STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	157618	A. BUILDING B. WING	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARAGON HOME HEALTHCARE	2420 NORTH COLISEUM BLVD STE 201A, FORT WAYNE, IN, 46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS - REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR §484.102 Survey Dates: June 12, 13, 16, 17, 18, 19, 2025 Active Census: 165 At this Emergency Preparedness survey, Paragon Home Healthcare was not found to be in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR §484.102.	E0000		
E0031	Emergency Officials Contact Information 483.73(c)(2) §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(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	E0031	**CorrectiveAction:** The Alternate Administrator started reviewof an emergency preparedness communication plan on 7/7/25 and updated thecontact information for regional and local EP staff for all counties served inthe communication plan. The Administrator has verified contact information for regionaland local EP staff for all	2025-07-18

	every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. Based on EP communication plan review, policy review, and interview, the home health agency failed to develop and maintain an EP communication plan which includes contact information for regional and local EP staff of all counties served, which had the potential to affect all active patients and staff.		counties served and it was on completed on 7/7/25 inthe Communication Plan. Effective, 7/7/25, any change in contact informationfor regional and local EP staff for all counties served will be updated in thecommunication plan. In orderto correct the above deficiency cited under E-0031, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services (DCS) and the Alternate Director of Clinical Services (ADCS)reviewed the Emergency Preparedness Planning and Resource Manual and Agencypolicy 2.3.1 titled, “Communication Plan and Policy for Emergency OperationsPlan (EOP) that included an emergency preparedness communication plan thatcomplied with Federal, State and local laws. The Administrator has maintainedthe emergency preparedness communication plan to include all of the followingrequired subject areas (2) Contact information for the following: (i) regional,and local emergency preparedness staff,	

	Findings include: 1. The undated agency policy Emergency Operations Plan and Policies indicated resources which may be used in an emergency included local, regional & emergency preparedness organizations &. 2. The agency s Geographic Area Served form, completed on 6/16/25 at 4:16 PM by Alternate Administrator, evidenced the agency serviced the following counties: Adams, Allen, Decatur, Dekalb, Elkhart, Huntington, LaPorte, Noble, St. Joseph, Wells, and Whitley. 3. The agency s EP communication plan failed to evidence contact information for regional and local EP staff for all counties served. 4. During an interview on 6/19/25 beginning at 3:45 PM, Administrator reported the EP communication plan did not include contact information for regional and local EP staff outside of Allen county.		and will ensure that it will bereviewed, maintained and updated at least every 2 years and more often if anychanges occur. The Communication Plan with the deficiencies was identified,reviewed and updated. The Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services have completedre-orientation of agency's policies pertaining to the requirement on 7/7/25provided by the Governing Body Chair. An in-service meeting was conducted bythe Administrator on 7/9/25 to educate all staff to discuss the importance ofimplementing an emergency preparedness communication plan that complied withFederal, State and local laws to include all of the following required subjectareas (2) Contact information for thefollowing: (i) regional, and local emergency preparedness staff. All staff wereinformed and re-educated on the requirement that the Contact information forthe following: (i) regional and local	

			emergency preparedness staff must bereported to the Administrator to keep the communication plan current. All staffunderstood and acknowledged the requirement. All new staff will be oriented ofthis requirement at the time of hire. The above mentioned corrective actionswere implemented on 7/7/25 and completed on 7/18/25. **Measuresto assure No recurrence:** In order to ensure that there is norecurrence of this deficiency, the Administrator will utilize an audit toolwith the help of the Alternate Administrator to ensure that preparednesscommunication plan that complies with Federal, State and local laws to includeall of the following required subject areas (2) Contact information for thefollowing: (i) regional, and local emergency preparedness staff, and willensure that it will be reviewed, maintained and updated at least every 2 yearsand more often if any changes occur. This process will help us identify andimplement	

			improvements in maintaining the emergency preparedness communicationplan and make corrective adjustments in the future. **Monitoring:** In order to ensure the implementationand effectiveness of this correction action, the Administrator will bemonitoring the Emergency Preparedness Plan for evidence of successfulmaintenance of emergency communication plan on a quarterly basis for the next 4quarters to ensure proper implementation and to achieve 100% compliance. Once100% compliance is achieved, this process will continue to be monitored onsemi-yearly basis. Quarterly audit results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the Quality Committee willcontinue to audit 100% of Emergency Plan including communication plan once ayear to ensure compliance is maintained. The Administrator and QAPI Committeewill send a written report to the Governing Body quarterly for their	

			recommendations. The Administrator will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
E0037	EP Training Program 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and	E0037	**Corrective Action:** The Administratorstarted review of all current 45 personnel files on 6/23/25. Review of 75%personnel files was conducted by week ending 6/27/25. Review of 20% personnelfiles was conducted by week ending 7/3/25. Review of remaining 5% personnelfiles was completed on 7/10/25 and it was concluded that all Personnel filesare in compliance and include documented evidence of Annual EP training forexisting personnel files and for (1) newly hired personnel. In order tocorrect the above deficiency cited, in Management meeting on 7/7/2025, theAdministrator, Alternate Administrator, Director of Clinical Services (DCS) andAlternate Director of Clinical Services (DCS reviewed, discussed the agency'sEmergency Preparedness and Planning Manual. During this meeting, deficienciescited under E-0037 were reviewed, addressed and discussed in detail. TheAdministrator has completed re-orientation of agency's policies pertaining tothe requirement on 7/7/25 provided by the Governing Body Chair. An in-servicemeeting was conducted by the Administrator and attended by all staff on 7/9/25to discuss agency's Emergency Preparedness and Planning Manual. During thismeeting, deficiencies cited under E-0037 were reviewed, addressed and discussedin detail with all staff. The Administrator emphasized on the importance thatthe Home Health agency is required to have a documented evidence of EP trainingfor all staff. All staff understood and acknowledged	2025-07-18

	[facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training.		the requirement. Allactive staff or newly hired staff will receive EP training annually and uponhire respectively and have documented evidence in their Personnel records. The abovementioned corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measures to assure No recurrence:** In order toensure that there is no recurrence of this deficiency, the HR Manager has madea process update to tracking EP Training upon hire and annually and it willalert the staff and Administrator of any upcoming EP Training for staff. The HRManager will also utilize an HR audit tool to ensure that all personnel recordcontents are current and all personnel files contain documented evidence of EPtraining for all staff. This process of utilizing Tracking system and HR audittool will help us identify any discrepancies in the personnel files and enforceall staff to have their files completed and up to date. **Monitoring:** In order toensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizePersonnel records Tracking system and the HR audit tool and audit 100% of allpersonnel file records on a monthly basis to ensure that all active personnelfile records show documented evidence of EP training for all staff. TheAdministrator will review HR Manager's audit findings of all active personnelfile records. Monthly reports will be generated and results will be compiledand sent to the Administrator to ensure that processes have improved. Thisprocess will continue for each month for the next 3 months until 100%compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. If complianceis not achieved at the desired target of 100% compliance and any deficienciesare identified within the next 3 months, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and	

	(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:		witheach individual personnel as needed. After 3 months, this process will continueto be monitored on a quarterly basis and will be included in the quarterly HRaudit review. Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will continueto audit 100% of personnel file records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Administratorwill be responsible for corrective action of this deficiency, measure to assureno recurrence and monitoring of this deficiency.	

	(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.			

