STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157704	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREATLAND HOME HEALTH	**9616 INDIANAPOLIS BLVD 2ND FLOOR STE D , HIGHLAND, Indiana, 46322**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments The Indiana Department of Health conducted an Emergency Preparedness survey, conducted in accordance with 42 CFR §484.102, for a Home Health Provider and Suppliers. Survey Dates: June 11, 12, and 13, 2025 Census: 9 During this Emergency Preparedness survey, GreatLand Home Health Services was found to be out of compliance with Conditions of Participation at 42 CFR §484.102: Emergency Preparedness Requirements for Medicare Participating Providers and Suppliers.	E0000		
E0001	Establishment of the Emergency Program (EP) CFR(s): 484.102 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency	E0001		

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

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E0001	Continued from page 1 preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to evidence a current Emergency Preparedness Plan for review during their recertification survey. The Provider failed to evidence a plan which was updated at least every two years (Tag E0004); failed to evidence updated policies and procedures at least every two years (Tag E0013); failed to evidence they developed and implemented their policies and procedures to include procedures to inform the State and local emergency officials about patients in need of evacuation from their residences due to an emergency situation (Tag E0019); failed to evidence they developed procedures to follow up with on-duty staff and patients to determine services that are needed, in the event there is an interruption in services during or due to an emergency (Tag E0021); failed to evidence they developed a system of medical documentation that preserves patient information, protects the confidentiality of patient information, secures and maintains the availability of medical records in an emergency situation (Tag E0023); failed to evidence they developed procedures for the use of volunteers and other emergency staffing strategies to address surge needs during an emergency situation (Tag E0024); failed to evidence a communication plan to include the names and contact information for their staff and patients' physicians (Tag E0030); failed to evidence they developed a communication plan which included a primary and alternate means for communicating with agency staff and Federal, State, tribal, regional and local emergency management agencies (Tag E0032); failed to evidence they developed a communication plan which included a method for sharing information and medical documentation for patients under the agency's care with other health providers and failed to develop a means for providing	E0001		

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E0001	Continued from page 2 information about the general condition and location of patients under their care (Tag E0033); failed to evidence they developed a communication plan which included a means of providing information about the agency's needs, and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or designee (Tag E0034); and failed to evidence all employees completed EP training (Tag E0037). During an entrance conference on 06/11/2025, beginning at 11:40 AM, communication with the Administrator, via phone, indicated the Office Manager could provide the documentation requested. A Documentation Request Form, signed by the Office Manager, on 06/11/2025, evidenced the 1st request for the agency's Emergency Preparedness Plan. A request for the agency's Emergency Preparedness Plan was in writing, on 06/13/2025 at 10:40 AM, to the office manager. At the time of exit on 06/13/2025 at 5 PM, the surveyor was not provided with documentation of the agency's Emergency Preparedness comprehensive plan for review, to demonstrate compliance with the condition of participation at §484.102. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the Condition of Participation at 42 CFR 484.102 Condition, with the likelihood to affect all 9 current patients receiving Home Health services from this provider.	E0001		
G0000	INITIAL COMMENTS This visit was for a home health Recertification and State Re-licensure survey. Survey Dates: June 11, 12, and 13, 2025 Unduplicated Skilled Admissions for the last 12 Months: 70 During this survey, GreatLand Home Health Services was found to be out of compliance at 42 CFR 484.60 Care planning, coordination, quality of care, §484.65 Quality Assessment /Performance Improvement, and 484.105 Organization and Administration of Services. This deficiency report reflects State Findings cited in	G0000		

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G0000	Continued from page 3 accordance with 410 IAC 17. Based on the Condition-level deficiencies during the June 13, 2025 recertification survey, GreatLand Home Health LLC was subject to an extended survey, pursuant to section 1891(c)(2)(D) of the Social Security Act. Therefore, and pursuant to section 1891(a)(3)(D)(iii) of the Act, your agency is precluded from operating or being the site of a home health aide training, skills competency, and/or competency evaluation program, for a period of two years, beginning June 13, 2025 and continuing through June 12, 2027. Abbreviations used in report: EMR for Electronic Clinical Records, HHA for Home Health Aide, CM for the Clinical Manager, RN for Registered Nurse, POC for Plan of Care, SOC for Start of Care, OT for Occupational Therapist, SN for Skilled Nurse, and PT for Physical Therapist.	G0000		
G0528	Health, psychosocial, functional, cognition CFR(s): 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; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the comprehensive assessment accurately reflected the patient's status and included the patient's active health status and medical problems to assist the agency in developing the patients' plan of care in 1 of 1 home visits observed with a patient with start of care before 06/10/2025 (Patient #2). Findings include: An undated policy, titled, "Comprehensive Assessment of Patients OASIS" indicated the components of a comprehensive assessment would include but not limited to head-to-toe assessment. A Resumption of Care Visit Note, dated 05/21/2025, indicated Patient #2 had IV (intravenous) access and failed to evidence assessment of the site to include location, type of IV access, and skin assessment of IV access.	G0528		

