STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157601	A. BUILDING B. WING	04/10/2025

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 This visit was a revisit of an Emergency Preparedness survey, conducted on February 28, 2025, by the Indiana State Department of Health, in accordance with 42 CFR 484.102. Survey dates: 04/09/2025 and 04/10/2025	E0000		

E0030	Names and Contact Information 483.73(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.542(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §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].	E0030	The agency revised its Emergency Preparedness Plan policy titled "Communication Plan for Emergency Preparedness B-400G" to include a comprehensive communication directory. This directory contains the names and up-to-date contact information of: Staff were re-educated on May 1, 2025, regarding the revised policy and their responsibilities in maintaining and using the directory. - The Administrator will conduct monthly audits to ensure the directory remains current and is readily accessible. - Staff remain trained on the policy and directory use	2025-05-01

	(v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the 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 the contact information for each patients' attending physician and failed to evidence the contact information for all providers who provide services to agency patients under an arrangement / agreements. Findings include: 1. The policy titled "Communication Plan for Emergency Preparedness			

	communication plan must include, "a. Names and contact information" the other Entities providing services and the Patients physicians. 2. The Emergency Preparedness Plan failed to evidence a communication plan that included the contact information for their patients' physicians and Entity C, a contracted therapy service. 3. On 04/10/2025 at 11:05AM the CM indicated their Emergency Preparedness plan failed include the contact information for the Agency's current patients' physicians and Entity C, the contracted services for therapy services.			
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), §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,	E0036	The agency acknowledges the deficiency regarding incomplete documentation and staff participation in the emergency preparedness training and testing requirement. Although an emergency preparedness drill was conducted on **March 13, 2025, not all staff were able to attend, and documentation was incomplete at the time of resurvey due to administrative scheduling conflicts.** **To correct the deficiency, the agency conducted a follow-up tabletop exercise on April 30, 2025, which included participation from all remaining staff who had missed the March 13 drill.** **The Administrator has completed all associated logs including:**	2025-04-30

	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. *[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		**- Attendance logs** **- Exercise scenario and objectives** **- After-action report** **These documents have been filed in the Emergency Preparedness Binder and are available for review.** **The Administrator will be responsible for scheduling all future emergency preparedness drills in advance to ensure maximum staff participation.** **- Drills and exercises will be added to the agency's annual training calendar, with at least one drill per year and an additional exercise (e.g., tabletop) to meet CMS requirements.** **- The Emergency Preparedness Plan and training calendar will be reviewed semi-annually to verify compliance.** **- Attendance and documentation will be completed on the day of each event and filed immediately in the Emergency Preparedness binder.** **- Make-up sessions will be scheduled within 10 business days for any staff unable to attend.** **The Administrator is responsible for:** **- Conducting drills and exercises** **- Completing and filing all required documentation** **- Monitoring staff participation** **- Reviewing the Emergency Preparedness Plan and training calendar semi-annually**	

	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. Findings include: 1. The agency's correction plan, indicated they would have an Emergency Preparedness drill on 03/13/2025. A review of the Emergency Preparedness Plan failed to evidence a current emergency preparedness exercise. 2. On 04/10/2025 at 11:10, the CM indicated the agency did not conduct the testing exercise as stated in their plan of correction, dated 03/14/2025.			
G0000	INITIAL COMMENTS This visit was for a Post Condition Revisit of a Federal Recertification and State Re-Licensure survey of a home health provider, dated 2/26/2025.	G0000		

	Survey Dates: 04/09/2025 and 04/10/2025 Unduplicated Skilled Admissions for the last 12 Months: 99 During the Post Condition revisit survey, fifteen (15) standard level deficiencies were recited, two (2) Conditions of Participation at 42 CFR 484.55 Comprehensive assessment of patients and 42 CFR 484.60 Care Planning and six (6) standard level deficiencies were determined to be back in compliance. Based on the Condition-level deficiencies during the 02/26/2025 survey, your agency was subject to an extended survey pursuant to section 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. Abbreviations used in report: OT Occupational Therapist, PT Physical Therapist, POC Plan of Care, CM Clinical Manager, SOC - Start of Care, HHA - Home Health Aide, RN - Registered Nurse, SN - Skilled Nurse. QR: 4/17/2025 A1			
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; (v) The frequency of visits; (vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;	G0434	The agency identified that visit frequency was not always reviewed with patients or their representatives prior to initiating care, as required. To correct this, an in-service training was conducted for all clinical staff on April 28, 2025, covering: - The consent process - Proper documentation requirements - The necessity of reviewing visit frequency with patients or their representatives before care begins. The Administrator, Joanna Olarte, BSN, implemented a new process to ensure chart audits are conducted within 48 hours of admission. Missing documentation will be corrected immediately, and involved staff will receive targeted re-education. -48-hour post-admission chart audits will be performed for every new patient admission to confirm that visit frequency is and consent is documented appropriately.	2025-04-28

	(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 patients were informed of and consented to care in advance of treatments, in 1 of 4 active records reviewed (Patient #11) and 1 of 1 closed record reviewed (Patient #12) Findings include: 1. The clinical record review record for Patient #11 evidenced a form titled 'Admission Consent' dated 04/01/2025 signed by Patient #11 and the Alternate Clinical Manager indicated Patient #1 was to receive SN services. The document failed to evidence Patient #11 was informed of the frequency of the SN visits to be provided. 3. On 04/10/2025 at 11:15AM during an interview, the Clinical Manager and Alternate Clinical Manager indicated they had no documentary evidence Patient #11 and Patient 12 were provided advanced notice of the frequency of their SN visits		- Deficiencies will be addressed in real time. - Results of these audits will be discussed in monthly QAPI meetings, and trends will be monitored to identify ongoing compliance or areas needing improvement. - Ongoing training will be scheduled for new hires and as part of annual staff competency reviews. Joanna Olarte, BSN, Administrator, is responsible for: - Overseeing the initial and ongoing staff training - Conducting and/or delegating 48-hour chart audits - Ensuring deficiencies are corrected and documented - Monitoring and reporting findings through QAPI	

	to be provided. 410 IAC 17-12-3(b)(2)(D)(i)(AA)and(BB) 2. The closed clinical record review for Patient #12 evidenced an Admission Consent, dated 03/27/2025 signed by Person F, a representative for Patient #12, and the Alternate Clinical Manager; the consent indicated Patient #12 was to receive SN services. The document failed to evidence Patient #12 was informed of the frequency of the SN visits to be provided.			
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 ordered therapy initial assessments were completed within five (5) days of the start of care, in 1 of 1 re-admitted clinical records reviewed. (Patient #14)	G0520	1. On 04/28/2025, the Clinical Manager conducted a mandatory in-service training for all field clinicians focusing on: *CMS requirements for timely completion of comprehensive assessments and therapy evaluations within 5 days of SOC. *The necessity of securing a verbal or written physician order prior to rendering care with appropriate documentation of order details (who, what, when, how) *Requirement to notify the attending physician and the patient prior to making any changes to the plan of care or omitting services. * A 100% audit of all patients admitted in the past 60 days were completed. Any instances of missed or delayed therapy evaluations were identified and for each attending physicians were and late entry orders were obtained and filed in the clinical records.	2025-04-28