	*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. Based on record review and interview, the home health agency failed to ensure all office staff were trained in EP for 1 of 1 office staff file reviewed (Admin 9). Findings include: 1. Admin 9 s personnel evidenced a hire date of 3/23/24. The file failed to evidence completion of EP training upon hire or annually. 2. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator relayed she thought EP training wasn t required by office staff and she verified the personnel file for Admin 9 did not include any EP training.			
E0039	EP Testing Requirements	E0039	**CorrectiveAction:** In order to correct the	2025-07-16

	483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions		abovedeficiency cited under E-0039, during the management meeting on 7/7/25, theAdministrator, Alternate Administrator, Director of Clinical Services andAlternate Director of Clinical Services reviewed the EP testing requirements. TheAdministrator has confirmed that our next tentative table-top exercise will includeafter-action review and will revise the EP plan as needed.	

	designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise		An in-service meeting was conducted bythe Administrator on 7/9/2025 to educate all staff and to discuss the importanceof an after-action review and revision of the EP Plan as needed followingexercise. Re-education to all participants on updates to the Conditions ofParticipation section on Emergency Preparedness Planning and Resource Manualthat included policy and implementation of a community based full-scaleexercise was discussed. All staff understood and acknowledged the requirementand importance of a community based full-scale exercise as documented in theEmergency Preparedness Planning and Resource Manual. The Agency has completed Table-Topexercise that includes After-Action review and Revision of EP as needed on7/16/25. **Measuresto assure No recurrence:** In order to ensure that there is norecurrence of this deficiency, the Administrator will utilize an audit toolwith the help of the	

	that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that		Alternate Administrator to ensure an after-action reviewand revision of the EP Plan as needed following exercise is documented. Thisprocess will help us identify and implement improvements in conducting exercisesand analyze results, feedback and the HHAs response to and maintaindocumentation of all drills, tabletop exercises, and emergency events, andrevise the HHAs emergency plan, as needed and make corrective adjustments inthe future. **Monitoring:** In order to ensure the implementationand effectiveness of this correction action, the Administrator will bemonitoring the Emergency Preparedness for evidence of an after-action reviewand revision of the EP Plan as needed following exercise on a quarterly basisfor the next four quarters to ensure proper implementation and to achieve 100%compliance. Once 100% compliance is achieved, this process will continue to bemonitored and included in the Emergency Preparedness	

	[facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i)		and Safety Plan onsemi-yearly basis. Semi-yearly audit results will be compiled and sent to theQAPI Committee for review. Once threshold is met, the Quality Committee willcontinue to audit 100% of Emergency Plan once a year to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Administrator will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led			

	using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed.			

*[For HHAs at §484.102]

(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at

least annually. The HHA must do the following:

(i) Participate in a full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or.

(B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

*[For OPOs at §486.360]

(d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following:

	(i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. Based on EP review and interview, the home health agency failed to conduct an after-action review of its tabletop exercises, which had the potential to affect all active patients and staff. Findings include: 1. The agency s EP			

	conducted EP tabletop exercises on 5/02/2024 and 11/01/2024. The documentation failed to evidence the agency conducted an after-action review and revised the EP plan as needed. 2. During an interview on 6/19/2025 beginning at 3:45 PM, Administrator reported the agency did not document an after-action review of its 2024 EP testing.			
G0000	INITIAL COMMENTS This visit was for a Federal Complaint survey of a Deemed HHA Provider. Survey Dates: June 12, 13, 16, 17, 18 and 19, 2025 Complaint: IN115701 with related deficiencies cited. 12 Month Unduplicated Skilled Admissions: 761 Survey was announced as fully extended on 6/13/25 at 3:14 PM During this Federal Complaint Survey, Paragon Home Healthcare was found to be out of compliance with Conditions of Participation 484.60 Care planning, coordination of	G0000		

	services, and quality of care; 484.80 Home health aide services and 484.110 Clinical records. Based on the Condition-level deficiencies during the 6/19/25 survey, your HHA was subject to an extended survey pursuant to section 1891(c)(2)(D) of the Social Security Act on 6/13/25. 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 June 19, 2025, and continuing through June 18, 2027. This deficiency report reflects State Findings cited in accordance with 410 IAC 17. Refer to State Form for additional State Findings. <u>Abbreviations</u> CM-Clinical Manager, COTA-Certified Occupational Therapist Assistant, EMR-Electronic Medical Record, EP-Emergency Preparedness, HHA-Home Health Aide, LPN-Licensed Practical Nurse,			

	OASIS-Outcome and Assessment Information Set, OT-Occupational Therapist, POC-Plan of Care, PT-Physical Therapist, ROC-Resumption of Care, QAPI-Quality Assurance Performance Improvement, SN-Skilled Nurse, SOC-Start of Care QR 6/27/25 A2			
G0372	Encoding and transmitting OASIS 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary. Based on record review and interview, the home health agency failed to ensure OASIS transmissions were submitted on time for 1 of 1 agency. Findings include: 1. The agency policy Reporting of OASIS Information indicated the agency will electronically transmit completed, encoded and locked OASIS data for each completed OASIS assessment at	G0372	**Corrective Action:** Inorder to correct the above deficiency cited, the Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices discussed and reviewed the organization's policy, 6.2.1 titled"Reporting of Oasis Information". During this managementmeeting on 7/7/2025, deficiency cited under G0372 was reviewed. The policy, 6.2.1titled "Reporting of Oasis Information" was updated to reflect that our HomeHealth Agency must encode and electronically transmit each	2025-07-18

	least monthly. 2. The OASIS Error Summary by Agency Report evidenced a 19.58% late submission rate for the period of 1/01/24 to 12/31/24. 3. The OASIS Error Detail Report evidenced 375 late submissions for the period 1/01/24 to 12/31/24. 4. During an interview on 6/13/25 at 4:01 PM, the Alternate Administrator relayed she was unsure when the OASIS should be submitted and she was unsure who was responsible for submitting the OASIS data. 5. During an interview on 6/17/25 at 5:04 PM, the Administrator relayed the billing department was responsible for submitting the OASIS within 30 days of completion of the assessments.		the CMS system, regarding each beneficiary with respect to whichinformation is required to be transmitted (as determined by the Secretary),within 30 days of completing the assessment of the beneficiary. Thisupdated policy was approved effective 7/7/25. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policy pertaining to therequirement on 7/7/2025 provided by the Governing Body Chair. An in-service meeting was conductedby the Administrator and attended by all staff including contracted staff on 7/9/2025to discuss the updated agency policy 6.2.1 titled "Reporting of OasisInformation". All staff will be informed and educated that our Home HealthAgency must encode and electronically transmit each completed OASIS assessmentto the CMS system, regarding each beneficiary with	

			respect to which informationis required to be transmitted (as determined by the Secretary), within 30 daysof completing the assessment of the beneficiary. All staff understood andacknowledged the requirement and the importance of the need to encode andelectronically transmit each completed OASIS assessment to the CMS system,regarding each beneficiary with respect to which information is required to betransmitted (as determined by the Secretary), within 30 days of completing theassessment of the beneficiary. All new staff will be oriented of thisrequirement at the time of hire. **Measures to assure Norecurrence:** Inorder to ensure that there is no recurrence of this deficiency, the OfficeManager will utilize an Oasis tracking tool to ensure that our Home HealthAgency encodes and electronically transmits each completed OASIS assessment tothe CMS system, regarding each beneficiary with respect to	

			which information isrequired to be transmitted (as determined by the Secretary), within 30 days ofcompleting the assessment of the beneficiary. This process will involve ourclinicians completing and submitting the Oasis to the home health agency and ensuringthat the Oasis is processed and electronically transmitted within 30 days ofcompleting the assessment of the beneficiary. **Monitoring:** Inorder to ensure implementation and effectiveness of this corrective action, theAdministrative Assistant will audit 100% active charts to ensure that theclinicians are completing and submitting the Oasis to the home health agency andensuring that the Oasis is processed and electronically transmitted within 30days of completing the assessment of the beneficiary on a weekly basis. MonthlyOasis validation reports will be generated and results will be compiled by the OfficeManager and sent to Administrator to ensure that	

			electronicallytransmitted within 30 days of completing the assessment of the beneficiary andthe processes have improved. If any deficiencies are identified, they willcontinue to be addressed with each personnel as needed. This process willcontinue for the next 30 days until 90-100% compliance is achieved. After 30days, this process will continue to be monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of oasis submissions on aquarterly to ensure compliance is maintained. The Administrator and QAPICommittee will send a written report to the Governing Body quarterly for theirrecommendations.	

