thebenefits of care at home as compared to care in a hospital, extended carefacility or alternate setting, whether the physical facilities in the client'shome are adequate for giving the client proper care. Coordination of CarePolicy	

	follows: Based on record review and interview, the agency failed to provide services to meet the assessed needs of the patient in 1 of 1 active patient with wounds. (Patient #3) The findings include:		states that All personnel furnishing services shall maintain a liaisonto assure that their efforts are coordinated effectively and support theobjectives outlined in the Plan of treatment. This may be done through formalcare conferences; maintaining complete, current Treatment plans; and writtenand verbal interaction. Special instructions #5 states that when multiple disciplines are involved and/or whenclients have needs that require on-going services or cannot be met by theagency, a discharge care conference shall be conducted when necessary. Theconference will review the client's discharge potential, determine theappropriateness of continuing services, and develop a discharge plan. Thedischarge plan shall include written/verbal instruction regarding ongoing careneeds and information about resources available. For patient #3, at the time of admission, PCGstated that patient was supposed to be transferred to the nursing home butpatient strongly disagrees staying at the long-term care facility. He insistedhe be	

	A clinical record review for Patient #3 evidenced a SOC comprehensive assessment dated 12/11/2024 completed by RN 2 which indicated the patient's primary payor source was traidional Medicare, was bedbound and unable to reposition self, had a history of falls and was at a high risk for falls, forgetful, had impaired judgment, received coumadin therapy (a medication to thin the blood to treat/prevent blood clots), was dependent for personal care, feeding, and medication administration, required thickened liquids due to difficulty swallowing, incontinent of bowel and bladder, had pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (some skin loss or damage involving the top-most skin layers) to the right and left buttocks, and lived alone. The skilled nurse visit note completed by RN 2 dated 12/20/2024 indicated the patient laid in soiled briefs all night and there was no caregiver available after the evening caregiver left. RN 2 indicated the patient's buttocks		discharged home instead. Services the agency is able to offer werediscussed with the patient and PCG at the time of referral. During the SOC, andpatient was only agreeable for: SN and PT and reiterated wants the samevisiting personnel, declined any other services offered him as documented inthe SOC OASIS page 28-29 ***(exhibit #32 a-b)*** and as documented byRN2 during the SOC signed by the patient in agreement on the Statement ofPatient Financial Liability ***(exhibit #33)***, same copieshas been presented and provided to surveyors during the survey. The need formore hours of care from Amada Senior Care was also discussed during SOC. As amatter of fact, PCG claimed during the admission that she has already forwardeda request to Amada Senior Care providing caregivers for a possible increase inthe number of hours as documented by RN2 on the OASIS page 29 ***(exhibit #34)***.Patient and PCG are aware of the risk of him being left alone at night that iswhy a camera was installed to monitor patient 24/7, and PCG is available 24/7to provide	

	were reddened from laying in soaked briefs all night and the patient required maximum assistance to use the urinal comfortably. The skilled nurse visit completed by RN 2 dated 12/27/2024 indicated the patient needed to have a Texas catheter (an external tube held in place with a plastic covering around the penis to drain urine from the body) or a foley catheter (an indwelling tube inserted into the bladder to drain urine from the body) to keep skin dry. On 01/09/2025, at 10:44 AM, the patient's primary caregiver indicated Entity F provided personal care services 4 hours in the morning and in the evening 7 days a week and indicated the patient needed care 24 hours a day, 7 days a week. The primary caregiver indicated the patient was left alone after the caregiver from Entity F left in the evenings and indicated there was a camera set-up on the patient that the primary caregiver had access to in order to monitor the patient. The record failed to evidence the agency provided services to meet the patient's needs to		assistance when its needed. Several attempts have been made for MSW evaluationvisit but patient continued to refuse as relayed by the PCG to the office. PCGwants approval from patient first before obtaining order for MSW from MD as documentedon 01-10-2025 ***(exhibit #35 a-c)***, and on 01-14-2025 ***(exhibit#36 a-b).*** Regarding RN recommendation for a Texas catheter, PCG stated wantsto discuss it first with the patient before obtaining an order from PCP, prefersthe PureWick external catheter. MD office was notified through Trillian ***(exhibit#37 a-b)*** regarding RN recommendation and patient preference. MD office.AS per MD office, patient does not qualify for a PureWick external catheterwhich was then communicated to RN and PCG, but MD office stated will continueto look for a possible medical supplier that would cover. The Clinical Chart Review form and SOCform- Admission / Initial Visit Checklist were revised and approved by the GB on01-24-2025 to include on the Admission / Initial Visit Checklist in item 11.b- Servicesoffered	

	include a referral to medical social work (MSW) services to assist the patient in acquiring additional services to meet the patient's needs and failed to evidence additional documentation regarding the assessed need for a catheter. The agency failed to inform the physician of the patient's assessed needs for which care was not provided and failed to provide patient/caregiver education to the risks of being left unattended. On 01/09/2025, at 10:59 AM, RN 2 indicated the patient was not referred to MSW services and MSW services "would not hurt." RN 2 indicated the CM was supposed to follow-up with the physician regarding the Texas or foley catheter. On 01/09/2024, at 12:20 PM, the CM indicated the agency's services included MSW but had not referred the patient for MSW services and there was no communication with the physician regarding the assessed need for a catheter. The CM indicated the patient should be in a skilled nursing facility or in hospice care.		and consented by patient and/or all disciplines to provide carenotified ***(exhibit #38)***, and Clinical Chart Review form to includeA.3- Admission / Initial Visit Checklist completed and signed ***(exhibit #39)***. Itwill be the responsibility of the admitting personnel to fill up and completethe Admission / Initial Visit Checklist signed and date when completed, andwill be submitted together with the rest of the SOC documents. The Clinical Managershall be responsible in monitoring compliance by using the revised ClinicalChart Review form during initial chart audit and monthly thereafter. Disseminationof information regarding the revised forms completed on 01-30-2025.	

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. Based on record review and interview the agency failed to ensure each patient received the home health services that are written in the individualized plan of care that identifies patient-specific measurable outcomes and goals in 6 of 6 active clinical records reviewed (Patients #1, 2, 3, 4, 5, and 8). Findings include: # The clinical record for Patient #1 included an initial POC dated 11/1/2024 to 12/30/2024 indicating RN visits ordered once every other day for 2 visits then once a week for eight weeks and PT to evaluate and	G0572	On 01-10-2025, the Clinical Manager called foran emergency meeting of all Staff, and provided an in-service regarding thePolicy and Procedure on Plan of Treatment ***(exhibit #8),*** WoundCare Policy ***(exhibit #27)***, Physician Orders ***(exhibit #40)***,and Policy and Procedure on Coordination of Client Services ***(exhibit #6).*** Discussed the Planof Treatment Policy, emphasized that the Plan of treatment is based on acomprehensive assessment and information provided by the client/family andhealth team members. Planning for treatment is a dynamic process that addressesthe care, treatment and services to be provided. Special Instructions were discussedan individualized Plan of treatment should be signed by a physician with thefollowing items: all pertinent diagnoses with onset dates, mental status, frequencyand duration of all visits/services, specific procedures and modalities fortherapy services, diagnostic tests including laboratory and x-rays,	2025-01-30

	plan of treatment signed by PT 1 on 11/5/2024 failed to evidence dates of care and indicated PT services were twice a week for eight weeks. The clinical record included the subsequent POC dated 12/31/2024 to 2/28/2025 that indicated services were RN visits once a week for 9 weeks and PT to evaluate and treat. The home health POC failed to evidence PT frequencies and treatments. The clinical record revealed PT missed visit documentation on 11/29/2024, 12/7/2024, and 12/24/2024, documented by PT 1 and each missed visit was documented as patient requested. The clinical record failed to evidence attempts to reschedule PT visits for each missed visit nor attempts to schedule PT 2. During an interview on 1/9/2025 at 9:50 AM, PT 1 relayed the missed visit on 12/24/2024 was due to the holiday and he couldn't find another time in his schedule to reschedule Patient. PT revealed the missed visits on 11/29/2024 and 12/7/2024 were due to working around Patient's caregivers and he couldn't find another time in his schedule to		surgicalprocedure(s), prognosis, rehabilitation potential, functional limitations andprecautions, activities permitted, specific dietary/nutritional requirements orrestrictions, medications, treatments, and procedures, medical supplies andequipment, safety measures & precautions-infection control, instructionsto client/caregiver, as applicable, treatment goals, instructions for timelydischarge or referral, discharge plans, name and address of client's physician,and other items such as disaster and emergency preparedness/plan. Discussed the Wound Care Policy that wasrevised and approved by the Governing Body on 01-10-2025. Emphasized during thein-service proper documentationof wounds should include measurement using disposable paper rules and sterilecotton-tip applicators to include length x width x depth, undermining, tunneling,and including description of wound bed, surrounding area, drainage, slough,color, odor, bone/muscle exposure, eschar, or any other observations to clearlydescribe	

	reschedule Patient visits. During an interview on 1/8/2024 beginning at 9:50 AM, Administrator revealed the electronic medical record creates separate plans of care for each service. During an interview on 1/9/2024 at 3:40 PM, Administrator relayed PT 2 was not contacted in efforts to cover missed visits by PT 1. # The clinical record for Patient #2 included an initial POC dated 10/23/2024 to 12/21/2024 indicating RN visits once a week for nine weeks and two extra visits if needed and PT to evaluate and treat Patient. A separate PT plan of treatment signed by PT 1 on 10/30/2024 failed to evidence dates of care and indicated PT services were once a week for one week then twice a week for eight weeks. A second PT plan of treatment signed by PT 1 on 12/23/2024 indicated PT services twice a week for eight weeks. The home health POC failed to evidence PT frequencies and treatments. The clinical record revealed PT missed visit documentation on 11/8/2024, 11/29/2024,		the wound. In-serviceincluded discussion of the policy on Physician Orders states that allmedications, treatments and services provided to clients must be ordered by aphysician. The orders may be initiated via telephone or in writing and must becountersigned by the physician in a timely manner. All verbal orders will beaccepted only from physicians who have a current license and must be “readback” to the physician to verify the accuracy of the orders and to decreaseerrors to inaccurate documentation of verbal orders. If agency staff obtainverbal/telephone orders from the physician, they must inform the supervisingnurse/therapist of the change. The registered nurse or therapist responsiblefor furnishing or supervising the ordered service will co-sign the telephone orderform before it is sent to the physician. Orders can be initiated once thesupervising nurse/therapist has been notified. ForPatient #3, SOC order dated	

	12/7/2024, 12/13/2024, and 12/27/2024, documented by PT 1 and each missed visit was documented as patient requested. The clinical record failed to evidence attempts to reschedule PT visits for each missed visit nor attempts to schedule PT 2. During an interview at a home visit on 1/8/2025 beginning at 11:50 AM, Other C, a spouse and primary caregiver for Patient #2, indicated only one PT appointment was requested to be changed on 12/27/24 and it was cancelled because PT couldn't reschedule. During an interview on 1/8/2024 beginning at 9:50 AM, Administrator revealed the electronic medical record creates separate plans of care for each service. During an interview on 1/9/2024 at 3:40 PM, Administrator relayed PT 2 was not contacted in efforts to cover missed visits by PT 1. During an interview on 1/9/2025 beginning at 9:50 AM, PT 1 revealed that he had called Patient to notify them that he felt ill and the Patient canceled therefore the missed visit was		RN 2 documented on herSOC notes on Oasis page 29 ***(exhibit #41)*** that MD was notified on12-11-2024 regarding the SOC visit findings and need for SN and PT. The POC/485-page11 MD certified that he authorized the above services and will be providedunder the established plan of treatment (referring to the pages 1-10 of thePOC/485) that he approved and which will be reviewed periodically ***(exhibit#42).*** Completed Plan of treatment was sent to the physician on12-13-2024, 2 days after the admission. As per conversation on Trillian, notificationsent to Trillian on 12-10-2024 ***(exhibit #43 a-c)*** that patient isbeing discharged from the hospital and intends to be readmitted under theagency care, and new medication profile sent to MD after coordinating regardinghis new medication list. As per SOC notes, SOC OASIS page 29 indicated sheprovided teachings on pain management to mitigate pain both non-pharmacologicallyand pharmacologically ***(exhibit #44).*** As per agency, a separateform Entitled Physical Therapy Evaluation Plan of	

	documented 'per patient request'; PT could not recall dates he was ill. # The clinical record for Patient #8 revealed a POC dated 11/19/2024 to 1/17/2025 that included RN visits once a week for 9 weeks with 2 visits that can be done as needed, HHA services once a week for one week then twice a week for eight weeks, and PT to evaluate and treat Patient. A separate PT plan of treatment signed by PT 1 on 11/26/2025 failed to evidence dates of care and indicated PT services were once a week for eight weeks. The home health POC failed to evidence PT frequencies and treatments. The clinical record revealed a PT missed visit on 12/6/2024 per patient request, resulting in no PT services the week of 12/2/2024 and a HHA missed visit on 12/25/2024 per patient request with no other scheduled HHA visits that week, resulting in no HHA service visits the week of 12/23/2024. The clinical record failed to evidence attempts to reschedule PT visits and HHA missed visit and failed to evidence a second HHA scheduled visit the week of		Treatment is completed duringPT initial visit with the frequency and duration of visits, treatmentmodalities, short term and long- term goals including documentation of carecoordination with patient/PCG, all disciplines involved and the Physician ***(exhibit#45 a-b)*** TheClinical Chart Review Form ***(exhibit 46 a-b)#***was revised andapproved by the GB on 01-24-2025 to include the following items B.1- 485/ POCproofread-complete/correct prior to MD approval/sign, itemC.1- Read back, signed & dated by the one who received the telephone order,C.2- Signed, dated by MD, and should be strictly implemented, C.3- SOC/Recertorders: w/ treatments/services/frequency/ duration, item F.8- Care coordinationdone RE: change in condition/ POC, abnormal Vital signs, item F.10- WoundAssessment/measurement/care specified- on SN note, and item G.4- Significantfindings recorded/Coordinated-SN abnormal VS TheClinical Manager/QA will be	

	12/23/2024. During an interview on 1/8/2025 at 8:06 AM, HHA 1 relayed she was on vacation and unavailable from 12/20/2024 to 12/30/2024 and the Administrator was aware weeks ahead. During an interview on 1/9/2025 at 12:10 PM, Patient #8 relayed that only one PT visit was missed on 12/6/2024 and it was because of a physician's appointment and PT couldn't reschedule. During an interview on 1/9/2025 at 11:55 AM, Other A, a primary caregiver and family member of Patient #8, relayed PT started the day they were supposed to and the only missed visit was for an appointment. 410 IAC 17-13-1(a) 1. An undated policy titled "Wound Care Policy" indicated wounds should be assessed weekly and include measurements of length, width, and depth and description of wound. 2. A clinical record review for		responsible in monitoring to assure complianceusing the revised Clinical Chart Review form during initial chart audit, and monthlychart audit thereafter. Policy and Procedure on Coordination ofClient Services ***(exhibit #6)*** was discussed; emphasized regardingthe purpose of care coordination of client services to ensure services arecoordinated between members of the interdisciplinary team effectively as well as special instructions #7which states that The primary care Nurse or Therapist will assumeresponsibility for updating/ changing the Treatment plan and communicatingchanges to caregivers within 24 hours following the conference or changes. Thephysician will be contacted when his/her approval for that change is necessaryand to alert physician to changes in client condition. Active records will bereviewed on an ongoing basis by the Nursing Supervisor or designated RegisteredNurse/Therapist. In-services discussed Policy and Procedure on Service on Hold	