	Findings include: 2. The clinical record review for Patient #14 evidenced a Admission order, dated 03/12/2025, which indicated SN 1 time a week, PT and OT was to evaluate and treat. OT evaluation was scheduled for 03/14/2025. A communication note was written on 03/14/2025 by the Clinical Supervisor indicated the patient had a physician appointment and the OT visit would be rescheduled. The clinical record failed to evidence OT scheduled the assessment with Patient and failed to evidence the OT evaluation /assessment was completed within 5 days of the SOC. 3. On 04/10/2025 at 11:20 AM, the Clinical Manager stated, "Patient #14's therapy services were placed on hold on 03/19/2025" (7 days after admission) and Patient did not receive their OT evaluation within 5 days after the SOC. 1. A review of an undated		* Effective immediately, if the care is initiated based on a verbal order, clinicians must document the order details immediately- verbal order content (what specific service, frequency, duration) provider name, who received the order, date/time and submit it for written physician signature to be signed within 30 days. * The SOC will only be documented as the first billable visit following the receipt of physician orders authorizing the care provided. 2. A tracking log system was implemented to monitor all therapy referrals and ensure evaluations are completed within 5 days of SOC. A notification protocol now requires clinicians to report any delayed or unfulfilled therapy orders to the clinical manager, who will: -notify the attending physician and document the communication. -inform the patient prior to the change. Ongoing monthly audits will be performed by the QAPI team to ensure compliance. 3. Clinical Manager is responsible for clinician education, oversight of evaluations and communication with physicians. QAPI team is responsible for audits and reports findings to administrator. Administrator is responsible for enforcing policy and monitoring of sustained compliance.	

	agency policy titled "COMPREHENSIVE ASSESSMENT C-145" indicated the comprehensive assessment was to be completed within five (5) days of the initial visit.			
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 interview the agency failed ensure patients comprehensive assessments evidenced an assessment of gastrostomy (a tube inserted through the wall of the abdomen directly into the stomach) and nutrition status for 1 of 1 patient with a gastrostomy (Patient #13); assessment of Foley a catheter (a thin, flexible tube inserted into the bladder to drain urine) and urine, for 1 of 1 patient with a Foley catheter (Patient #4); assessment of a peripherally inserted central catheter (PICC) (PICC is a long, thin, flexible tube inserted into a vein in the arm and threaded to a larger vein near the heart, allowing for long-term	G0528	The deficiency related to incomplete or inadequate assessment of specialized devices was corrected on April 30, 2025. The following corrective actions were taken: - The Administrator conducted an in-service training for all field staff (Nursing and Physical Therapy) on April 30, 2025, covering the proper assessment and documentation of specialized devices (e.g., gastrostomy tubes, Foley catheters, PICC lines, dialysis access sites, and wound assessments). - Staff competency was validated post-training. - The QAPI team developed a standardized checklist tool to ensure all required assessment elements are captured during comprehensive assessments. - Affected patient records were reviewed and updated as needed to ensure documentation completeness. - The QAPI team implemented a 100% audit of all comprehensive assessments for a period of 90 days, beginning May 1, 2025. - This audit uses the newly developed Specialized Device Assessment Checklist. - After 90 days, targeted auditing will continue as part of the agency's routine quality assurance monitoring.	2025-04-30

	medications, fluids, or blood draw) site with lab orders in 1 of 1 patient with a PICC line (Patient #11); failed to identify and/or assess patient's access sites who were receiving dialysis, and failed to document the dialysis facility, in 1 of 1 active record (Patient #14) and 1 of 1 closed record who received dialysis treatment and had a wound (Patient #12). Findings include:		- Audit results will be reviewed monthly by the Administrator and presented during QAPI Committee meetings. - Trends or repeated deficiencies will be addressed with additional training or workflow changes. The Administrator is responsible for initial training and oversight. The QAPI team is responsible for developing the checklist, conducting the audits, and reporting results to the Administrator. The deficiency was corrected by **April 30, 2025, with training conducted, competency validation completed, and audits initiated.**	

	5. The clinical record review for Patient #11 evidenced discharge instructions were received by the agency on 03/31/2025 from Entity E, an acute care hospital; The orders included to perform PICC care, obtain / collect a complete blood count (CBC), CBC measures the number and types of cells in your blood, including red blood cells, white blood cells, and platelets, to assess overall health and diagnose various conditions) and a comprehensive metabolic panel (CMP) (a group of 14 tests that provides an overall picture of your body's chemical balance and metabolism, assessing kidney and liver function, blood sugar, and electrolyte levels) drawn weekly. The clinical record review for Patient #11 evidenced an initial comprehensive assessment, dated 04/01/2025 and completed by the Alternate Clinical Director, which indicated diagnoses as but not limited to Local infection of the skin and subcutaneous tissue (an infection that is confined to a specific area of the body,			

	affecting the outer layers of the skin [dermis] and the underlying fatty tissue [subcutaneous tissue]) and pressure ulcer (localized skin and tissue damage caused by prolonged pressure, often over bony prominences, that restricts blood flow, leading to tissue death) of unspecified site. Special Treatments were IV Medications, Antibiotics, IV Access which included a peripherally inserted central catheter (PICC) (PICC is a long, thin, flexible tube inserted into a vein in the arm and threaded to a larger vein near the heart, allowing for long-term access for administering medications, fluids, or blood draw) Line, The admission summary indicated Patient #11 was recently discharged from the hospital with osteomyelitis to the left hip wound. Had wounds to the left hip, left buttock, and bilateral knees. Also has redness to the hip with no open area noted. Sent home on IV antibiotics with a picc line noted to the right upper arm. The assessment failed to			

	multiple sclerosis as diagnoses, failed to identify labs were to be drawn weekly, and failed to assess PICC line site. On 04/10/2025 at 11:54 AM, the Alternate Clinical Director indicated they were to draw the CBC and CMP weekly, and would take the blood samples to Entity E, an acute care hospital, failed to assessed the PICC line, and Osteomyelitis needed to be listed as a diagnosis in the comprehensive assessment for Patient #11. 6. The clinical record review for Patient #14 evidenced an initial comprehensive assessment dated 03/12/2025 and completed by the Alternate Clinical Director which indicated Patient #14 was receiving dialysis and their treatment schedule was Tuesday, Thursday, and Saturday.			