			The Administrator will beresponsible for corrective action of this deficiency, measure to assure norecurrence and monitoring of this deficiency.	
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; (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 home health agency failed to ensure patients were informed about and received the initial therapy assessment for 2 of 4 active records reviewed with a referral for therapy services in the past	G0434	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure the patients were informed about and received the initial therapy orany other discipline assessments, patients were notified of delay in PT or anyother services it was documented, therapy evaluations were completed withinfive days of the comprehensive assessment and Frequencies for all disciplinesordered were followed as per plan of care. 25% review of active charts wascompleted by week ending 6/28/25. 15% review of active charts was completed byweek ending 7/3/25. 15% review of active charts will be completed by weekending 7/12/25. 20% review of active charts will be completed by 7/19/25, 15%review of active charts will	2025-07-18

	1 of 2 discharge records reviewed with discharge in the past 30 days (Patient #15). Findings include: 1. The undated agency policy Patient Admission Criteria indicated during the initial visit, the admitting professional will verify the information on the referral form. 2. The undated agency policy Patient Bill of Rights and Responsibilities indicated patients have the right to be admitted by the Agency only if it has the resources needed to provide care safely and at the required level of intensity, as determined by a professional assessment and the patient has the right to receive all services in the plan of care. 3. Patient #9 s clinical record included a recertification POC for the certification period 5/06/25 to 7/04/25. The POC included orders for SN visits two times a week for one week and then three times a week for three weeks; HHA visits two times a week for four weeks; OT visits one time a week for one week, two times a week for		be completed by 7/26/25. Remaining 10% review ofcharts will be completed by week ending 8/2/25 to complete 100% audit of allactive chart audits. In orderto correct the above deficiency cited under G0434, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the organization's policy titled “Patient Bill of Rights andResponsibilities 12.1.4" that the clinician is to provide information tothe patient both orally and in writing and that patients have the right toreceive all services in the plan of care and the right to participate in, beinformed about and consent or refuse care in advance of and during treatment.The clinical records with the deficiencies were identified and reviewed. TheAdministrator, Alternate Administrator Director of Clinical Services and theAlternate Director of Clinical Services have completed re-orientation ofagency’s policies pertaining to the	

	week for one week; and PT re-eval and treat. The record failed to evidence a PT Evaluation was performed and failed to evidence documentation that the Patient was notified of the delay in PT services. During an interview on 6/13/25 at 1:07 PM, the CM relayed the PT evaluation should be done within five days of the comprehensive assessment. During an interview on 6/17/25 at 2:26 PM, Patient #9 relayed he was told all of the PT s went on vacation at the same time and someone would be calling him to do the PT evaluation when they returned from vacation and he stated he was still waiting on someone to call him for the PT evaluation. 4. Patient #12 s medical record evidenced documentation of a verbal SOC order dated 05/19/2025 and included an order for physical therapy to evaluate and treat. The record failed to evidence a physical therapy evaluation. Documentation failed to evidence the patient was notified there would be no		requirement on 7/7/25 provided by theGoverning Body Chair. An in-service meeting was conducted bythe Administrator and attended by all staff on 7/9/25 to discuss the agencypolicy titled, Patient Bill of Rights and Responsibilities 12.1.4". Allstaff were informed and re-educated on the requirement that that the clinicianis to provide information to the patient both orally and in writing:"Patients have the right to receive all services in the plan of care andthe right to participate in, be informed about and consent or refuse care inadvance of and during treatment". Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the requirementand importance of the need to ensure the patients were informed about andreceived the initial therapy or any other discipline assessments, patients werenotified of delay in PT or any other services it was documented,	

	physical therapy assessment. During an interview on 06/17/2025 at 03:50 PM, the Alternate Administrator confirmed Patient #12 did not receive a physical therapy evaluation and was unsure if the MD discontinued the order for the evaluation. 5. Patient #15 s clinical record included a POC for the initial certification period of 5/12/2025 7/10/2025. The POC included orders for SN visits three times a week and HHA visits three times a week. SN interventions included but were not limited to performing wound care to wounds on both heels. The record evidenced a SOC visit was completed on 5/12/2025. RN 4 noted Patient lived alone with no available caregiver, was legally blind with highly impaired ability to see in adequate light, and required assistance with grooming, dressing, bathing, ambulating, and meal set-up. The record failed to evidence a subsequent SN visit was conducted until 5/22/2025 and failed to evidence a HHA visit was		therapyevaluations were completed within five days of the comprehensive assessment andFrequencies for all disciplines ordered were followed as per plan of care. Allnew staff will be oriented of this requirement at the time of hire. Thecorrective actions were implemented on 7/7/25 and will be completed on 7/18/25. **Measuresto assure No recurrence** In orderto ensure that there is no recurrence of this deficiency, the Agency iscurrently utilizing “Home Health Notify”, a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients,Physicians and External organizations to ensure real-time visibility intopatient care and to ensure that the patients were informed about and receivedthe initial therapy assessment. The Alternate Director of Clinical Serviceswill utilize a chart audit tool and audit 100% of all active patients on aweekly basis to ensure that all clinical records show evidence that thepatients were informed about and received	

	conducted. Patient was admitted to a local hospital on 5/22/2025 and discharged from the agency. A review of messages sent between home health staff on Secure Messaging App B evidenced on 5/09/2025 at 11:44 AM, Intake Manager 7 informed staff to contact Person C, healthcare advocate for Patient, if staff were unable to reach Patient to schedule visits. The record failed to evidence nursing and aide staff attempted to contact Person C after being unable to schedule visits with Patient. During an interview on 6/16/2025 beginning at 8:30 AM, Person C reported they and Patient had no record of calls from agency staff attempting to schedule visits. Person C stated agency staff did not show for visits on multiple occasions. During an interview on 6/17/2025 beginning at 11:17 AM, LPN 1 reported she had not been told by the agency to contact Person C to arrange for visits until the visit on 5/22/2025. During an interview on		the initial therapy or any otherdiscipline assessments, patients were notified of delay in PT or any other servicesit was documented, therapy evaluations were completed within five days of thecomprehensive assessment and Frequencies for all disciplines ordered werefollowed as per plan of care. The Alternate Director of Clinical Services willfurther ensure that communication with the patient or patient's representativeis present documenting delay in initiating therapy or any other services. Thisprocess of utilizing chart audit tool will help us identify any discrepanciesin clinical records and take corrective measures accordingly. **Monitoring** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place; the Alternate Director ofClinical Services will audit 100% of all new admissions on a weekly basis toensure that all clinical	