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G0528	Continued from page 4 A RN Subsequent Visit Note, dated 05/26/2025, indicated Patient had IV access of a Hickman central venous catheter (a long-term tunneled silicon catheter in the chest). An RN Recert With Skill Visit Note, dated 05/27/2025, indicated Patient remained on TPN (total parental nutrition through catheter) via a Hickman catheter. During an interview, on 06/12/2025, beginning at 2:00 PM, RN 1 indicated resumption of care should include documentation of the Hickman catheter. 410 IAC 17-14-1(a)(1)(B)	G0528		
G0536	A review of all current medications CFR(s): 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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure all medications the patient was taking were reviewed to identify significant drug interactions, potential adverse effects and noncompliance with drug therapy in 1 of 1 home visit with a start of care date before 06/10/2025 (Patient #2) and in 1 of 3 active clinical records reviewed without a home visit.(Patient 3). Findings include: 1. An undated policy titled, “Medication Profile,” indicated the medication would be updated when the patient’s medications change. The policy indicated medication education should include possible side effects, adverse effects, and possible interactions with other medications. The policy indicated the purpose of the medication profile was to list and notify the physician of medications that the patient was routinely taking on an as needed basis. The policy indicated the admitting therapist/nurse was to record all medication the patient was taking on a routine or on an as needed basis. The policy indicated upon admission to the agency the admitting RN or therapist was provided in the admission packet sheet to record	G0536		

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G0536	Continued from page 5 medications the patient was taking on a routine or on an as needed basis. The policy indicated the nursing staff would check all medications a patient was taking to identify possible actual or potential drug interactions and promptly report any problems to the physicians. The policy indicated the medication profile would be updated at least every 60 days or as needed, and all new medications would be added to the medication profile and checked for interactions risks by the case manager. 2. During an observation of a home visit, on 06/12/2025, beginning at 9:00 AM, Patient #2 presented a medication list that included but not limited to Tylenol (pain reliever) 500 milligrams [mg] 2 tablets every 8 hours as needed, and Abilify (anti-depressant) 10 mg one tablet every day. Patient indicated he/she had been taking the medications as listed since being discharged from the hospital on 05/20/2025. Patient indicated he/she was taking Zofran (anti-nausea/vomiting medication) every day due to nausea after intestinal surgery, weight loss and use of TPN (total parental nutrition provided intravenously) and presented a prescription bottle for Zofran 4 mg for use under the tongue to dissolve one tablet every 6 hours as needed for nausea, was observed with 3 liters of oxygen by nasal cannula being worn, and was on Eliquis (blood thinner) and Plavix (antiplatelet medication), and presented a prescription liquid for a nebulizer (a drug delivery device used to deliver medication in the form of a mist inhaled into the lungs) named, Ohtuvayre 3 mg/2.5 milliliters to use twice per day. An Agency Medication List, received on 06/12/2025, failed to evidence use of Tylenol, Ohtuvayre, Zofran, Abilify and indicated oxygen 2.5 liters continuous was documented as entered by other staff, A on 06/12/2025. A Plan of Care, for certification period 06/01/2025 to 07/30/2025, failed to include medications of Eliquis, Zofran, Ohtuvayre nebulizer, oxygen, Tylenol, Abilify, Wellbutrin, Valium, Nexium, Imodium, Metoprolol, and Remeron. A Resumption of Care RN Visit Note, dated 05/21/2025, indicated a drug regimen review was completed and reviewed to identify potential clinically significant medication issues and no issues were found during the review. A Drugs.com medication interactions check indicated major drug interactions between Plavix (antiplatelet) and Eliquis that could increase bleeding risk, between	G0536		

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G0536	Continued from page 6 Plavix and rosuvastatin (cholesterol lowering medication) that had potential for liver damage, between Plavix and Nexium that had the potential to reduce Plavix effects, between Wellbutrin and Abilify could increase risk of seizures, between Imodium and Plavix could cause irregular heart rhythm, between Zofran and Remeron that could cause serotonin syndrome (increase heart rate, cause confusion and change blood pressure), between Wellbutrin and Zofran could cause serotonin syndrome, and Wellbutrin and Remeron that could cause increased risk of seizures. During an interview, on 06/12/2025, beginning at 12:20 PM, the Administrator indicated the electronic medical record system would check for medication interactions and the nurse would notify the physician of interactions. During an interview, on 06/12/2025, beginning at 2:00 PM, RN 1 indicated medications were reviewed at the resumption of care. RN 1 indicated Zofran should have been updated on the medication list and was unaware Patient was taking Ohtuvayre nebulizer treatment, RN 1 indicated she was responsible for creating the plan of care and did not include the oxygen because there was not a place to put the oxygen use on the plan of care. RN 1 indicated if Patient did not tell her of the new medications, she would not be able to update the medication list after the hospitalization. RN 1 ended the interview via phone on 06/12/2025 at 2:11 PM and attempts to interview RN 1 were not responded to at time of exit on 06/13/2025 at 5:00 PM. 3. A clinical record review for Patient #3 evidenced a RN visit note dated 05/03/2025 stated “provided education on … taking antihypertensive medications as prescribed.” A clinical record review for Patient #3 evidenced a POC for recertification dated 04/27/2025-06/25/2025 that lacked evidence of any antihypertensive (blood pressure lowering) medications. The POC included for the SN to review Patients medication profile and reconcile medications every visit. On 06/13/2025 at 2:10 PM, Patient 3 indicated that she had been taking Amlodipine (an antihypertensive, blood pressure lowering drug) 10mg every AM since she has been with the agency. 410 IAC 17-14-1(a)(1)(B)	G0536		
G0570	Care planning, coordination, quality of care	G0570		

