STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157601	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL HOME HEALTH SERVICES INC	7863 BROADWAY STE 202, 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 An Emergency Preparedness survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 484.102. Survey dates: February 18-21, 2025 and February 24-25, 2025 At this Emergency Preparedness survey, Cardinal Home Health Services, Inc., was found to not be in compliance with 42 CFR 484.102, Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E0000		
E0009	Local, State, Tribal Collaboration Process	E0009	The Alternate Administrator initiated contact with Indiana District 1 Hospital Emergency Planning Committee's Deputy Director on 3/24/2025 as well as the	2025-03-25

	483.73(a)(4) §403.748(a)(4), §416.54(a)(4), §418.113(a)(4), §441.184(a)(4), §460.84(a)(4), §482.15(a)(4), §483.73(a)(4), §483.475(a)(4), §484.102(a)(4), §485.68(a)(4), §485.542(a)(4), §485.625(a)(4), §485.727(a)(5), §485.920(a)(4), §486.360(a)(4), §491.12(a)(4), §494.62(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years [annually for LTC facilities]. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. * * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. Based on record review and interview, the agency failed to ensure a process for collaboration and cooperation with local, state, and federal emergency preparedness officials in an effort to maintain an integrated response during an emergency. The findings include:		District & Local Readiness Manager via email and phone call add the agency to the email list for local meetings and tabletop exercises. The Deputy Director called back on 3/25/25 and added Cardinal Home Health to the list and registered the Administrator for the upcoming meeting on April 16, 2025. The administrator will be attending the monthly meetings and will be responsible for attending the Emergency Preparedness Trainings of the staff.	

	The Emergency Preparedness Plan failed to evidence any collaboration or documented communication with local, state, and federal emergency preparedness officials since the change of ownership in June 2024. On 02/25/2025, at 2:45 PM, the CM/agency owner indicated she had not collaborated with local, state, and federal emergency preparedness officials since assuming ownership last year.			
E0030	Names and Contact Information 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:]	E0030	1. The administrator established contact with local, state and federal emergency preparedness officials to ensure proper collaboration which includes County Emergency Management Agency, Local Fire Department and FEMA Regional Office. 2. All communications, meetings, and collaborations were documented in a dedicated Emergency Preparedness Communication Log, which is integrated into our EP Handbook. 3. The Emergency Preparedness Plan was updated to include current names and contact information for:	2025-03-20

	(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the		-All staff members -Entities providing services under arrangement -Patients' physicians -Volunteers -Indiana Department of Health -ISDH Division of Long-Term Care 4. An Inservice Training was provided to all field staff regarding the updates on the Emergency Preparedness Plan and Implementation Protocol.	

following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Volunteers.

*[For Hospices at §418.113(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Hospice employees.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Other hospices.

*[For HHAs at §484.102(c):] The communication plan must include all of the following:

(1) Names and contact information for the following:

(i) Staff.

(ii) Entities providing services under arrangement.

(iii) Patients' physicians.

(iv) Volunteers.

*[For OPOs at §486.360(c):] The communication plan must include all of the following:

(2) Names and contact information for the following:

(i) Staff.

	(ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). Based on record review and interview, the agency failed to ensure the communication plan included contact information for the physicians and all services provided under arrangement. The findings include: The Emergency Preparedness Plan failed to evidence a communication plan to include contact information for the physicians and Entity 2 with whom the agency contracted therapy services. On 02/25/2025, at 2:45 PM, the CM indicated the Emergency Preparedness plan failed include contact information for the physicians and Entity 2.			
E0036	EP Training and Testing 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d),	E0036	The agency conducted an internal emergency preparedness drill on 3/13/2025 simulating a severe weather event (tornado) in accordance with 484.102(d) and Indiana requirements. The drill evaluated staff response to a tornado warning, emergency communication procedures, continuity of patient care, and safety protocols during weather emergencies. Documentation of the drill included objectives, staff participation, after-action evaluation, and	2025-03-14

	§485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.		identified areas for improvement. Staff education on severe weather emergency procedures was provided immediately following the drill. The Clinical Supervisor, was responsible for conducting this exercise and ensuring proper documentation was completed by 3/14/25. Annual emergency drills were added to the agency's compliance calendar, with the QAPI Committee designated to review emergency preparedness quarterly. The Clinical Supervisor was appointed as the ongoing responsible party to ensure annual drills are conducted, with automated calendar reminders implemented to maintain compliance with emergency preparedness requirements.	

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).

*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.

Based on record review and interview, the agency failed to conduct exercises to test the emergency plan at least annually.

The findings include:

A review of the Emergency Preparedness Plan failed to evidence any testing exercise for 2024.

On 02/25/2025, at 2:45 PM, the CM indicated the agency did not conduct any testing exercise in 2024.

G0000	INITIAL COMMENTS This visit was for a Federal Recertification and State Re-Licensure survey of a home health provider. Survey Date: February 18-21, 2025 and February 24, 25, and 26, 2025 Unduplicated Skilled Admissions for the last 12 Months: 56 This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. During this Federal Complaint Survey, Cardinal Home Health Services, Inc. was found to be out of compliance with Conditions of Participation 42 CFR 484.55 Comprehensive assessment of patients and 42 CFR 484.60 Care planning, coordination of services, and quality of care. Based on the Condition-level deficiencies during the 02/26/2025 survey, your agency was subject to an extended survey pursuant to section	G0000		

1891(c)(2)(D) of the Social Security Act on 02/24/2025. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating a home health aide training, skills competency and/or competency evaluation programs for a period of two years beginning 02/26/2025 and continuing through 02/25/2027.

An Immediate Jeopardy, identified at §484.60 Care planning, coordination of services, and quality of care, began on 01/24/2025 when COTA 1 documented Patient #1 complained of pain rated at 7 out of 10 to their right heel and PT 2 documented Patient #1 had pain when bearing weight and was non weight bearing to the right foot, due to a wound. COTA 1 and PT 2 failed to coordinate care with the OT, nurse case manager, and Entity 1 related to the wound and failed to notify the physician of the complaints of pain, the wound, and to obtain treatment orders. On 01/28/2025, Entity 1 sent the home health agency authorization for skilled nursing 3 times a week for wound care and included wound care

orders. The agency failed evidence they provided skilled nursing services for wound care until 02/05/2025; the documentation of the skilled nurse visits provided, failed to evidence wound care was provided per Entity 1's orders. The agency failed to revise the plan of care to include the order from Entity 1. Patient #1 had a sharps debridement of the wound, on 01/23/2025 by Entity 1, 50% percent of Patient #1's right heel was observed with dry, thick, and yellow tissue peeling away exposing a dark red/purple area with active bleeding, and Patient #1 had complaints of increased pain to the right foot.

The Administrator and Clinical Manager were notified of the Immediate Jeopardy on 02/24/2025 at 12:02 PM. An unacceptable removal plan for the Immediate Jeopardy was received on February 24, 2025 at 2:48 PM and on February 25, 2025 at 11:34 AM. The Immediate Jeopardy was unremoved at the time of exit on February 26, 2025.

A revisit was conducted on

conducted comprehensive assessments for 12 of 12 active patients with wounds and obtained physician orders for wound treatment. Care was coordinated with staff involved with each patient with wounds, and care plans were revised to include the wounds and current wound treatment orders. One patient, expected to readmit after a hospitalization, was originally counted in the agency's removal plan of 13 patients with wounds; the patient could not be accepted upon hospital discharge due to a change in their insurance and was admitted to another home health agency. Due to the actions taken by the agency, the Immediate Jeopardy was removed on 03/06/2025, at 3:20 PM.