	6/18/2025 beginning at 2:04 PM, HHA 2 thought she had attempted to contact Patient and Person C to schedule a HHA visit, but was unsure where these attempts were documented.		records show evidence that the patients were informedabout and received the initial therapy or any other discipline assessments,patients were notified of delay in PT or any other services it was documented, therapyevaluations were completed within five days of the comprehensive assessment andFrequencies for all disciplines ordered were followed as per plan of care andit must be present in home health agency's clinical record. The Director ofClinical Services will monitor and review Alternate Director of ClinicalServices' audit findings of all active patients. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each week for thenext 30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100% complianceand any deficiencies are identified within 30 days, they will	

			continue to beaddressed with staff re-training and re-education in workshops and in-servicesand with each individual personnel as needed. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly chart audit review. Quarterly audits results will be compiled andsent to the QAPI Committee for review. Once threshold is met, the QAPICommittee will continue to audit 20% of clinical records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
G0436	Receive all services in plan of care 484.50(c)(5)	G0436	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal	2025-07-18

	Receive all services outlined in the plan of care. Based on record review and interview, the home health agency failed to ensure the patient received all visits as ordered on the POC for 4 of 5 active records reviewed with SOC in the past 40 days (Patient #1, 3, 7 and 13) and 2 of 2 discharged records reviewed with discharge in the past 30 days (Patient #14 and 15). Findings include: 1. The undated agency policy Patient Bill of Rights and Responsibilities indicated patients have the right to be admitted by the Agency only if it has the resources needed to provide care safely and at the required level of intensity, as determined by a professional assessment and the patient has the right to receive all services in the plan of care. 2. Patient #1 s clinical record evidenced a SOC on 5/13/25 and included a POC for the certification period 5/13/25 to 7/11/25. The POC indicated the patient was to receive SN visits three times a week for five weeks; OT visits one time a		audit review of all active clinical records on 6/23/25to ensure that the patients received all services and visits as ordered on thePOC and the patient and physician was notified of the delay in services. 25%review of active charts was completed by week ending 6/28/25. 15% review of activecharts was completed by week ending 7/3/25. 15% review of active charts will becompleted by week ending 7/12/25. 20% review of active charts will be completedby 7/19/25, 15% review of active charts will be completed by 7/26/25. Remaining10% review of charts will be completed by week ending 8/2/25 to complete 100%audit of all active chart audits. In orderto correct the above deficiency cited under G0436, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the organization's policy titled “Patient Bill of Rights andResponsibilities 12.1.4" that the thatthe patient has the right	

	week for one week, two times a week for three weeks, one time a week for one week; and PT evaluation and treat visit effective 5/13/25. The clinical record evidenced the PT evaluation was completed by PT 1 on 5/26/25, 13 days after SOC. The record failed to evidence documentation that Patient #1 and the physician were notified of the delay in the PT Evaluation as ordered on the POC. During an interview on 6/13/25 at 1:07 PM, the CM relayed the PT evaluation should be done within five days of the SOC comprehensive assessment. During an interview on 6/13/25 at 1:54 PM, PT 1 relayed she was hired and completed the PT evaluation on 5/26/25. She was unsure if the patient or physician was notified of the delay of PT services. 3. Patient #3 s clinical record evidenced a SOC on 5/06/25 and included a POC for the certification period 5/06/25 to 7/04/25. The POC indicated the patient was to receive an OT evaluation and treat visit and a PT evaluation and treat visit effective 5/06/25. The clinical		to receive all services outlined in the plan of care". Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Alternate Administrator Director of Clinical Services and theAlternate Director of Clinical Services have completed re-orientation ofagency's policies pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. An in-service meeting was conducted bythe Administrator and attended by all staff on 7/9/25 to discuss the agencypolicy titled, Patient Bill of Rights and Responsibilities 12.1.4". Allstaff were informed and re-educated on the requirement that the patient has the right to receive allservices outlined in the plan of care" and the patient and physician mustbe notified of the delay in services. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the requirementand importance of the need to ensure patients	

	record evidenced the OT evaluation was completed by OT 2 on 5/12/25, 6 days after SOC. The clinical record failed to evidence the PT evaluation had been completed and failed to include documentation that Patient #3 and the physician were notified of the delay in the OT and PT Evaluations as ordered on the POC. During an interview on 6/13/25 at 1:07 PM, the CM relayed the OT and PT evaluations should be done within five days of the SOC comprehensive assessment. During an interview on 6/13/25 at 1:45 PM, OT 1 relayed she thought the initial OT evaluation should be done within 24 hours and she was unsure if the patient or physician was notified of the delay of OT services. During an interview on 6/17/25 at 12:17 PM, PT 4 relayed the PT evaluation should be done within 24 to 48 hours of initial patient encounter and he was not the PT originally assigned to do the evaluation. He also		startof services. All new staff will be oriented of this requirement at the time ofhire. The corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measuresto assure No recurrence** In orderto ensure that there is no recurrence of this deficiency, the Agency iscurrently utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients,Physicians and External organizations to ensure real-time visibility intopatient care and to ensure that the patients received all services outlined inthe plan of care and the patient and physician was notified of the delay inservices. The Alternate Director of Clinical Services will utilize a chartaudit tool and audit 100% of all active patients on a weekly basis to ensurethat all clinical records show evidence that patients received all servicesoutlined in the plan of care and the patient and physician was notified of	

	patient or physician was notified of the delay of PT services. 4. Patient #7 s clinical record evidenced a SOC on 5/19/25 and included a ROC POC effective 6/03/25. The ROC indicated the patient was to receive an OT evaluation and treat visit and a PT evaluation and treat visit. The clinical record evidenced the OT evaluation was completed by OT 3 on 6/12/25, 9 days after ROC and the PT evaluation was completed by PT 2 on 6/12/25, 9 days after ROC. The clinical record failed to include documentation that Patient #7 and the physician were notified of the delays in the OT and PT Evaluations as ordered on the ROC. During an interview on 6/13/25 at 2:42 PM, OT 3 relayed she completed the evaluation when she had time and she was unsure if Patient #7 or the physician had been notified of the delay in the OT Evaluation. During an interview on 6/13/25		thedelay in services. This process of utilizing chart audit tool will help usidentify any discrepancies in clinical records and take corrective measuresaccordingly. **Monitoring** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place; the Alternate Director ofClinical Services will audit 100% of all new admissions on a weekly basis toensure that all clinical records show evidence that the patients received all servicesoutlined in the plan of care and the patient and physician notification of thedelay in services must be present in home health agency's clinical record. The Director of Clinical Services will monitorand review Alternate Director of Clinical Services' audit findings of allactive patients. Weekly reports will be generated and results will be compiledand sent to the Administrator to ensure that processes have improved.	