	Patient #3 evidenced a document titled "Physician Telephone/Verbal Order" dated 12/11/2024 and signed by RN 2 which was identified as the SOC orders from the physician indicating skilled nursing was to provide a skilled assessment and patient education and indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (some skin loss or damage involving the top-most skin layers) to the right and left buttocks. The POC for the initial certification period 12/11/2024-02/08/2025 signed by RN 2 indicated skilled nursing and PT orders to include wound care. The POC indicated the skilled nurse was to provide instruction on non-pharmacological interventions on pain management and provide an assessment of the skin. On 01/09/2024, at 10:59 AM, RN 2 indicated she wrote the SOC orders and developed the POC which were sent to the physician for review and signature, but there was no communication with the		***(exhibit#7)*** were discussed. emphasized special instruction #1which states thatwhen services are suspended the Clinical manager or designee will place theservices "on hold" with a reason identified which will be included in themissed visit report. Missed Visit Report Form was revised ***(exhibit #47)***to include expected consequences of the missed visit and emphasized that if amissed visit is anticipated to report to the clinical manager, office oron-call phone any time 24/7. If patient agrees a substitute will be assigned ina timely manner. It was also discussed possible strategies to prevent a missvisit by: scheduling visits early part of the week, and to as much as possiblesave Friday and Saturday of each week to give time to cover for all missedvisits incurred during the week to avoid missed visits; another remediation isto offer a substitute but office has to be notified immediately to give ample timefor the Clinical Manager to reassign patient for the week. The Electronic Health Record	

	physician's office to receive or verify verbal SOC orders or review the POC. On 01/09/2024, at 12:56 PM, the CM indicated the POC was not sent to the physician for signature until 12/13/2024. The CM indicated there was no documentation the agency contacted the physician to review the POC. The SOC comprehensive assessment dated 12/11/2024 and completed by RN 2 indicated the patient's reported pain was 7 on a scale of 0-10 and failed to evidence RN 2 provided education on non-pharmacological pain management per the POC. On 01/09/2025, at 11:59 AM, the CM indicated there was no documentation the RN provided non-pharmacological pain management education. A skilled nurse visit note completed by RN 2 and dated 12/27/2024 indicated the patient had a deep tissue injury (a type of pressure ulcer causing damage to soft tissue) to the right great toe and failed to evidence an assessment of the		provider was requested therevision of the missed visit report form, waiting for the completion of therevision of the forms in their system. On 01-24-2025, the Clinical Manager contacted allpatients and their representatives/surrogates via phone and discussed thatmissed visits are not tolerated by the agency, and available substitutes areavailable in case the visiting staff is not available. Disseminationof information regarding the revised forms completed on 01-30-2025. It will be the responsibility of the Clinical Managerto ensure that all staff are required to discuss the expected consequences of amissed visit, and all patients and/or representative understand the effects andconsequences of a missed visit to patient care, goals and the plan of treatmentby properly filling out/ completing the revised missed visit form. It shall bethe responsibility of the Clinical Manager to monitor compliance by utilizingthe revised Clinical	

	measurements and appearance. On 01/09/2025, at 12:16 PM, the CM indicated there was not any assessment documented of the deep tissue injury. 3. A clinical record review for Patient #4 evidenced a plan of care for certification period 11/09/2024-1/07/2025 which indicated the agency was to notify the physician for a heart rate less than 60 beats per minute (bpm) and the agency was to provide HHA services 2 times a week for 8 weeks. The clinical record review failed to evidence the agency provided HHA services the week of 12/22/2024.		Chart Review Form during initial chart audit and monthlythereafter.	

	HHA visit notes completed by HHA 1 indicated the heart rate was 56 bpm on 12/07/2024, 57 bpm on 12/31/2024, and 58 bpm on 12/10/2024 and 12/19/2024 and failed to evidence the physician was notified of the heart rate less than 60 bpm. A skilled nurse visit completed by RN 1 and dated 01/03/2025 indicated the heart rate was 59 bpm and failed to indicate the physician was notified. On 1/09/2025, at 3:20 PM, the CM indicated the agency did not notify the physician of the heart rate less than 60 bpm. 4. A clinical record review for Patient #5 evidenced a POC for the recertification period 09/22/2024-11/20/2024 signed by RN 2 which indicated the agency was to provide PT services 2 times a week for 8 weeks and nursing 1 times a week for 8 weeks. The record failed to evidence the agency developed the POC with the physician as the POC. On 01/09/2025, at 10:30 AM, PT 1 indicated he did not call the physician to review the plan of			

	would send the PT re-evaluation and POC to the physician for review and signature. On 01/09/2025, at 10:59 AM, RN 2 indicated she did not speak to the physician to review the POC but rather called and left a message with someone at the physician's office and did not receive a call back confirming the continuation of home health care orders.			
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	On 01-10-2025, the Clinical Manager called foran emergency meeting of all Staff, and provided an in-serviceregarding the Policy and Procedure on Plan of treatment ***(exhibit#8)***, and the policy on Coordination of ClientServices ***(exhibit#6)***. Discussedthe Plan of Treatment Policy; emphasized that the Plan of treatment is based ona comprehensive assessment and information provided by the client/family andhealth team members. Planning for treatment is a dynamic process that addressesthe care, treatment and services to be provided. Special Instructions discussedand emphasized that	2025-01-30

	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, clinical record review, and interview, the agency failed to ensure the plan of care included all services provided to the patient in 3 of 6 active clinical records reviewed. (Patient #1, 3, 4) The findings include: #The clinical record for Patient #1 revealed an initial comprehensive assessment, completed on 11/1/2024 by Administrator and an initial POC dated 11/1/2024 to 12/30/2024 that was signed by the physician on 11/21/2024. The comprehensive assessment documentation included a notation that Patient received assistance from paid caregivers seven days a week from 8:00 AM to 11:00 AM and 4:00 PM to 7:00 PM. The plans of care failed to evidence the services		an Plan of treatment should be individualized andpatient-centered duly signed by a physician with the following items: The individualized plan of care must includethe following: all pertinentdiagnoses, mental, psychosocial, and cognitive status, types of services, supplies, and equipment required, frequency and duration of visits to be made, prognosis, rehabilitation potential,functional limitations, activitiespermitted, nutritional requirements,all medications and treatments, safety measuresto protect againstinjury, description of thepatient's risk for emergency department visits and hospital re-admission, andall necessary interventions to address the underlying risk factors,patient and caregiver education and trainingto facilitate timely discharge, patient-specific interventions andeducation; measurable outcomes and goals identified by the HHA andthe patient, information related to any advanceddirectives, and any additional itemsthe HHA and/orphysician/allowed practitioner may choose to	

	provided to Patient by Entity B nor the frequency and hours. During an interview on 1/9/2025 at 1:45 PM, Other E, director of Entity B, relayed Patient receives personal care from staff daily that included transferring Patient with a lift into a wheelchair, bathing, dressing, grooming, cleaning and meal preparation with set care hours. 1. During an observation of care at the home of Patient #4 on 1/07/2025, at 3:46 PM, RN 1 stuck the patient's right index finger with a lancet (sharp needle used to draw blood to check blood sugar) and obtained a blood sample. On 01/07/2024, at 3:37 PM, RN 1 indicated the patient was not able to be weighed due to the patient's inability to stand but the POC had to include the intervention related to the patient's weight due to the patient's diagnosis causing edema (swelling). A clinical record review evidenced skilled nurse visit notes completed by RN 1 dated 11/13/2024, 11/18/2024,		include. Educatedon the Policy on Coordination of Client Services. Discussed that all personnelfurnishing services shall maintain a liaison to assure that their efforts arecoordinated effectively and support the objectives outlined in the Plan oftreatment with interaction both written and verbal should be well documented inthe client's electronic health record to assure a current/updated treatmentplan. Special instructions discussed, and state that interdisciplinary careconferences shall be conducted as often as necessary to respond to changes inthe client's needs, services, care, or goals. Emphasizedthat when developing a POC/485, make sure that it is unique/individualized andpatient-centered when it comes to physical assessment, treatments,instructions/teachings provided to patient and caregivers, coordination of careto other entities providing	

	12/09/2024, and 12/23/2024 indicated the RN checked the patient's blood sugar. The POC for certification period 11/09/2024-01/07/2025 failed to evidence the skilled nursing interventions included obtaining the patient's blood sugar. The POC indicated the patient's diagnoses included pulmonary fibrosis (scarring of the lungs which can cause fluid retention and causing swelling of the lower limbs in particular) and indicated the agency should notify the physician of a weight gain of more than 5 pounds in a week or more than 2 pounds in a day. On 01/09/2025, beginning at 3:27 PM, the CM indicated the POC did not include check blood sugar for skilled nursing interventions. The CM indicated the POC was not individualized if the patient was unable to stand to obtain weight and should have included a thigh measurement for the monitoring of edema instead. 2. A clinical record review for Patient #3 evidenced a POC for an initial certification period of 12/11/2024-02/08/2025 which indicated the skilled nurse		care should be more specific by including the typeof service being provided with frequency not just documented on the OASIS as theagency does but also should be also be included in detail in the plan oftreatment as pointed out by the surveyors. The Clinical ChartReview form was revised and approved by the Governing Body on 01-24-2025 toinclude item B.1-485/ POC proofread-complete/correct prior to MDapproval/sign, and item B.9- POC- individualized, patient centered & goaldirected ***(exhibit #48)***. Disseminationof information regarding the revised forms completed on 01-30-2025. It shall be the responsibility of the ClinicalManager to ensure compliance by utilizing the revised Clinical Chart ReviewForm during initial chart review and monthly thereafter.	

	would coordinate care with the paid help. The skilled nurse visit note completed by RN 2 dated 12/20/2024 indicated she spoke with the patient's primary caregiver urging the primary caregiver to speak to Entity F about providing additional services. The POC failed to evidence the agency and type and frequency of services to be provided to the patient. On 01/09/2025, at 10:44 AM, the patient's primary caregiver indicated Entity F provided personal care services 4 hours in the morning and in the evening 7 days a week for bathing, personal care, feeding, and transferring. On 01/09/2025, at 11:55 AM, the CM indicated the POC did not include the agency through which the personal care services were provided and the type and frequency of services provided.			
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.	G0580	Theclinical manager called for an emergency meeting of all Staff on 01-10-2025,and provided an in-service regarding the Policy and Procedure on MedicalSupervision ***(exhibit***	2025-01-30

	Based on record review and interviews, the agency failed to ensure services and treatments were administered only as ordered by a physician in 5 of 6 active clinical records reviewed (Patients #1, 2, 3, 5, 8). Findings include: # The agency policy titled "Physician Orders" indicated all medications, treatments and services for patients would be ordered by a physician. Verbal orders may be taken in accordance State and Federal laws and be read back to the physician to verify the accuracy of the orders. # During an interview on 1/8/2025 beginning at 9:50 AM, Administrator relayed that after the initial comprehensive assessment for Patient #2, a physician verbal order was created and sent to the physician to be signed as orders for care. Administrator relayed that the physician was not consulted for the documentation on the verbal order. The clinical record for Patient #1 revealed an initial comprehensive assessment, completed on 11/1/2024 by		***#49)***, Physician Orders ***(exhibit #40)***,the policy on Plan of Treatment ***(exhibit #8),*** and the Admission Policy***(exhibit #26).*** The policy entitled Medical Supervision states Physicianswill be informed, at the time their clients are admitted to the agency managingclient care. A Plan of treatment is developed for each client at the time ofadmission and signed by the physician within an appropriate time frame, andprimary physician shall be responsible for providing signed orders, and forestablishing and reviewing the client's Plan of treatment throughout the timethe client is receiving services. Thepolicy Physician Order states that all medications, treatments and servicesprovided to clients must be ordered by a physician, including the wound careand no other products should be used unless ordered by the physician. Furthermore,the Admission Policy was also discussed. It states that Clients are acceptedfor treatment in the home on the basis of reasonable criteria and under theexpectation that the client's	

	Administrator and an initial POC dated 11/1/2024 to 12/30/2024 and signed on 11/21/2024. The record included a verbal ordered dated 11/1/2024 for a comprehensive assessment, RN visits once a week for 9 weeks plus two extra visits as needed with specified assessments, and PT to evaluate and treat patient; the verbal order dated 11/1/2025 was signed by a physician on 11/19/2024. RN visits were documented 11/1/2024, 11/4/2024, and 11/14/2024 and PT visits were documented on 11/5/2024, 11/8/2024, 11/12/2024, and 11/15/2024. The clinical record failed to evidence an appropriate order for care prior to the physician signing and acknowledging the care orders on 11/19/2024.		medical, nursing, and social needs can be metadequately by Agency in the client's place of residence. Therefore, it is amust that services available for the patient should be presented as early asreferral period, and services the agency cannot provide. Emphasized during the discussion is the special#10- Agency services must be appropriate and available to meet the specificneeds and requests of the client and caregiver. Policy pertaining to Plan of Treatmentdiscussed. Emphasized during this in-service that Plan of treatment/485 shouldbe developed following the initial assessment and the original will be sent tothe physician for signature. The written plan of treatment must be signed bythe physician and returned to the agency. A copy of the Plan of treatment shallbe maintained within the client's clinical record until the original Plan oftreatment is signed dated and returned by the MD. Inthe case of patient # 3, POC dated 12-11-2024 to 02-08-2025 signed by	

	# During an interview on 1/8/2025 beginning at 11:15 AM, RN 2 relayed that after the initial comprehensive assessment for Patient #2, a physician verbal order was created and sent to the physician to be signed as orders for care. RN 2 relayed that the physician was not consulted for the documentation on the verbal order.		thephysician 3 days after the SOC on 12-14-2024 ***(exhibit #50)*** indicatedthat foam dressing is supposed to be used for the pressure ulcers as listed inthe medication list POC page 2 ***(exhibit #51)***, as indicated in thePOC SN treatment page 5 ***(exhibit #52)***, and as included in themedication list ***(exhibit #53)*** sent to MD together with theAdmission order ***(exhibit #54 a-d)*** the same wound care identifiedin the SOC OASIS page 29 ***(exhibit #55***), and same medicationupdate that MD was notified and acknowledge via Trillian app dated 12-12-2024 ***(exhibit#56***). These were the same documents provided to the surveyors duringthe survey. ForPatient #5, dates of receipts were tagged by mistake. The recertificationreferred to as POC signed on 12-02-2024 is for the episode 11-21-2024 to01-19-2025 ***(exhibit #57)*** not the episode for 09-22-2024 to11-20-2024 that was tagged this episode referred to as it was signed and datedby MD on 09-25-2025 received same day	

	The clinical record for Patient #2 revealed an initial assessment completed 10/23/2024 by RN 2. A verbal order dated 10/23/2024 for a comprehensive assessment, RN services once a week for nine weeks plus two visits if needed, with specified assessments and evaluations to be provided to Patient; the verbal order included PT services to evaluate and treat. The verbal order was signed by the physician 11/8/2024. RN visits were documented on 11/1/2024 and 11/6/2024 with PT documentation on 10/30/2024 and 11/6/2024. The clinical record failed to evidence an appropriate order for care prior to the physician signing and acknowledging the care orders on 11/8/2024.		and replaced as soon as the signed copy of the plan of treatment isreceived. Inthe case of patient #1 with admission date of 11-01-2024, there was an initialorder received by the office to Evaluate/admit patient to the agency on11-01-2024 at 9:30 AM ***(exhibit #59)*** sent the same day signed anddated by MD on 11-05-2024, and upon completion of the admission process afollow up SOC/admission ordered same day,11-01-2024 at 12:35 PM ***(exhibit#60 a-d)*** with her signature, and subsequently sent back to the agencysigned and dated by MD on 11-19-2024. The same order referred to on SOC OASISpage 29 ***(exhibit 61)***, Inthe case of patient #8, on 11-19-2024 a referral was made by her new PCP andsent on 11-19-2024 at 9:54 AM medical records of the patient ***(exhibit #62a-i).*** PCP was called back at 10:33 AM and confirmed referral of thepatient for evaluation and for possible	