Abbreviations used in report: COTA – Certified Occupational Therapy Assistant, OT – Occupational Therapist, PT – Physical Therapist, POC – Plan of Care, CM – Clinical Manager, SOC - Start of Care, HHA - Home Health Aide, RN - Registered Nurse, LPN - Licensed Practical Nurse, SN - Skilled Nurse.

	QR: A 1 02/26/2025			
G0372	Encoding and transmitting OASIS 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary. Based on record review and interview, the agency failed to electronically transmit the completed Outcome and Assessment Information Set (OASIS) assessment to the Centers for Medicare and Medicaid Services (CMS) system within 30 days of the completion of the patient assessment in 1 of 3 active clinical records reviewed with skilled services with a payor source of either Medicare or Medicaid and with an OASIS assessment completed more than 30 days. (Patient #2) The findings include: A clinical record review for Patient #2 evidenced a start of care OASIS assessment completed on 09/14/2024 which was transmitted more	G0372	1. The clinical supervisor completed a comprehensive audit of all active patient records with Medicare or Medicaid as the payor source to identify any additional OASIS assessments that had not been transmitted timely. Any identified delayed transmissions were immediately submitted to CMS. 2. The agency implemented a new OASIS transmission tracking system that includes weekly reviews of all completed OASIS assessments to ensure timely transmission. The clinical supervisor established a process whereby all OASIS assessments are transmitted within 14 business days of completion, well within the 30-day requirement. This process includes a tracking log monitored by the Clinical supervisor that identifies completion dates, due dates for transmission, and actual transmission dates for all OASIS assessments. 3. Staff Inservice Training was provided on 3/20/25 to all field staff regarding Timely Patient documentation so that the requirement to transmit OASIS assessments within 30 days be complied to. This education included the new process for tracking OASIS transmissions and the importance of timely submission. The agency's Quality Assurance Performance Improvement (QAPI) program now includes a monthly audit of OASIS transmission timeliness, with results reported to the QAPI Committee. The Clinical supervisor was designated as the responsible party for ensuring all OASIS assessments are transmitted within required timeframes, with oversight by the Administrator.	2025-03-20

	on 01/09/2025, a recertification OASIS assessment completed on 11/12/2024 which was transmitted more than 30 days after completion on 01/09/2025, and a recertification OASIS assessment completed on 01/09/2025 which the status indicated to be "export ready". The clinical record failed to evidence the OASIS assessment completed on 01/09/2025 had been transmitted. On 02/24/2025, at 3:13 PM, the CM indicated the recertification OASIS assessment had not yet been transmitted and indicated she was aware the OASIS transmissions were behind schedule for some patients.			
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 Supervisor provided comprehensive education to all clinical staff on 3/07/25 regarding the requirements for informed consent, specifically emphasizing the need to document all disciplines providing care on the dedicated field of the consent, the frequency of visits, and any changes to the plan of care. This education included a review of the revised consent form and proper documentation procedures. -The administrator implemented a process whereby the intake coordinator or admitting clinician must complete all fields on the consent form during the admission visit, with the agency supervisor reviewing each admission consent for completeness within 48 hours of admission. Additionally, the agency established a procedure requiring clinicians to	2025-03-07

	(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 review and interview, the agency failed to ensure the patient was informed of and consent to care in advance of treatment and with any changes in care in 5 of 5 active clinical records reviewed. (Patient #1, 2, 3, 4, 5) The findings include: 1. The policy revised March 2018 titled "Consent for Treatment and Services" indicated the consent from at time of admission would be completed to include the disciplines and frequency of services to be provided. 2. A clinical record review for Patient #1 evidenced an OT POC for the initial certification period 12/24/2024-02/21/2025 which indicated the agency would provide OT services 2 times a week for 4 weeks. The		document patient notification and consent for any changes in the plan of care, including changes in visit frequency or addition of new disciplines.	

	12/24/2024 indicated the agency would provide nursing and PT services and failed to evidence the frequency of visits to be provided and failed to evidence the agency was to provide OT services. On 02/21/2025, at 2:19 PM, the CM indicated the admission consent did not include OT and the frequency of services to be provided. A physician order from Entity 1 dated 01/28/2025 indicated skilled nursing was authorized 3 times a week for wound care. The clinical record failed to evidence the Patient was informed of the change in nursing frequency. On 02/21/2025, at 3:12 PM, the CM indicated there was no documentation the Patient was notified of the changes in nursing frequency. 3. A clinical record review for Patient #2 evidenced the Admission Consent dated 09/14/2024 which indicated the agency would provide skilled nursing services and failed to evidence the frequency of the visits to be provided.			

On 02/24/2025, at 3:12 PM, the CM indicated the frequency of services to be provided should be completed.

4. A clinical record review for Patient #3 evidenced a POC for the initial certification period 02/07/2025-04/07/2025 which indicated the agency would provide skilled nursing 1 time a week for 9 weeks, and the PT POC evidenced the agency would provide PT services 2 times a week for 5 weeks effective 02/11/2025. The clinical record failed to evidence the Admission Consent to inform the Patient of the services and frequency to be provided.

On 02/24/2025, at 3:15 PM, th3 CM indicated the admission consent was not present in the clinical record.

5. A clinical record review for Patient #4 evidenced the Admission Consent dated 02/05/2024 which indicated the agency would provide skilled nursing and HHA services and failed to evidence the frequency of the services to be provided.

On 02/24/2025, at 3:24 PM, the CM indicated the frequency of

	the services were not included on the consent form. 6. A clinical record review for Patient #5 evidenced the Admission Consent dated 01/14/2025 which indicated the agency would provide nursing, HHA, PT and OT services and failed to evidence the frequency of the services to be provided. On 02/25/2025, at 2:12 PM, the CM indicated the frequency of the services were not provided.			
G0510	Comprehensive Assessment of Patients 484.55 Condition of participation: Comprehensive assessment of patients. Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment. Based on observation, record review, and interview, the home health agency failed to ensure: the initial assessment was completed within 48 hours of referral (see tag G0514); the comprehensive assessment was completed within 5 days of the SOC (see tag G0520); the comprehensive assessment	G0510	-The clinical supervisor conducted comprehensive staff education on all aspects of the patient assessment process on 03/07/2025. This education included the regulatory requirements, agency policies, documentation standards, and consequences of non-compliance. -The agency's Quality Assurance Performance Improvement (QAPI) program was restructured to include focused auditing of assessment compliance, with weekly audits of all new admissions and monthly audits of 20% of active patient records. All deficiency findings will be reported to the agency supervisor on a monthly basis and the clinical staff with identified deficiency will be closely monitored and provided ongoing focused training as needed. - The clinical supervisor reviewed all active patient records and completed or updated comprehensive assessments as needed to address identified deficiencies. Any missing or incomplete assessments were corrected according to current patient status and documented appropriately in the clinical record.	2025-03-07

	included the patient's current health status (see tag G0528); the comprehensive assessment included a review of all patient medications (see tag G0536); the comprehensive assessment included the assessment of the caregiver's willingness, ability, and availability to provide care (see tag G0538); and the comprehensive assessment was revised after a change in condition (see tag G0544). 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 484.55 Comprehensive Assessment of Patients.			
G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date.	G0514	1. The clinical supervisor reviewed all admissions from the past 90 days to identify any other instances where initial assessments were not completed within 48 hours of referral. For any identified cases, the agency documented the circumstances of the delay, notified the referring physician, and implemented corrective measures to prevent future occurrences. 2. The administrator revised its referral intake process to include the following improvements: a. A new tracking system was implemented that flags all new referrals with a clearly	2025-03-14