	at 2:30 PM, PT 2 verified the PT evaluation was not completed within five days of ROC and he was unsure if Patient #7 or the physician had been notified of the delay in the PT Evaluation. 5. Patient #13 s clinical record evidenced a SOC on 6/10/25 and included a POC for the certification period 6/10/25 to 8/08/25. The POC indicated the patient was to receive SN visits three times a week for one week, two times a week for two weeks and one time a week for one week; an OT evaluation visit one time a week for one week; and a PT evaluation visit one time a week for one week. The clinical record evidenced the OT evaluation was completed by OT 4 on 6/13/25 and SN visits were completed by the CM on 6/10/25 and 6/13/25. The record failed to evidence Patient #13 received three SN visits as ordered on the POC. The PT evaluation was completed by PT 1 on 6/16/25, 6 days after SOC. The record failed to evidence documentation that Patient #13 and the physician were notified of the delay in the PT Evaluation		Thisprocess will continue for each week for the next 30 days until 100% complianceis achieved and to maintain this level of compliance all new employees at thetime of hire will be oriented with this requirement. If compliance is not achievedat the desired target of 100% compliance and any deficiencies are identifiedwithin 30 days, they will continue to be addressed with staff re-training andre-education in workshops and in-services and with each individual personnel asneeded. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations.	

	as ordered on the POC. During an interview on 6/16/25 at 12:35 PM, the CM verified Patient #13 did not receive three SN visits as ordered during the week of 6/10/25 and he stated he needed to mark it as a missed visit. During an interview on 6/18/25 at 10:29 AM, PT 1 relayed she discussed the delay in PT evaluation on Sunday 6/15/25 and she left a message with the physician on 6/16/25 after the PT evaluation visit. She also verified she had not completed any documentation of the discussion of the delay with the patient and had not documented the PT evaluation visit yet. 6. Patient #14 s clinical record evidenced a SOC on 4/11/25 and included a POC for the certification period 4/11/25 to 6/09/25. The POC indicated the patient was to receive a PT evaluation and treat visit and OT visits one time a week for		The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	one week, two times a week for three weeks and then one time a week for one week. Review of the agency complaint log evidenced Patient #14 filed a complaint on 5/01/25 due to not receiving the PT evaluation. The clinical record evidenced the PT evaluation was completed on 5/02/25, 21 days after SOC. The record failed to evidence documentation that Patient #14 and the physician were notified of the delay in the PT Evaluation as ordered on the POC. During an interview on 6/18/25 at 10:59 AM, PT 2 relayed he was not sure why the PT evaluation was delayed and he was unsure if the patient or physician had been notified of the delay in PT services. 6. Patient #15 s clinical record evidenced Patient was discharged from a local hospital			

	5/12/2025. Patient was referred for SN, PT, and OT services. A POC for the initial certification period of 5/12/2025 7/10/2025 included orders for SN visits three times a week, HHA visits three times a week, and an OT evaluation. SN interventions included but were not limited to performing wound care to wounds on both heels. The record evidenced a SOC visit was completed on 5/12/2025. RN 4 noted Patient lived alone with no available caregiver, was legally blind with highly impaired ability to see in adequate light, and required assistance with grooming, dressing, bathing, ambulating, and meal set-up. The record failed to evidence a subsequent SN visit was conducted until 5/22/2025. Patient was admitted to a local hospital for multiple falls on 5/22/2025 and discharged from the agency. The record failed to evidence a HHA visit was conducted while Patient was on services, and failed to evidence an OT evaluation was conducted while Patient was on services. A review of messages sent			

	Secure Messaging App B evidenced on 5/09/2025 at 11:44 AM, Intake Manager 7 informed staff to contact Person C, healthcare advocate for Patient, if staff were unable to reach Patient to schedule visits. The record failed to evidence nursing and aide staff attempted to contact Person C after being unable to schedule visits with Patient. The messages also failed to evidenced Former Employee D, an OT, attempted to contact Patient or Person C to schedule the OT evaluation until 5/19/2025, which was seven days after the SOC. During an interview on 6/16/2025 beginning at 8:30 AM, Person C reported they and Patient had no record of calls from agency staff attempting to schedule visits. Person C stated agency staff did not show for visits on multiple occasions. The healthcare advocate reported Patient was unable to perform wound care and did not have any available caregivers to perform the wound care when SN staff did not come for the visits. During an interview on			

	6/17/2025 beginning at 11:17 AM, LPN 1 reported she had not been told by the agency to contact Person C to arrange for visits until the visit on 5/22/2025. During an interview on 6/18/2025 beginning at 2:04 PM, HHA 2 thought she had attempted to contact Patient and Person C to schedule a HHA visit, but was unsure where these attempts were documented. During an interview on 6/19/2025 beginning at 10:57 AM, Alternate Administrator reported the agency had delays in conducting the PT and/or OT evaluation visits due to requiring an order from the physician prior to the evaluation.			
G0478	Investigate complaints made by patient 484.50(e)(1)(i) The HHA must (i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics: (A) Treatment or care that is (or fails to be)	G0478	**CorrectiveAction:** The Administrator started internal audit review of all complaintlogs on 6/23/25 to ensure the agency documented, investigated, followed up andresolved complaints regarding treatment of care which failed to be furnished.	2025-07-18

	furnished, is furnished inconsistently, or is furnished inappropriately; (B) Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA. Based on record review, policy review, and interview, the home health agency failed to document and investigate complaints regarding treatment of care which failed to be furnished for 1 of 2 records reviewed which evidenced a report was made to the agency that treatment failed to be furnished by staff (Patient #15). Findings include: 1. The undated agency policy Complaint Resolution, indicated the agency would document the existence, investigate, and document the resolution of a complaint. 2. Patient #15 s clinical record evidenced a SOC of 5/12/2025. The agency noted Patient was discharged from a local hospital on 5/09/2025. Patient was referred for SN, PT, and OT services. A POC for the initial certification period of 5/12/2025 7/10/2025 evidenced Patient was to receive SN visits three times a		100% review of complaint logs wascompleted by week ending 6/28/25. 100% review of complaint logs was completedby week ending 7/5/25. 100% review of complaint logs will be completed by weekending 7/12/25. The Alternate Director of Clinical Servicesstarted internal audit review of all active clinical records on 6/23/25 toensure that the agency documented,investigated, followed up and resolved complaints regarding treatment of carewhich failed to be furnished. 25% review of active charts was completed by weekending 6/28/25. 15% review of active charts was completed by week ending 7/3/25.15% review of active charts will be completed by week ending 7/12/25. 20%review of active charts will be completed by 7/19/25, 15% review of activecharts will be completed by 7/26/25. Remaining 10% review of charts will be completedby week ending 8/2/25 to complete 100% audit of all active chart audits.	

	week, and a MSW, PT, and OT evaluation. SN interventions were to include wound care to be performed at each visit to wounds on both of Patient s heels. The record evidenced Patient received only one subsequent SN visit, and no HHA, MSW, PT, or OT visits prior to being re-admitted to a hospital on 5/22/2025. Review of messages sent between staff on Secure Messaging Application B evidenced on 5/21/2025, MSW 1 reported she spoke with Person C, healthcare advocate for Patient #15. Person C was reportedly stressed out as no one is calling [him/her], and asking when Patient s wound care and therapy would begin. On 5/21/2025 at 4:24 PM, Scheduler 7 sent a message to staff reporting Person C called the office upset that nursing has not seen Patient since SOC. 3. The agency s log of complaints received 1/01/2025 6/12/2025 failed to evidence a complaint regarding failure to furnish care to Patient #15 was documented, investigated, and resolved.		In orderto correct the above deficiency cited under G0478, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the organization's policy under section XII titled “Patient Bill ofRights and Responsibilities 12.1.5" that the patient has the right “tohave complaints investigated and complaint resolution policy 12.3.1 that theAgency will investigate complaints made by a patient, the patient’srepresentative (if any) and the patient’s caregivers and family”. The clinicalrecords and complaint logs with the deficiencies were identified and reviewed.The Administrator, Alternate Administrator, Director of Clinical Services andAlternate Director of Clinical Services have completed re-orientation ofagency’s policies pertaining to the requirement on 8/23/23 provided by theGoverning Body Chair. Anin-service meeting was	