	The assessment failed to identify Patients' dialysis access site and the ESRD where they received dialysis. 7. The clinical record review for Patient #4 evidenced an assessment, completed by the Alternate Clinical Manager, dated 03/28/2025 indicated Patient had a foley catheter (a type of catheter that dwells in the bladder and is held in place by an inflated balloon to drain urine) was being managed by the Agency, with the last change date of 3/14/2025. The assessment failed to include the foley catheter size, balloon dwell, patency, and a urine assessment, color and volume. On 04/10/2025 at 12:58 PM, the Clinical Manager indicated the foley catheter size and balloon dwell was not assessed nor an assessment of the urine. 410 IAC 17-14-1(a)(1)(B) 1. A review of an agency policy titled "COMPREHENSIVE CLIENT ASSESSMENT C-145" indicated the Comprehensive Assessment must be complete and			

	status. 2. The closed clinical record review for Patient #12 evidenced a comprehensive assessment dated 03/27/2025 completed by the Alternate Clinical Manager, contained diagnoses which included but were not limited to: pressure ulcer of sacral region, stage 2 (a wound that develops due to prolonged pressure on the skin over the bony area at the base of the spine, having a break in the top two layers of skin) and end stage renal failure (a medical condition where the kidneys no longer function properly, requiring dialysis [procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly]). The comprehensive assessment indicated the patient used oxygen at 2 liters per minute, intermittently via a nasal canula. The patient also had an AV fistula/shunt (long term arteriovenous access site for long term dialysis use) and received hemodialysis on Monday, Wednesday, and Friday. The admission summary			

	indicated recently discharged from hospital with pneumonia (lung inflammation caused by bacterial or viral infection, in which the air sacs fill with pus and may become solid). The comprehensive assessment failed to evidence a diagnosis of status-post pneumonia, failed to evidence treatment and frequency of wound changes, failed to evidence the AV fistula had been assessed, name of facility for dialysis treatment, failed to evidence supplies for oxygen, and failed to identify contact information for an oxygen supplier. 3. The clinical record review for Patient #13 evidenced an initial comprehensive assessment, dated 03/14/2025 and completed by the Alternate Clinical Manager, identified patient with a feeding tube and wound on right ankle. The assessment failed to assess Patients' gastrostomy site, failed to specify the method of administration (bolus[a single dose of a drug or other			

	continuous) for feedings, failed to identify how and when feeding tube was flushed, failed to identify the individual who managed the feeding tube, and failed to identify who managed the wound, the treatment and frequency of the wound changes. On 04/10/2025 at 11:38 AM, the Alternate Clinical Manager indicated Patient #13's comprehensive assessment failed to include supplies used for cleaning the PEG tube site, the supplies or equipment used for feedings, the feedings the patient was receiving, volume, and frequency. The Alternate Clinical Manager indicated she did not know who supplied Patients tube feeding and supplies; she indicated Patient removed feeding tube frequently, indicated this was a common occurrence as the patient often pulled their tube out, related to their cognitive status.			
G0536	A review of all current medications 484.55(c)(5)	G0536	The deficiency was addressed through immediate and comprehensive corrective action: - The QAPI team conducted comprehensive	2025-04-30

	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 2 of 3 new admissions clinical records reviewed (Patient #11 and #13) and 1 of 1 closed record reviewed (Patient #12). Findings include: 5. The clinical record review for Patient #11 with a Start of Care date of 04/01/2025 for the certification period of 04/01/2025 to 05/30/2025 evidenced a comprehensive assessment completed by the Alternate Clinical Manager, indicated interactions were identified during the medication review and reported to the attending physician. The assessment failed to evidence the specific medications, by name, in which interactions were identified, if actual or were potential interactions, reported to attending physician; the		medication reviews for all affected patients (#11, #12, and #13) and ensured proper documentation of: • Identified medication interactions • Classification as actual or potential • Physician notification with documented date, time, and response - A mandatory medication interaction documentation template was implemented in the EMR to standardize and enforce documentation requirements. - All clinical staff completed training on April 30, 2025, covering: • How to identify and document medication interactions • Appropriate physician communication • Patient and caregiver education protocols - The QAPI team will perform 100% audits of medication reviews for all patients for a period of 90 days to ensure proper use of the new documentation template. - After the 90-day period, ongoing audits of a 25% random sample of clinical records will be conducted monthly. - Audit results will be reported to the QAPI Committee. - Any deficiencies will be immediately addressed with staff re-education and, if needed, process modifications. - New hires will be required to complete the medication interaction documentation training during orientation. The QAPI team is responsible for: - Implementing the EMR template - Conducting and evaluating audits - Delivering and tracking staff training The Administrator will oversee compliance, review audit results, and direct any necessary corrective actions. The deficiency was fully corrected with	

	documentation failed to evidence coordination and education with Patient / primary caregiver regarding the interactions identified. 410 IAC 17-14-1(a)(1)(B) 1. A review of an agency policy titled 'COMPREHENSIVE ASSESSMENT C-145' stated, " & f. A review of all medications including over the counter medications the client is taken in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy &." 2. The closed clinical record review for Patient #12 evidenced a comprehensive assessment dated 03/27/2025, indicated, interactions were identified during the medication review and reported to the attending physician. The assessment failed to evidence the specific medications, by name, in which interactions were identified, if actual or were		training and process implementation completed by April 30, 2025.	

potential interactions, reported to attending physician; the documentation failed to evidence coordination and education with Patient / primary caregiver regarding the interactions identified.

3. The clinical record review for Patient #13, evidenced an initial comprehensive assessment, dated 3/14/2025, which indicated interactions were identified during the medication review and were reported to the attending physician. The assessment failed to evidence the specific medications, by name, in which interactions were Identified, if actual or were potential interactions, reported to attending physician; the documentation failed to evidence coordination and education with Patient / primary caregiver regarding the interactions identified.

On 04/10/2025 at 11:38 AM, when queried regarding communication with the Patient #13's physician regarding medication interactions, the Alternate Clinical Manager

	indicated did not recall which medication she had reported to the physician. 4. On 04/10/2025 at 12:35 PM, the Clinical Manager and Alternate Clinical Manager indicated the agency's EMR (Electronic Medical Record system) automatically checked for drug interactions, and stated, "drug interactions are there". The Clinical Manager indicated when medications are added or updated in the record, the system required a drug interaction report to be run, and indicated all interactions get sent to physicians. When queried, the Clinical Manager was not able to detail or show how the report got to patients' physicians and stated, "we don't keep a copy of the interactions faxed" and indicated the agency would need to start faxing these manually in order to have documentation it was done, and added, "we are not tracking".			
G0572	Plan of care 484.60(a)(1)	G0572	1. Corrective action taken for Identified deficiency: The Clinical Manager conducted a chart audit of all the patients admitted, recertified, or resumed within the past 60 days. Any service provided prior to a documented, specific physician order was identified.	2025-05-01