	Based on record review and interview, the agency failed to conduct an initial assessment visit within 48 hours of the referral in 1 of 3 active clinical records reviewed with a SOC since 12/01/2024. (Patient #1) The findings include: A clinical record review for Patient #1 evidenced the Patient was referred on 12/20/2024 and the initial assessment was not until 12/24/2024. On 02/21/2025, at 2:30 PM, the CM indicated the agency had difficulty reaching the patient to schedule the initial assessment visit and did not communicate with the physician regarding the delay in the SOC.		marked 48-hour assessment deadline. b.The agency established a progressive contact protocol requiring: b.1. Initial contact attempt within 2 hours of receiving the referral b.2. A minimum of three contact attempts within the first 24 hours using various methods (phone, text, email) b.3. Contact with the referring physician or discharge planner if unable to reach the patient after the initial three attempts b.4. Documentation of all contact attempts in the clinical record 3. The administrator revised its policy to require physician notification whenever an initial assessment cannot be completed within the 48-hour timeframe, with documentation of the communication in the clinical record.	
G0520	5 calendar days after start of care 484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care. Based on record review and interview, the agency failed to ensure the comprehensive	G0520	1. The clinical supervisor completed a 100% audit of all patients admitted since 01/01/2025 who had occupational therapy or other therapy services ordered at SOC to identify any other instances where comprehensive assessments were not completed within 5 days. For any identified cases, the agency documented the circumstances of the delay and implemented corrective measures and was entered as late entry orders. 2. An Inservice Training was conducted for all	2025-02-27

	assessment was completed within 5 days of the SOC in 1 of 1 active clinical record reviewed with OT services ordered at SOC since 01/01/2025. (Patient #5) The findings include: A clinical record review for Patient #5 evidenced a SOC physician order, dated 01/14/2025, which indicated OT was to evaluate and treat. The record failed to evidence the OT evaluation /assessment was completed, within 5 days of the SOC; the assessment was conducted by OT 2, dated 01/20/2025. On 02/25/2025, at 2:25 PM, the CM indicated she was unsure why the OT assessment was not completed within 5 days of the SOC.		coordination process established for all new admissions, requiring the admitting nurse to immediately communicate therapy and other discipline orders to the therapy supervisor for prompt scheduling. All staff must report to the agency supervisor within 24hrs and enter a communication note reason for any delays in service and ensure that the attending physician is notified.	
G0528	Health, psychosocial, functional, cognition 484.55(c)(1) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information: (1) The patient's current health, psychosocial, functional, and cognitive status; Based on record review and	G0528	-The clinical supervisor conducted a 100% audit of all active patients with wounds and/or indwelling catheters to identify any other instances where comprehensive assessments lacked complete documentation of these conditions. For any identified cases, the agency immediately updated the assessments to include all required elements. As part of the agency QAPI monitoring plan, weekly review of all new assessments for patients with wounds and/or catheters by the QAPI staff and monthly audits of 25% of active patient records with wounds and/or catheters to verify complete documentation. All audit findings will be reported during monthly meetings to clincal Supervisor.	2025-02-27

	interview, the agency failed to complete a comprehensive assessment to include the status of the wound in 1 of 1 active clinical records reviewed with a urinary catheter (a plastic tube inserted into the bladder to drain urine). (Patient #4) The findings include: A clinical record review for Patient #4 evidenced a skilled nursing visit note, dated 01/17/2025 and completed by the Alternate CM, indicated Patient had a foley catheter (a type of catheter that dwells in the bladder and is held in place by an inflated balloon). The recertification comprehensive assessment, completed by the Alternate CM and dated 01/28/2025, failed to evidence an assessment of the foley catheter to include the size, patency, amount and quality of the urine draining, and the size of the balloon. The comprehensive assessment indicated Patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (partial thickness) to the left thigh; the documentation failed to evidence an assessment of the size of the		- An inservice training was provided to all staff nurses regarding comprehensive assessments with emphasis on proper assessment and documentation of catheters and wounds. - The Clinical Supervisor and Alternate Supervisor conducted a reassessment visit on all patients with wounds where clinicians performed thorough assessments, documented all required elements, and obtained/clarified orders from the patients' attending physicians regarding wound care and catheter management protocols.	

	wound. On 02/24/2025, beginning at 3:25 PM, the CM indicated wound measurements were not documented in the comprehensive assessment and indicated the comprehensive assessment did not include an assessment of the foley catheter and should include the size, balloon size, patency, and urine amount. On 02/25/2025, at 7:49 AM, the Alternate CM indicated Patient did have a foley catheter.			
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 the medications to include drug interactions in 1 of 3 active clinical records reviewed with a SOC since 12/01/2024. (Patient #1)	G0536	-The clinical supervisor conducted a 100% audit of all active patient records to identify any other instances where medication reviews were incomplete or failed to identify potential drug interactions. The EMR software was contacted by the administrator to resolve the software issues when running drug interactions which they were able to resolve within 48hrs. -The administrator also established a secondary verification using an alternative resource (Micromedex and/or drugs.com) if the EMR software is not working properly.	2025-03-14

The findings include:

A clinical record review for Patient #1 evidenced a SOC comprehensive assessment dated 12/24/2024 which indicated the Patient had no drug interactions. A POC for an initial certification period 12/24/2024-02/21/2025 indicated the Patient's medications included: carvedilol (to treat heart failure), albuterol (to treat shortness of breath), spironolactone (to remove excess fluid), sildenafil (for erectile dysfunction), atorvastatin (for high cholesterol), and sacubitril-valsartan (for heart failure). A review of www.drugs.com indicated 12 drug interactions to include interactions between carvedilol and albuterol, carvedilol and spironolactone, carvedilol and sildenafil, carvedilol and sacubitril-valsartan, spironolactone and albuterol, atorvastatin and sacubitril-valsartan, sacubitril-valsartan and spironolactone, and sacubitril-valsartan and albuterol.

	On 02/21/2025, at 3:25 PM, the Administrator indicated the program used to check for medication interactions was not working for this patient's medication review.			
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 primary caregiver's ability, willingness, and availability to provide care in 3 of 4 active clinical records reviewed with wounds. (Patient #1, 3, 5) The findings include: 1. A clinical record review for Patient #1 evidenced a start of care comprehensive assessment dated 12/24/2024 which indicated the Patient needed assistance with bathing, grooming, dressing, and toileting and indicated the patient had diabetes (a chronic	G0538	-The clinical supervisor conducted a 100% audit of all active patient records for accuracy and specificity on the nature of the assistance provided by the patient caregivers. All late entries are documented into the EMR system per agency protocol. -The clinical supervisor also conducted staff education on G0538 Agency Deficiency, corrective actions taken as well as steps to maintain compliance and accuracy of patient record on caregiver status.	2025-03-07

sugar) and was to check blood sugars. The comprehensive assessment indicated the patient lived with a caregiver and failed to include the assessment of the caregiver’s ability, willingness, and availability of personal and diabetic care.

On 02/19/2025, at 1:02 PM, the Patient indicated they lived with a caregiver who worked during the day.

On 02/21/2025, at 2:42 PM, the CM indicated the comprehensive assessment did not include what care the caregiver was providing.