	# During an interview on 1/8/2025 beginning at 11:15 AM, RN 2 relayed that after the initial comprehensive assessment for Patient #8, a physician verbal order was created and sent to the physician to be signed as orders for care. RN 2 relayed that the physician was not consulted for the documentation on the verbal order. The clinical record for Patient #8 revealed an initial assessment completed 11/19/2024 by RN 2. A verbal order dated 11/19/2024 for a comprehensive assessment, RN services once a week for nine weeks plus two visits if needed, with specified assessments and evaluations to be provided to Patient, PT services to evaluate and treat, and an HHA once a week for one week then twice a week for eight weeks. The verbal order was signed by the physician 11/26/2024. An RN comprehensive assessment was documented on 11/19/2024 and HHA service documentation was completed on 11/22/2024 and 11/25/2024. The clinical record failed to evidence an appropriate order for care prior to the physician		admission order that was sent same dayfor signature. After 2 days, MD signed and dated the order, 11-21-2024 sentback to the agency on 11-22-2024 ***(exhibit #63 a-b)***. Aftercompletion of the referral, admitting RN was notified, and immediatelyscheduled her for evaluation for home health services. After completion of theadmission process, MD medication list from PCP progress notes dated 11-12-2024reconciled and found to be the same as home medications, an updated medicationlist ***(exhibit #64 a-b)*** bearing the medication changes on11-12-2024, MD was notified regarding the admission, medication reviewed and completed***(exhibit #65 a-b)*** the admission process with an order dated11-19-2024 signed 4:25 PM along with the medication profile of the patient witha creation date of 11-19-2024, sent back signed and dated on 11-26-2024 ***(exhibit#66 a-d)***. Inall cases of referrals received, it is the practice of the agency toimmediately contact the	

	signing and acknowledging the care orders on 11/26/2024. 410 IAC 17-13-1(a) 1. A clinical record review for Patient #3 evidenced a document titled "Physician Telephone/Verbal Order" dated 12/11/2024 and signed by RN 2 which was identified as the SOC orders indicating skilled nursing was to provide a skilled assessment and patient education and indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (some skin loss or damage involving the top-most skin layers) to the right and left buttocks but failed to include wound care orders. The SOC assessment completed by RN 2 and dated 12/11/2024 indicated the RN provided wound care to include a foam dressing to the pressure ulcers on the left and right buttocks. On 01/09/2024, at 10:59 AM, RN 2 indicated she was not aware the SOC orders did not include a foam dressing for wound care. RN 2 indicated she applied a foam dressing to the		patient and/or their caregiver to notify about thereferral. Permission and approval are solicited so the rest of the informationneeded in the revised Referral Form ***(exhibit 67)*** are completedwith the help/assistance of the patient and/or the caregiver, and right thereand then, services that the agency are able to provide are presented to them tofacilitate the assignment of the new patient to admitting personnel, andfacilitate admission process. TheAdmission/Initial Visit Checklist, the Clinical Chart Review Form, and theReferral Form were revised and approved by the Governing Body on 01-24-2025.The Admission/Initial Visit Checklist revised to include item #5- After SOC, developed a POT/485 andMedication Profile completed with patient &/ or representative, read backand sent to MD to MD for signature ***(exhibit #68)***. Clinical ChartReview Form revised to include Item A.2- Referral Form fill out completely bythe by the in-take nurse, item B.3- Medication list complete, w/PRN use &atpar w/DX- as ordered by MD, item C.2-	

	buttocks per the request of the caregiver since that is what was in the patient's home. RN 2 indicated she wrote the SOC orders which were sent to the physician for review and signature, but there was no communication with the physician's office to receive or verify verbal SOC orders. On 01/09/2024, at 12:56 PM, the CM indicated there was no order for wound care on the SOC order but was added to the POC which was not sent to the physician for signature until 12/13/2024. The CM indicated there was no documentation the agency contacted the physician for SOC orders. The POC for the initial certification period of 12/11/2024-02/08/2025 which indicated the patient had pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (some skin loss or damage involving the top-most skin layers) to the right and left buttocks requiring a foam dressing every 3 days. A skilled nurse visit note completed by RN 2 and dated 12/27/2024		Signed, dated by MD, and should bestrictly implemented, and item E.1-Medication/dose/route/frequency/ PRN usereconciled w/ patient & MD ***(exhibit #69)***. Referral Form wasrevised to include assistance provided by the caregiver, and other entitiesproviding care, type of services being provided, frequency and duration ***(exhibit#70)***. Disseminationof information regarding the revised forms completed on 01-30-2025. It shall be the responsibility of the In-takenurse to fill out and make sure it is completed at the time or referral tofacilitate admission. The Admitting Staff shall make sure the revisedAdmission/Initial Visit Checklist shall be completed and submitted immediatelyto facilitate the POC signed by MD. The Clinical Manager/QA will be responsiblefor monitoring to ensure compliance utilizing the revised Clinical Chart ReviewForm during the initial chart audit of the new patient.	

	indicated the RN applied a duoderm (an occlusive wound dressing that forms a gel-like substance over the wound) to the wounds on both buttocks. The clinical record failed to evidence a physician order for the douderm. On 01/09/2025, at 10:59 PM, RN 2 indicated she did not obtain a physician order for the duoderm and thought the CM called the physician to get the order. On 01/09/2025, at 12:16 PM, the CM indicated there was not a physician order for the duoderm. 2. A clinical record review for Patient #5 evidenced a POC for the recertification period 09/22/2024-11/20/2024 signed by RN 2 and signed by the physician on 12/2/2024 which indicated the agency was to provide PT services 2 times a week for 8 weeks and nursing 1 times a week for 8 weeks. The record evidenced PT 1 and RN 2 both provided services on 11/26/2024 and failed to evidence the services were provided with a physician order			

	physician signing the POC on 12/2/2024 and signing the PT evaluation and treatment plan on 12/5/2024. On 01/09/2025, at 10:30 AM, PT 1 indicated he did not call the physician for orders but would send the PT re-evaluation and POC to the physician for review and signature. On 01/09/2025, at 10:59 AM, RN 2 indicated she did not speak to the physician to review the POC but rather called and left a message with someone at the physician's office and did not receive a call back confirming the continuation of home health care orders. 1. A clinical record review for Patient #3 evidenced a document titled "Physician Telephone/Verbal Order" dated 12/11/2024 and signed by RN 2 which was identified as the SOC orders indicating skilled nursing was to provide a skilled assessment and patient education and indicated the patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (some skin loss or			

	damage involving the top-most skin layers) to the right and left buttocks but failed to include wound care orders. The SOC assessment completed by RN 2 and dated 12/11/2024 indicated the RN provided wound care to include a foam dressing to the pressure ulcers on the left and right buttocks. On 01/09/2024, at 10:59 AM, RN 2 indicated she was not aware the SOC orders did not include a foam dressing for wound care. RN 2 indicated she applied a foam dressing to the buttocks per the request of the caregiver since that is what was in the patient's home. RN 2 indicated she wrote the SOC orders which were sent to the physician for review and signature, but there was no communication with the physician's office to receive or verify verbal SOC orders. On 01/09/2024, at 12:56 PM, the CM indicated there was no order for wound care on the SOC order; indicated it was added to the POC which was not sent to the physician, for signature, until 12/13/2024. The			

documentation the agency contacted the physician for SOC orders.

The POC for the initial certification period of 12/11/2024-02/08/2025 which indicated the patient had pressure ulcers (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (some skin loss or damage involving the top-most skin layers) to the right and left buttocks requiring a foam dressing every 3 days. A skilled nurse visit note completed by RN 2 and dated 12/27/2024 indicated the RN applied a duoderm (an occlusive wound dressing that forms a gel-like substance over the wound) to the wounds on both buttocks. The clinical record failed to evidence a physician order for the douderm.

On 01/09/2025, at 10:59 PM, RN 2 indicated she did not obtain a physician order for the duoderm and thought the CM called the physician to get the order.

On 01/09/2025, at 12:16 PM, the CM indicated there was not

	a physician order for the duoderm. 2. A clinical record review for Patient #5 evidenced a POC for the recertification period 09/22/2024-11/20/2024 signed by RN 2 and signed by the physician on 12/2/2024 which indicated the agency was to provide PT services 2 times a week for 8 weeks and nursing 1 times a week for 8 weeks. The record evidenced PT 1 and RN 2 both provided services on 11/26/2024 and failed to evidence the services were provided with a physician order by the PT and RN prior to the physician signing the POC on 12/2/2024 and signing the PT evaluation and treatment plan on 12/5/2024. On 01/09/2025, at 10:30 AM, PT 1 indicated he did not call the physician for orders but would send the PT re-evaluation and POC to the physician for review and signature. On 01/09/2025, at 10:59 AM, RN 2 indicated she did not speak to the physician to review the POC but rather called and left a message with someone at			

not receive a call back confirming the continuation of home health care orders.

3. During an interview on 1/8/2025 beginning at 9:50 AM, Administrator relayed that after the initial comprehensive assessment for Patient #2, a physician verbal order was created and sent to the physician to be signed as orders for care. Administrator relayed that the physician was not consulted for the documentation on the verbal order.

4. The clinical record for Patient #1 revealed an initial comprehensive assessment, completed on 11/1/2024 by Administrator and an initial POC dated 11/1/2024 to 12/30/2024 and signed on 11/21/2024. The record included a verbal ordered dated 11/1/2024 for a comprehensive assessment, RN visits once a week for 9 weeks plus two extra visits as needed with specified assessments, and PT to evaluate and treat patient; the verbal order dated 11/1/2025 was signed by a physician on 11/19/2024. RN visits were documented

	11/14/2024 and PT visits were documented on 11/5/2024, 11/8/2024, 11/12/2024, and 11/15/2024. The clinical record failed to evidence an appropriate order for care prior to the physician signing and acknowledging the care orders on 11/19/2024. 5. During an interview on 1/8/2025 beginning at 11:15 AM, RN 2 relayed that after the initial comprehensive assessment for Patient #2, a physician verbal order was created and sent to the physician to be signed as orders for care. RN 2 relayed that the physician was not consulted for the documentation on the verbal order. The clinical record for Patient #2 revealed an initial assessment completed 10/23/2024 by RN 2. A verbal order dated 10/23/2024 for a comprehensive assessment, RN services once a week for nine weeks plus two visits if needed, with specified assessments and evaluations to be provided to Patient; the verbal order included PT services to evaluate and treat. The verbal order was			

	11/8/2024. RN visits were documented on 11/1/2024 and 11/6/2024 with PT documentation on 10/30/2024 and 11/6/2024. The clinical record failed to evidence an appropriate order for care prior to the physician signing and acknowledging the care orders on 11/8/2024. 6. During an interview on 1/8/2025 beginning at 11:15 AM, RN 2 relayed that after the initial comprehensive assessment for Patient #8, a physician verbal order was created and sent to the physician to be signed as orders for care. RN 2 relayed that the physician was not consulted for the documentation on the verbal order. The clinical record for Patient #8 revealed an initial assessment completed 11/19/2024 by RN 2. A verbal order dated 11/19/2024 for a comprehensive assessment, RN services once a week for nine weeks plus two visits if needed, with specified assessments and evaluations to be provided to Patient, PT services to evaluate and treat, and an HHA once a week for one week then twice a			

	week for eight weeks. The verbal order was signed by the physician 11/26/2024. An RN comprehensive assessment was documented on 11/19/2024 and HHA service documentation was completed on 11/22/2024 and 11/25/2024. The clinical record failed to evidence an appropriate order for care prior to the physician signing and acknowledging the care orders on 11/26/2024. 7. The agency policy titled "Physician Orders" indicated all medications, treatments and services for patients would be ordered by a physician. Verbal orders may be taken in accordance State and Federal laws and be read back to the physician to verify the accuracy of the orders. 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.	G0590	On 01-10-2025, the clinical manager calledfor an emergency meeting of all personnel, and provided an in-service regardingthe Policy and Procedure on Client Reassessment /Updated of ComprehensiveAssessment ***(exhibit #26)***, Plan of	2025-01-30

	Based on record review and interview, the agency failed to notify the physician of changes in the patient's condition in 3 of 6 active clinical records reviewed. (Patient #3, 4, 5) The findings include: 1. A clinical record review for Patient #4 evidenced a POC for recertification period 11/09/2024-01/07/2025 which indicated the patient's diagnoses included pulmonary fibrosis (scarring of the lungs which can cause fluid retention and causing swelling of the lower limbs in particular) and the agency should notify the physician of a weight gain of more than 5 pounds in a week or more than 2 pounds in a day. The plan of care indicated the agency was to provide PT services 2 times a week. The recertification assessment completed by RN 1 on 11/06/2024 and the skilled nursing visit notes completed by RN 1 on 11/13/2024 and 11/16/2024 indicated the patient had 2+ pitting edema (swelling that when the skin is pressed, leaves an indentation measured from 1+ to 4+ in		Treatment ***(exhibit #8)***, Serviceagreement ***(exhibit #71)***, Physician Order ***(exhibit #40)***,Therapy Services ***(exhibit #72)***, Coordinationof Client Services ***(exhibit #6)***, and Clinical Documentation ***(exhibit#73)***, Policy on Client Reassessment /Updated ofComprehensive Assessment was discussed, emphasized that ComprehensiveAssessment will be updated and revised as often as the client's conditionwarrants due to major decline or improvement in health status. Specialinstructions #2 states that clients are reassessed when significant changesoccur in their condition, and #3- states that clients are reassessed whensignificant changes occur in their diagnosis. Policy on Plan of Treatment states thatplanning for treatment is a dynamic process that addresses the care, treatmentand services to be provided. The plan will be consistently reviewed to ensurethat client needs are met, and will be updated as necessary, but at least every60 days. Emphasized special instructions 1, 9 & 10 were emphasized that aplan of	

	severity) to the legs at 2+. The skilled nurse visit note completed by RN 1 on 11/25/2024 indicated the patient had 3+ pitting edema to the legs and failed to evidence a weight was obtained and the physician was notified of the change in edema. On 01/07/2025, at 3:46 PM, RN 1 indicated she could not weigh the patient due to the patient's inability to stand and did not notify the physician of the increase in edema. A document titled "Physician Telephone/Verbal Order" signed by PT 1 on 11/16/2024 indicated the PT visit frequency was changed to 1 time a week for the next 8 weeks. On 01/09/2025, at 10:30 AM, PT 1 indicated he has never called the physician's office for orders. PT 1 indicated he documents communication with the physician on a verbal order form and sends it the physician for review and signature. On 01/09/2025, at 3:45 PM, the CM indicated there was no documentation the physician was notified of the change in PT frequency prior to sending the		treatment should be individualized and should be signed by thephysician, a copy shall be provided to the professional staff (RN) to bereviewed with the patient or patient representative; and shall promptly alertthe physician as well as the patient or patient representative for any changesthat suggest a need to alter the Plan of treatment; verbal/telephone ordersshall be obtained from the client's physician for changes in the Plan oftreatment. Further discussed that the plan of careshould be individualized and patient-centered making sure that parameters ofassessment are updated unique for the patient. Other ways to further assesspatient should all be utilized to ensure accuracy of assessment and evaluationreiterated during the in-service and it is a must that significant changes bereported promptly to the physician. Service Agreement policy discussed duringthe in-service. Emphasized special instruction # 4 which states that clientshall be advised, of any changes in type or frequency of services,	

	document titled "Physician Telephone/Verbal Order" dated 11/16/2024 and written by PT 1 to the MD office on 12/11/2024. 2. A clinical record review for Patient #3 evidenced a SOC order dated 12/11/2024 and signed by the physician which indicated PT was to evaluate and treat for functional deficit. Documents titled "Physician Telephone/Verbal Order" indicated the PT visit for that day was on hold per patient request for document dated 12/14/2024 and signed by PT 1 and the document dated 12/17/2024 and signed by PT 1 indicated PT services were on hold until further orders per patient request. On 01/09/2025, at 10:30 AM, PT 1 indicated the patient was refusing therapy so he put the PT services on hold. PT 1 indicated he did not speak to the physician or get a verbal order from the physician's office related to the PT services on hold or to notify the physician the patient was refusing PT services. PT 1 indicated he completed the verbal order form which was then sent to the		coverage ofservices and any change in financial liability. Furthermore, the policy ofPhysician orders clearly states that all medications, treatments and servicesprovided to clients must be ordered by a physician. Therefore, any change infrequency of any discipline, the physician must be notified, and an order mustbe initiated via telephone or in writing and must be countersigned by thephysician for any changes in the plan of care to include change of frequenciesof PT. Policyon Therapy Services was also discussed during the in-service. It further statesin special instructions #3 thatthetherapist will consult and collaborate with the registered nurse who is thecase manager. The therapist will participate in implementing the physician'splan of treatment and evaluating client progress. 1 Alsodiscussed the policy on Coordination of Client Services which states that Allpersonnel furnishing services shall maintain a liaison to assure that theirefforts are coordinated effectively and support the	

	and review. On 01/09/2024, at 11:55 AM, the CM indicated she would look for any communication with the physician that the physician was informed of the patient refusing PT services. No additional information or documentation was provided before survey exit on 1/09/2025. A skilled nurse visit note completed by RN 2 and dated 12/27/2024 which indicated a new deep tissue injury (a type of pressure ulcer causing damage to soft tissue from pressure) to the right great toe and failed to evidence the physician was notified of the new wound. On 01/09/2025, at 12:16 PM, the CM indicated there was no communication with the physician regarding the deep tissue injury. 3. A clinical record review for Patient #5 evidenced a plan of care for the recertification period 09/22/2024-11/20/2024 which indicated the agency was to provide PT services 2 times a week for 8 weeks. A document		treatment. This may be done through formal care conferences;maintaining complete, current Treatment plans; and written and verbalinteraction to ensure services are coordinated between members of theinterdisciplinary team, provide the attending physician with an ongoingassessment of the client and identify the client's response to servicesprovided, and ensure continuity of care. Special instructions provide guidancein the event changes in the plan of care occur, the primary care Nurse orTherapist will assume responsibility for updating/ changing the Treatment planand communicating changes to caregivers within 24 hours following theconference or changes, and the physician will be contacted when his/herapproval for that change is necessary and to alert physician to changes inclient condition. Policypertaining to Clinical Documentation was also discussed. Emphasized importanceof implementation to ensure that there is an accurate record of the	