	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 establish care with attending physician and failed to obtain orders in 1 of 1 active clinical records reviewed with a peripherally inserted central catheter (PICC) ([PICC], a long, thin, flexible tube inserted into a vein in the arm and threaded to a larger vein near the heart, allowing for long-term access for administering medications, fluids, or blood draw). (Patient #11) Findings include: 1. A review of an agency's policy titled "PLAN OF CARE 580" indicated the physician shall be consulted to approve additions or modifications and the skilled assessment order will be documented on a Doctor's /allowed physician practitioner's (NPP) Order Form.		Corrective action included: *Obtaining late entries from the attending physician that specified: - What service was ordered -Who gave and who received the order -The date and time -Physician signature or co-signature *Each affected plan of care and clinical record was updated to reflect full order compliance. 2. A 100% audit of all admissions, resumptions of care, and recertifications from the past 90 days was completed. The QA team ensured each record contained full documentation of physician orders before services began. All incomplete orders were corrected immediately. 3. Order verification protocol implemented: * A physician Order Verification Form is now required for all initial and specialty services. * The form captures: -Specific service ordered (e,g "wound care, 3x/week for 4 weeks") - Who gave the order, who received it, and the date/time -Signature of physician or follow up signature for verbal orders within 48 hours * A checklist is now part of the SOC packet to ensure: -All required services (labs, wound care, therapies) are reviewed and approved by the attending before delivery -Nothing is initiated without documentation and a physician order *Staff Training conducted: On 05/01/2025, the Clinical Manager led a mandatory in-service	

	2. The clinical record review for Patient #11 evidenced discharge instructions were received by the agency, from Entity E and acute care hospital, on 03/31/2025; the orders included to perform PICC care, obtain / collect a complete blood count (CBC), (CBC measures the number and types of cells in your blood, including red blood cells, white blood cells, and platelets, to assess overall health and diagnose various conditions) and a comprehensive metabolic panel (CMP) (a group of 14 tests that provides an overall picture of your body's chemical balance and metabolism, assessing kidney and liver function, blood sugar, and electrolyte levels), draw weekly. The clinical record evidenced an initial comprehensive assessment, dated 04/01/2025 and completed by the Alternate Clinical Director, which indicated diagnoses included, but not limited to a local infection of the skin and subcutaneous tissue (an		training for all clinicians, office staff, and QA personnel. Emphasis was placed on: -CMS requirements for specific, pre-authorized orders -Prohibited use of vague terms like "Eval and Treat" -Required documentation for who gave/received the order, the exact service and physician signature. 4. Starting 05/01/25, the QA coordinator will audit: -100% of new SOC, ROC, Recertification charts weekly for 90 days. -Verifying that each service has: Specific physician-approved order, documentation of who gave it/who received it, date/time, signature or timely co-signature -Monthly QAPI meetings will review trends and any errors. -Staff who fail to follow the protocol will receive immediate re-training. Repeat violations will result in disciplinary action. 5. Clinical Manager is responsible for training, audits, second level review of the POC and ensuring that physician orders are documented and verified. Administrator is responsible for policy enforcement, oversight of compliance activities.	

	infection that is confined to a specific area of the body, affecting the outer layers of the skin [dermis] and the underlying fatty tissue [subcutaneous tissue]) and a pressure ulcer (localized skin and tissue damage caused by prolonged pressure, often over bony prominences, that restricts blood flow, leading to tissue death) of an unspecified site. Special Treatments were IV Medications, Antibiotics, IV Access which included a peripherally inserted central catheter (PICC) (PICC is a long, thin, flexible tube inserted into a vein in the arm and threaded to a larger vein near the heart, allowing for long-term access for administering medications, fluids, or blood draw) Line. The admission summary indicated Patient #11 was recently discharged from the hospital with osteomyelitis to the left hip wound, had wounds to the left hip, left buttock, and bilateral knees, had redness to the hip with no open area noted, was sent home on IV antibiotics with a PICC line noted to the right upper arm. The Plan of Care failed to			

	weekly and failed to identify PICC line dressing change orders. The clinical record failed to evidence they contacted the ordering physician to discussed or established orders for PICC line care, labs to be drawn, and wound care orders. 3. On 04/10/2025 at 11:54 AM, the Alternate Clinical Director indicated they were to draw the CBC and CMP weekly, and would take the blood samples to Entity E, and didn't realize lab and wound care orders were not in the Plan of Care nor evidence of the attending physician was consulted to develop the POC. 410 IAC 17-13-1(a)			
G0574	Plan of care must include the following 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status;	G0574	All Plans of Care for patients identified during the survey as deficient were immediately reviewed and corrected to include all required elements under §484.60(a)(–xvi), including diagnoses, mental/cognitive status, all treatments, medications, DME, nutritional needs, supplier information, and	2025-05-01

	(iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. Based on record review and interview, the agency failed to ensure the POC was developed to include types of services, supplies, equipment, medications, and treatments required in 4 of 4 active clinical records reviewed. (Patients #4, 11, 13, and 14) Findings include: 1. A review of an agency's policy titled "PLAN OF CARE		education plans. Interventions and supply details were updated in collaboration with the patients' physicians to ensure complete documentation. All active patient charts were reviewed using the revised chart audit tool to identify any other instances of incomplete POCs. Corrections were made where necessary, and the affected clinical staff received one-on-one coaching. For the next 60 days, 100% of new admissions will be audited to ensure inclusion of all required POC elements. -A revised Chart Audit Checklist was implemented to align with all 16 required POC elements under §484.60(a)(–xvi). -A second-level review process has been initiated, requiring all POCs to be reviewed by a senior clinical staff member prior to submission for physician signature. -The Clinical Manager will provide ongoing support and clarification for staff during care planning. -The Administrator will oversee compliance monitoring. -Weekly audits of all new POCs will be conducted for 60 days, with findings documented. -All compliance data and trends	

	C-580" indicated the Plan of Care shall be completed in full to include but not limited to: All pertinent diagnosis(es), Type, frequency, and duration of all visits/services, Specific procedures and modalities for therapy services, Diagnostic tests, including laboratory, Specific dietary or nutritional requirements or restrictions, Medications, treatments, and procedures, Medical supplies and equipment required, Other appropriate items, all of the above items must always be addressed on the Plan of Care. 2. The clinical record for Patient #11 evidenced Discharge Instructions from Entity E, an acute care hospital, to perform peripherally inserted central catheter ([PICC], is a long, thin, flexible tube inserted into a vein in the arm and threaded to a larger vein near the heart, allowing for long-term access for administering medications, fluids, or blood draw) PICC line care, have a CBC (a complete blood count, measures the number and types of cells in your blood, including red blood		will be presented during monthly QAPI meetings for discussion and additional intervention, as needed. -A random audit of 20% of all new admissions will continue quarterly thereafter as part of routine quality assurance. May 1, 2025 – Retraining and checklist implementation completed. Monitoring ongoing through July 1, 2025, with continued integration into the agency's QAPI program thereafter.	