2. A clinical record review for Patient #3 evidenced a SOC comprehensive assessment dated 02/07/2025 which indicated the Patient required assistance with activities of daily living and personal care, had diabetes and received insulin (medication for high blood sugar) injections daily, and had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (partial thickness) to the sacrum

treatment. The comprehensive assessment indicated the Patient lived with the caregiver who provided care as needed and failed to assess the caregiver's availability and ability to provide care to include wound care and insulin administration.

On 02/20/2025, beginning at 10:47 AM, the Patient's caregiver indicated they work and another family member comes to take care of the Patient.

On 02/24/2025, at 3:16 PM, the CM indicated she was unsure what the caregiver's availability and ability was to provide care because it was not documented in the comprehensive assessment.

3. A clinical record review for Patient #5 evidenced the SOC comprehensive assessment completed 01/14/2025 by the Alternate CM which indicated the Patient had an open wound to the left hip and indicated the nurse performed wound care by applying silver alginate and a dry dressing. The comprehensive assessment

	another person but failed to evidence the assessment of the Patient’s wound care. On 02/25/2025, at 2:21 PM, the CM indicated there was no assessment of who was providing wound care in the absence of the agency and indicated there was no assessment of the care the caregiver was willing and able to provide.			
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, observation, and interview, the agency failed to ensure patients comprehensive assessment was updated, including collection of OASIS data elements, when patients' status deteriorated and developed a stage II wound, for 1 of 1 active record	G0544	The Administrator implemented the following corrective actions to address this deficiency: 1. The Administrator conducted an inservice training for all field staff on criteria that warrant Change in Condition OASIS assessments, with specific emphasis on wound development as a qualifying condition. 2. The Administrator revised the agency's policies and procedures to clearly define significant changes in condition requiring updated assessments. 3. The Administrator implemented a communication protocol requiring immediate notification to the Clinical supervisor when patients develop new wounds or experience other significant changes in condition, with the Clinical supervisor determining the need for updated comprehensive assessments. 4. The Administrator established weekly case conferences to review all patients with recent	2025-03-07

	reviewed who received SN, PT, and OT services and was admitted without a documented wound. [Patient #1] A clinical record review for Patient #1 evidenced a SOC comprehensive assessment dated 12/24/2024 and indicated the Patient had no wounds. Visit notes completed by COTA 1 dated 01/24/2025 and 01/27/2025 evidenced the Patient complained of pain 7/10 to the right heel and had recent treatment from Entity 1 and visit note dated 01/29/2025 indicated the Patient complained of pain 6/10 to the right heel. A PT visit note completed by PT 2 dated 01/24/2025 indicated the Patient complained of pain when bearing weight and indicated the Patient was not to bear weight on the right foot due to a wound. A skilled nursing visit note completed by the Alternate CM indicated the Patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (partial thickness) to the right heel. The clinical record failed to evidence a revision of		changes in condition, ensuring that comprehensive assessments are updated appropriately. 5. The Administrator revised the agency's QAPI program to include focused auditing of clinical documentation for timeliness of assessment updates following significant changes in patient condition.	

	the comprehensive assessment. During an observation of care at the Patient's home on 02/19/2025, from 12:14 PM to 1:05 PM, the Alternate CM was observed performing wound care and 50% of the right heel had dry, thick, and yellow tissue peeling away exposing a dark red/purple area. Bright red drops of blood were observed dripping onto the floor. Patient #1 indicated their pain was 9/10 to the right foot and indicated they could not bear weight to the right foot due to the wound. On 02/19/2025, at 12:39 PM, the Alternate CM indicated the wound was not present at time of admission and was acquired while receiving home health services. On 02/21/2025, at 2:49 PM, the CM) indicated a new wound warranted a change in condition needing a revised comprehensive assessment and indicated there was not a revision completed.			

G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on observation, record review, and interview, the home health agency failed to ensure: the POC was reviewed by the physician, individualized and followed by all agency staff (See tag G0572), the POC included all required information / elements for the treatment of the patient (See tag G0574), all treatments provided by agency staff were ordered by a physician (See tag G0580), and coordination of care for all services provided to the patient (See tag G0606). The cumulative effect of these systemic problems has resulted in the home health agency	G0570	1. The Administrator conducted comprehensive staff education regarding all aspects of care planning, coordination, and provision of services according to the plan of care. This education included: -Requirements for physician review and approval of plans of care -Elements of a complete and individualized plan of care -Necessity of physician orders for all treatments -Coordination of care between disciplines -Documentation requirements related to care planning and provision 2. The Clinical supervisor restructured the agency's quality assurance performance improvement (QAPI) program to include: -Weekly audits of new admissions for compliance with care planning requirements -Monthly audits of active patient records for ongoing compliance -Tracking and trending of deficiencies to identify patterns requiring systemic intervention -Regular reporting to the governing body on care planning compliance on a quarterly basis -Development and implementation of performance improvement projects targeting identified issues 3. On 2/27/2025, the Clinical supervisor and Alternate Clinical supervisor have completed full reassessment of 100% of all the active wound cases of the agency, with orders obtained, verified from the attending providers and entered into the EMR record. The care plan has been updated as well and were also provided into the patient's home. Every follow up nurse has been provided encounter via	2025-02-27

	quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care.		telephone conference in addition to the orders that are accessible to them in the home and in the EMR.	
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 develop the POC in conjunction with the physician and failed to provide services as directed in the POC in 5 of 5 active clinical records reviewed. (Patient #1, 2, 3, 4, 5) The findings include: 1. A clinical record review for Patient #1 evidenced a POC for initial certification period of 12/24/2024-02/21/2025, which indicated OT and PT were to	G0572	The Clinical Supervisor conducted a review of the identified deficiencies and implemented the following corrective actions: 1. Physician Collaboration: -Revised procedures to require physician consultation for all discipline-specific POCs -Implemented a centralized process for POC submission and signature tracking 2. Visit Monitoring by the QAPI staff: -Established weekly visit verification to identify and reschedule missed visits promptly as well as reporting protocols. 3. Documentation: -Updated documentation templates to include all required POC elements -Implemented supervisor review of documentation within 24 hours of missed visits or frequency change. 4. Staff Education: -Conducted staff education on physician involvement in POC development, service frequency requirements, and documentation	2025-02-27

	and full evaluation completed by PT 2 on 12/27/2024 indicated the agency was to provide PT services 1 time a week for 1 week and then 2 times a week for 5 weeks; the record failed to evidence the PT reviewed the PT POC with the physician. The clinical record failed to evidence the POC was sent to the physician for review failed to evidence the agency provided PT services 2 times, as directed in the POC during the certification week of 01/26/2025. The OT POC and full evaluation, dated 01/08/2025, indicated the agency was to provide OT services 1 time a week for 1 week, 2 times a week for 4 weeks, and 1 time a week for 1 week. The clinical record failed to evidence the agency provided OT services after the OT evaluation, dated 01/08/2025, until 01/22/2025. On 02/21/2025, beginning at 2:57 PM, the CM indicated the PT should have called the physician for PT orders and indicated the PT POC was not sent to the attending physician. The CM indicated she was		standards 5. Communication: -Implemented protocols requiring supervisor notification for any POC deviations within 24hrs of the change.	

not provided after 01/08/2025, nor until 01/22/2025. The CM indicated there was a PT missed visit on 01/28/2025, and there were no documented attempts to reschedule the PT visit.

On 02/26/2025, at 9:45 AM, PT 2 indicated he did not call the Patient's physician to develop the POC, he indicated the agency should fax the PT POC, to the attending, for review.