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G0570	Continued from page 7 CFR(s): 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. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure: skilled services were provided as ordered (See G0572); the plan of care included all required information / elements for the treatment of the patient (See G0574); all orders were recorded in the plan of care (See G0576); verbal orders were written and authenticated (See tag G0584); patients received written plan of care (see G0612); patients received a visit schedule (See tag G0614); patients received medication schedule/instructions (see G0616); and patients received name/contact information of the clinical manager (See G0622). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.60 Care Planning, Coordination of Care and Quality of Care.	G0570		
G0572	Plan of care CFR(s): 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	G0572		

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G0572	Continued from page 8 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. This STANDARD is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure skilled services were provided as ordered in 1 of 4 active clinical records reviewed with wounds. (Patient #3) Findings include: A clinical record for Patient #3 evidenced a POC for the certification dates of 04/27/2025-06/25/2025 which indicated the agency was to provide SN services 1 time a week for 9 weeks for wound care. The record failed to evidence the agency provided SN services during the weeks of 05/04/2025, 05/18/2025, 05/25/2025 and 06/08/2025. Missed visit notes dated 05/12/2025, 05/26/2025 and 06/13/2025 failed to evidence attempts to reschedule the visit. The record failed to evidence why the visit was missed for the week of 05/04/2025. The record failed to evidence an order from the physician prior to missed visit weeks to amend the SN visit frequency. On 06/13/2025 at 2:10 Patient 3 indicated she was to receive SN visits once a week. On 06/13/2025, multiple attempts were made to reach RN 1 by phone. Phone calls to RN 1 were not returned; no clinician was available for interview regarding questions of clinical record #3.	G0572		
G0574	Plan of care must include the following CFR(s): 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;	G0574		

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G0574	Continued from page 9 (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. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the patient's individualized plan of care included all medications and treatments, safety measure to protect against injury and the types of services, supplies and equipment required in 1 of 1 home visits observed of a patient with a start of care prior to 06/10/2025 (Patient #2), and in 1 of 1 active clinical records reviewed that received dialysis (a process to filter the blood of a patient whose kidneys do not work normally) (Patient #5). Findings include: 1. A RN Resumption of Care Visit Note, dated 05/21/2025, indicated Patient #2 was wearing a Zoll Life vest (a wearable defibrillator to treat life threatening heart rhythms) and had continuous oxygen 2.5 liters via nasal cannula.	G0574		

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G0574	Continued from page 10 A Plan of Care, for certification period 06/01/2025 to 07/30/2025, received on 06/11/2025, failed to evidence the Zoll Life vest and the oxygen use. During an observation of a home visit, on 06/12/2025, beginning at 9:00 AM, Patient indicated the use of a walker and was observed wearing oxygen at 3 liters via nasal cannula. During the observation Patient indicated he/she had recently stopped using the Zoll Life Vest. A Plan of Care, for certification period 06/01/2025 to 07/30/2025, received on 06/11/2025, failed to evidence the use of a walker. The Plan of Care failed to evidence the use of oxygen. During an observation of a home visit, on 06/13/2025, beginning at 9:00 AM, Patient #2 presented a medication list that included but not limited to Eliquis (blood thinning medication) and Plavix (antiplatelet medication). A Plan of Care, for certification period 06/01/2025 to 07/30/2025, received on 06/11/2025, failed to evidence safety measures to include oxygen precautions and bleeding precautions. During an interview, on 06/12/2025, beginning at 2:00 PM, RN 1 indicated the Patient's use of a life vest and oxygen were not put on the plan of care and should have been. RN 1 indicated she was responsible for the development of the plan of care. A RN Subsequent Visit Note, dated 06/11/2025, indicated the Hickman catheter (a long-term tunneled silicon catheter in the chest) dressing was changed using sterile technique. A Plan of Care, for certification period 06/01/2025 to 07/30/2025, received on 06/11/2025, failed to evidence orders for Hickman catheter care. A Plan of Care, for certification period 06/01/2025 to 07/30/2025, received on 06/11/2025, indicated signature by RN 1 and covering director of nursing, Administrative Staff 4 on 05/27/2025. During an interview, on 06/12/2025, beginning at 12:20 PM, the Administrator indicated oxygen use, the Hickman catheter care, and the use of a walker should be on the plan of care. RN 1 ended the interview via phone on 06/12/2025 at 2:11 PM and attempts to interview RN 1 were not responded to at time of exit on 06/13/2025 at 5:00 PM.	G0574		

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GREATLAND HOME HEALTH	9616 INDIANAPOLIS BLVD 2ND FLOOR STE D , HIGHLAND, Indiana, 46322

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G0574	Continued from page 11 2. A RN OASIS Admission Note, dated 04/17/2025, indicated Patient #5 was dependent on renal dialysis and had a dialysis port to the chest. A Plan of Care, for certification period 04/17/2025 to 06/15/2025, failed to evidence location and frequency of Patient's dialysis or of the dialysis port. During an interview, on 06/13/2025, beginning at 2:06 PM, RN 2 indicated Patient received dialysis at entity E, a hospital, and the address was entity F, a different address than entity E. A review of entity F address indicated entity G, was a dialysis facility. 410 IAC 17-13-1(a)(1)(B)(D)(ii, ix, x)	G0574		
G0576	All orders recorded in plan of care CFR(s): 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on record review, and interview, the agency failed to ensure all orders were recorded in the plan of care in 1 of 1 home visits observed before a start of care date of 06/10/2025 (Patient #2), and 1 of 1 active patients clinical record reviewed of a patient on dialysis (a process to filter the blood of a patient whose kidneys do not work normally) (Patient #5). Findings include: 1. A RN Subsequent Visit Note, dated 06/11/2025, indicated Patient #2 had a Hickman catheter (a long-term tunneled silicon catheter in the chest) and dressing was changed. A Plan of Care, for certification period 06/01/2025 to 07/30/2025, received on 06/11/2025, failed to evidence orders for Hickman catheter care. A RN Resumption of Care Visit Note, dated 05/21/2025, indicated Patient had an IV (intravenous) access and was receiving parenteral/IV feeding. During an interview, on 06/12/2025, beginning at 12:20 PM, the Administrator indicated the Hickman catheter care should be on the plan of care.	G0576		