	4. During an interview on 6/16/2025 beginning at 8:30 AM, Person C stated they spoke with Alternate Administrator to report their concerns of visits not being conducted with Patient. Person C reported they were not notified an investigation of the concern would be conducted nor a resolution of the complaint. 5. During an interview on 6/18/2025 beginning at 1:07 PM, Scheduler 7 stated Person C called the agency "a few times" to report complaints regarding staff not conducting visits within a timely manner. Scheduler 7 stated she reported Person C's complaints to Alternate Administrator. 6. During an interview on 6/18/2025 beginning at 1:32 PM, Alternate Administrator reported she spoke with Person C, who reported Patient was not getting their nursing visits as ordered and that staff had not contacted Person C to schedule visits. Alternate Administrator reported she did not document or investigate this report as a complaint.		conducted by the Administrator and attended by all staffon 7/9/25 to discuss the agency policy under section XII of the policy titledPatient Bill of Rights and Responsibilities 12.1.4 and complaint resolutionpolicy 12.3.1. All staff were informed and re-educated on the requirement thatthe patient has the right “to have complaints investigated and that the Agencywill investigate complaints made by a patient, the patient’s representative (ifany) and the patient’s caregivers and family. Citations listed in the clinical record reviews and complaints logs wereaddressed. All staff understood and acknowledged the requirement and importanceof the need to ensure that the patient has the right “to have complaintsinvestigated and that the Agency will investigate complaints made by a patient,the patient’s representative (if any) and the patient’s caregivers and family.All new staff will be oriented of this requirement at the time of hire. Thecorrective actions were implemented on 6/23/25 and completed on 7/18/25.	

G0514	RN performs assessment 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. Based on record review and interview, the home health agency failed to conduct an initial assessment to determine the patient's immediate care and support needs within 48 hours of referral for 4 of 5 active records reviewed with SOC in the past 40 days (Patient #1, 3, 12 and 13) and 1 of 1 discharged record reviewed with SN services in the past 30 days (Patient #15). Findings include: 1. The undated agency policy Initial Assessments/ Comprehensive Assessments indicated a RN, PT or SLP must conduct the initial assessment visit within 48 hours of referral, within 48 hours of the patient s return home or on the	G0514	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that an initial assessment to determine the patient's immediate needswas performed within 48 hours of referral, or within 48 hours of the patient'sreturn home, or on the physician or allowed practitioner -ordered start of caredate or reason for delay in conducting an initial assessment is documented. 25%review of active charts was completed by week ending 6/28/25. 15% review ofactive charts was completed by week ending 7/3/25. 15% review of active charts willbe completed by week ending 7/12/25. 20% review of active charts will becompleted by 7/19/25, 15% review of active charts will be completed by 7/26/25.Remaining 10% review of charts will be completed by week ending 8/2/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0514, during the	2025-07-18

	start of care date. 2. Patient #1 s clinical record evidenced a referral was received on 5/06/25 and an initial assessment/SOC visit was conducted on 5/13/25. The record failed to evidence documentation of the reason for delay in conducting an initial assessment. During an interview on 6/13/25 at 1:27 PM, the CM verified the initial assessment was not completed within 48 hours for Patient #1 and relayed it should have been documented in the communication notes or the Secure Messaging Application B that is used internally. Review of the Secure Messaging Application B notes for Patient #1 failed to evidence any documentation of the delay in the initial assessment. 3. Patient #3 s clinical record evidenced a referral was received on 4/29/25 with a planned discharge from the skilled nursing facility on 5/02/25. The initial assessment/SOC visit was conducted on 5/06/25. The record failed to evidence documentation of the reason		managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.6.1 titled, "Initial Assessments/ComprehensiveAssessments". The clinical records with the deficiencies were identified andreviewed. The Administrator, Alternate Administrator, Director of ClinicalServices and Alternate Director of Clinical Services have completedre-orientation of agency's policies pertaining to the requirement on 7/7/25provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed agency policy 9.6.1 titled, "InitialAssessments/Comprehensive Assessments" and the importance of the requirement thatan initial assessment visit must be held either within 48 hours of referral, orwithin 48 hours of the patient's return home, or on the physician or	

	for delay in conducting an initial assessment. During an interview on 6/13/25 at 1:27 PM, the CM verified the initial assessment was not completed within 48 hours for Patient #3 and relayed it should have been documented in the Secure Messaging Application B. Review of the Secure Messaging Application B notes for Patient #3 failed to evidence any documentation of the delay in the initial assessment. 5. Patient #13 s clinical record evidenced a referral was received on 6/04/25 with a planned discharge from the skilled nursing facility on 6/06/25. The initial assessment/SOC visit was conducted on 6/10/25. The record failed to evidence documentation of the reason for delay in conducting an initial assessment. During an interview on 6/17/25 at 12:35 PM, the CM verified the initial assessment was not completed within 48 hours for Patient #13. Review of the Secure Messaging Application B notes for Patient #13 failed to		allowedpractitioner -ordered start of care date" or reason for delay in conducting aninitial assessment is documented. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the agency policy9.6.1 titled, "Initial Assessments/Comprehensive Assessments" and therequirement that "an initial assessment visit must be held either within 48hours of referral, or within 48 hours of the patient's return home, or on thephysician or allowed practitioner -ordered start of care date" or reason for delayin conducting an initial assessment must be documented. All new staff will beoriented of this requirement at the time of hire. The corrective actions wereimplemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing "Home Health Notify", a HIPAA	

	evidence any documentation of the delay in the initial assessment. Patient #12 s medical record evidenced documentation of a verbal SOC order dated 05/19/2025. The SOC order stated, Patient seen and evaluated for Start of Care with [agency]. The Secure Messaging application B notes included a note by RN 1, which indicated a SOC date of 05/19/2025. During an interview on 06/18/2025 at 12:30 PM, RN 1 indicated the SOC assessment must be completed within 48 hours of the referral, but RN 1 did not know if Patient #12 s assessment was completed within that time frame. During an interview on 06/18/2025 at 01:25 PM, Intake Manager 7 indicated the referral date for Patient #12 was 05/16/2025. The agency failed to ensure the comprehensive assessment was completed within 48 hours of the referral. 6. Patient #15 s clinical record evidenced Patient was referred to the agency on 5/06/2025 and was discharged from a local hospital on 5/09/2025. On		compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that “an initial assessment to determine the patient's immediate needs isperformed within 48 hours of referral, or within 48 hours of the patient'sreturn home, or on the physician or allowed practitioner -ordered start of caredate” or reason for delay in conducting an initial assessment must bedocumented. The Alternate Director of Clinical Services will utilize a chartaudit tool to ensure that an initial assessment to determine the patient's immediateneeds is performed within 48 hours of referral, or within 48 hours of thepatient's return home, or on the physician or allowed practitioner -orderedstart of care date or reason for delay in conducting an initial assessment mustbe documented. This process of utilizing active chart audit tool will help usidentify any discrepancies in the clinical records and re-educate all staff onthe above mentioned requirement.	