2. A clinical record review for Patient #2 evidenced a POC for recertification period 11/13/2024-01/11/2025 which indicated the agency was to notify the physician of a systolic blood pressure (the pressure against the arteries when the heart is pumping and noted by the top number of a blood pressure reading) greater than 160. The recertification comprehensive assessment dated 01/09/2025 indicated the Patient's systolic blood pressure was 193 in the right arm and 171 in the left arm and failed to evidence the agency notified the physician of the elevated blood pressure. The POC for recertification period 01/12/2025- 03/12/2025 indicated the agency would

provide skilled nursing visits 1 time weekly to include review medications at every visit. The clinical record failed to evidence the agency provided skilled nursing visits during the weeks of 01/12/2025 and 02/09/2025. The skilled nurse visit notes dated 01/26/2025, 01/30/2025, and 02/06/2025 failed to evidence the skilled nurse reviewed the medications.

On 02/24/2025, beginning at 3:07 PM, the CM indicated there was no documentation the agency notified the physician of the elevated blood pressure and indicated the nurse did not review the medications. The CM indicated she was unaware the skilled nursing visits were not provided for the weeks of 01/12/2025 and 02/09/2025.

3. A clinical record review for Patient #3 evidenced a POC for the initial certification period 02/07/2025-04/07/2025 which indicated the agency was to provide skilled nursing services 1 time a week for 9 weeks, and the PT POC for certification period 02/07/2025-04/07/2025 indicated the agency was to provide PT services 2 times a

02/11/2025. The clinical record failed to evidence any skilled nursing visits had been provided since the SOC assessment on 02/07/2025 and failed to evidence any PT visits since the PT evaluation on 02/11/2025.

On 02/24/2025, at 3:23 PM, the CM indicated there were not any other nursing or PT visits documented, and she would check into it since she was not informed of any missed visits. No additional documentation or information was provided before survey exit on 02/26/2025.

4. A clinical record review for Patient #4 evidenced a POC for recertification period 01/30/2025-03/30/2025 which indicated the agency would provide skilled nursing services 2 times a week for 9 weeks. The clinical record failed to evidence the agency provided skilled nursing visits the week of 01/19/2025.

On 02/24/2025, at 3:35 PM, the CM indicated there were no nursing visits documented the week of 01/19/2025 and she would check into it. No

additional documentation or information was provided before survey exit on 02/26/2025.

5. A clinical record review for Patient #5 evidenced a POC for an initial certification period 01/14/2025-03/14/2025 which indicated the agency would provide nursing, HHA, PT, and OT services. An OT POC for an initial certification period of 01/14/2025-03/14/2025 indicated the agency was to provide OT services 1 time a week for 1 week, 2 times a week for 3 weeks, 1 time a week for 1 week, and 2 times a week for 3 weeks effective 1/20/2025. Week 2 beginning 01/26/2025 failed to evidence OT visits were provided and Week 4 beginning 02/09/2025 failed to evidence 2 OT visits were provided as directed in the POC.

On 02/25/2025, at 2:27 PM, the CM indicated the COTA had difficulty reaching the patient and the OT visits were not provided. The CM indicated the other disciplines were able to complete their visits as directed in the POC, and the office manager eventually reached the

	input on scheduling preferences.			
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 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.	G0574	The Clinical Supervisor conducted a review of the identified deficiencies and conducted a staff in service training to implement the following corrections: a. Documentation Processes: -Established a checklist for POC development to ensure all required elements are included -Implemented a QAPI review process for all POCs prior to implementation -Created a system to ensure wound treatments and specialty care are consistently documented in the POC b. The QAPI staff will conduct weekly reviews of all new POCs for completeness and monthly audit of active patient records to ensure POCs include all required elements. All audit findings will be reported to the agency supervisor during monthly meetings.	2025-02-27

Based on record review and interview, the agency failed to ensure the POC was developed to include all the safety precautions, interventions, and measurable goals in 5 of 5 active clinical records reviewed. (Patient #1, 2, 3, 4, 5)

The findings include:

1. A clinical record review for Patient #1 evidenced a POC for the initial POC which indicated OT was to evaluate and treat, and an OT POC for the initial certification period 12/24/2024-02/21/2025 indicated the agency would provide OT services 2 times a week for 4 weeks. The home health POC failed to include interventions and goals for the OT services. The POC indicated Patient’s medications included rivaroxaban (a medication used to thin the blood to prevent/treat blood clots) and failed to evidence bleeding precautions were included in the safety measures.

A SOC comprehensive assessment indicated Patient received oxygen at 2 liters per minute as needed via a nasal cannula (a plastic tube inserted into the nose), and during an observation of care at Patient’s

home on 02/19/2025, beginning at 12:14 PM, the oxygen concentrator was observed. The POC failed to include oxygen precautions in the safety measures.

On 02/21/2025, beginning at 2:23 PM, the CM indicated the OT interventions and goals were not in the home health POC but in the specific OT POC and indicated the oxygen and bleeding precautions were not included in the POC.

2. A clinical record review for Patient #2 evidenced a POC for recertification period 01/12/2025-03/12/2025 which included PT interventions and goals and the clinical record failed to evidence PT services were being provided.

On 02/24/2025, at 3:02 PM, the CM indicated the PT interventions and goals should not be included in the POC and were a carry-over from a previous certification period when the Patient received PT services.

3. A clinical record review for Patient #3 evidenced a SOC comprehensive assessment

on 02/07/2025 which indicated the Patient had a pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin) stage II (partial thickness) to the sacrum (lower back). The comprehensive assessment indicated the Alternate CM provided wound care to the sacrum by applying medi-honey (wound ointment) and a dry dressing. The comprehensive assessment indicated the Patient had diabetes and received insulin (medication for high blood sugar) injections daily, The POC for the initial certification period 02/07/2025-04/07/2025 failed to include the wound to the sacrum, wound treatment, and interventions and goals related to the wound and diabetes management. The POC indicated the primary diagnosis for home health was malignant neoplasm of the endometrium (cancer of the uterus lining) and failed to include interventions and goals related to the primary diagnosis.

On 02/25/2025, beginning at 3:22 PM, the CM indicated the POC did not include the

	and the interventions and goals related to the wound, diabetes, and the primary diagnosis. 4. A clinical record review for Patient #4 evidenced skilled nurse visit notes dated 12/31/2024, 01/07/2025, 01/10/2025, 01/15/2025, and 01/17/2025 completed by the Alternate CM which indicated the Patient had a pressure ulcer stage IV (full thickness exposing bone and/or tendon) to the left thigh. The visit note dated 12/31/2024 indicated the nurse performed wound care to include applying a wound vacuum dressing (a medical device that vacuum seals to the wound to apply negative pressure and remove excess drainage) to the left thigh. Visit notes dated 01/07/2025, 01/10/2025, 01/15/2025, and 01/17/2025 indicated the nurse applied silver alginate (an absorbent, antimicrobial wound treatment) and a dry dressing to the left thigh wound. The POC for recertification period 01/30/2025-03/202/2025 failed to evidence the wound, wound treatment, and goals related to the wound. On 02/24/2025, at 3:25 PM, the			