	platelets, to assess overall health and diagnose various conditions) and a CMP (comprehensive metabolic panel; a group of 14 tests that provides an overall picture of your body's chemical balance and metabolism, assessing kidney and liver function, blood sugar, and electrolyte levels) drawn weekly, wound care was for primary RN to perform dressing changes, to bilateral medial knees, and left buttock every 3 days and as needed to cleanse with normal saline, pat dry, apply hydrofera blue (a type of dressing with two organic pigments, methylene blue [a synthetic dye known for its color change when reduced, making it useful as a redox indicator, this allows for the monitoring of reactive oxygen species, which are crucial for wound healing] and gentian violet [an antiseptic], to provide a broad-spectrum bacteriostatic and antibacterial effect) to the wound bed, cover with foam dressing and for sacrum to apply Cavilon Skin Advance (a skin barrier product designed to manage was moderate to severe skin damage and protect at-risk skin which creates a durable, ultra-thin, and			

	waterproof barrier that adheres to wet, weepy skin and repels irritants, promoting healing) every Tuesday and Friday. The clinical record for Patient #11 evidenced a document titled 'OASIS-E1 Start of Care' dated 04/01/2025, completed by the Alternate Clinical Manager which indicated diagnoses as but not limited to Local infection of the skin and subcutaneous tissue (an infection that is confined to a specific area of the body, affecting the outer layers of the skin [dermis] and the underlying fatty tissue [subcutaneous tissue]) and pressure ulcer (localized skin and tissue damage caused by prolonged pressure, often over bony prominences, that restricts blood flow, leading to tissue death) of unspecified site. Special Treatments were IV Medications, Antibiotics, IV Access which included a peripherally inserted central catheter (PICC is a long, thin, flexible tube inserted into a vein in the arm and threaded to a larger vein near the heart, allowing for long-term access			

	for administering medications, fluids, or blood draw), indicated Patient #11 was incontinent of urine and bowel. The admission summary stated, " & Recently discharged from the hospital with osteomyelitis to the left hip wound. Has wounds to the left hip left buttock and bilateral knees. Also has redness to the coccyx with no open area noted. Sent home on IV antibiotics with a picc line noted to the right upper arm. Patient has been admitted to Cardinal Home Health Services due to need for SN services related to multiple sclerosis immobility wounds and chronic pain &" Durable Medical Equipment included were: Hospital Bed. The clinical record for Patient #11 evidenced an initial POC for the certification period of 04/01/2025 to 05/30/2025, signed and dated 04/01/2025 by the Alternate Clinical Manager failed to identify labs were to be drawn weekly, failed to specify PICC line care and how often, and failed to identify all DME supplies required to			

	care for the patient. On 04/10/2025 at 1:30 PM, the Alternate Clinical Manager indicated the Plan of Care was missing DME supplies, they didn't realize labs were required to be on the plan of care and they should have been specific with PICC line dressing changes. 3. The clinical record for Patient #14 evidenced a document titled 'OASIS-E1 Start of Care' dated 03/12/2025, completed by the Alternate Clinical Manager which indicated Patient was receiving dialysis (procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) on Tuesday, Thursday, and Saturdays, DME were a walker, tub/shower bench, and an elevated toilet seat and DME Provider was Entity I, the VA, and provided DME and Wound Supplies. The clinical record evidenced an			

	5/10/2025, created by and signed by the Alternate Clinical Manager and dated 3/12/2025. The POC indicated Entity I provided wound supplies. On 04/10/2025 at 10:45 AM during a phone interview with Person A, a family member of Patient #14 indicated Entity H is the dialysis center they utilize, Entity I provides all wound care supplies, such as "salve, normal saline, round and square bandages, tape, incontinent supplies, cotton swabs, had 2 walkers, a wheelchair, a shower bench, and uses wipes to wash with, the kind you add water to and there's no rinsing". The Plan of Care failed to identify where Patient #14 had received dialysis and failed to identify all wound care supplies and day to day supplies required to care for Patient #4. On 04/10/2025 at 11:53 AM, the Alternate Clinical Manager indicated they were not sure			

dialysis, and indicated why would she need to contact them.

4. The clinical record for Patient #4 evidenced a recertification assessment dated 03/28/2025 and completed by the Alternate Clinical Manager that indicated Patient had a foley catheter and had bowel incontinence. The summary indicated Patient was recertified due to the need for SN and aide services related to wound care, osteoarthritis, and chronic pain.

The POC for the re-certification period of 03/31/2025 to 05/29/2025 completed by the Alternate Clinical Manager failed to identify Foley catheter supplies to include size, wound care and day to day supplies required to care for Patient #4.

5. On 04/10/2025 at 11:58 AM during an interview with the Clinical Manager and Alternate Clinical Manager indicated they did not realize all supplies

	of Care for each patient. 6. The clinical record review for Patient #13 evidenced an initial comprehensive assessment dated 03/14/2025, indicated the patient had a wound to the right ankle, and had a gastrostomy tube through which the patient received feedings and medications. The Admission Summary indicated Patient was admitted for home care services which included, but was not limited to, wound care. Further review of the clinical record for Patient #13 evidenced a POC which evidenced a Medication list which included, but was not limited to: Mupirocin (a medication that treats skin infections caused by bacteria, prevents bacteria growth and kills existing bacteria on your skin) 2% topical ointment to be applied to PEG tube site every dressing and as needed, and Osmolite 1.2 (medical nutrition supplement primarily used for patients requiring tube feeding or who cannot meet their			

nutritional needs through regular meals) 240cc/can 5 cans per day per feeding tube.

The Plan of Care for Patient #13 failed to contain wound care orders to the right ankle, including frequency, and wound care supplies needed, failed to identify and specify type of gastrostomy tube the patient had, failed to specify the method of administration (bolus or continuous) for feedings, failed to include information regarding flushing of the tube and amount of water to be used with feedings or medications, failed to evidence information regarding who managed the gastrostomy site, feedings, and changes, failed to include supplies used for care and administration of enteral feedings, and failed to include information on supplier(s).

7. On 04/10/2025 at 12:50 PM, when queried as to the information lacking on the plan of care for Patient #13, a gastrostomy tube patient, the Alternate Clinical Manager indicated Patient #13 family's

	managed the feedings well and had been doing so for some time, the plan of care had not included this information, or supplier contact information, information on the feeding, how much the family was feeding, how much the patient was taking, and indicated for Patient #13 these were bolus feedings with syringes used. When queried regarding lack of orders for Patient #13's PEG tube site care, the Alternate Clinical Manager and Clinical Manager indicated new awareness that orders were needed. The Clinical Manager was shown the Plan of Care for Patient #13 and was asked to locate wound care orders on the document. The Clinical Manager indicated did not see orders for wound care. 410 IAC 17-13-1(a)(1)(D)(i-xiii)			
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	G0580	The agency corrected the deficiency by implementing the Clinical Record Review audit tool as the primary method for verifying that all services and treatments are provided only as ordered by a physician. This audit tool includes verification that all nursing interventions—such as wound care, gastrostomy site care, and other skilled services—are explicitly supported by physician orders in the Plan of Care or through written/verbal orders.	2025-05-01