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G0576	Continued from page 12 During an interview, on 06/12/2025, beginning at 2:00 PM, RN 1 indicated the Patient's Hickman catheter care should be on the plan of care. RN 1 indicated she was responsible for the development of the plan of care. 2. RN OASIS Admission, identified as a comprehensive assessment, dated 04/17/2025, for Patient #5 indicated a diagnosis of diabetes mellitus (a disorder with impaired ability for the body to produce or respond to insulin and maintain glucose levels), and indicated Patient was on insulin and checked blood sugars three times per day. A Plan of Care, for certification period 04/17/2025 to 06/15/2025, failed to evidence frequency blood sugar testing. A Skilled Nurse Visit Note, dated 04/25/2025, indicated under endocrine system (organ and glands that include but not limited to the pancreas that secrete insulin to regulate blood sugar levels) Patient was not assessed for endocrine due to not appropriate at time of evaluation. A Skilled Nurse Visit Note, dated 04/29/2025, indicated under endocrine system Patient was not assessed for endocrine due to not appropriate at time of evaluation. During an interview, on 06/13/2025, beginning at 2:06 PM, RN 2 indicated Patient checked own blood sugars and did not document blood sugars.	G0576		
G0584	Verbal orders CFR(s): 484.60(b)(3)(4) (3) Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies. (4) When services are provided on the basis of a physician or allowed practitioner's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician or allowed pracitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies.	G0584		

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G0584	Continued from page 13 This ELEMENT is NOT MET as evidenced by: Based on record review, and interview, the agency failed to ensure verbal orders were documented in the patient's clinical record and signed with date and time of orders in 1 of 1 home visits observed with a patient wound (Patient #1). Findings include: A RN Oasis Admission Report, dated 06/10/2025, indicated wound care was provided to Patient #1's neck, left arm incision, and left wrist surgical wound. During observation of a home visit, on 06/12/2025, beginning at 5:15 PM, RN 2 cleaned the left arm, donor site, with saline and hydrogen peroxide solution' she applied the half strength hydrogen peroxide solution to gauze and placed on the skin graft for five minutes. She applied Aquaphor to the skin graft and to all of the incision, and placed petroleum dressing to the skin graft, then wrapped the left arm incision closed with staples, and the wrist graft site with kerlix. RN 2 then cleaned the neck tracheostomy stoma and covered with steri strips. On 06/12/2025, a request for all of Patient 2's orders were requested. Documentation received included for patient orders from Entity C, a hospital. The agency was not able to provide documentation of verbal or written physician orders, obtained by the agency. During an interview, on 06/12/2025 beginning at 5:15 PM, RN 2 indicated Patient's plan of care had not been completed yet and she had taken the wound care orders from Entity C's Outpatient Referral Order and that she had contacted physician H, for the agency's start of care orders. The clinical records orders reviewed failed to evidence documentation of verbal orders from physician H for the wound care provided by the agency. 410 IAC 17-14-1(a)(H)	G0584		
G0612	Written instructions to patient include: CFR(s): 484.60(e) Standard: Written information to the patient. The HHA must provide the patient and caregiver with a copy of written instructions outlining:	G0612		

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G0612	Continued from page 14 This STANDARD is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to evidence the patient and caregiver were provided with a copy of written instructions and provided no later than the next visit after the plan of care had been approved by the physician in 1 of 1 home visits observed with a start of care prior to 06/10/2025 (Patient #2). Findings include: A RN Job Description, revised on 12/14/2018, indicated the RN responsibilities and essential function would include but not limited to educate patients and caregivers on disease process, medications, plan of care, and individualized treatment plans. During an observation of a home visit, on 06/12/2025 beginning at 9:00 AM, Patient #2 indicated he/she had not received a treatment plan from the agency and indicated hospital C was providing their home health care services. A Plan of Care for the certification period 04/02/2025 to 05/31/2025, indicated a start of care date of 04/02/2025. A Visit Note Report, dated 05/21/2025, indicated Resumption of Care after a 9-day hospitalization. During a phone interview on 6/12/2025 beginning at 2 PM, RN 1 declined further communication and ended the interview at 2:11 PM, attempts to interview RN 1 were not responded by time of exit on 06/13/2025 at 5:00 PM. During a phone interview with the administrator on 6/13/2025 at 1:55PM, the administrator was informed of the need to continue interview with RN1 who abruptly ended an interview the day before. The administrator relayed the Office Manager would contact the nurse for an interview.	G0612		
G0614	Visit schedule CFR(s): 484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure a patient received a written visit schedule in 1 of 1 home visits observed with an	G0614		