	Telephone/Verbal Order" signed by PT 1 on 10/5/2024 indicated PT frequency was changed to 1 time a week for 8 weeks. On 01/09/2025, at 10:30 AM, PT 1 indicated the patient had refused PT visits so he changed the visit frequency to 1 time a week. PT 1 indicated he did not communicate the patient refusals and the need to change PT visit frequency to the physician. On 01/08/2025, at 4:23 PM, the CM indicated the patient refused PT so often so the PT changed the visit frequency to 1 time weekly and indicated she would look for documentation the agency notified the physician of the PT refusal and need for frequency change. No additional documentation or information was provided before survey exit on 01/09/2025.		servicesprovided, client response and ongoing need for care, and to documentconformance with the Plan of treatment, modifications to the plan, andinterdisciplinary involvement. Special instructions #4 states that Telephone orother communication with clients, physicians, families, or other members of thehealth care team will be documented in clinical progress notes or other inter-agencycommunication form. It further states in special instructions #6 that servicesnot provided and the reason for the missed visits will be documented andreported to the physician. In the case of patient #4, admissiondiagnoses include Acute on chronic systolic congestive heart failure, and heredema has been fluctuating from +2 to +3. PT services for patient #4 was decreased to1 x/week x 8 weeks througha telephone order dated 11-16-2024 ***(exhibit #74)*** was initiatedindicating the decrease in the frequency to 1 x/week x 8 weeks was requested	

			the missed visit report ***(exhibit 75)***.PT documented and coordinated care with the patient, PCG, RN and supervisorthat patient continues to demonstrate limited compliance with all treatmentsprovided as documented in his visit on 11-21-2024 ***(exhibit 76 a-c),*** refusedto ambulate and perform standing exercises during that visit. For Patient #3,SOC order included PT to evaluate and treat for functional deficit dated12-11-2024 ***(exhibit # 77 a-b)***. Pt was able to get scheduled for theevaluation on 12-14-2024 after several calls and follow ups to convince patientto allow PT visit, however, on that day patient again refused the visit andrequested to be rescheduled the following week. PCG instructed PT to call againnext week. PCP was notified regarding visit cancellation/postponement ofevaluation, a MV report was created indicating PCP was notified ***(exhibit# 78)***, and an order was initiated signed and dated by MD on 12-14-2024***(exhibit# 79).*** On	

			12-17-2024, patient again refused the visit, this time, MD ordered tohold the PT visits until further orders signed and dated by MD on 01-02-2025 ***(exhibit# 80).*** These just show the persistence of the PT to provide services whichpatient repeatedly declined. For Patient #5,recertification period 09/22/2024 to 11/20/2024, patient refused the visit on10-05-2024 after several attempts to get her scheduled, a missed visit report ***(exhibit#81)***was created with notification that MD was notified indicatingpatient request to decrease to a weekly visit, and a telephone order to hold that PT visitthat day was signed and dated by MD ***(exhibit # 82).*** Copies of said exhibits were provided tosurveyors during the survey. Request for modification on the Missed Visit Form was forwarded tothe EHR provider to include a check box for the item- Expected consequences of themissed visit (MV) were discussed in detail with the patient and/orrepresentative ***(exhibit # 83)***.	

			The Clinical Chart Review Form ***(exhibit 84a-b)***was revised and approved by the GB on 01-24-2025 to include item B.8- All disciplinefrequency & duration included & updated as needed, B.9- POC- individualized, patientcentered & goal directed, C.1- Readback, signed & dated by the one who received the T.O., C.2- Signed, datedby MD, and should be strictly implemented, C.3- SOC/Recert orders: w/treatments/services/frequenc y/duration, F.8-Care coordination done RE: change in condition/ POC, abnormal VS, F10- MDnotified re: change in condition, and documented, F.13, G-5 & H.3-Compliant to freq., missed visit reported to MD, MV completed. Disseminationof information regarding the revised forms completed on 01-30-2025. It will be the responsibility of the Clinical Manager/QAto ensure that all MV are well coordinated and the revised MV shall be utilizedand completed, change in condition are communicated. Clinical manager to monitorcompliance by utilizing the revised Clinical	

			Chart Review form during initialchart audit, and monthly thereafter.	
G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interviews, the agency failed to ensure services were integrated to ensure the identification of patient needs and factors that could affect treatment effectiveness and coordination of care provided by all disciplines in 4 of 6 active clinical records reviewed (Patients #1, 2, 3, 5). Findings include: 3. The clinical record for Patient #1 included an initial POC dated 11/1/2024 to 12/30/2024 indicating RN visits ordered once every other day for 2 visits then once a week for eight weeks and PT to evaluate and treat Patient. A separate PT plan of treatment, signed by PT 1 and dated 11/05/2024 failed to evidence the dates of care	G0606	On 01-10-2025, the Clinical Manager calledfor an emergency meeting of all personnel, and provided an in-service regardingthe Policy and Procedure on Coordination of Client Services ***(exhibit #6)***,and Clinical documentation ***(exhibit #73)***. DiscussedCoordination of Client Services that all personnel furnishing services shallmaintain a liaison to assure that their efforts are coordinated effectively andsupport the objectives outlined in the Plan of treatment. This may be donethrough formal care conferences; maintaining complete, current Treatment plans;and written and verbal interaction to ensure services are coordinated betweenmembers of the interdisciplinary team, ensure appropriate, quality care isbeing provided to clients, and to establisheffective interchange, reporting, and coordination of client care does occur,thereby continuity of care is being maintained, such as during missed visits,and falls, all disciplines, patient/PCG, MD	2025-01-30

	and indicated PT services were ordered twice a week for eight weeks. The clinical record revealed documentation dated 11/29/2024, 12/7/2024, and 12/24/2024, documented by PT 1, indicating these scheduled visits were missed visit and each were documented that the patient requested no visit. The clinical record failed to evidence attempts to reschedule PT visits for each missed visit, attempts to schedule another therapist, nor coordination with Patient, nor his daily caregivers, or why Patient was requesting no PT service. During an interview on 01/09/2025 at 9:50 AM, PT 1 relayed the missed visit on 12/24/2024 was due to the holiday and he couldn't find another time in his schedule to reschedule Patient. PT revealed the missed visits on 11/29/2024 and 12/7/2024 were due to working around Patient's caregivers who bathe Patient and use a lift to get Patient out of bed. PT 1 relayed he couldn't find another time in his schedule to reschedule Patient's visits that worked around his caregivers.		including other entities providingcare as indicated should be notified as part of the care coordination. In-serviced provided regarding Clinical Documentation,emphasized special instructions 6- which states that Services not provided andthe reason for the missed visits will be documented and reported to thephysician. It was also emphasized during the in-service that missed visits arenot tolerated as they are constantly reminded, a substitute will be availableif the cause of the missed visit is due to the visiting staff. Documentation onmissed visit should include dates and times attempts to reschedule were made. Referral form was revised and approved by the Governing Body on01-24-2025 to include item on names of contact person/emergency contact personwith assistance provided, and a checklist to include other entities providingservices, type of services provided with the frequency and duration ***(exhibit#85)*** to be completed	

	4. The clinical record for Patient #2 an initial POC dated 10/23/2024 to 12/21/2024 indicating RN visits once a week for nine weeks and two extra visits if needed and PT to evaluate and treat Patient. A separate PT plan of treatment signed by PT 1 on 10/30/2024 failed to evidence dates of care and indicated PT services once a week for one week then twice a week for eight weeks. A second PT plan of treatment signed by PT 1 on 12/23/2024 indicated PT services twice a week for eight weeks. The clinical record revealed PT missed visit documentation on 11/8/2024, 11/29/2024, 12/7/2024, 12/13/2024, and 12/27/2024, documented by PT 1 and each missed visit was documented as patient requested. The clinical record failed to evidence attempts to reschedule PT visits for each missed visit, attempts to schedule another therapist, nor care coordination communication with RN. During an interview at 1/9/2025 beginning at 9:50 AM, PT relayed Patient #2 requested to be receive one service per day and several PT missed visits were due to multiple services		at the time of referral to facilitate admissionand development of POC after the admission procedure. The Admission/InitialChecklist form was also revised and approved to include items 11.B- Services offeredand consented by patient and/or all disciplines to provide care notified: ¨SN,¨PT, ¨OT, ¨HHAide, ¨MSW, ¨Others (paid help/other Health CareProviders) Specify services provided and frequency/duration, item 11.C-Identified PCG/cg who are willing and able to provide assistance withmedication, skin/wound care, incontinent/perineal care, food prep/feeding ***(exhibit #86)***. The ClinicalChart Review form was also revised and approved by GB on 01-24-2025, to includeitem I.2- coordinated w/ other entities: type of service, freq & duration ensurecare coordination with other entities providing care, items F.13, G.5 & H.3-Compliant to freq., Missed visit reported to MD, MV completed, ***(exhibit #87);*** and request forwarded to the EHR provider to revisedthe Missed Visit Form to include a checkbox for discussion of the expectedconsequences of the	

	self-scheduling to see Patient on the same day. 5. The agency policy titled "Coordination of Client Services" indicated all personnel furnishing services shall assure efforts are coordinated effectively and support the objectives in the plan of treatment to ensure the agency was providing quality care. 410 IAC 17-12-2(g), 17-12-2(h) 1. A clinical record review for Patient #3 evidenced a POC for an initial certification period of 12/11/2024-02/08/2025 which indicated the skilled nurse would coordinate care with the paid help. The skilled nurse visit note completed by RN 2 dated 12/20/2024 indicated the patient lived alone and laid in soiled briefs all night since there was no caregiver available after the evening caregiver leaves. The visit note indicated RN 2 spoke with the patient's primary caregiver urging the primary caregiver to speak to Entity F about providing additional services. On 01/09/2025, at 10:44 AM, the patient's primary caregiver indicated Entity F provided		missed visit (MV) with patient and /or representative***(exhibit#88).*** Disseminationof information regarding the revised forms completed on 01-30-2025. It will be the responsibility of the IntakeRN to ensure that the referral form is completed to facilitate admission. Itwill be the responsibility of the admitting personnel to fill out, completesign and date the revised Admission/Initial Checklist form at the time of Admission and to be submitted togetherwith the rest of the SOC documents. The Clinical Manager/QA will be responsiblein monitoring to guarantee compliance by utilizing the revised Clinical ChartReview form during initial audit and monthly thereafter. For patient #3, at the time of the referral ***(exhibit #89)***,Amada was already identified as the entity providing caregivers to patientMonday to Sunday 6 hours a day- 3 hours in am from 8:00 am to 11:00 am, and 3hours in pm from 4:00 pm to 7:00 pm. We were also notified at the time ofreferral that the patient identified a friend to be his PCG as	

	personal care services 4 hours in the morning and in the evening 7 days a week. The clinical record failed to evidence any coordination of care with Entity F. On 01/09/2025, at 10:59 AM, RN 2 indicated she had not coordinated care with Entity F regarding the need for additional services. On 01/09/2025, at 11:55 AM, the CM indicated she would look for care coordination with Entity F. No additional information or documentation was provided prior to survey exit on 01/09/2025. 2. A clinical record review for Patient #5 evidenced POCs for the recertification periods of 09/22/2024-11/20/2024 and 11/21/2024-01/19/2025 indicating the agency was to provide SN and PT services. Communication notes dated 11/16/2024 and 01/03/2025 signed by the CM indicated the patient had a fall on 11/16/2024 and 01/02/2025 and failed to evidence the skilled nurse and PT were notified of the falls. On 01/09/2025, beginning at		he is needingcloser monitoring. The agency was told that all care coordination regarding thepatient care will all be directed to the PCG whom the patient identified anddirected to refer to as identified in the referral form dated 12-10-2024. Atthe time of admission, admitting personnel -RN coordinated care with PCGregarding Amada Senior Care. As per PCG, she already coordinated care with themas documented in her notes page 29 on the SOC OASIS ***(exhibit # 90 a-b),*** andon page 12 on SOC OASIS page 12 ***(exhibit #91).*** As reported byPCG, during the survey, hours were increased finally to 8 hours/day- 4 in the morningand 4 in the evening. For continuous monitoring of the patient, PCG stated patientagreed to a 24/7 video camera which was installed to closely monitor patientespecially at times when caregivers are not available. Patient usually sleepsall night. The morning and evening caregivers change him upon arrival and makessure he is clean and dry before they leave to keep him clean and dry asstrictly imposed by the RN2 which she repeatedly documented in her skillednotes.	