	interview, the agency failed to ensure orders were obtained for wound care and gastrostomy site care in 1 of 1 active record reviewed with a wound and gastrostomy. (Patient #13) Findings include: 1. A an agency policy title "PLAN OF CARE C-580" indicated the Plan of Care shall be completed in full to include type, frequency, and duration of all visits/services, specific procedures and modalities for therapy services, medications, treatments, and procedures. 2. The clinical record review for Patient #13 evidenced an initial comprehensive assessment dated 03/13/2025, completed by the Alternate Clinical Manager contained diagnoses which included, but were not limited to: encounter for change or removal of surgical wound dressing, unspecified open wound right ankle, gastrostomy status (or G-tube, presence of an artificial opening into the stomach often for receiving nutrition or medications), and unspecified dementia (term for		All active and new admissions are now reviewed using this tool on a rolling basis. Discrepancies identified during audits are immediately corrected, and responsible clinicians receive targeted re-education. - The Clinical Manager oversees ongoing chart audits to ensure all clinical documentation aligns with physician directives. - Audit findings are reviewed monthly during QAPI meetings to monitor compliance trends. - Patterns of noncompliance will result in targeted training sessions and review of clinical documentation protocols. - The Clinical Record Review tool will remain part of the agency's standard QA process, ensuring sustainable adherence. The Clinical Manager is responsible for: - Conducting rolling audits using the Clinical Record Review tool - Ensuring that discrepancies are corrected - Delivering targeted re-education as needed The Administrator will monitor compliance trends and ensure oversight during QAPI reviews. The tool was implemented and staff training completed by May 1, 2025. Audits began immediately and are ongoing.	

	several diseases that affect memory, thinking, and the ability to perform daily activities, including the ability to eat independently). A section titled 'Nutrition' indicated Family stated appetite was good when [patient] is awake, was fed per PEG (percutaneous endoscopic gastrostomy, a feeding tube that's inserted through the stomach wall, allows patients to receive nutrition directly into their stomach) on days [patient] sleeps all day. Indicated Patient had a wound to the right ankle which the nurse provided the following care for: right ankle cleansed with normal saline, pat dry, zero form placed over wound bed and covered with a dry dressing. The clinical record failed to evidence orders were received by the attending to include wound care orders for the right ankle and failed to evidence orders for PEG tube site care as completed on 3/13/2025. The clinical record evidenced			

	dated March 18, 21, 25, and 28, of 2025 which indicated the skilled nurse had performed the following wound care to the right ankle: "Cleansed with normal saline patted dry xeroform (a non-adherent wound dressing impregnated with a bacteriostatic agent) placed to wound bed. Covered with dry dressing" and the performed PEG tube site care "cleansed with normal saline. Ointment applied." The POC for Patient #13 failed to evidence wound care orders for the right ankle and orders for care of the gastrostomy tube site. On 04/10/2025 at 12:51 PM, the Alternate Clinical Manager and Clinical Manager indicated they were not previously aware care orders were needed for PEG tube site care. The Clinical Manager indicated she could not locate wound care orders to evidence. 410 IAC 17-13-1(a)			

G0606	Integrate all services 484.60(d)(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. Based on record review and interview the agency failed to coordinate care with all healthcare providers providing care in 1 of 1 active records reviewed of patients receiving dialysis. (Patient #14) Findings include: 1. A review of an agency's policy titled, "COORDINATION OF CLIENT SERVICES 360" indicated coordination of care will include dealing with multiple programs for the complex clients and coordination will include providers of care who are not part of the agency. 2. The clinical record review for Patient #14 evidenced an initial comprehensive assessment dated 03/12/2025 and signed by the Alternate Clinical Manager, which indicated	G0606	The deficiency regarding inadequate coordination with external providers was corrected as of May 1, through the following actions: - All clinical staff were retrained by the Clinical Manager on the requirement to identify and coordinate with external providers, including: • Dialysis centers • Specialty physicians • DME and pharmacy suppliers - The agency developed and implemented a Care Coordination Form, which must be completed for all new admissions and updated throughout the patient's episode of care. - The form identifies all external providers referenced in the comprehensive assessment or reported by the patient or ensures documentation of communication efforts. - The Clinical Manager will conduct ongoing chart audits to confirm that: • All relevant external providers are identified • Coordination efforts are clearly documented in the clinical record - Audit results will be reviewed during monthly QAPI meetings. - Any failure to document required coordination will result in immediate corrective action, including 1:1 staff re-education. - The Care Coordination Form is now a required component of the clinical documentation packet and part of new staff orientation. The Clinical Manager is responsible for: - Conducting retraining - Performing and reviewing audits - Ensuring completion and use of the Care Coordination Form The QAPI Committee will and track trends	2025-05-01

	Hemodialysis on Tuesdays, Thursdays, and Saturdays but failed to identify where. The record failed to evidence coordination notes with the dialysis center. 3. On 04/10/2025 at 10:45 AM Person A, a family member of Patient #14 indicated Entity H is the dialysis center they utilize. 4. On 04/10/2025 at 11:53 AM, the Alternate Clinical Manager indicated they were not aware coordination of care needed to occur with all patient care providers and when queried where Patient #14 was receiving dialysis, they indicated they were not sure. 410 IAC 17-12-2(h)		related to compliance. The corrective actions, including staff training and form implementation, were completed by May 1, 2025.	
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,	G0644	To correct this, the agency held a Governing Body meeting on May 3, 2025, during which the following items were approved and documented in the minutes: The frequency of QAPI data collection (monthly),	2025-05-03

	where applicable, and other relevant data, in the design of its program. (2) The HHA must use the data collected to- (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be approved by the HHA's governing body. Based on record review and interview the agency failed to ensure the Governing Body approved the frequency and detail of data collection and utilized quality indicator data from the OASIS (Outcome and Assessment Information Set) for the Quality Assurance and Performance Improvement (QAPI) program. Findings include: 1. A review of the QAPI program and 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. 2. On 04/10/2025 at 1:45 PM,		The types of data to be collected (OASIS-based quality measures, adverse event reports, infection tracking, re-hospitalizations, and patient satisfaction trends), The required level of detail and responsibility for analysis and follow-up. Furthermore, the QAPI Committee has resumed regular meetings. The next QAPI meeting is scheduled for May 17, 2025, and a formal agenda includes: Review of updated OASIS quality measures (e.g., improvement in ambulation, hospitalization rates), Review of trends in missed visits, infection rates, and emergency care episodes, Documentation of corrective action plans tied to deficient clinical performance. The QAPI program has also been revised to include a QAPI Data Dashboard summarizing performance benchmarks and indicators. This dashboard will be presented to the Governing Body quarterly for review, action, and approval. The Clinical Manager will ensure that all relevant clinical and operational data are entered into the dashboard, reviewed monthly, and that evidence of data-driven improvements is maintained in the QAPI binder.	

	the Alternate Administrator/Clinical Manager indicated the Governing Body minutes presented, dated 03/28/2025, were the most recent, there had been no other meetings conducted, and agreed did not address QAPI. The Alternate Administrator/Clinical Manager also confirmed the QAPI meeting minutes dated 01/18/2025 were the most recent, and there had been no other QAPI related meetings held after that time. The Alternate Administrator/Clinical Manager indicated the agency had not worked on corrective actions related to the QAPI program since the previous survey had ended, stating the agency had an upcoming QAPI meeting, "on the 17th" and would address corrective actions at that time. 410 IAC 17-12-2(a)		The agency will conduct an internal QAPI process audit every 90 days to ensure ongoing compliance. Minutes from QAPI and Governing Body meetings will be retained and made available for future survey review.	