	CM indicated the POC did not include the wound, wound treatment order, and goals related to wounds. 5. A clinical record review for Patient #5 evidenced a POC for initial certification period 01/14/2025-03/14/2025 which indicated the agency would provide HHA services 2 times a week for 9 weeks and failed to evidence interventions and goals for the HHA services. The POC indicated the patient's primary diagnosis was cellulitis (deep skin infection) of the back and failed to evidence interventions and goals related to the primary diagnosis. The SOC comprehensive assessment completed 01/14/2025 by the Alternate CM indicated the Patient had an open wound to the left hip and indicated the nurse performed wound care by applying silver alginate and a dry dressing. The POC failed to evidence the wound and wound treatment. On 02/25/2025, beginning at 2:13 PM, the CM indicated there were no interventions and goals related to the primary diagnosis			

	indicated the wound and wound treatment order was not included in the POC.			
G0580	Only as ordered by a physician 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the agency failed to ensure care was provided as directed by a physician in 2 of 4 active clinical records reviewed with a wound. (Patient #1, 3) The findings include: 1. A clinical record review for Patient #1 evidenced a physician order from Entity 1, dated and faxed to the agency on 01/28/2025, which indicated skilled nursing was ordered and authorized for wound care consisting of medi-honey (a wound ointment) and a padded dry dressing 3 times per week to the right heel pressure ulcer (wounds to the skin and underlying tissue resulting from prolonged pressure to the skin). The agency failed to provide wound care until 2/5/2025; per	G0580	1. An Emergency Inservice Meeting was completed on led by the Clinical Supervisor regarding immediate implementation of Physician Order Protocol as follows: a. All orders to be reviewed by the alternate supervisor or the agency supervisor with the assessing clinician entering the orders. b. All orders should reflect effective date of implementation. c. All new orders should also be written on the home folder. d. The field staff were taught how to enter orders via mobile app of the EMR. e. All staff were also trained on how to properly chart late entry documentation. 2. An Emergency Inservice Meeting/Training was completed regarding Interdisciplinary Communication Mandate effective immediately that is outlined as follows by the clinical Supervisor: a. Mandatory interdisciplinary case conference weekly with the clinical supervisor or administrator b. Implementation of a "See Something, Say Something" protocol requiring all clinical staff to report any new or worsening patient conditions to nursing case managers within 24 hours via phone call. If unable to contact RNCM, staff should contact agency supervisor. c. Discipline specific responsibilities clearly defined for wound assessment and reporting. 5. The Administrator conducted a one on one	2025-02-27

	SN which failed to evidence the treatment was provided as ordered. Skilled nursing visit notes dated 2/7/2025, 2/12/2025, and 2/14/2025 also failed to evidence medi-honey was applied as ordered. The agency failed to provide nursing services 3 times a week during the weeks of 2/2/2025 and 2/9/2025. On 02/21/2025, at 9:27 AM, the Alternate CM indicated she was unsure when she was notified by the Administrator of Patient #1's wound and treatment orders. The Alternate CM indicated she did not see the wound care order until present at the patient's house where the order and supplies were present on 02/05/2025. On 02/21/2024, at 3:04 PM, the CM indicated she was unsure why skilled nursing services were not provided 3 times a week per the order on 01/28/2025. 2. A clinical record review for Patient #3 evidenced a SOC comprehensive assessment completed by the Alternate CM on 02/07/2025 which indicated Patient had a pressure ulcer		zoom meeting with the COTA and PT referenced here regarding their specific responsibilities on what to report to the RNCM, OT, or clinical Supervisor.	

	stage II (partial thickness) to the sacrum (lower back). The comprehensive assessment indicated the Alternate CM provided wound care to the sacrum by applying medi-honey and a dry dressing. The clinical record failed to evidence a physician order for wound care. On 02/24/2025, at 3:21 PM, the CM indicated there was not a wound care order in the clinical record. On 02/25/2025, at 7:49 AM, the Alternate CM indicated she knew what wound care to perform, the caregiver instructed her to what wound care was provided in the hospital, prior to admission to home health. The Alternate CM indicated there was no communication with Patient's physician regarding wound care.			
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	G0606	The Agency Supervisor implemented the following corrective actions: 1. Interdisciplinary Communication Protocol: -Established mandatory weekly case conferences to discuss all patients receiving care from multiple providers or disciplines	2025-02-26

	of care provided by all disciplines. Based on record review and interview, the agency failed to coordinate care with all healthcare providers providing care in 1 of 1 clinical record reviewed with another home care company providing care (Patient #1) and in 1 of 1 clinical record reviewed with a LPN providing services (Patient #2). The findings include: 1. A clinical record review for Patient #1 evidenced a POC for the initial certification period of 12/24/2024 – 02/21/2025 which indicated the agency was to provide: SN services 1 time a month for 3 months for a full assessment, PT services 2 times a week for 5 weeks, and effective 01/08/2025 OT services 2 times a week for 4 weeks. Visit notes, completed by COTA 1 and dated 01/24/2025 and 01/27/2025, evidenced Patient complained of pain 7/10 to their right heel and had recent treatment from Entity 1. The visit note dated 01/29/2025 indicated Patient complained of pain 6/10 to their right heel. A PT visit note completed by PT 2 and dated 01/24/2025 indicated Patient complained of pain when		-Implemented a "See Something, Say Something" protocol requiring all clinical staff to report new or changing conditions to nursing case managers -Defined clear communication responsibilities for each discipline, particularly regarding wound assessments and medication side effects 2. Care Coordination System: -Developed a comprehensive system to identify and document all healthcare providers involved in each patient's care -Created standardized procedures for regular communication with external providers -Established protocols for information sharing between all providers involved in patient care 3. Intake Process Enhancement: -Revised the intake process to include identification of all healthcare providers -Implemented documentation requirements for provider contact information -Established procedures for initial coordination with all providers 4. Staff Education: -Conducted staff training on care coordination requirements -Provided education on communication expectations between disciplines -Clarified reporting responsibilities for LPNs to supervising RNs	

bearing weight and indicated Patient was not to bear weight on the right foot due to a wound. The clinical record failed to evidence COTA 1 and PT 2 coordinated care with the OT, nurse case manager, and Entity 1 related to the wound.

On 02/21/2025, at 9:40 AM, PT 2 indicated he was informed by the Patient of a wound on the right foot at the visit on 1/24/25, did not notify the nurse case manager regarding the wound since Patient #1 had a dressing in place to the right foot, and Patient #1 reported they received treatment at their physician's office.

On 02/21/2025, at 11:24 AM, COTA 1 indicated she did not communicate with the nurse case manager related to the wound, because she assumed nursing was providing wound care. COTA 1 could not definitely remember if she informed the occupational therapist about the wound.

On 02/21/2025, at 10:25 AM, OT 2 indicated COTA 1 did not inform her of the Patient's wound and increased pain.

On 02/21/2025, at 3:04 PM, the

CM indicated there was no coordination with Entity 1 and the Patient's physician regarding the wound until 02/21/2024 when the agency requested documentation of the patient's wound treatment.

The SOC comprehensive assessment dated 12/24/2024 indicated the patient required assistance with bathing, dressing, and grooming. The clinical record failed to evidence any coordination with any other agency providing HHA services.

On 02/19/2025, at 12:43 PM, Patient indicated she/he received HHA services 3 times a week on Monday, Wednesday, and Friday from another Entity.

On 02/19/2025, at 12:43 PM, the Alternate CM indicated she believed Entity #1 was providing the HHA services.

On 02/21/2025, at 2:54 PM, the CM indicated she was unaware the Patient was receiving HHA services and indicated there was no care coordination.