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G0614	Continued from page 15 occupational therapist (Patient #2). Findings include: During an observation of a home visit by OT 1, on 06/12/2025 beginning at 9:00 AM, Patient #2 indicated he/she had not received a visit schedule. Patient #2 indicated he/she was called the day before a home health visit and did not know prior to the phone call the frequency or when a home visit would occur. Patient failed to have a written visit scheduled provided by the agency in the home. During an interview during the home visit OT 1 indicated she did not provide Patient with a visit schedule because she worked as needed for the agency and other agencies, so the schedule would change based on her availability for a visit.	G0614		
G0616	Patient medication schedule/instructions CFR(s): 484.60(e)(2) Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure a patient was provided with a copy of written instructions outlining the patient's medication schedule and instructions in 1 of 1 home visits observed with a patient start of care before 06/10/2025 (Patient #2). Findings include: During an observation of a home visit, on 06/12/2025 beginning at 9:00 AM, Patient #2 indicated he/she had not received a medication list from the agency. During an interview, on 06/12/2025, beginning at 12:20 PM, the Administrator indicated medication lists were mailed to the patient. On 06/12/2025, at 2:19 PM, a request to the office manager for documentation of the medication list being mailed to Patient #2 and was not received as of exit on 06/13/2025, at 5:00 PM.	G0616		
G0622	Name/contact information of clinical manager	G0622		

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G0622	Continued from page 16 CFR(s): 484.60(e)(5) Name and contact information of the HHA clinical manager. This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the patient was provided contact information for the agency's clinical manager in 2 of 2 home visits observed (Patient #1, Patient #2). Findings include: During an observation of a home visit, on 06/12/2025 beginning at 5:15 PM, a family member of Patient #1, with SOC of 06/10/2025, indicated they were verbally given the agency's phone number and was not given an admission packet with further information. During an interview, on 06/12/2025, beginning at 5:15 PM, RN 2 indicated she had not brought the admission packet to Patient's home yet and would have the physical therapist bring the admission packet during the physical therapy evaluation. 2. During an observation of a home visit, on 06/12/2025, beginning at 9:00 AM, Patient #2, with SOC of 04/02/2025, indicated he/she had not received an admission packet from the home health agency with the phone number or address and was unaware of how to reach the home health agency and was not provided contact information for the agency. During a phone interview on 6/12/2025, which began at 2 PM, RN 1 ended the interview at 2:11 PM; attempts and requests to interview RN 1 were not responded nor provided by time of exit on 06/13/2025 at 5:00 PM. During a phone interview with the administrator, on 6/13/2025 beginning at 1:55 PM, the administrator was informed RN 1 ended the call and questions and concerns remained as RN1 declined to continue the interview on 6/12/2025. The administrator relayed the Office Manager would contact RN 1 to continue the interview.	G0622		
G0640	Quality assessment/performance improvement CFR(s): 484.65 Condition of participation: Quality assessment and performance improvement (QAPI). The HHA must develop, implement, evaluate, and maintain	G0640		

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G0640	Continued from page 17 an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. This CONDITION is NOT MET as evidenced by: Based on record review and interview, the home health agency failed to evidence they had a QAPI program that measured, analyzed, and tracked quality indicators (G0642); utilized data to identify opportunities for improvement (G0644); improvement activities focused on high risk or problem prone areas (G0646); performance improvement activities analyze patient adverse events and implement preventative actions (G0654); and that the Governing Body approved the data detail and frequency of collection (G0660). The cumulative effect of these systemic problems has resulted in the home health agency inability to ensure provision of quality health care in a safe environment for the condition of participation 42CFR 484.65 Quality Assessment and Performance Improvement (QAPI). The findings include: During an entrance conference, on 06/11/2025, beginning at 11:40 AM, the Administrator via phone indicated the office manager would provide documentation for the survey. A documentation request form, signed by the office manager on 06/11/2025, indicated a request for the QAPI meeting minutes and supporting documentation to be provided within 24 hours of the entrance conference. A written request to the office manager, on 06/13/2025 at 10:40 AM, for the QAPI documentation was not received upon exit from the survey on 06/13/2025, at 5:00 PM. The cumulative effect of these systemic problems resulted in the home health agency's inability to ensure the provision of quality health care in a safe environment for the condition of participation 42 CFR	G0640		

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G0640	Continued from page 18 §484.65 Condition: Quality Assessment/Performance Improvement. 410 IAC 17-12-2(a)	G0640		
G0710	Provide services in the plan of care CFR(s): 484.75(b)(3) Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; This ELEMENT is NOT MET as evidenced by: Based on record review, and interview, the agency failed to provide services as outlined in the plan of care in 1 of 1 home visits observed with a start of care before 06/10/2025 (Patient #2). Findings include: 1. A revised RN job description dated 12/14/2018 and titled, “Registered Nurse,” indicated the RN responsibilities would include but not limited to initiate the plan of care under doctor’s orders. 2. A POC for Patient #2's certification period 04/02/2025 to 05/31/2025 indicated skilled nurse to obtain IV (intravenous) access via Hickman (type of catheter) for infusion of TPN (total parental nutrition IV), change Hickman catheter twice weekly with bio patch over insertion site using aseptic technique and the skilled nurse should report signs and symptoms of increase fluid retention, dehydration, temperature greater than 101 and any difficulty with infusion or flushing of the catheter. The POC indicated skilled nurse frequency visit of 2 times per week for 1 week and 1 time per week for 8 weeks. Skilled Visit Notes indicated weekly visits dated 04/11/2025, 04/17/2025, 04/21/2025, 04/29/2025 and 05/06/2025, hospitalization on 05/11/2025. During an interview, on 06/12/2025, beginning at 2:00 PM, RN 1 indicated Patient had been seen weekly and was not aware of the POC order of 2 times per week Hickman catheter dressing change. During an interview on 06/12/2025, beginning at 2:45 PM, the Administrator indicated he would need to check to see if orders were changed for Hickman catheter dressing change frequency. The individual covering for the Director of Nursing, Administrative Staff 4 indicated the order in the clinical record indicated	G0710		