	2:36 PM, the CM indicated there was no documentation the nurse and PT were notified of the falls on 11/16/2024 and 01/02/2025.			
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 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 home health agency failed to ensure: measure, analyze, and track quality indicators (G0642); utilize data to identify opportunities for improvement (G0644); improvement activities must focus on high risk or problem prone areas (G0646); performance improvement activities analyze patient adverse events and	G0640	TheGoverning Body called for an emergency meeting on 01-24-2025, and discussed regardingthe Policy and Procedure on Performance Improvement ***(exhibit #92)***.Discussed that there should be an establish performanceimprovement plan to continuously measure, assess, and improve the performanceof clinical and other processes. This plan will be based on the organization'smission and goals and designed to improve client outcomes and the perceptionsof clients/families about the quality and value of services. The agency willadopt a performance improvement model to guide the process through collaborationof all services and disciplines, will meet the needs of clients, staff and thecommunity, and to improve client and agency outcomes through a coordinatedcollaborative approach to assessing and	2025-01-24

	implement preventative actions (G0654); and the Governing Body must approve the data detail and frequency of collection (G0660). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.65 Quality Assessment and Performance Improvement (QAPI). A deficient practice citation was also evidenced at this standard as follows: Based on record review and interview, the agency failed to: ensure the governing body approved the frequency of the data collection, QAPI program utilized quality indicator data to include updated OASIS (Outcome and Assessment Information Set) data to identify opportunities for improvement, the QAPI program focused on high risk areas, and the agency implemented performance improvement actions. The findings include:		improving organizational performance. Duringthe meeting on 01-05-2024 ***(exhibit # 93)***, the Governing Body approvedthe continuity of data collection on fall, infection and hospitalization. TheGoverning Body assigned the Clinical Manager/QA to collect occurrences of fall ***(exhibit#94)***, infection ***(exhibit #95),*** and hospitalization ***(exhibit#96)*** reported by but not limited to visiting staff, PCG/representativesand other entities providing care in the home, aggregated monthly, thenquarterly ***(exhibit #97 a-b))***, data analysis of why adverse events happened,develop a plan of action to prevent recurrence and implement preventative actions. Data collected will be utilized to determine trends and areasfor improvement. Developactivities focus on improvement of performance to resolve high risk or problemprone areas, and ensure provision of quality health care by reducingoccurrences of fall, infection and hospitalization. Fishbone root cause analysis model ***(exhibit98 & 99).*** Data will be collected, analyzed the	

	A review of an undated policy titled "Performance Improvement" indicated the agency would develop and maintain an ongoing performance improvement program by collecting and evaluating data and implementing performance improvement actions. The review of QAPI binder and the governing body meeting minutes dated 01/05/2024 failed to evidence the governing body approved the frequency and detail of the data collection. The most recent Measure Performance Summary dated April 2023 indicated the agency did not meet the benchmark for timely initiation of care, improvement in dyspnea (difficulty breathing), drug regimen review, and patient falls with major injury. The infection log indicated dated in 2024 evidenced 38 infections, the hospitalization log in 2024 evidenced 30 hospitalizations, and the fall log evidenced 17 falls in 2024. The reported average census in 2024 was 18. There was no assessment of the data to determine trends or cause and current level of performance and areas to be		root cause of theproblem, and develop an action plan to reduce/prevent the occurrence of adverseevent, implementation of the plan of action, and will be re-evaluated quarterlyand annually for effectivity of actions implemented to evaluate level ofperformance, and by the end of the year identify successes, and failure of theplan of actions. It shall be the responsibilityof the Governing Body to ensure implementation of the Fishbone Root Cause AnalysisModel. QAPI report shall be prepared at the end of the year by the ClinicalManager/QA which will be submitted to the Governing Body during the annualmeeting for possible solutions and immediate remediation to improve quality ofcare provided	

	improved, and the QAPI program failed to evidence performance improvement actions. No QAPI meeting minutes were present for 2024 and 2025. On 01/09/2025, at 4:25 PM, the CM indicated there was no assessment of the QAPI data for falls, hospitalizations, and infections to determine trends and areas for improvement. The CM indicated there were no performance improvement action plans and the governing body did not approve the data detail and frequency to be collected. The CM indicated meetings to review the QAPI were to take place quarterly, but she was behind in getting data together and have another meeting. 410 IAC 17-12-2(a)			
G0680	Infection prevention and control 484.70 Condition of Participation: Infection prevention and control.	G0680	On 01-10-2025, the Clinical Manager calledfor an emergency meeting of all personnel, and provided an in-service regardingthe Policy and Procedure on Infection Prevention/ Control ***(exhibit #100)*** andthe Infection Control Surveillance ***(exhibit #101).***	2025-01-30

	The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases. Based on observation, record review, and interview, the home health agency failed to ensure: standard precautions and agency policies were followed to prevent infection (see tag 0682) and infection surveillance was maintained to prevent infection (See G0684). The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care for the Condition of Participation 42 CFR 484.70 Infection Prevention and Control.		InfectionPrevention/ Control states that the agency should strictly observe the recommended precautions for home care asidentified by the Centers for Disease Control and Prevention (CDC) to reducethe risk of transmission of microbes from both recognized and unrecognizedsources of infection and ensure employee andclient safety. Policy regarding Infection Control Surveillance was alsodiscussed. Policy states implementing a process of identifying all infectionsin the client and/or employee population and evaluate effectiveness of currentcontrol measures or identify an action plan to improve incidence of infections. As approved by the Governing body, theClinical Manager/QA will collect occurrences of infection ***(exhibit # 95)*** reportedby visiting staff, PCG/representatives and other entities providing care in thehome, aggregated monthly, then quarterly. Data will be collected, analyzed using the rootcause analysis ***(exhibit#99)***, developan action plan to reduce/prevent the occurrence	

			ofaction, and will be re-evaluated quarterly and annually for effectivity ofactions implemented to evaluate level of performance, and by the end of theyear identify successes, and failure of the plan of actions implemented. Itshall be the responsibility of the Governing Body to ensure implementation ofthe plan of action to eventually improve agency performance and quality of care.QAPI report shall be prepared at the end of the year by the Clinical Manager/QAwhich will be submitted to the Governing Body during the annual meeting forpossible solutions, and immediate remediation to improve quality of care.	
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 follow standard precautions and agency policy to	G0682	On 01-10-2025, the Clinical Manager calledfor an emergency meeting of all personnel, and provided an in-service regardingthe Policy and Procedure on Infection Prevention/Control ***(exhibit # 100)***, Handwashing/ Hand Hygiene ***(exhibit# 102)***, Bag Technique ***(exhibit #103)***, and Foley CatheterCare ***(exhibit 104)).*** The policy on Infection Prevention/ Controlstates that	2025-01-30

	prevent the transmission of infections in 2 of 3 active clinical records reviewed with a home visit (Patient #1, 2). Findings include: 5. During a home visit on 1/8/2024 beginning at 11:51 AM, PT 1 used a blood pressure cuff, thermometer, and oxygen saturation monitor to assess Patient's vitals signs. At the end of the home visit, PT 1 used Clorox disinfectant wipes to cleanse the supplies and the supplies were placed directly into PT's supply bag in under 8 seconds each. PT failed to evidence appropriate drying time needed to disinfect the supplies. During an interview at the home visit, PT 1 relayed the drying time for Clorox disinfectant wipes was 4 minutes and he thought it was thirty seconds. 410 IAC 17-12-1(m) 1. A review of an undated policy titled "Foley Catheter Care" indicated sterile gloves should be worn for the insertion of the new catheter. 2. A review of an undated policy titled "Infection		the agency should strictly observe the recommended precautions for home care as identified by the Centers forDisease Control and Prevention (CDC) to reduce the risk of transmissionof microbes from both recognized and unrecognized sources of infection and ensure employee and client safety. In an effort of the agency to reduce the risk of infectionin clients and staff members, thorough hand washing/hand antisepsis is,therefore, required to all employees. The agency strictly imposes everyone tofollow the established guidelines for infection control/ prevention. Handwashing/Hand Hygiene policy special instructions #3 states indicationsof handwashing and hand antisepsisincludes before performing invasive procedures, before caring forclients at high-risk for infection, when there is prolonged or intense contactwith the client (bathing the client), between tasks on the same client, beforetouching a wound, after removing gloves, after touching objects that arepotentially contaminated, after caring for a client who is infected with drugresistant organisms, when hands are visibly soiled, after using the toilet,blowing the nose or covering a sneeze, after assisting client to use thebathroom, before eating,	

	Prevention/Control" indicated hands were to be washed immediately after gloves were removed and equipment used for patient care was to be properly cleaned. 3. A review of an undated policy titled "Handwashing/Hand Hygiene" indicated staff should wash their hands with soap and water for 15 seconds. 4. On 01/06/2025, between 3:54 PM and 4:52 PM, at the home of Patient #1, RN 2 was observed to have placed the nurse bag on top of the patient's bed on top of the agency folder with the edges of the bag touching the patient's bed. RN 2 obtained the patient's vital signs by using a blood pressure cuff applied to the patient's left arm and pulse oximeter (a medical devise measuring the amount of oxygen in the blood) on the left index finger. RN 2 placed the stethoscope to the patient's chest, abdomen, and back. RN 2 removed her gloves and did not perform hand hygiene. RN 2 wiped the stethoscope, blood pressure cuff, and pulse oximeter with disposable sanitizing wipes and placed each item immediately into the		drinking, handling food/ serving food, and when handsare visibly dirty or contaminated with proteinaceous material or are visiblysoiled with blood or other body fluids, wash hands with either anon-antimicrobial soap and water or an antimicrobial soap with water. It wasalso emphasized that if hands are not visibly soiled, use an alcohol-based handrub for routinely decontaminating hands in all other clinical situations takingnote of the drying time as per product recommendation. Alternatively, washhands with antimicrobial soap and water in all clinical situations. Decontaminatehands before having direct contact with clients, before donning sterile glovesto insert urinary catheters, vascular catheters or other invasive devices thatdo not require surgical procedures; after contact with client's intact skin,after contact with body fluids, excretions, non-intact skin and wound dressings;and hands after contact with inanimateobjects including equipment in the immediate vicinity of the client; afterremoving gloves; and before eating and after using a restroom.	

	nurse bag. The directions on the disposable wipe container indicated the surface should be wiped and left to air dry for 4 minutes. RN 2 then removed the agency folder to document vital signs and placed the nurse bag directly on the patient's bed. RN 2 was observed deflating the balloon and removing foley catheter (a plastic tube inserted into the bladder and anchored by an inflated balloon to drain urine from the body), removing gloves from both hands, cleansing the tip of the penis with premoistened cotton swabs, and then opening a package of sterile gloves, touching the outside of the sterile gloves and not maintaining sterility before applying gloves to both hands, and inserting the new catheter into the penis. RN 2 was not observed performing hand hygiene after removing gloves after removing the catheter and before applying sterile gloves and cleansing the penis and inserting the new catheter. RN 2 removed gloves and washed hands with soap and water for 8 seconds. A clinical record review		Antimicrobialimpregnated wipes (towelettes) are not as effective as alcohol-based hand rubsor washing hands with antimicrobial soap and water. Multiple use cloth towelsare not recommended for use in health care settings. Proper handwashingdemonstrated and required return demonstrated to all staff ensure practice ofproper and frequent handwashing ***(exhibit # 102)***. Procedure as tohow to insert a foley catheter was discussed and demonstrated with the RNsfollowing aseptic/sterile technique ***(exhibit #104).*** It shall be the responsibility of the Clinical Managerto monitor compliance to ensure compliance with all the infection controlprecautionary measures by including Handwashing/ Hand Hygiene, and BagTechnique, plus IFC insertion with RNs as a topic for the monthly in-servicewith demonstration and return demonstration ***(exhibit #105)***, byincluding the Hand washing and Bag Technique for everyone, and to include forRNs Foley Care & Management as part of the skills competency evaluated ***(exhibit#106 & 107)*** every year to ensure competency on infection control toensure infection control and infection prevention..	

	evidenced a POC for recertification period 12/31/2024-02/28/2025 which indicated the skilled nurse was to change the foley catheter monthly. A communication note indicated the agency received a physician order dated 12/30/2024 for a urinalysis and culture (a laboratory test on a urine sample to detect infection/bacteria). A communication note dated 01/02/2025 indicated the patient was started on antibiotic and a laboratory report dated 12/31/2024 indicated the patient's urine contained multiple organisms consistent with contamination. On 01/09/2025, at 10:59 AM, RN 2 indicated hands should be washed for 20 seconds and equipment should be left to dry for 20-30 seconds before returning to nurse bag. RN 2 indicated she was not aware the disposable sanitizing wipe container indicated equipment was to dry for 4 minutes after use. On 01/09/2025, at 12:32 PM, the CM indicated hands should be washed for at least 20			

	bag should not be placed on the patient's bed. The CM was not sure if the agency policy required staff to use sterile gloves for catheter insertion.			
G0684	Infection control 484.70(b)(1)(2) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include: (1) A method for identifying infectious and communicable disease problems; and (2) A plan for the appropriate actions that are expected to result in improvement and disease prevention. Based on record review and interview, the agency failed to maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. The findings include:	G0684	The clinical manager called for anemergency meeting of all Staff on 01-10-2025 and provided an in-serviceregarding the Policy and Procedure on Infection Prevention/ Control ***(exhibit#100)*** and the Infection Control Surveillance ***(exhibit #101).*** InfectionPrevention/ Control states that the agency should strictly observe the recommended precautions for home care asidentified by the Centers for Disease Control and Prevention (CDC) to reducethe risk of transmission of microbes from both recognized and unrecognizedsources of infection and ensure employee andclient safety. Policy regarding Infection Control Surveillance was alsodiscussed. Policy states implementing a process of identifying all infectionsin the client and/or employee population and evaluate effectiveness of currentcontrol measures or	2025-01-30

	A review of an undated agency policy titled “Infection Control Surveillance” indicated the agency would maintain a continuous data collection and monitoring system to identity to identify infection trends and investigate trends to determine source of contamination. The agency would maintain an infection log and implement follow-up actions based on infections. The infection log provided by the CM on 01/06/2025 evidenced 14 infections logged and failed to evidence any logged infections since 06/17/2024. The infection log evidenced 8 of the 14 infections through 06/17/2024 were urinary tract infections and the infection program failed to include any investigation or follow-up actions. On 01/06/2025, at 10:55 AM, the CM indicated no additional infections were logged since 06/17/2025 and indicated she would need to go pull the additional infections from the clinical records. On 01/09/2025, at 4:25 PM, the		identify an action plan to improve incidence of infections.The Agency will continue to collectinformation regarding infection ***(exhibit #95 &97 a-b)***. Data collected willbe utilized to determinetrends and areas for improvement.Develop activities focus on improvement of performance to resolve high risk orproblem prone areas-infection and ensure provision of quality health care byreducing occurrences of infection. Root cause analysis (***Exhibit 99)***shall be utilized to analyze the root cause of infection, and develop an actionplan, implementation of the plan of action, and by the end of the yearevaluated to determine level of performance. It shall be the responsibility ofthe Governing Body to ensure implementation of the Fishbone Root Cause AnalysisModel. QAPI report shall be done by the end of the year.	

	CM indicated there were no follow-up actions or investigations related to infections.			
G0716	Preparing clinical notes 484.75(b)(6) Preparing clinical notes; Based on record review and interview, the agency failed to ensure skilled professionals assumed responsibility for prepared clinical notes in 5 of 6 active clinical records reviewed (Patient s#1, 2, 3, 5, 8). Findings include: # The agency policy titled "Clinical Documentation" indicated each direct contact with patients would be documented by skilled professionals and incorporated into the clinical records within 7 days. # The clinical record for Patient #1 included an initial POC dated 11/1/2024 to 12/30/2024 indicating RN visits ordered once every other day for 2 visits then once a week for eight weeks and PT to evaluate and	G0716	On01-10-2025, the Clinical Manager called for an emergency meeting of all personnel,and provided an in-service regarding the Policy and Procedure on ClinicalDocumentation ***(exhibit #73)***. The policy is there in order toensure that there is an accurate record of the services provided, clientresponse and ongoing need for care, and to document conformance with the Planof treatment, modifications to the plan, and interdisciplinary involvement.Special instructions #1-5 state that all skilled services provided by Nursing,Therapy, HHAide and/or Social Services will be documented in the clinical record,separately completed for each visit signedand dated by the appropriate professional, actual time of the client visit willbe included in each note, additional information that is pertinent tothe client's care or condition may be documented on the Progress Note or	2025-01-24

	included RN visit documentation on 12/27/2024 and failed to evidence a scheduled nor documented RN visit the week of 12/30/2024 and 1/6/2025. During an interview on 1/8/2025 at 11:15 AM, RN 2 # The clinical record for Patient #2 an initial POC dated 10/23/2024 to 12/21/2024 indicating RN visits once a week for nine weeks and two extra visits if needed and PT to evaluate and treat Patient. The clinical record included RN visit documentation on 12/26/2024. The record failed to evidence a scheduled nor documented RN visit the week of 12/30/2024 and 1/6/2025. During an interview on 1/8/2025 at 11:15 AM, RN 2 relayed she had seen Patient every week as ordered, including the week of 12/30/2024 and 1/6/2025. RN revealed the documentation had not yet been completed. # The clinical record review of Patient #8 revealed a POC dated 11/19/2024 to 1/17/2025, signed by RN 2, that included RN visits once a week for 9		FlowSheet, telephone or other communication with clients, physicians, families, orother members of the health care team will be documented in clinical progressnotes or other interagency communication form, and emphasized that documentationof services ordered on the plan of treatment will be completed the day serviceis rendered and incorporated into the clinical record within seven (7) daysafter the care has been provided. It is the policy of the agency that all timesheets***(exhibit #108)*** with the visit verification form by Friday and allnotes be completed on the EHR the following Monday. Any notes not completed byMonday even visits were already made, will not be included in the payroll. Allpersonnel were reminded that it is a must for them to submit weekly timesheets, Visit Verification Form with the skilled notes completed on the EHR forit to get included on the pay check. TheClinical Manager shall be responsible in monitoring to ensure that all notesare entered	

	weeks with 2 visits that can be done as needed. The clinical record included RN visit documentation on 12/19/2024. The record failed to evidence a scheduled nor documented RN visit the week of 12/23/2024, 12/30/2024, and 1/6/2025. During an interview on 1/8/2025 at 11:15 AM, RN 2 relayed she had seen Patient every week as ordered, including the week of 12/23/2024, 12/30/2024, and 1/6/2025. RN revealed the documentation had not yet been completed. 410 IAC 17-14-1(a)(1)(E) 1. A clinical record review for Patient #3 evidenced a POC from the initial certification period 12/11/2024-02/08/2025 which indicated the agency was to provide skilled nursing services 1 time a week for 9 weeks. The clinical record on 01/09/2025 failed to evidence nursing visits since 12/27/2024.		in a timely manner based on the Weekly Time Sheet submitted andcollated every Monday, and will strictly observe incomplete notes no paypolicy. The office manager will be responsible gathering all the weeklytimesheet to coincide if visit notes are completed on the EHR, and a weeklyreminder will be sent to the group text messaging that notes are expected to beentered within 48 hours and for completion up to seven (7) days from the timeof the actual visit. Every visiting personnel will be evaluated every year for promptnesson submission of notes ***(exhibit #109, #110 & #111)***.	