2. A clinical record review for Patient #2 evidenced a SN visit note completed by LPN 1, dated

	Patient reported a recurring rash and indicated the only new medication was Pepcid (to treat reflux). The record failed to evidence LPN 1 coordinated care with the RN case manager of a possible medication side effect. On 02/25/2025, at 7:49 AM, the Alternate CM/Patient's nurse case manager indicated she was not aware of a rash due to a possible medication side effect and stated, "That's [LPN 1's] patient."			
G0644	Program data 484.65(b)(1),(2),(3) Standard: Program data. (1) The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and	G0644	The Clinical Supervisor implemented the following corrective actions:QAPI Program Redesign: 1. Revised the QAPI program to incorporate OASIS data as a primary source of quality indicatorsIdentified specific OASIS measures for monitoring, including:-Improvement in ambulation/locomotion-Improvement in pain interfering with activity-Improvement in	2025-03-07

	interview, the agency failed to ensure the Governing Body approved the frequency and detail of the data collection and utilized quality indicator data from the OASIS Outcome and Assessment Information Set (OASIS) for the Quality Assessment Performance Improvement (QAPI) program. The findings include: The QAPI program and the Governing Body minutes failed to evidence the Governing Body approved the frequency and detail of the data collection. The QAPI program failed to utilize quality indicator data from the OASIS in the program's design. On 02/25/2025, at 2:35 PM, the CM indicated there was no documented approval by the Governing Body of the frequency and detail of the data collection and indicated there was no incorporation of OASIS data in the program.		dyspnea-Improvement in wound status-Acute care hospitalization ratesThis was presented to and approved by the Governing Body for implementation. The program will be reviewed on a quarterly basis. 2. Data Utilization Framework:a. Implemented a systematic process for using OASISand other quality data to:-Monitor effectiveness and safety of services-Identify trends requiring intervention-Develop targeted performance improvement initiativesb. Created a reporting structure for communicatingquality findings to all levels of staff	

			3. Staff Education:-Conducted staff training on the importance of accurate OASIS data collection-Provided education on how OASIS data supports quality improvement-Shared QAPI findings and initiatives with all staff to promote engagement	
G0646	Program activities 484.65(c) (1) The HHA's performance improvement activities must (i) Focus on high risk, high volume, or problem-prone areas; (ii) Consider incidence, prevalence, and severity of problems in those areas; and (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients. Based on record review and interview, the agency failed to ensure performance improvement activities focused on high risk and problem-prone areas. The findings include:	G0646	1. The Clinical Supervisor implemented a Hospitalization Reduction Initiative as follows:-Developed a targeted performance improvement project focused on reducing acute care hospitalizations-Conducted a root cause analysis of all hospitalizations from Q3 and Q4 2024 to identify patterns and contributing factors-Implemented a risk stratification tool to identify patients at high risk for hospitalization-Created an intervention protocol for high-risk patients 2. An Inservice Training was	2025-03-14

	The Quality Assessment Performance Improvement (QAPI) program indicated hospitalizations increased from 5 in Quarter 3 2024 with an average patient census of 38 equaling 13% to 15 in Quarter 4 2024 with an average patient census of 52 equaling 29%. The QAPI program failed to evidence performance improvement activities related to the increased hospitalization rate. On 02/25/2025, at 2:35 PM, the CM indicated there were no performance improvement activities related to hospitalizations.		conducted by the Clinical Supervisor to field staff regarding Performance Improvement activities to reduce hospitalization rates.	
G0774	12 hours inservice every 12 months 484.80(d) Standard: In-service training. A home health aide must receive at least l2 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient. Based on record review and interview, the agency failed to ensure the HHA completed 12 hours of in-service training in a 12-month period for 3 of 3 HHA personnel records reviewed out of a total 3 HHA actively employed	G0774	The clinical supervisor provided an updated inservice training to all home health aides to maintain compliance with training requirements based on Indiana Association for Home and Hospice Care training literature.	2025-03-24

	with the agency. (HHA 1, HHA 2, and HHA 3) The findings include: The review of the agency's in-service documentation binder evidenced HHA 1, date of hire 09/05/2019, completed 6 hours of HHA in-services in 2024, HHA 2, date of hire 11/04/2019, completed 4 hours of HHA in-services in 2024, and HHA 3, dated of hire 09/05/2019, completed 5 hours of HHA in-services in 2024. On 02/20/2025, at 2:01 PM, the CM indicated there was no additional HHA in-services completed in 2024.			
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	G0800	The clinical supervisor conducted an inservice training with the RN case managers and HHAides regarding: -Following the care plan as written -Proper documentation of all services provided as well as proper documentation of services not rendered or corrections/revisions to aide care plan -Process for requesting changes to the care plan when patient needs change -Consequences of providing services not included in the care plan	2025-03-07

	ensure the HHA provided services as directed in the care plan in 1 of 2 active clinical records reviewed with HHA services. (Patient #5) The findings include: A clinical record review for Patient #5 evidenced a HHA Care Plan dated 01/14/2025 which indicated the HHA was to provide oral care, incontinent care, and range of motion at every visit. HHA visit notes completed by HHA 1 dated 01/15/2025, 01/17/2025, 01/20/2025, 01/24/2025, 01/29/2025, 02/01/2025, 02/05/2025, 02/08/2025, and 02/12/2025 indicated the HHA did not provide oral care, incontinent care, and range of motion as directed in the care plan and indicated the HHA provided a shampoo and hair care which was not included in the care plan. On 02/25/2025, at 2:25 PM, the CM indicated the HHA did not follow the care plan as directed.			
G0808	Onsite supervisory visit every 14 days 484.80(h)(1)(i)	G0808	The Clinical Supervisor implemented the following corrective actions: 1. Audited 100% of active charts with HHAide services to monitor	2025-03-07

	(1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services (A) A registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section. Based on record review and interview, the agency failed to ensure the HHA was supervised no less frequently than every 14 days when HHA services were provided along with skilled services in 1 of 2 active clinical records reviewed with HHA services. (Patient #4) The findings include: A clinical record review for Patient #4 evidenced a POC for recertification period 01/30/2025-03/30/2025 which indicated the agency would provide skilled nursing and HHA services both 2 times a week for 9 weeks. The clinical record evidenced skilled nursing services were provided on		for compliance with aide supervision. 2. Created a supervision calendar with clear assignments for RNs responsible for each supervision visit 3. Conducted training for all nursing staff on: -Regulatory requirements for HHA supervision -Documentation requirements for supervisory visits -Proper assessment of HHA service quality and appropriateness 4. Implemented weekly audits of all patients receiving HHA services to verify supervision compliance and address audit findings during monthly meetings. 5. Provided inservice training for both RN and aides on aide supervision requirements and compliance policies.	

	01/31/2025, 02/04/2025, and 02/07/2025 and HHA services were provided 02/01/2025, 02/03/2025, 02/08/2025, 02/09/2025, 02/15/2025, and 02/16/2025. The record failed to evidence supervision of the HHA since 01/28/2025. On 02/24/2025, at 3:34 PM, the CM indicated there was no other documented HHA supervision since 01/28/2025.			
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	1. The Clinical Supervisor provided comprehensive education to all supervising RNs on: -Thorough review of HHA documentation as part of the supervision process -Proper verification that HHAs are following the care plan -Complete documentation of supervision findings -Required follow-up actions when discrepancies are identified 2. The clinical supervisor implemented weekly audits of all patients receiving HHA services to verify supervision compliance and address audit findings during monthly meetings.	2025-03-07

ensure the HHA supervision included the HHA followed the aide care plan in 1 of 2 active clinical records reviewed with HHA services. (Patient #5)

The findings include:

A clinical record review for Patient #5 evidenced a HHA Care Plan dated 01/14/2025 which indicated the HHA was to provide oral care, incontinent care, and range of motion at every visit. HHA visit notes completed by HHA 1 dated 01/15/2025, 01/17/2025, 01/20/2025, and 01/24/2025 indicated the HHA did not provide oral care, incontinent care, and range of motion as directed in the care plan and indicated the HHA provided a shampoo and hair care which was not included in the care plan.