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G0710	Continued from page 19 the Hickman Catheter dressing change was to be 2 times per week. 410 IAC 17-14-1(a)(H)	G0710		
G0716	Preparing clinical notes CFR(s): 484.75(b)(6) Preparing clinical notes; This ELEMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the agency failed to ensure the skilled professionals completed clinical notes / documentation in 1 of 1 active clinical records reviewed of a patient who received dialysis (a process to filter the blood of a patient whose kidneys do not work normally) (Patient #5) and failed to ensure medical records were accurate and complete in 1 of 1 active clinical records reviewed with a hickman catheter (Patient #2). Findings include: 1. An undated policy, titled, “Registered Nurse,” indicated the RN’s responsibilities would include but not limited to prepare documentation and clinical notes. 2. A Plan of Care, for certification period 04/17/2025 to 06/15/2025, for Patient #5 indicated skilled nurse visits 1 time per week for 1 week, and then 2 times per week for 8 weeks. Coordination Notes, dated 05/23/2025, 05/27/2025 and 06/01/2025 indicated Patient did not answer phone or was not home for visit. A review of skilled nurse visit notes, on 06/12/2025, failed to evidence skilled nurse visit notes for week of 06/01/2025 and week of 06/08/2025. During an interview on 06/13/2025, beginning at 2:06 PM, RN 2 indicated she had not completed documentation for the skilled nurse visits the week of 06/01/2025 and 06/08/2025. During an interview, on 06/13/2025, beginning at 3:00 PM, the office manager indicated Patient #5 was scheduled for skilled nurse visits on Tuesday June 3, Friday June 6, Tuesday June 10 and Friday June 13. During an entrance conference, on 06/11/2025, beginning	G0716		

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G0716	Continued from page 20 at 11:40 AM, the Administrator indicated clinicians were to turn in documentation following a patient visit within 48 hours. 3. During an observation of a home visit, for Patient #2, on 06/12/2025, beginning at 9:00 AM, Patient was observed with 3 liters of oxygen via nasal cannula in use, indicated the use of a walker, indicated had a Hickman catheter for total parental nutrition and had nurse's visits for catheter care. A Plan of Care, received on 06/11/2025, for certification period 06/01/2025 to 07/30/2025, order number 168997, for Patient #2 failed to include Patient's hickman catheter care orders, use of oxygen or walker. The Plan of Care was signed by RN 1, and covering Director of Nursing, Administrative Staff 4 on 05/27/2025. During an interview on 06/12/2025, beginning at 12:45 PM, the Administrator and Administrative Staff 4 were notified Patient #2's current plan of care did not include the hickman catheter care orders, oxygen or walker. The Administrator indicated he would need to review the plan of care for the information requested, and requested the Administrator return the call after the plan of care was reviewed. Requested the office manager on 06/12/2025, at 2:45 PM to call the Administrator and Administrative Staff 4 to follow up from the 12:45 PM interview. During an interview, on 06/12/2025, beginning at 2:50 PM, the Administrator indicated the orders for the hickman catheter care, oxygen and walker use were on the plan of care for 06/01/2025 to 07/30/2025. Requested the office manager provide another copy of the plan of care for certification 06/01/2025 to 07/30/2025 and received a plan of care for 06/01/2025 to 07/30/2025, order number 168997, signed by RN 1, and Administrative Staff 4 on 05/27/2025 with orders for hickman catheter care, oxygen and walker use. During the interview, when requested the Administrator and Administrative Staff 4 failed to respond when inquired who and when was the hickman catheter care orders, oxygen, and walker use entered into the EMR. Requested contact information for the Providers EMR contact. The office manager returned and indicated the EMR contact did not need to be contacted due to the plan of care for 06/01/2025 to 07/30/2025 had not been approved and the POC provided on 06/12/2025 was correct and approved.	G0716		

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G0716	Continued from page 21 During an interview, on 06/12/2025 beginning at 3:15 PM, the Providers EMR representative indicated the POC, order number 168997, was "unapproved" and then "reapproved" on 06/12/2025, and indicated Patient POC was “manipulated” by Administrative Staff 4 on 06/12/2025 at 14:46 PM. 410 IAC 17-14-1(a)(1)(e)-RN	G0716		
G0940	Organization and administration of services CFR(s): 484.105 Condition of participation: Organization and administration of services. The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs. The HHA must assure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished. This CONDITION is NOT MET as evidenced by: Based on observation, record review, and interview, the home health agency failed to ensure: the Administrator was responsible for all day to day operations (See G948); the Clinical Manager was available (See G950); and failed to ensure the administrator had a predesignated person authorized in writing to assume responsibility in the absence of the administration (See G954). The cumulative effect of this systemic problem resulted in the agency being out of compliance with §484.105 Condition of participation: Organization and administration of services. 1. An undated policy, titled, “Rights, Responsibilities and Ethics: After Hours Care,” indicated after 5:00 PM the answering would relay to the RN on call, a backup call system was provided to the answering service if the RN cannot be reached. First alternate RN, then second alternate RN, then Clinical Manager in that order. 2. An undated job description, titled, “Nurse	G0940		