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. Findings include: 1. A review of the agency's QAPI binder evidenced a document titled 'QAPI Meeting Minutes' dated 01/18/2025, and failed to evidence new or updated QAPI related activities had been conducted after that date. 2. On 04/10/2025 at 1:45 PM, the Alternate Administrator /Clinical Manager indicated the QAPI meeting minutes	G0646	The agency will reconvene its QAPI Committee on May 17, 2025, and begin active performance improvement planning in alignment with 42 CFR §484.65(c). The committee, led by Administrator will implement a structured Performance Improvement Project (PIP) approach targeting identified problem-prone areas, such as: Incomplete physician orders on Plan of Care Lack of coordination with external providers Missed documentation of patient consent for services Each PIP will include: A defined problem statement Data source (OASIS, chart audits, incident logs) Root cause analysis (RCA) methodology Measurable goals and timelines Assigned responsibilities Evidence of implementation and monitoring The Clinical Manager, will ensure root cause analysis training is completed for all QAPI members by May 20, 2025. A standardized RCA tool and PIP tracking template will be added to the QAPI binder. The QAPI program will be reviewed monthly, with updated documentation maintained and reviewed by the Governing Body quarterly.	2025-05-20

	were the most recent, and there had not been another QAPI-related meeting held since. The Alternate Administrator /Clinical Manager indicated the agency had not worked on corrective actions related to the QAPI program since the previous survey and stated the agency would address corrective actions at their next scheduled meeting "on the 17th." The Alternate Administrator /Clinical Manager indicated, when asked, the agency had not conducted root cause analysis activities, related to the program's performance improvement component of their QAPI and replied, "we will work on this."			
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	All active HHAs were retrained on May 1, 2025, regarding the requirement to follow the Aide Care Plan and document all tasks accurately. The in-service training covered: -Documentation of all ordered tasks on each visit -Scope of practice under state regulations -Proper procedures for noting refusals or missed tasks The Clinical manager also conducted a meeting with the QAPI team on ensuring the clinical audit tool is utilize to address these issues right away.	2025-05-01

	interview, the agency failed to ensure the HHA provided services as directed in the care plan in 2 of 2 active clinical records reviewed receiving HHA services. (Patients #4 and 13) Findings include: 1. A agency's policy titled "HOME HEALTH AIDE: DOCUMENTATION C-800" indicated Home Health Aides will document care/services provided on the home health aide charting form and Care/services provided should be in accordance with direction provided in the Home Health Aide Care Plan.		QAPI team will perform weekly audits of HHA documentation, cross-checking visit notes against the care plan to ensure all services are being provided and documented as ordered. Any discrepancies will result in immediate follow-up and staff coaching. All findings and trends will be reviewed monthly as part of the QAPI program to ensure ongoing compliance with 42 CFR §484.80(g)(2).	

	2. The clinical record review for Patient #4 evidenced an Aide Care Plan dated 03/28/2025 completed by the Alternate Clinical Manager which indicated the HHA was to provide oral care and nail care at every visit. HHA visit notes completed by HHA 1 dated 03/22/2025, 03/23/2025, 03/29/2025, and 03/31/2025 failed to evidence oral care and nail care was provided during each visit. 3. On 04/10/2025 at 1:15 PM, the Alternate Clinical Director indicated they needed to educate their HHAs to follow the care plan. 4. The clinical record review for Patient #13 evidenced an Aide care plan dated 03/14/2025 which indicated the Aide was to provide nail care, range of motion, and unspecified equipment care during ea. Aide Visit notes completed by HHA 2 on 03/14/2025, 03/19/2025, 03/21/2025, 03/21/2025, 03/26/2025, and			

	nail care, range of motion, and equipment care had been provided to the patient as directed in the aide care plan On 04/10/2025 at 1:25 PM, the Clinical Manager and Alternate Clinical Manger were queried as to the discrepancies found on the Aide visit notes versus what had been ordered in the aide care plan, both indicated they had not been aware of what Aides had documented in their visit notes.			
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	G0818	1. As of 06/03/2025, all RN supervisors were retrained on the required elements of effective HHA supervision, including: *Cross-verifying aide documentation with the written Aide Plan of Care. *Observing aide task performance during supervisory visits when feasible. *Confirming that each required task is being performed consistently and safely. *Documenting changes in condition and caregiver documentation. Effective immediately, all RN supervisory visits include a task by task comparison between the services performed and the Aide Plan of Care. These visits are documented using a newly revised HHA supervision checklist. When aide performance gaps are identified, the RN must notify the patient and or caregiver within 24 hours, document variance and initiate corrective actions and or re-education of the aide.	2025-06-03

	condition; and (vi) Honoring patient rights. Based on record review and interview, the agency failed to ensure the HHA supervision included the HHA followed the aide care plan in 2 of 2 active clinical records reviewed which received HHA services. (Patient #4 and 13) Findings include: 1. A review of an agency's policy titled "HOME HEALTH AIDE: DOCUMENTATION C-800" indicated if the HHA documentation is completed electronically, the RN/Therapist will review this documentation.		2. All aide documentation is now reviewed by the supervising RN within 72 hours of the visit. Routine RN supervisory visits will continue every 14 days, in accordance with CMS 484.80 (h) In addition, unannounced supervisory visits will be conducted at least every 60 days or more frequently for high-risk or previously noncompliant aide cases. Supervisory visits audits are to be conducted biweekly by the Clinical Manager. Trends and issues are reviewed monthly in QAPI meetings to ensure sustained compliance. 3. Field RNs are responsible for direct supervision, documentation, and patient/caregiver follow up. Clinical Supervisor is responsible for oversight of documentation and corrective action. Clinical Manager is responsible for bi-weekly audits and QAPI review. Administrator is responsible for overall compliance and policy enforcement.	

A review of an policy titled "HOME HEALTH AIDE SUPERVISION C-340" indicated Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including but not limited to the following elements: Following the client's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional.

3. The clinical record review for Patient #4 evidenced a HHA Care Plan dated 03/28/2025 which indicated the HHA was to provide but not limited to: oral care and nail care at every visit. HHA visit notes completed by HHA 1 dated 03/22/2025, 03/23/2025, 03/29/2025,and 03/31/2025 failed to evidence oral care and nail care was provided at each visit as directed in the care plan.