	On 01/09/2025, at 12:00 PM, the CM indicated RN 2 provided skilled nurse visits on 01/03/2024 and 01/07/2025 but had not yet documented the visit notes. 2. A clinical record review for Patient #5 evidenced a POC for the recertification period 11/21/2024-01/19/2025 indicating the agency was to provide skilled nursing services 1 time a week. The clinical record on 01/09/2024 failed to evidence skilled nursing visits were provided since 12/17/2024. On 01/08/2025, at 4:23 PM, the CM indicated there were no other nursing visits documented since 12/17/2024 and indicated RN 2 provided a visit last week but had not documented it yet.			
G0798	Home health aide assignments and duties 484.80(g)(1) Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or	G0798	**a** On 01-10-2025, the clinical manager called for anemergency meeting of all personnel, and provided an in-service regarding thePolicy and Procedure on Home Health Aide Treatment Plan ***(exhibit #112).*** Thepolicy states that a complete andappropriate treatment plan, identifying	2025-01-30

	other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interviews, the agency failed to ensure the RN assigned tasks appropriately to the HHA in 2 of 2 active clinical records reviewed with HHA services (Patients #4, 8). Findings include:		duties to be performed by the HomeHealth Aide, shall be developed by a Registered Nurse or Therapist. All homehealth aide staff will follow the identified plan. The Treatment plan will beavailable to all persons involved in client care, including contractedproviders in order to provide a means of assigning duties to the Home HealthAide that are clear to the Nurse, Home Health Aide, and to the client/caregiverbeing served, to provide documentation that the supervising Nurse oriented theassigned Aide to the client's care before initiating the care, and to provide documentation that the client's care isindividualized to his/her specific needs. Special instructions #1 states that followingthe initial nursing assessment and consultation with the client/caregiver, awritten plan identifying personal care and supportive care services developed by the admitting clinician;states that the HHAide treatment plan shall be developed in plain, non-technicallay terms and identify the duties to be performed such as, but not limitedto: personal care,	

	# The clinical record review of Patient #8 revealed a POC dated 11/19/2024 to 1/17/2025 that included RN visits once a week for 9 weeks with 2 visits that can be done as needed and HHA services once a week for one week then twice a week for eight weeks. The clinical record for Patient #8 revealed an initial comprehensive assessment, completed on 11/19/2024 that indicated Patient was alert to person place and time with forgetfulness and confusion with new and complex situations. The HHA care plan, signed by RN 2 on 11/19/2024, revealed a sponge bath as requested, a tub bath as requested, a shower as requested, shampoo/grooming as requested, and mouth care as requested. The HHA care plan failed to evidence patient specific duties assigned by RN 2. During an interview on 1/7/2025 at 9:50 AM, Administrator relayed the care plan says 'as requested' so Patient can choose care, but it does not provided direction for care frequency.		ambulation andexercise, household services essential to health care at home, assistance withmedications that are ordinarily self-administered, meal planning andpreparation when supportive of health maintenance and promotion; #3 HHAideshall be assigned to the patient after ordered by the physician to include thefrequency and duration of the visit; #4- Prior to initiating care, HHAide shallbe oriented to the client's care needs and shall be updated on modifications orchanges in the client's care: #6- HHAide is not be responsible performing anyprocedure that is not assigned or that is beyond his/her ability. Tasks must berelated to the physical care needs of the client. On 01-08-2025, the EHR providerwas contacted to revise the HHAide Aide Care Plan ***(exhibit #113)*** afterapproved by the Governing Body on 01-07-2025 to include column for frequenciesof tasks identified specific for each patient for HHAide to follow every visit.Hard copy shall be temporarily used while waiting for the EHR provider tocomplete the revision. It shall	

	410 IAC 17-14-1(m)		be the responsibility of the Clinical Manager/QAto ensure HHAide Care Plan is individualized and unique for each patient byutilizing the revised Clinical Chart Review during initial and monthly chartaudit. Disseminationof information regarding the revised forms completed on 01-30-2025.	

	1. A clinical record review for Patient #4 evidenced an initial plan of care signed by the physician for certification period 09/10/2024-11/08/2024, which indicated the patient had a diagnosis of epilepsy (seizures) and the safety measures included seizure precautions. The plan of care indicated the agency was to notify the physician if the heart rate was less than 60 beats per minute (bpm). The HHA care plans dated 09/10/2024 and 11/06/2024 and signed by the RN failed to evidence seizure precautions and indicated the HHA was to notify the RN if the heart rate was less than 50 bpm and not 60 bpm as ordered in the plan of care signed by the physician. The HHA care plans indicated the HHA was to assist the patient with ambulation and transfers with the use of a wheelchair, walker, and cane and indicated the HHA was to assist with a home exercise program as directed by the therapist. Bathing and oral care were assigned per request and failed to evidence the RN directed the care based on the patient's assessed need. During an observation of care at			

	the patient's home on 01/07/2025, at 3:09 PM, no cane was observed in the patient's home. The agency folder was observed to include diagrams and instructions of home exercises the patient was to complete created by PT 1 and dated 11/01/2023. On 01/07/2025, at 3:15 PM, the patient's caregiver indicated the patient did not ambulate with a cane. On 01/09/2025, at 10:52 AM, HHA 1 (the patient's scheduled HHA) indicated she was never instructed about the seizure precautions and indicated the patient had a difficult time walking so did not use a cane. HHA 1 indicated she was not aware of a cane in the patient's home and was not aware of any home exercise program provided by the therapist. HHA 1 indicated she only performed range of motion exercises. On 01/09/2025, at 10:30 AM, PT 1 indicated the patient did not ambulate with a cane and the home exercises on the agency folder were old and the patient was no longer able to complete those exercises as directed.			

	On 01/09/2025, at 3:23 PM, the CM indicated there were no seizure precautions on the HHA care plan and the task to assist with ambulation with the use of a cane should not be included on the care plan. The CM indicated the HHA plan of care should match the plan of care signed by the physician related to the heart rate parameters.			
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 agency failed to ensure the HHA completed tasks per the care plan in 1 of 2 active clinical record reviewed with HHA services. (Patient #4) The findings include: A clinical record review for Patient #4 evidenced HHA visit notes completed by HHA 1 and	G0800	On 01-10-2025, the clinical manager called foran emergency meeting of all personnel, and provided an in-service regarding thePolicy and Procedure on Home Health Aide Treatment Plan ***(exhibit #114).*** Thepolicy states that a complete and appropriate treatment plan, identifying duties to beperformed by the Home Health Aide, shall be developed by a Registered Nurse orTherapist. All home health aide staff will follow the identified plan. TheTreatment plan will be available to all persons involved in client care,including contracted providers in order to provide a means of assigning dutiesto the Home Health Aide that are clear to the Nurse, Home Health Aide, and tothe client/caregiver	2025-01-30

	dated 11/12/2024, 11/14/2024, 11/20/2024, 11/23/2024, 11/26/2024, 11/29/2024, 12/04/2024, 12/07/2024, 12/10/2024, 12/17/2024, 12/19/2024, 12/31/2024, and 1/03/2025 which indicated the HHA performed active and passive range of motion to upper and lower extremities. The HHA care plan dated 11/06/2024 failed to evidence the HHA was directed to perform range of motion exercises. On 01/09/2025, at 10:52 AM, HHA 1 (the patient's scheduled HHA) indicated she completed active and passive range of motions during the patient's personal care and was not aware it was not indicated as a task to perform on the HHA care plan. On 01/09/2025, at 3:23 PM, the CM indicated there were no seizure precautions on the HHA care plan and the task to assist with ambulation with the use of a cane should not be included on the care plan.		being served, to provide documentation that thesupervising Nurse oriented the assigned Aide to the client's care beforeinitiating the care, and to providedocumentation that the client's care is individualized to his/her specificneeds. Special instructions #1 states that following the initial nursingassessment and consultation with the client/caregiver, a written planidentifying personal care and supportive care services developedby the admitting clinician; # states that the HHAide treatment plan shall bedeveloped in plain, non-technical lay terms and identify the duties to beperformed such as, but not limited to: personal care, ambulation and exercise, household services essential tohealth care at home, assistance with medications that are ordinarily self-administered,meal planning and preparation when supportive of health maintenance andpromotion; #3 HHAide shall be assigned to the patient after ordered by thephysician to include the frequency and duration of the	

			visit; #4- Prior toinitiating care, HHAide shall be oriented to the client's care needs and shallbe updated on modifications or changes in the client's care: #6- HHAide is notbe responsible performing any procedure that is not assigned or that is beyondhis/her ability. Tasks must be related to the physical care needs of theclient. On 01-08-2025, the EHR provider was contacted to revise the HHAide AideCare Plan ***(exhibit #115)*** after being approved by the GoverningBody on 01-07-2025 to include column for frequencies of tasks including thetype of exercise that can be performed during the visit. Hard copy shall betemporarily used while waiting for the EHR provider to complete the revision. TheClinical Chart Review was revised and approved by the Governing Body on01-24-2025 to include item G.1- Completed & e-signed by SN- HHA Care Plan- revised1-10-2025***(exhibit #116)***. Disseminationof information regarding the revised forms completed on 01-30-2025. It shall be the responsibility of	

			the assignedRN to the patient to ensure that tasks are performed as often as indicated inthe individualized Home Health Aide Care Plan unique for each patient, and theClinical Manager/QA will monitor to ensure HHAide Care Plan is individualizedand unique for each patient by utilizing the revised Clinical Chart Reviewduring monthly chart audit.	
G0818	HH aide supervision elements 484.80(h)(4)(i-vi) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements: (i) Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; (ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection prevention and control policies and procedures; (v) Reporting changes in the patient's condition; and (vi) Honoring patient rights. Based on record review and	G0818	On 01-10-2025, the clinical manager called for an emergencymeeting of all personnel, and provided an in-service regarding the Policy andProcedure on Home Health Aide Supervision ***(exhibit #114).*** Itstates that the agency shall provide Home Health Aide services under thedirection and supervision of a Registered Professional Nurse/Therapist whenpersonal care services are indicated and ordered by the physician as required.During supervision, the HHAide will be observed to ensure the HHAide is competentin performing the basic skills and is competent and is performing the tasks delegatedbased on the individualized Home Health	2025-01-30

	interview, the agency failed to ensure the HHA supervision included the aide's compliance with infection control, reported changes in the patient's condition, and honored the patient's rights in 2 of 2 active clinical records reviewed with HHA services. (Patient #4, 8) The findings include: # The clinical record review of Patient #8 revealed a POC dated 11/19/2024 to 1/17/2025 that included RN visits once a week for 9 weeks with 2 visits that can be done as needed and HHA services once a week for one week then twice a week for eight weeks. The RN visit documentation 12/19/2024, 12/12/24, and 12/5/2024 revealed the following supervision goals as 'met': patient clean and comfortable, established good rapport with patient, appropriate and necessary personal care given, environment is safe and clean, and progress towards personal care. The HHA supervision documentation failed to address honoring Patient's rights, infection prevention, nor if the HHA care plan was being followed. During an interview on		Aide Care Plan. During supervision, theHHAide is provided with opportunity direct interaction with the nurse andclient as it relates to the current plan of treatment. Special instructions #1 statethat the nursing supervisor or the designated Registered Nurse/Therapist willgive the Home Health Aide direction for client care by way of the Home Health Aide Care Plan. A copy ofthis written plan is to be left in the client's home and revised periodically,as necessary copy of which shall be kept in the client's chart: #3-specialinstructions further provides guidance as to who and how often the supervisionmust be made, as stated the Registered Nurse/Therapist must make a supervisoryvisit to the client's residence at least every 2 weeks, to assess relationshipsand determine whether goals are being met, and #4 special instructions directsthat the supervisory visits are to be documented in the client's chart on theHome Health Aide Supervision Form. The client/caregiver will be notified Ithere are changes. The HHAide supervisory form was changed	

	1/8/2025 at 9:50 AM, Administrator revealed the HHA supervisory documentation did not include evaluation if the plan of care was followed, patient rights, nor infection control. 410 IAC 17-14-1(n) 1. The clinical record review for Patient #4 evidenced HHA supervision visits completed by RN 1 and dated 11/13/2024, 11/18/2024, 11/25/2024, 12/02/2024, 12/09/2024, and 12/23/2024 which failed to include the supervision of the HHA to include compliance with infection control, reporting changes of the patient's condition, and honoring the patient's rights. On 01/09/2025, at 3:31 PM, the CM indicated the form used for supervision visits was not comprehensive to include all of the required elements of HHA supervision so there was no documentation of HHA supervision of a complete supervision visit.		***(exhibit #117)***,and all RN and Therapists were directed to utilize the form that was presentedto the surveyors during the survey. To ensure compliance, the Clinical Manager/QA required andinstructed all RN and Therapist to perform HHAide supervisory visit every 2weeks utilizing the new Supervisory Visit Notes for HHAide (e***xhibit 117),***and requested the EHR provider to add the items #3-The aidemaintains an open communication with patient, representative (if any),caregivers, and family, and item #4-The aide relates well with the patient/family,and respects patient's rights. The Clinical Chart Reviewform revised and approved by Governing Body on 01-24-2025 to include the items:F.14-HHAsupervision done q 14 days/less using the new form, and item G.7- Supervisiondone (RN/PT) Q 14 days/ less-using new form ***(exhibit #117)***. Disseminationof information regarding the revised forms completed on 01-30-2025. Theclinical manager/QA shall	

			monitor and ensure that HHAide supervisory q 2 weeksutilizing the new Supervisory Visit Notes for HHA using the revised ClinicalChart Review form during monthly chart audit to ensure compliance.	
G0960	Make patient and personnel assignments, 484.105(c)(1) Making patient and personnel assignments, Based on record reviews and interview, the CM failed to demonstrate oversight of the nursing services and monitoring to ensure nursing services were provided to patients as ordered, to include making patient and personnel assignments in 3 of 6 active records reviewed with nursing services ordered. Findings include: The clinical record review of Patient #8 revealed a POC dated 11/19/2024 to 1/17/2025 that included RN visits once a week for 9 weeks with 2 visits that can be done as needed. The clinical record included RN visit documentation on	G0960	On 01-10-2025, the ClinicalManager called for an emergency meeting of all personnel, and provided anin-service to properly complete the form entitled Weekly Time Sheet ***(exhibit#119)*** to complete the projected visit for the next 2 weeks which willserve as a basis for the creation of tasks on EHR to enable the clinical managerto monitor projected tasks/visits to be provided by all visiting personnel tothe patient aside from just basing it from the weekly time sheets (paper-based),and to enable everyone to view the planned visits of other visiting personnel. TheClinical Manager assigned the office manager to create tasks of the visitingstaff on the EHR based on the submitted Weekly Time Sheet to enable	2025-01-30