The HHA supervision visit dated 01/28/2025 and signed by the Alternate CM indicated the HHA provided services per the care plan and failed to evidence the RN provided supervision to ensure the HHA followed the aide care plan as directed.

On 02/26/2025, at 11:53 AM,

	the Alternate CM indicated she was not aware HHA 1 did not provide services as directed in the care plan and indicated she did not review the HHA visit notes.			
G1022	Discharge and transfer summaries 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 provide to the physician the discharge summary within 5 business days of discharge from the agency in 2 of 2 closed records reviewed. (Patient #6, 7) The findings include: 1. A clinical record review for	G1022	The Clinical Supervisor implemented the following corrective actions: 1. Process Improvement: -Revised discharge process with verification of summary transmission -Implemented tracking system for timely submissions -Established 3-day internal deadline (ahead of 5-day requirement) 2. Documentation: -Added transmission confirmation to discharge form -Required documentation of date, method, and recipient 3. Staff Education: -Trained staff on requirements and documentation standards 4. Quality Monitoring: -Weekly audits of all discharges	2025-03-20

	Patient #6 evidenced a discharge summary dated 01/08/2025 which indicated the agency discharged the Patient on 12/31/2024 and failed to evidence the agency sent the discharge summary to the physician. 2. A clinical record review for Patient #7 evidenced a discharge summary dated 12/30/2024 which indicated the agency discharged the Patient on 12/26/2024 and failed to evidence the agency sent the discharge summary to the physician. 3. On 02/25/2025, beginning at 2:31 PM, the CM indicated there was no documentation the discharge summary was sent to the physician for either Patient #6 or Patient #7.		-Tracking log with verification of all summary transmissions	
G1024	Authentication 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	G1024	The Clinical Supervisor implemented the following corrective actions: 1. Documentation Timeline Enforcement: -Reinforced policy requiring documentation completion within 24 hours of visit and visit reporting updates within 24hrs of visit -Established escalation process for documentation exceeding 48 hours	2025-03-20

	entry. Based on record review and interview, the agency failed to ensure the staff documented timely, into the clinical record, in 3 of 5 active clinical records reviewed. (Patient #1, 4, and 5) The findings include: 1. A policy revised February 2021 titled "Timely Submission of Patient Documentation" indicated visit reports should be submitted the next scheduled work day and was not to exceed 3 days. 2. A clinical record review for Patient #1 evidenced a PT Evaluation/Assessment completed by PT 2 and dated 12/27/2024; the clinical record failed to evidence PT 2 documented and submitted the assessment in the electronic health record [EHR] until 01/12/2025. The PT Discharge, dated 1/31/2025, was not completed and submitted by PT 2 until 02/09/2025. The OT Discharge was scheduled in the electronic health record for 02/11/2025; the status was "not yet started." On 02/21/2025, beginning at 2:56 PM, the CM indicated the		2. System Improvements: -Created dashboard showing all overdue documentation by clinician -Implemented mobile documentation options to facilitate timely entry -Weekly chart monitoring of all active patients will be reviewed by the QAPI staff to ensure compliance and timeliness of documentation. All audit findings will be reported during monthly QAPI meetings to Clinical Supervisor. 3. Staff Education: -Conducted training on timely documentation requirements -Provided guidance on efficient documentation practices -Established clear expectations for documentation compliance	

PT documentation should have been completed within 5 days. The CM indicated the OT had not yet started the documentation of Patients' OT discharge.

3. A clinical record review for Patient #4 evidenced a POC for recertification period 01/30/2025 -03/30/2025 which indicated the agency would provide skilled nursing [SN] services 2 times a week for 9 weeks. The EHR evidenced SN visits were scheduled; and the status of the SN visit documentation for the dates 02/11/2025, 02/14/2025, 02/18/2025, and 02/21/2025 was “not yet completed."

On 02/24/2025, at 3:34 PM, the CM indicated the SN visits were completed, not yet documented.

4. A clinical record review for Patient #5 evidenced the agency provided skilled nursing and HHA services, and the last HHA supervisory visit in the electronic health record was completed on 01/28/2025. The EHR indicated SN visits were scheduled on 02/04/2025, 02/14/2025, 02/16/2025,

	02/18/2025, 02/21/2025; the status of these visits was “not yet started” and failed to evidence any documentation for the visits. On 02/25/2025, at 2:28 PM, the CM indicated the Alternate CM completed a HHA supervision visit on 02/11/2025 and had not yet documented. The CM indicated the Alternate CM completed visits every Friday and the CM completed visits every Tuesday and had not yet documented the visits.			
N0000	Initial Comments This visit was for a State Re-Licensure survey of a home health provider. Survey Date: February 18-21, 2025 and February 24-25, 2025 Unduplicated Skilled Admissions for the last 12 Months: 56	N0000		
N9999	Final Observations Authority IC 16-27-1.5-5 "Approved dementia	N9999	The Clinical supervisor provided an updated inservice training to all home health aides to maintain compliance with training requirements including 3hrs of dementia	2025-03-24

	training for home health aides" Sec. 5 (a) This section applies to a registered home health aide who: (1) is employed as a home health aide; and (2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder. (b) As used in this section, "approved dementia training" refers to a dementia training program: (1) for use in training home health aides in the care of individuals described in subsection (a)(2); and (2) that has been approved by the state 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:		training. The Administrator will conduct quarterly review of HR files to ensure that dementia training requirements are met by the home health aides.	

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

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

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

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

(iv) Procedures for providing patient centered quality care.

(v) The daily activities of individuals with dementia.

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

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

(B) The dementia training program:

(i) must be culturally competent; and

(ii) may be provided online.

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

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

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

(i) A home health aide:

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

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

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

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

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

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

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

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

(B) delegates responsibility for administering the gastrointestinal and jejunostomy tube 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 use an approved dementia training program to ensure home health aides received at least 3 hours of dementia training by December 31, 2024, for care of patients with a diagnosis of dementia or related cognitive disorder in 3 of 3 HHA personnel records reviewed of a total of 3 active HHAs employed with the agency. (HHA 1, HHA 2, and HHA 3)

The findings include:

1. A clinical record review for Patient #8 indicated the diagnoses included dementia and indicated HHA 2, date of hire 11/04/2019, provided home health aide services to the patient in 2024.

2. A clinical record review for Patient #9 indicated the diagnoses included dementia and indicated HHA 1, date of hire 09/05/2019, provided home health aide services to the patient in 2024.

3. A clinical record review for Patient #10 indicated the Patient had a cognitive deficit, had impaired decision making, was forgetful, and was not oriented to place and time. The clinical record indicated HHA 3, date of hire 09/05/2019, provided home health aide services to the patient in 2024.

4. The personnel records for HHA 1, HHA 2, and HHA 3 and the in-service binder failed to evidence dementia training.

5. On 02/20/2025, beginning at 2:01 PM, the CM indicated the previous owner indicated no dementia training had been completed in 2024, and the CM indicated no other dementia training was provided.

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
Vanessa Adraneda	Alternate Administrator	4/2/2025 12:17:10 PM