G0534	Patient's needs 484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs; Based on record review and interview, the home health agency failed to ensure the RN performed a wound assessment during the recertification comprehensive assessment for 1 of 1 active clinical record reviewed with wounds and HHA services (Patient #9). Findings include: 1. The undated agency policy Initial Assessments/Comprehensive Assessments indicated the comprehensive assessment must include integumentary status. 2. Patient #9 s clinical record included a comprehensive assessment completed by RN 1 on 5/6/25. The comprehensive assessment evidenced Patient #9 had a pressure ulcer and wound care was performed earlier that day. Patient #9 showed RN 1 a picture of the wound. RN 1 failed to assess Patient #9 s wound during the	G0534	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the Comprehensive Assessment includes integumentary status. 25%review of active charts was completed by week ending 6/28/25. 15% review ofactive charts was completed by week ending 7/3/25. 15% review of active charts willbe completed by week ending 7/12/25. 20% review of active charts will becompleted by 7/19/25, 15% review of active charts will be completed by 7/26/25.Remaining 10% review of charts will be completed by week ending 8/2/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0534, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.6.1 titled “Initial	2025-07-18

	comprehensive assessment. During an interview on 6/18/25 at 1:49 PM, RN 1 confirmed she did not perform a skin assessment on Patient #9 during the comprehensive assessment. She stated he is comfortable with the LPN and they have a routine. When asked when she had performed a skin assessment on Patient #9, she relayed it was done on SOC on 11/07/24, six months prior. During an interview on 6/19/25 at 4:34 PM, the Administrator relayed the nurse who is taking care of the patient is responsible for wound assessment and the RN should assess the wound upon every supervisory visit.		Assessments/ComprehensiveAssessments" that the Comprehensive Assessment includes patient's Medical,nursing, rehabilitative, social and discharge planning needs. The clinicalrecords with the deficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed agency policy 9.6.1 titled, "InitialAssessments/Comprehensive Assessments" and the importance of the requirement thatthe Comprehensive Assessment includes patient's Medical, nursing,rehabilitative, social and discharge planning needs and to ensure that the RNperforms a skin and wound assessment in the integumentary status during	

			Citations listed in the clinical record reviews wereaddressed. All staff understood and acknowledged the agency policy 9.6.1titled, “Initial Assessments/Comprehensive Assessments” and the requirement thatthe Comprehensive Assessment includes patient’s Medical, nursing,rehabilitative, social and discharge planning needs and the RN performs a skinand wound assessment in the integumentary status during the comprehensiveassessment. All new staff will be oriented of this requirement at the time ofhire. The corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into	

			patient care and toensure that RN performs a skin and wound assessment in the integumentary statusduring the comprehensive assessment and it must be documented. The AlternateDirector of Clinical Services will utilize a chart audit tool to ensure that theRN performs a skin and wound assessment in the integumentary status during thecomprehensive assessment and it must be documented. This process of utilizingactive chart audit tool will help us identify any discrepancies in the clinicalrecords and re-educate all staff on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure that the RN performs a skin and woundassessment in the integumentary status during the comprehensive assessment	

			the clinical record. The Director of ClinicalServices will monitor and review Alternate Director of Clinical Services' auditfindings of all new admissions and active charts. Reports will be generated andresults will be compiled to ensure processes have improved. If any deficienciesare identified, they will continue to be addressed with each personnel asneeded. This process will continue for each week for the next 30 days until100% compliance is achieved. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audit results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the Quality Committee will continueto audit 20% of clinical records quarterly to ensure compliance is maintained.The Administrator and QAPI Committee will send a written report to theGoverning Body quarterly for their recommendations. TheDirector of Clinical Services	

			will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0536	A review of all current medications 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment included an accurate review of all medications the patient was currently taking for 2 of 6 home visit observations conducted (Patients #1, #10). 2. Patient #1 s clinical record evidenced a SOC on 5/13/25 and included a comprehensive assessment completed by the CM on 5/13/25 and a POC for the certification period 5/13/25 to 7/11/25. SN visits completed on 5/15/25, 5/16/25, 5/19/25, 5/23/25, 5/26/25, 5/28/25, 6/02/25 and 6/09/25 which evidenced drug regimen review	G0536	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that comprehensive assessment included an accurate review of allmedications the patient was currently taking. 20% review of active charts willbe completed by week ending 7/12/25. 25% review of active charts will becompleted by week ending 7/19/25. 30% review of active charts will be completedby week ending 7/26/25. Remaining 25% review of active charts will be completedby 8/2/25 to complete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0536, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical	2025-07-18

	was completed. During a home visit observation conducted with Patient #1 and the CM on 6/13/25 at 9:27 AM, Surveyor comparison of the home health agency s POC medication list against the medications in the home evidenced the following discrepancy: a) Levofloxacin (an antibiotic used to treat a bacterial infection) 750 milligrams (mg), 1 tablet by mouth at bedtime for 14 days. Per Patient #1, they finished this medication a couple of weeks ago. During the entrance conference on 6/12/25 at 9:27 AM, the Alternate Administrator relayed medications should be reconciled on a regular basis. During an interview on 6/17/25 at 12:35 PM, the CM relayed mediations should be reconciled in the home every visit, at least once a week. Findings include: 1. The undated agency policy Medication Reconciliation indicated during the admission comprehensive assessment, the		Services reviewed anddiscussed the agency policy 8.15.1 titled, “Medication Reconciliation”. Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Alternate Administrator, Director of Clinical Services andAlternate Director of Clinical Services have completed re-orientation ofagency’s policies pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the agency policy 8.15.1titled, “Medication Reconciliation” and the importance of the requirement thatthe comprehensive assessment included an accurate review of all medications thepatient was currently taking. Citations listed in the clinical record reviewswere addressed. All staff understood and acknowledged the agency policy 8.15.1titled, “Medication Reconciliation” and the requirement that the comprehensiveassessment included an accurate review of all medications the patient	

	admitting clinician should create and document a complete list of medications that [the] patient is taking at home, including dose, strength, route, and frequency. 3. Patient #10 s clinical record evidenced RN 2 conducted an initial comprehensive assessment on 4/23/2025. RN 2 documented Patient s Hydrocodone-acetaminophen order was 5-325 mg, one tablet every four hours PRN. During a home visit observation on 6/16/2025 beginning at 1:38 PM, Patient #10 s medication bottles were reviewed. The bottles evidenced Patient s prescription for Hydrocodone-acetaminophen (a combination of an opioid and Tylenol used to treat pain) was 10-325 milligrams (mg), one tablet five times a day as needed (PRN). During an interview on 6/16/2025 beginning at 2:45 PM, Patient reported they had been on the Hydrocodone-acetaminophen dose of 10-325 mg, one tablet five times a day PRN, prior to admission to the home health		wascurrently taking. All new staff will be oriented of this requirement at thetime of hire. The corrective actions were implemented on 6/23/25 and will becompleted on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that comprehensive assessment included an accurate review of allmedications the patient was currently taking. The Alternate Director ofClinical Services will utilize a chart audit tool to ensure that the comprehensiveassessment included an accurate review of all medications the patient wascurrently taking. This process of utilizing active chart audit tool will helpus identify any discrepancies in the clinical	

	agency. During an interview on 6/19/2025 beginning at 2:13 PM, RN 2 reported on admission, she would review all medication bottles in the home and compare to the ordering physician s medication list.		records and re-educate all staffon the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure that comprehensive assessmentincluded an accurate review of all medications the patient was currently takingand it is being clearly documented in the clinical record. The Director ofClinical Services will monitor and review Alternate Director of ClinicalServices' audit findings of all new admissions and active charts. Reports willbe generated and results will be compiled to ensure processes have improved. Ifany deficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for each week for the next 30days until 100% compliance is achieved. After 30 days, this process	

			willcontinue to be monitored on a quarterly basis and will be included in thequarterly chart audit review. Quarterly audit results will be compiled and sentto the QAPI Committee for review. Once threshold is met, the Quality Committeewill continue to audit 20% of clinical records quarterly to ensure complianceis maintained. The Administrator and QAPI Committee will send a written reportto the Governing Body quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0546	Last 5 days of every 60 days unless: 484.55(d)(1)(i,ii,iii) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a- (i) Beneficiary elected transfer; (ii) Significant change in condition; or	G0546	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that comprehensive assessment included an accurate review of allmedications the patient was currently taking. 25% review of	2025-07-18