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(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
G0940	Continued from page 22 Supervision, Clinical Manager, Case Manager," indicated the agency's clinical manager, alternate clinical manager were responsible for overseeing the clinical operations of patient care and the clinical manager/administrator were responsible for overseeing the daily operations of the agency. 3. Upon entrance to the agency on 06/11/2025, beginning at 10:00 AM, the Office Manager requested the survey be rescheduled due to no Administrative Staff was available for the survey. During an interview, on 06/11/2025 beginning at 10:00 AM, the Office Manager relayed she was non-clinical; the administrator and alternate administrator were on vacation and were not available until Monday 06/16/2025. The Office Manager indicated the director of nursing was unavailable, was off ill. She indicated there was not an alternate director of nursing. The Office Manager indicated she would reach out to the 2 field RN's for patient concerns, she further relayed the 2 field RN's were not aware of administrative duties. The Office Manager indicated she had reached out to the administrator and the director of nursing, reached the voicemail for the administrator and texted the director of nursing; she relayed she had not received any return calls/texts. 4. During an entrance conference held via phone on 06/11/2025, beginning at 11:40 AM, the Administrator indicated the Office Manager, Administrative Staff 6, would be able to provide all documentation required for the survey. During the conference a written copy for the Provider included requested documentation(s) for the survey; the written copy was provided to the Office Manager. The items requested for review as part of the federal certification survey, were reviewed verbally; the list included, but was not limited to, Emergency Preparedness Plan within 1 hour of conclusion of entrance conference, QAPI meeting minutes and supporting documentation within 24 hours of entrance conference and documentation to include unduplicated census form, CMS-1572, and state home health information form. The Provider's copy of the requested documentation was signed by the Office Manager as received on 06/11/2025. The administrator identified the Clinical Manager was Administrative Staff 3 and the alternate Clinical Manager was Administrator staff 4. 5. During a phone interview, on 06/12/2025, beginning at 12:45 PM, the Administrator was notified of the federal form CMS 1572, the state home health form, and unduplicated census form were not yet received. The administrator was notified the forms requested could be	G0940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 157704	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/13/2025

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GREATLAND HOME HEALTH	9616 INDIANAPOLIS BLVD 2ND FLOOR STE D , HIGHLAND, Indiana, 46322

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G0940	Continued from page 23 provided via email. 6. On 06/13/2025, at 3:15 PM, the Office Manager presented the Providers CMS-1572, state form, and unduplicated skilled census of 70. 7. On 6/12/2025 at 8:30 PM, an after-hours call was conducted to the agency's on-call service. The on call answering service was reached and requested they reach the RN on call and return call. The answering service indicated she attempted to call the 1st number listed for the agency's on call staff. The representative relayed the 1st number call was listed as Entity J, a city and the call went to voice mail. The answering service representative indicated they called the 2nd number listed and indicated the call was going to Administrative Staff 4. The answering service indicated the 2nd on call number went to voice mail and she indicated they left a voice mail for Administrative Staff 4 to return the call and indicated they forwarded / provided contact information to return the call. A. On 06/13/2025 8:00 AM failed to receive a return call from Administrative Staff 4. B. During an interview on 06/13/2025, beginning at 12:10 PM, the Administrator indicated he would need to check with Administrative Staff 4 about not returning the after-hours call. C. During an interview on 06/13/2025, beginning at 12:21 PM, the Administrator indicated Administrative Staff 4 did not return the afterhours call because it was received as a nonurgent call and Administrative Staff 4 was going to call back in the AM. As of 12:21 PM, no call was received from Administrative Staff 4 related to the after-hours call. 8. During a phone interview, on 06/13/2025, beginning at 1:54 PM, the Administrator was notified RN 1 ended the interview on 06/12/2025 and had indicated she would be available at the home visit on 06/13/2025, however the home visit was not completed. Notified the administrator requesting interview with RN1, RN 2, and Administrative Staff 3 related to survey findings. As of survey exit, on 06/13/2025 at 5:00 PM, RN 1 was not available for further interview(s). 9. A home visit observation of RN 1 with Patient #3 was confirmed by the Office Manager on 06/12/2025 for a scheduled visit on 06/13/2025 between 9 to 10 AM. On 06/13/2025, at 8:40 AM surveyor(s) arrived at the	G0940		