	12/19/2024. The record failed to evidence a scheduled nor documented RN visit the week of 12/23/2024, 12/30/2024, and 1/6/2025. The clinical record review of Patient #2 revealed a POC dated 10/23/2024 to 12/30/2025 that included RN visits once a week for 9 weeks with 2 visits that can be done as needed. The clinical record included RN visit documentation on 12/27/2024. The record failed to evidence a scheduled nor documented RN visit the week of 12/30/2024 and 1/6/2025. The clinical record review of Patient #1 revealed a POC dated 12/22/2024 to 2/19/2025 that included RN visits once a week for 9 weeks with 2 visits that can be done as needed. The clinical record included RN visit documentation on 12/26/2024. The record failed to evidence a scheduled nor documented RN visit the week of 12/30/2024 and 1/6/2025. During an interview on 1/8/2025 at 9:50 AM, Administrator relayed she does not schedule patient visits and		theclinical manager and the rest of the visiting staff of projected tasks. The InitialOrientation Checklist at the time of hiring was revised and approved by theGoverning Body on 01-24-2025 to include the item IX- Weekly Time Sheetsubmitted on time w/ the projected visits for the succeeding 2 weeks ***(exhibit#120***) which will be used as a guideline when providing orientation tonewly hired personnel, and will be emphasized non-completion means non-paymentof visits. Non-completion will not be tolerated, non-completion, non-inclusionin the payroll. The Clinical Chart Review was also revised and approved by theGoverning Body to include the item I.10- Projected visits/tasks are scheduledon EHR ***(exhibit #121)***. It will be the responsibility of the officemanager to ensure that submitted Weekly Time Sheets are properly filled out andcompleted before getting visits included in the payroll, and all projectedvisits /tasks are scheduled/created on the EHR.	

	agency staff make their own schedule for patient visits.		Disseminationof information regarding the revised forms completed on 01-30-2025. The Clinical Manager will be responsible for monitoring to ensure complianceby utilizing the revised Clinical Chart Review to ensure compliance whenperforming initial and monthly chart audits.	
G0984	In accordance with current clinical practice 484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Based on record review and interview, the agency failed to ensure agency services were provided in accordance with current clinical practice guidelines and accepted professional standards of practice in 5 of the 5 clinical records reviewed with more than 60 days of admission (Patient #1, 2, 4, 5, 6). Findings include: # The agency policy titled "Physician Summary" indicated a summary report will be provided to the physician no less than every sixty days to include the patient's current condition, response to current	G0984	The clinical manager called for an emergency meeting of allStaff on 01-10-2025 and provided an in-service regarding the Policy andProcedure on PhysicianSummary ***(Exhibit #122)*** states that a summary report will beprovided to the physician no less than every sixty (60) days. The summary willprovide a written progress report of the client's current condition, thetreatment/services provided, and the client's response to the current treatmentand/or medications, and pertinent changes in the client's physical, emotional,or environmental condition since the last report to assure the physician is periodically informed of client condition andprogress, and to coordinate information between physicians and other members ofthe	2025-01-30

	treatment or medications, and changes in the patient's condition since the prior report. During an interview on 1/8/2025 at 10:20 AM, Administrator relayed the 60 day summary was included in the comprehensive assessments patients that was not sent to the physicians. She revealed the agency has not sent 60-day summaries to physicians. The clinical record for Patient #1 revealed an initial POC dated 11/1/2024 to 12/30/2024 and POC dated 12/31/2024 to 2/28/2025. The clinical record failed to evidence 60-day summary documentation sent to the physician. The clinical record for Patient #2 revealed an initial POC dated 10/23/2024 to 12/21/2025 and a POC dated 12/22/2024 to 2/19/2025. The clinical record failed to evidence 60-day summary documentation sent to the physician. The clinical record for Patient #6 revealed a start of care comprehensive assessment on 8/30/2023 and a discharge date of 12/22/2024. The review of		health care team. Special instructions #1 states that the progressnote/physician summary will be completed by the professional completing thePlan of treatment. The summary note will include but not limited to: a-Clinicalsummary of the care, treatment and services provided during the previous 60-dayepisode of care, b- Client response to the services and progress towardestablished goals. Summary of current needs and involvement of othercommunity/family caregivers or services, and c-Date sent to physician and thename of the physician. Duringthe in-service, the clinical Manager instructed all personnel staff that a60-day summary will be recalled (as practiced in the past). It will be includedin the plan of treatment. Discussed what needs to be included in the 60-daysummary: patient'scurrent condition, response to current treatment or medications, and changes in the patient's condition since the priorreport. It was emphasized that the person completing the OASIS and Plan oftreatment	

	evidence 60-day summary documentation sent to the physician for the 14 months of agency admission. 1. A clinical record review for Patient #4, start of care 09/10/2024, failed to evidence a summary of care had been sent to the physician since SOC. 2. A clinical record review for Patient #5, start of care 11/27/2023, failed to evidence a summary of care had been sent to the physician since certification period beginning 9/22/2024.		shall also complete the 60-day summary to be included in the plan oftreatment/ will be sent as a separate document ***(exhibit #123)***. Recert weeklyreminders of projected recert list will include about the 60-day summary whenrecertification is being done. TheClinical manager revised the Clinical Chart Review and approved by the GoverningBody on 01-24-2025 to include the items on Oasis Collected A.3 and B.12- 60-day summary ofcare completed as required ***(exhibit #124)***. It will be the responsibilityof the staff completing the OASIS and Plan of Treatment/care/ 485 to alsocomplete the 60-day summary. Disseminationof information regarding the revised forms completed on 01-30-2025. The Clinical Manager/QAwill be responsible in monitoring and ensuring compliance by utilizing the revisedClinical Chart Review when completing the monthly chart audit.	
G1022	Discharge and transfer summaries	G1022	On 01-10-2025, the Clinical	2025-01-30

	484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to 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 (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. Based on record review and interview, the agency failed to ensure a completed discharge summary was provided to the physician in 2 of 2 closed clinical records reviewed (Patient #6, 7). Findings include: 1 .The agency policy titled "Discharge Summary" indicated when a patient was discharged from the agency, a discharge summary will be completed that includes instructions provided to the family and unmet needs. The skilled professional would assure that if goals have not been met, appropriate referrals were made to meet continuing needs of the patient.		Manager called for an emergencymeeting of all personnel, and provided an in-service regarding the Policy andProcedure on Discharge Summary ***(exhibit 125).*** The policy statesthat a dischargesummary will be completed for clients discharged from the agency so that when aclient is discharged from the agency, the supervising professional shallcomplete a Discharge Summary form within the time frame defined by the agency.A copy will be mailed to the physician, and will be incorporated findings fromthe discharge OASIS assessment and shall include, but not be limited to:admission and discharge dates, services provided, diagnosis(es), status uponadmission, status at time of discharge, notification of discharge, reason fordischarge, transfer information if applicable, unmet needs, referrals made, andinstructions provided for the family. Patient#5, above information required are contained in page 20-21 in the dischargeOASIS which contains all the required information for a discharge	

	2. The clinical record for Patient #6 revealed an initial SOC comprehensive assessment dated 8/30/2023 and a POC dated 8/24/2024 to 10/22/2024 that included orders for RN visits once a week. The clinical record included a verbal order dated 10/22/2024 indicating Patient may be discharged, signed by the physician 11/15/2024. The patient was discharged on 10/22/2024. The discharge summary, signed by the physician 11/5/2024, failed to evidence Patient discharge instructions nor goals that are met. During an interview on 1/8/2024 beginning at 9:50 AM, Administrator relayed the Patient's discharge instructions are in the discharge comprehensive assessment which is not sent to the physician and the discharge summary did not include the goals. 2. The clinical record for Patient #7 revealed an initial comprehensive assessment on 9/26/2024 and an initial POC for dates 9/26/2024 to 11/24/2024 for RN visits once a week for 9 weeks and PT to evaluate and		Summary ***(exhibit126 a-b).*** Contrary to the tag***,*** discharge summary sent toMD states the patient was discharged with goals met on 2 areas in the form sentto and signed by MD, copy of which was available at the EHR ***(exhibit 127& 128)*** and ***(exhibit 129).*** The discharge notificationalso included the medication list same medications discussed with the patient,and copy patient had on the Patient red book at the time of discharge. Patient#7, discharged on 11-08-2024, discharge documents on EHR shows aboveinformation required are contained in page 20-21 in the discharge OASIS whichcontains all the required information for a discharge Summary ***(exhibit 130a-b).*** Contrary to the tag***,*** the discharge summary sent toMD states the patient was discharged with goals not met on 2 areas in the form statingthe reason for goals not met is due to early discharge as requested by patient sentto and signed by MD, copy of which was available at the EHR ***(exhibit 131)***and ***(exhibit 132)***. The discharge notification alsoincluded the medication list	

	treat. The clinical record included a verbal physician's order to discharge Patient per Patient request dated 11/8/2024 and signed by the physician 11/15/2024 and a discharge summary report signed by the physician on 11/15/2024. The discharge summary failed to evidence progress in goals nor discharge instructions provided to Patient. During an interview on 1/8/2025 beginning at 9:50 AM, Administrator relayed the discharge summary for Patient #7 did not include progress in goals nor discharge instructions provided to Patient. 410 IAC 17-15-1(a)(7)		of the same medications discussed with thepatient, and copy patient had on the Patient red book at the time of discharge. Movingforward pages 20-21 shall be included when sending DC Summary to MD or will beutilizing the separate 60-day summary form separately, to make the reportcomplete and compliant. 01-30-2025,disseminated information regarding the Discharge Summary that must be completedat the time of discharge. TheClinical Manager revised the Clinical Chart Review ***(exhibit #133)***form to specifically include item K.3- Complete DC Summarysent MD w/in 5 business days. The Discharging personnel will be completing theDischarge Summary, and it will be the responsibility of the Clinical Manager/QAto ensure compliance by utilizing the Clinical Chart Review during the finalchart audit at the time of discharge.	
G1024	Authentication	G1024	The clinical manager called for	2025-01-30

	484.110(b) Standard: Authentication. All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. Based on record review and interviews the agency failed to ensure all entries in the clinical record are appropriately authenticated in 6 of 6 active clinical records reviewed (Patients #1, 2, 3, 4, 5, 8). Findings include: 1 .The agency policy titled "Physician Orders" indicated all medications, treatments and services for patients would be ordered by a physician. Verbal orders may be taken in accordance State and Federal laws and be read back to the physician to verify the accuracy of the orders. 2. During an interview on 1/8/2025 at 9:50 AM, Administrator revealed she did not collaborate with the physician for initial orders for patient care and a verbal order was sent to obtain orders for		an emergency meeting of allStaff on 01-10-2025 and provided an in-service regarding the Policy andProcedure on Electronic Signature ***(exhibit #134)*** and PhysicianOrder ***(exhibit #40)***. Electronic Signature policy states that an electronicsignature will authenticate certain clinical record documents generated in thecomputerized medical record system. Thedocuments affected by this policy include visit notes, charting sessions,verbal orders, and summaries. It is designed for the purpose of thecomputerized home care record; the employee's use of the ID number and personalPIN will serve as their legal signature. Employee ID numbers are issued by theAgency upon employment or when point of care documentation systems areimplemented. Itis a practice of the agency that at the time of hire, a new employee who willhave an access to the PHI thru the EHR, the new hire will submit an emailaddress as assigned an initial pass word, and is directed	

	care. In an interview on 1/9/2025 at 4:08 PM, Administrator relayed a verbal order was created for a service visit is missed to notify the physician, and the physician was not contacted for the verbal order. During an interview on 1/9/2025 at 9:50 AM, PT 1 relayed the physician was not called for the missed visit verbal orders rather the verbal orders were created to notify the physician. The clinical record for Patient #1 revealed an initial comprehensive assessment, completed on 11/1/2024 by Administrator. The record included a verbal ordered dated 11/1/2024 for a comprehensive assessment, RN visits once a week for 9 weeks plus two extra visits as needed with specified assessments, and PT to evaluate and treat patient; the verbal order dated 11/1/2025 was signed by a physician on 11/19/2024. The verbal order failed to be authenticated by consulting with the physician prior to the physician's signature. The clinical record for Patient #1 revealed verbal		to use thisinformation to open the EHR, and is directed to change the password of choiceto maintain confidentiality of records entered confirmed by her e-signaturewith the name and discipline/occupation as in exhibit (***exhibit 135).*** Discussedthe Policy on Physician Order during the in-service. Emphasized that allmedications, treatments and services provided to clients must be ordered by aphysician. The orders may be initiated via telephone or in writing and must becountersigned by the physician in a timely manner. Verbal orders may be takenby licensed personnel designated by the agency and that all verbal orders mustbe "read back" to the physician to verify the accuracy of the orders and todecrease errors to inaccurate documentation of verbal orders. Specialinstructions #1 emphasized, states that the order must be read back to assure thatit was heard and interpreted correctly with the date the date & time theorder was received, the specific order, and the signature and title of theperson receiving the order	

	orders, signed by PT 1, to hold PT service visits and resume PT services the following week on 11/29/2024 (signed by a physician 12/12/2024) and 12/7/2024 (signed by a physician on 12/12/2024). A verbal order for a missed visit on 12/24/2024, signed by PT 1, indicated Patient may resume PT visits on 12/26/2024 and was not signed by a physician. The verbal orders failed to evidence authentication by a physician prior to being signed. 3. During an interview on 1/9/2025 at 4:08 PM, Administrator relayed a verbal order was created for a service visit is missed in order to notify the physician, and the physician was not contacted for the verbal order. During an interview on 1/9/2025 at 9:50 AM, PT 1 relayed the physician was not called for the missed visit verbal orders rather the verbal orders were created to notify the physician. During an interview on 1/8/2025 beginning at 11:15 AM, RN 2 relayed that after the initial comprehensive		and be sent physician for signature. Documentationmust be placed in the record to indicate the supervisor was notified of thechanges. Special instructions #6 further allows the agency to follow and use asystem to ensure the telephone orders and other documentations needing mdsignature shall be signed and dated by the physician and returned to theclient's clinical record within an appropriate time frame. Agency willimplement a tracking system to assure timely response. Theclinical manager contacted the EHR provider to revise the Verbal order to collaboratewith the physician for orders include authentication of the order received and readback to the physician to verify the accuracy of the orders and to prevent errorsto inaccurate documentation of verbal orders. The EHR provider provided theVerbal Order form #13 which was approved by the Governing Body. All visitingpersonnel, RN & therapist, use of verbal order to Verbal order #13 ***(exhibit#136)*** for implementation immediately.	

	assessment for Patient #2, a physician verbal order was created and sent to the physician to be signed as orders for care. RN 2 relayed that the physician was not consulted for the documentation on the verbal order. The clinical record for Patient #2 revealed an initial assessment completed 10/23/2024 by RN 2. A verbal order dated 10/23/2024 for a comprehensive assessment, RN services once a week for nine weeks plus two visits if needed, with specified assessments and evaluations to provided to Patient; the verbal order included PT services to evaluate and treat. The verbal order was signed by the physician 11/8/2024. The verbal order failed to be authenticated by consulting with the physician prior to the physician's signature. The clinical record for Patient #2 revealed verbal orders to hold PT service visits and resume PT services the following week on 11/8/2024 (signed by a physician 11/15/2024), 11/29/2024 (signed by a physician 12/9/2024), 12/7/2024 (signed by a physician on 12/13/2024),		TheClinical Chart Audit form was revised and approved by the Governing Body on01-24-2025 to include the item C.1- Received & read back to MD by onereceived the verbal order, and C.2- Signed, dated by MD ***(exhibit # 137)***,and should be strictly implemented. Disseminationof information regarding the revised forms completed on 01-30-2025. Itshall be the responsibility of the one receiving the order to authenticate theorder received by reading to assure that it was heard and interpreted correctlywith the date the date & time the order was received, the specific order,and the signature and title of the person receiving the order using the Verbalorder #13 on the EHR found under Treatment Plan-Verbal order. It shall be the responsibility of the ClinicalManager/QA to monitor compliance by utilizing the revised Clinical Chart Reviewduring initial and monthly chart audits	

	12/13/2024 (signed by a physician 12/23/2024), and 12/27/2024 (not signed by a physician as of 1/8/2024), signed by PT 1. The verbal orders failed to evidence authentication by a physician prior to being signed. 4. During an interview on 1/8/2025 beginning at 11:15 AM, RN 2 relayed that after the initial comprehensive assessment for Patient #8, a physician verbal order was created and sent to the physician to be signed as orders for care. RN 2 relayed that the physician was not consulted for the documentation on the verbal order. During an interview on 1/9/2025 at 4:08 PM, Administrator relayed a verbal order is created when a service visit is missed in order to notify the physician, and the physician was not contacted for the verbal order. During an interview on 1/9/2025 at 9:50 AM, PT 1 relayed the physician was not called for the missed visit verbal orders rather the verbal orders were created to notify the			

physician.