The HHA supervision visit dated 03/25/2025 and 04/08/2025 and signed by the Alternate Clinical Manager indicated HHA 1provided services per the HHA

	care plan and failed to evidence the RN provided supervision to ensure HHA 1 followed the aide care plan as directed. 4. On 04/10/2025 at 1:20 PM, the Alternate Clinical Director indicated there needs to be more education with the aides and to correct the HHA plan of care. 5. A clinical record review for Patient #13 evidenced an Aide Care Plan dated 03/14/2025 which indicated the Aide was to provide care which included, but was not limited to: nail care, range of motion, and equipment care. Aide visit notes completed by HHA 2 on 03/14/2025, 03/19/2025, 03/21/2025, 03/21/2025, 03/26/2025, and 03/28/2025 failed to evidence nail care, range of motion, and equipment care had been provided to the patient as directed in the Aide care plan. Aide visit notes completed by			

	HHA 2 on 03/14/2025, 03/19/2025, 03/21/2025, 03/21/2025, 03/26/2025, and 03/28/2025 evidenced the Aide had recorded bowel movements, but had not documented the date(s) and had provided assistance with transfers, both of which were not included in the aide care plan. The HHA Supervision visit dated 03/28/2025, signed by the Alternate Clinical Manager indicated HHA 3 had provided services per the Aide Care Plan and failed to evidence the RN had provided supervision to ensure HHA 2 had followed the aide care plan as directed. On 04/10/2025 at 1:25 PM, the Clinical Manager and Alternate Clinical Manger were queried as to the discrepancies found on the Aide visit notes versus what had been ordered in the aide care plan, both indicated they had not been aware of what Aides had documented in the visit note.			

	410 IAC 17-14-1(n)			
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 ensure physicians received patients' discharge summary within five (5) business days of discharge from the agency, in 1 of 1 discharge/readmitted clinical record (Patient #14) and 1 of 1 (Patient #12) closed clinical record. Findings include: 4. The clinical record review for	G1022	All clinical staff participated in a mandatory in-service training on April 30, 2025, focused on: -Reviewing the current policy DISCHARGE and TRANSFER SUMMARY, which outlines the requirements for timely submission of discharge and transfer summaries; -Clarifying the distinction between discharge and transfer events; -Emphasizing the importance of sending documentation within the specified timelines; -Understanding the responsibility for documenting and confirming communication with physicians and facilities. No changes were made to the existing policy; however, all staff signed an attestation acknowledging review and understanding of the discharge and transfer policy. To support compliance, the clinical leadership team will conduct weekly audits of all patient discharges and transfers to verify that summaries are completed and sent according to regulatory deadlines. Documentation will be monitored using an internal tracking system, and any delays will be addressed with immediate follow-up. These audits will be discussed during QAPI meetings to monitor ongoing compliance.	2025-04-30

	Patient #14 evidenced a 'OASIS Transfer', and a 'Home Health Transfer Summary' dated 02/27/2025 and signed by the Alternate Clinical Manager, which indicated Patient #14 was transferred from Entity H, a dialysis center to Entity E, an acute care hospital, of which both indicated was sent to Person G, the ordering physician for Patient #14. A 'Transfer Order' was written and signed by the Clinical Manager on 02/27/2025 indicated the Agency confirmed Patient #14 was admitted to Entity E from dialysis per Person A. A 'Discharge Order' was written and signed by the Alternate Clinical Manager dated 03/07/2025 indicated to discharge Patient #14 from all home health services, patient had no projected date to be discharged from Entity E. The discharge order indicated it was sent to Person G on 03/07/2025. The clinical record failed to evidence a discharge summary. 5. On 04/10/2025 at 1:15 PM,			

when queried if a discharge summary was sent to the ordering physician, the Clinical Manager and the Alternate Clinical Manager indicated no, a discharge summary was not sent.

410 IAC 17-15-1(a)(6)

1. A review of an agency policy titled "DISCHARGE SUMMARY C-820" indicated when a client is discharged from the agency, the supervising professional shall complete a Discharge Summary form and send to the primary care practitioner or other health care professional within 5 business days of the client discharge.

2. The closed clinical record review for Patient #12 evidenced a 'Transfer Discharge' dated 03/09/2025, which indicated the patient had reported to an unknown emergency room, was admitted to an unknown acute care hospital and was discharged from the agency. A 'Home Health Transfer Summary' dated 03/19/2025 signed by the

	Alternate Clinical Manager, was also sent to Patient #12's physician on 03/19/2025. The clinical record failed to evidence a discharge summary. 3. On 04/10/2025 at 1:57 PM, the Clinical Manager indicated the 'Home Health Transfer Summary' was considered the agency's discharge summary as well, and when queried whether a discharge summary had been sent within the 5 days of discharge to the physician, stated, "no" it had not.			
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 entry. Based on record review and interview the agency failed to ensure staff documented timely into the clinical record, in 1 of 1	G1024	The agency conducted a focused review of all recent discharge documentation and implemented the following actions: 1. Staff Training All clinical staff were retrained on Apr 30, 2025, with an emphasis on: -Timely documentation standards (within 24–48 hours of patient discharge or transfer), -Proper authentication, including electronic signature, date, and credentials (title), -Review of the current DISCHARGE PROCESS policy. -Staff were reminded that late documentation	2025-04-30

	closed records. (Patient #12) Findings include: 1. An agency policy titled "DISCHARGE PROCESS C-500" indicated a completed discharge summary will be sent to the attending provider within 5 business days of the client's discharge. 2. The clinical record for Patient #12 contained a Discharge date of 03/09/2025 and indicated the Home Health Transfer Summary had not been completed or sent to the patient's ordering provider until 03/19/2025, 10 days after the date of discharge.		survey compliance. 2. Documentation Tracking and Audit A Late Documentation Tracking Log has been implemented to monitor all discharges, transfers, and associated clinical entries. Clinical supervisors now conduct weekly audits of all entries for timeliness and proper authentication. -Any clinician who submits documentation outside of the required timeframe without justification will be counseled, and repeat infractions will be escalated with progressive corrective action. 3. Technology Enhancements While external AI-based documentation support and auditing tools are still on review, the agency has already instituted a manual reminder system within its EMR to flag due or overdue summaries and other key documentation items. 4. QAPI Oversight Timeliness of documentation and authentication compliance will be reviewed monthly as a standing agenda item in QAPI meetings. Trends and outliers will be identified for improvement planning and reporting to the Governing Body quarterly.	

	On 04/10/2025 at 1:57 PM, the Clinical Manager indicated the 'Home Health Transfer Summary' was considered the agency's discharge summary as well, and when queried whether a discharge summary had been sent within 5 days of discharge to the physician, stated, "no" it had not. On 04/10/2025 at 2:00 PM, the Clinical Manager indicated was aware documentation from staff and clinicians was still being completed late, indicated felt had been harassing co-workers, and planned to utilize outside resources which included an artificial intelligence company, and additionally had hired an external group to audit, but none of these were currently in effect. 410 IAC 17-15-1(a)(7)			
N0000	Initial Comments This was a revisit for a State	N0000		

	Re-licensure survey of a Home Health Provider, conducted on February 26, 2025. Survey dates: 04/09/2025 and 04/10/2025 12-month unduplicated skilled census: 99			

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
Joanna Olarte	Administrator	6/5/2025 12:55:13 PM