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G0940	Continued from page 24 address listed on Patient 3's POC dated 04/27/2025 to 06/25/2025; the POC was provided to surveyor on 6/12/2025 by the Office Manager. At 9:20 AM, no nurse had arrived to Patients address. A phone call was placed to the Office Manager. The Office Manager relayed they reached RN 1, who relayed to the Office Manager they were at Patient 3's address, indicated RN 1 was not at the location listed on the POC, was providing skilled care elsewhere, location was not revealed. The Office Manager indicated she did not know where RN 1 was providing care to Patient 3 and would need to return call with information. By survey exit, the location was not provided by the Office Manager nor the administrator, nor was RN 1 available for interviews nor return calls in request for interviews. At 9:30 AM, surveyor approached the front door of the address listed on the POC for Patient 3; an elderly female opened the door. The individual indicated the agency did provide care for one of their family members and named Patient 3. The individual relayed Patient 3 resided temporarily at the address on the POC and relayed Patient 3 returned to their private residence in Chicago Illinois the 1st week of May. The individual named RN 1 as a nurse which was providing Patient 3 their skilled nurse wound service and care. The individual indicated RN 1 was due for a visit the morning of 6/13/2025 between 9 – 10 AM at Patients 3's residence in Chicago Illinois. During an interview, on 06/13/2025, beginning at 12:10 PM, the Administrator indicated they were unaware Patient 3 was not residing nor receiving their skilled services at the address listed on patient's POC. The administrator then relayed Patient #3 was a patient with another home health agency. When notified Patient #3 was on the agency's current active patient list, the Administrator indicated Patient would need to be transferred to the other home health agency in Location K. The administrator indicated Patient had not been flipped to the other home health agency. 10. During day 1 and day 2 of the survey, full access to each active patients EMR was not made available for review. The clinical records which were made available were added one by one as approved by the Office Manager, though the entire record was not available. On 06/12/2025, access to Patient #3's physician orders were not yet available; the orders were grayed out, not visible. Full unrestricted access to the EMR of the agency's nine active patients and the discharged records were not made available until June 13, 2025 at	G0940		

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G0940	Continued from page 25 11:30 AM, day 3 of the survey. 11. During a phone interview, on 06/13/2025 beginning at 11:34 AM, the Administrator indicated the alternate Clinical Manager was Administrative Staff 5, who was part time and was not available as they were on vacation. The administrator indicated Administrative Staff 4 was not the alternate Clinical Manager, they were covering for the Clinical Manager, identified as Administrative Staff 3. The administrator relayed Administrative Staff 3 was not available for the survey. 12. During an interview on 06/13/2025, beginning at 2:43 PM, Administrative Staff 4 indicated she did not return the afterhours call because the answering service sends emails if the calls are not urgent for the staff to receive in the morning and indicated the afterhours call triage service determined urgent versus nonurgent call status. Administrative Staff 4 indicated the Administrator would need to provide documents requested for review, for the survey. Administrative Staff 4 indicated her title was clinical director of nursing and she began in the position 2 weeks prior. Administrative Staff 4 indicated Administrative Staff 5, was the alternate director of nursing and indicated Administrative Staff 3 was the director of nursing and was on medical leave, beginning 2 weeks prior. Administrative Staff 4 indicated she was not involved with the agency's QAPI program nor their Emergency Preparedness Plan. She indicated she would respond to the needs of the agency via the Office Managers mobile phone. 13. Throughout the survey, 06/11/2025 to 06/13/2025, the Administrator was available via phone, of the Office Managers cell phone. The CM, Administrative Staff 3 and the alternate CM, Administrative Staff 5, were not available. Administrative Staff 4, identified by the administrator as covering for the CM was available by phone. On 6/13/2025 at 10:40 AM, a written request for documentation of the appointment of an alternate administrator was requested in writing. As of survey exit on 06/13/2025 at 5:00 PM, appointment of the alternate CM was not received for review. 410 IAC 17-12-1(d)(8), 410 IAC 17-12-1(c)(1), 410 IAC 17-12-1(d)	G0940		
G1018	Contact information for the patient CFR(s): 484.110(a)(4)	G1018		

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G1018	Continued from page 26 Contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s); This ELEMENT is NOT MET as evidenced by: Based on record review and interview, the agency failed to ensure accurate contact information for patients in 1 of 1 home visits observations confirmed but not completed (Patient #3). Findings include: During a phone call to the agency on 06/13/2025, beginning at 9:20 AM, the office manager was notified surveyors were at Patient #3's home for a visit at the address listed on the POC and the RN had not arrived. The office manager contacted RN 1 and RN 1 indicated she was at the home of Patient #3 but was not at the address in city D and the office manager indicated she would need to call return call with the correct address. Upon entrance to the agency at 10:40 AM the office manager had not returned the call to verify the address of Patient. During an interview, on 06/13/2025, beginning at 12:10 PM, the Administrator indicated Patient #3 was a patient at Entity E, a Home health agency in Illinois. The Administrator was notified Patient was on the agency's active roster. The Administrator indicated Patient would need to be transferred to Entity E. 410 IAC 17-15-1(a)(1)	G1018		
G1022	Discharge and transfer summaries CFR(s): 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	G1022		

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G1022	Continued from page 27 aware of the transfer. This ELEMENT is NOT MET as evidenced by: Based on record review, and interview, the agency failed to evidence a discharge/transfer was completed in 1 of 1 home visits completed with a resumption of care (Patient #2). Findings include: 1. A Visit Note Report, dated 05/11/2025, for Patient #2 indicated Patient was transferred to an inpatient facility and was not discharged from the agency. A RN Resumption of Care, dated 05/21/2025, indicated resumption of care visit was completed following Patient's 9-day hospitalization. On 06/13/2025, a request for Patient's discharge/transfer summary to the office manager failed to evidence documentation of a summary. RN 1 ended the interview via phone on 06/12/2025 at 2:11 PM and attempts to interview RN 1 were not responded to at time of exit on 06/13/2025 at 5:00 PM and was unable to interview if discharge/transfer summary was completed on Patient #2. 410 IAC 17-15-1(a)(6)	G1022		