The clinical record for Patient #8 revealed an initial assessment completed 11/19/2024 by RN 2. A verbal order dated 11/19/2024 for a comprehensive assessment, RN services once a week for nine weeks plus two visits if needed, with specified assessments and evaluations to provided to Patient, PT services to evaluate and treat, and an HHA once a week for one week then twice a week for eight weeks. The verbal order was signed by the physician 11/26/2024. The verbal order failed to be authenticated by consulting with the physician prior to the physician's signature. The clinical record for Patient #8 revealed verbal orders to hold PT service visits and resume PT services the following week on 11/23/2024 and 12/6/2024. The verbal orders failed to evidence authentication by a physician.

410 IAC 17-15-1(b)

1. A clinical record review for Patient #3 evidenced a document titled "Physician

	12/11/2024 and signed by RN 2 which was identified as the SOC orders from the physician indicating skilled nursing was to provide a skilled assessment and patient education. On 01/09/2024, at 10:59 AM, RN 2 indicated she wrote the SOC orders which were sent to the physician for review and signature, but there was no communication with the physician's office to receive or verify verbal SOC orders or review the POC. 2. A clinical record review for Patient #4 evidenced the plan of care for the recertification period of 11/09/2024-01/07/2025 signed by the physician which indicated the agency was to provide PT services 2 times a week for 6 weeks and HHA services 2 times a week for 8 weeks. Documents titled "Physician Telephone/Verbal Order" indicated the patient requested a hold of PT services on 11/16/2024 and PT visit frequency was changed to 1 time a week for the next 8 weeks and was signed by PT 1 and the document dated			

indicated the patient requested the HHA visits be held for the week.

On 1/07/2025, at 3:15 PM, the patient's caregiver indicated neither the caregiver nor the patient refused PT or HHA services.

On 01/07/2025, at 3:15 PM, RN 1 indicated she left a message with the medical assistant at the physician's office on 12/24/2024 related to the aide services on hold and did not speak with the physician nor did she get a return message from the physician's office for a verbal order for the patient's HHA hold.

3. A clinical record review for Patient #5 evidenced a plan of care for the recertification period 09/22/2024-11/20/2024 which indicated the agency was to provide PT services 2 times a week for 8 weeks. A document titled "Physician Telephone/Verbal Order" signed by PT 1 on 10/5/2024 indicated PT frequency was changed to 1 time a week for 8 weeks.

4. On 01/09/2025, at 10:30 AM, PT 1 indicated he has never

	called the physician's office for orders. PT 1 indicated he documents communication with the physician on a verbal order form and sends it to the physician for review and signature.			
N0000	Initial Comments This visit was for a State Re-licensure Survey of a Home Health provider. Survey Dates: January 6, 7, 8, and 9, 2025 Unduplicated skilled admissions: 12 QR: A 1 01/23/2025	N0000		
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	N0458	TheGoverning Body held an emergency meeting on 01-09-2025 immediately after thestate survey, and reviewed the Policy and Procedure on Personnel Records ***(exhibit#138)***. The policy states that Personnel files will be established andmaintained for all personnel to provide a mechanism for maintaining	2025-01-30

	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. Based on record review and interview the agency failed to ensure personnel records were kept current with documentation of a national expanded criminal history, job description, a copy of the current license, and annual performance evaluations in 4 of 8 personnel records reviewed (Alternate Administrator, RN 1, Data Entry Coder, OT 1). Findings include: 1. The personnel record review for RN 1 revealed RN license documentation expiring 10/31/2023. The record failed to evidence documentation of a current RN license.		accurate,complete, and current personnel information. Special instructions #1 a-statesthat personnel records of employees will include but not limited to:Pre-employment Information: employment application (signed and dated),interview documentation, reference checks, drug screening effective, criminalhistory and background checks as required by law, and credentials;1 b- Employment Information: competencytesting for home health aides and specific competencies per job title, licenseand certifications, CPR certification, signed and dated job description, skillschecklist, orientation checklist – completed and signed, confidentialitystatement (signed), conflict of interest statement (signed) if applicable,receipt of handbook acknowledgement, employee benefit information, and I-9 andpayroll information (maintained in separate file); 1 c- Ongoing Employment:performance appraisals, updated job descriptions, education record,in-services, updated license/certifications, competency reviews, commendations,disciplinary	

	During an interview on 1/6/2025 at 3:22 PM, Administrator relayed a copy of the current license was not in the personnel record for RN 1. 2. The personnel record review of Alternate Administrator revealed a job description of CM. The personnel record failed to evidence a job description of Alternate Administrator. During an interview on 1/6/2025 at 3:22 PM, Administrator relayed the job description for Alternate Administrator was absent from the personnel file. 3. The personnel file for Data Entry Coder and Biller failed to evidence a national criminal background check. During an interview on 1/6/2025 beginning at 3:22 PM, Administrator relayed Data Entry and Coder had access to patient records and the national criminal background was not in the personnel file for Data Entry and Coder. 4. The personnel file for OT 1 revealed a performance evaluation dated 8/31/2022.		action forms, and incident reports; #1 d- Medical History/HealthStatus – Maintained Confidentially: pre-employment should include: physical, hepatitis Bdeclination or immunization record, TBscreening (2-step Mantoux), chest x-ray or evidence of treatment as indicated, anddrug screening effective; #1 e- Employment: records should includeongoing immunization and TB testing, illness record, attendance, workersCompensation claims, criminal background (as required)- check results, and Drugscreening effective July 1, 2017(as required). TheGoverning Body emphasized that all personnel who have access to client recordsbe it in paper and EHR shall be required to undergo a National ExpandedCriminal History Background Check as in the case of Data Entry Coder, andlicenses of all professional licensed personnel should be checked on a regularbasis specifically at the renewal period: nurses are renewed on odd years, andHHAide, therapist and MSW are renewed on even years as in the case of RN 1.	

	performance evaluation in 2023 nor 2024. During an interview on 1/6/2025 at 3:22 PM, Administrator relayed OT 1 had medical time off in 2024 and the performance evaluation had not been completed.		TheEmployee Records Checklist ***(exhibit 139)*** was revised and approvedon 01-24-2025 by the Governing Body to include multiple lines to enable entryof multiple job descriptions (JD) such in the case of the Alternate-Administrator to clearly reference from when updating and auditing personnelrecords, provided a column to indicate expiration dates should be indicated onthe checklist so as to know when an update is required, and to includePerformance Evaluation with the time frame as to when it should be done andonce completed should be signed and dated by the rater and the discipline beingevaluated after the probationary period and annually thereafter as in the caseof OT 1. Date of completion will be entered so as to know when will be the nextevaluation due date. Duringthe survey, current professional license of RN 1 ***(exhibit #140)*** wasobtained from the Indiana Professional Licensure Agency (IPLA), and the National Expanded Criminal History BackgroundCheck ***(exhibit #141)*** of the Data Entry Coder was checkedand	

			copy of the results were presented to the surveyors. The AlternateAdministrator Job Description copy ***(exhibit # 142)*** was requested andprovided, at the same time an updated copy was signed and dated by theAlternate Administrator on 01-10-2025. In the case of OT 1, his last OT visitwas on 05-26-2022, and on 01-07-2023 he applied for a medical leave.Performance evaluation was completed on 09-06-2022. No patients assigned for theyear 2023, so no basis of performance evaluation as there were no visits done.On 12-16-2024, he started accepting patient assignment, and so on 01-30-2025, aperformance evaluation was completed ***(exhibit #144).*** Disseminationof information regarding the revised forms completed on 01-30-2025 TheGoverning Body assigned the office manager to be responsible in maintainingaccurate, complete, and current personnel information by updating the personnelrecords utilizing the revised Employee Records	

			Checklist at the time of hireand during monthly personnel records audit. Reports will be submitted to the Administratoras to the completeness of the records upon completion of the monthly audit.	
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	N0464	The Governing Body held an emergency meetingon 01-09-2025 immediately after the state survey, and reviewed the Policy andProcedure on HealthScreening ***(exhibit #145)*** and Personnel Records ***(exhibit #146)***. TheHealth Screening policy states that all employees withpersonal contact with clients must have documentation of baseline healthscreening prior to providing care to clients. This includes, at a minimum, TBskin testing via the Mantoux method to ensure visiting personnel are freeof tuberculosis before providing directclient care. Special instruction #2 states that thereshall be documentation of completion of a tuberculin (TB) skin test, via theMantoux method. OSHA	2025-01-30

	(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). (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 record review and interview the agency failed to ensure staff with patient contact were evaluated for tuberculosis with a baseline two-step tuberculin skin test and an annual screening for tuberculosis in 3 of 8 personnel records reviewed of direct care staff (PT 1, OT 1, RN 2). Findings include: 1.The personnel file for PT 1		there is documented evidenceof a negative skin test within the twelve months prior to employment, testingcompleted at the time of hire will fulfill the two-step requirement. If theemployee does not have documented evidence of a negative Mantoux skin test withinthe past twelve months, a Mantoux skin test will be given at the time of hireand repeated within three weeks of the first test. The policyPersonnel Records states that personnel files will be established andmaintained for all personnel to provide a mechanism for maintaining accurate,complete, and current personnel information. Special instructions #1d-MedicalHistory/Health Status – Maintained Confidentially: pre-employment shouldinclude: physical, hepatitis B declination or immunization record, TB screening (2-step Mantoux), chest x-ray orevidence of treatment as indicated. Inthe case of PT 1, he was asked to complete the TB screening that he failed toanswer, and another TB Screening was completed on 01-09-2025	

	revealed a Tuberculin screening document signed and dated on 3/04/2024. The document failed to evidence the screening questionnaire was completed, nor evidence of annual skin testing. During an interview on 1/6/2025 beginning at 3:22 PM, Administrator relayed the form was signed and not completed. 2. The personnel file for OT 1 revealed a Tuberculin screening document signed and dated 02/01/2022. The record failed to evidence an updated Tuberculosis screening document since 02/01/2022, nor annual skin testing. During an interview on 1/6/2025 beginning at 3:22 PM, Administrator relayed the personnel was file was not updated with the tuberculosis screening.		***(exhibit #147).*** Asper records, OT 1 works as a part time employee. On 01-07-2023 he applied for amedical leave. On 12-12-2024, he started accepting patient assignment, he wasinstructed to complete a TB screening prior to visiting on 12-16-2024 ***(exhibit#148).*** ForRN 2, at the time of hire was requested to complete a Mantoux test on06-14-2023 with a negative (-) result on 06-16-2023 ***(exhibit # 149)***,and presented a Baseline TB Screening Tool dated 01-27-2023 ***(exhibit 150)***she completed from another home health agency stating that she wastested positive (+) Mantoux test in the past. MD waived chest x-ray andattested physical examination revealed no signs and symptoms of TB, and a copyof her chest x-ray she pulled out from her records from mychart ***(exhibit#151),*** with the official copy ***(exhibit #152).*** TheGoverning Body emphasized that TB screening requirement to all personnel whohas direct	

	3. The personnel record for RN 2 revealed a hire date of 3/14/2023. the file included one tuberculosis skin test, dated 6/16/2023; the record failed to evidence a baseline two-step tuberculosis skin test nor chest radiograph to exclude a diagnosis of tuberculosis. During an interview on 1/6/2025 beginning at 3:22 PM, Administrator relayed there was not two-step tuberculosis skin tests on file for RN 2 nor other forms of baseline screening or testing.		strictly implemented at the time ofhire, and after a baseline testing shall be required to complete a TB screeningannually. The Employee Checklist ***(exhibit #153)*** was revised andapproved by the Governing Body on 01-24-2025 to emphasize the TB screeningrequirement: Mantoux Test x 2 steps, unless theindividual has documentation that a tuberculin skin test has been applied atany time during the previous twelve (12) months with a negative result, or anegative result of QuantiFERON -TB assay, or a chest radiograph to excludea diagnosis of tuberculosis. It will be the responsibility of the OfficeManager and the Clinical Manager/QA to ensure that this is strictly implementedby utilizing the revised Employee Records Checklist at the time of hire/initialaudit and during monthly personnel record audit to ensure compliance.	
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:	N9999	TheGoverning Body held an emergency meeting on 01-09-2025 immediately after thestate survey, and discuss about the approved dementia training for home healthaides as	2025-01-30

	(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 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		mandated. As per deliberation, the Governing Body decided to become amember of the Indiana Association for Home and Hospice Care (IAHHC) as one ofthe approved providers of the training. Application process was initiated andwas issued a certificate of membership ***(exhibit #154).*** HHAide wasthen directed to complete the said training to comply to the required six (6)hour- initial requirement ***(exhibit #155 a-h),*** and HHAide isinstructed regarding need to complete 3 hours of Dementia Training annuallywhich should be completed on or before the year ends, December 31st. TheGoverning Body revised and approved the Employee Records Checklist on01-24-2025 to include Dementia Training for HHAide as required: 6 hoursinitially, and 3 hours to be completed annually, by the end of the year- Dec.31 ***(exhibit 156)***. Disseminationof information regarding the revised forms completed on 01-30-2025 TheGoverning Body assigned	

	treating individuals with dementia. (iii) Guidelines for the assessment and care of an individual with dementia. (iv) Procedures for providing patient centered quality care. (v) The daily activities of individuals with dementia. (vi) Dementia related behaviors, communication, and positive intervention. (vii) The role of an individual's family in caring for an individual with dementia. (B) The dementia training program: (i) must be culturally competent; and (ii) may be provided online. (2) Establish and implement a process for state department approval of a dementia training program. (g) To the extent allowed by 42 CFR 484.80, the hours of approved dementia training completed under this section satisfies an equivalent number of hours of the home health aide training required by 42 CFR 484.80. (h) An entity that provides approved dementia training shall provide to each home health aide who successfully completes the training a certificate of completion. (i) A home health aide: (1) is responsible for maintaining the home health aide's certificate of completion; and (2) may use the certificate of completion as proof of compliance with this section. 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		the office manager to be responsible in maintainingaccurate, complete, and current personnel information by updating the personnelrecords utilizing the revised Employee Records Checklist to ensure completionof the six (6)-hour Dementia Training to up to 60-days from the date of hirefor new employees, and completion of the 3-hour annual requirement to becompleted every December 31st of the succeeding years thereafter.The Employee Records Checklist will be used by the office manager duringpersonnel record audit to ensure said training is completed on time. Reportswill be submitted to the Administrator as to the completeness of the recordsupon completion of the initial and monthly audits.	

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 feedings to the registered home health aide 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 record review and interview, the agency failed to ensure at least 6 hours of approved dementia training was provided to HHA's in the first 60 days of hire in 1 of 1 HHA personnel record reviewed (HHA #1).

Findings include:

A clinical record review for Patient #4 evidenced a physician's progress note dated 09/25/2024 which indicated the patient had a decline in memory. The plan of care for the recertification period 11/09/2024-01/07/2025 signed by RN 1 indicated the diagnoses included Parkinson's disease (a progressive brain disorder) and indicated the patient was disoriented to date/time, forgetful, and easily confused in new and complex situations. The POC indicated the agency was to provide HHA services 2 times a week for 8 weeks.

HHA visit notes completed by HHA 1 indicated HHA services were provided on 11/12/2024, 11/14/2024, 11/20/2024, 11/23/2024, 11/26/2024, 11/29/2024, 12/04/2024,

	12/07/2024, 12/10/2024, 12/17/2024, 12/19/2024, 12/31/2024, and 01/03/2025. On 01/07/2025, at 3:37 PM, RN 1 indicated the patient had dementia and was confused and forgetful. The personnel record of HHA 1 was reviewed and revealed a hire date of 2/9/2022; the record failed to evidence 6 hours of approved dementia training was completed. During an interview on 1/6/2025 at 3:22 PM, Administrator relayed the dementia training was from a private source and was not approved dementia training.			

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
Antonietta Gaoat	Administrator	2/2/2025 2:07:25 AM