	(iii) Discharge and return to the same HHA during the 60-day episode. Based on record review and interview, the RN failed to update the comprehensive assessment within 5 days of recertification for 2 of 5 active records reviewed with wounds (Patient #2 and 9). Findings include: 1. The undated agency policy Reassessments/Update of the Comprehensive Assessment indicated the comprehensive assessment must be updated and revised the last 5 days of every 60 days, e.g. days 56-60 of the current period. 2. Patient #2 s clinical record was reviewed on 6/12/25 and evidenced a SOC on 4/03/25 and a current certification period of 6/02/25 to 7/31/25. The record failed to include an updated comprehensive assessment had been completed in the last five days of the previous certification period. During an interview on 6/13/25 at 2:45 PM, RN 2 relayed she completed an updated comprehensive assessment on		active charts wascompleted by week ending 6/28/25. 15% review of active charts was completed byweek ending 7/3/25. 15% review of active charts will be completed by weekending 7/12/25. 20% review of active charts will be completed by 7/19/25, 15% reviewof active charts will be completed by 7/26/25. Remaining 10% review of chartswill be completed by week ending 8/2/25 to complete 100% audit of all activechart audits. In orderto correct the above deficiency cited under G0546, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.7.1 titled, “Reassessments Update of theComprehensive Assessment”. The clinical records with the deficiencies wereidentified and reviewed. The Administrator, Alternate Administrator, Directorof Clinical Services and Alternate	

	document the assessment until 6/12/25. 3. Patient #9 s clinical record was reviewed on 6/17/25 and evidenced a SOC on 11/07/24 and included a POC for the certification period 5/06/25 to 7/04/25. The record failed to include an updated comprehensive assessment had been completed in the last five days of the previous certification period. During an interview on 6/17/25 at 4:25 PM, RN 1 indicated the updated comprehensive assessment was completed late for Patient #9 due to a scheduling conflict.		Director of Clinical Services have completedre-orientation of agency's policies pertaining to the requirement on 7/7/25provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the agency policy 9.7.1titled, "Reassessments Update of the Comprehensive Assessment" and theimportance of the requirement to update the comprehensive assessment within 5days of recertification. Citations listed in the clinical record reviews wereaddressed. All staff understood and acknowledged the agency policy 9.7.1titled, "Reassessments Update of the Comprehensive Assessment" and theimportance of the requirement to update the comprehensive assessment within 5days of recertification. All new staff will be oriented of this requirement atthe time of hire. The corrective actions were implemented on 6/23/25 and willbe completed on 7/18/25.	

			Measuresto assure No recurrence: In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and to updatethe comprehensive assessment within 5 days of recertification. The AlternateDirector of Clinical Services will utilize a chart audit tool to ensure to updatethe comprehensive assessment within 5 days of recertification. This process ofutilizing active chart audit tool will help us identify any discrepancies inthe clinical records and re-educate all staff on the above mentionedrequirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective	

			Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure to update the comprehensiveassessment within 5 days of recertification and it is being clearly documentedin the clinical record. The Director of Clinical Services will monitor andreview Alternate Director of Clinical Services' audit findings of all newadmissions and active charts. Reports will be generated and results will becompiled to ensure processes have improved. If any deficiencies are identified,they will continue to be addressed with each personnel as needed. This processwill continue for each week for the next 30 days until 100% compliance isachieved. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audit results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the Quality Committee will continue to audit 20%of clinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a	

			written report to the Governing Bodyquarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0570	Care planning, coordination, quality of care 484.60 Condition of participation: Care planning, coordination of services, and quality of care. Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence. Each patient must receive an individualized written plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. Services must be furnished in accordance with accepted standards of practice. Based on record review and interview, the home health agency failed to ensure the	G0570	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the recertification POC was established and reviewed by theattending physician/practitioner; all verbal orders were recorded in the POC;services were provided only as ordered by a physician or allowed practitioner;the POC was reviewed with the physician or attending practitioner no lessfrequently than once every 60 days; to promptly alert the physician for achange in the patient condition and/or need to alter the POC; provide a plan ofcare to the patient in a timely manner; and provide the patient	2025-07-18

	established and reviewed by the attending physician/practitioner (See G572); failed to ensure all verbal orders were recorded in the POC (See G576); failed to ensure services were provided only as ordered by a physician or allowed practitioner (See G580); failed to ensure the POC was reviewed with the physician or attending practitioner no less frequently than once every 60 days (See G588); failed to promptly alert the physician for a change in the patient condition and/or need to alter the POC (See G590); failed to provide a plan of care to the patient in a timely manner (See G620); and failed to provide the patient and/or caregiver with accurate clinical manager information (See G622). A deficient practice citation was also evidenced at this standard as follows: Findings include: The cumulative effect of these systemic problems had the potential to impact all 165 active patients which resulted in the agency being found out of compliance with the Condition of Participation 42 CFR 484.60		and/orcaregiver with accurate clinical manager information. 35% review of activecharts was completed by week ending 6/28/25. 30% review of active charts was completedby week ending 7/3/25. Remaining 35% review of charts will be completed by weekending 7/12/25 to complete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0570, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policies pertaining to the requirement. The clinicalrecords with the deficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 7/7/25 provided by the Governing Body Chair.	

	Care Planning, Coordination of Services and Quality of Care. Findings include: 1. Patient #15 s clinical record evidenced Patient was discharged from a local hospital on 5/09/2025 and SOC date was 5/12/2025. Patient was referred for SN, PT, and OT services. A POC for the initial certification period of 5/12/2025 7/10/2025 included orders for SN visits three times a week, HHA visits three times a week, a MSW, PT, and OT evaluation. SN interventions included but were not limited to performing wound care to wounds on both heels. The record evidenced a SOC visit was completed on 5/12/2025. RN 4 noted Patient lived alone with no available caregiver, was legally blind with highly impaired ability to see in adequate light, and required assistance with grooming, dressing, bathing, ambulating, and meal set-up. The record failed to evidence a subsequent SN visit was conducted until 5/22/2025, which was 10 days between visits, and failed to evidence a HHA visit nor OT		Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policiesand the importance of the requirement to review that the recertification POCwas established and reviewed by the attending physician/practitioner; allverbal orders were recorded in the POC; services were provided only as orderedby a physician or allowed practitioner; the POC was reviewed with the physicianor attending practitioner no less frequently than once every 60 days; topromptly alert the physician for a change in the patient condition and/or needto alter the POC; provide a plan of care to the patient in a timely manner; andprovide the patient and/or caregiver with accurate clinical manager information.Citations listed in the clinical record reviews were addressed. All staffunderstood and acknowledged the agency policies and the importance of therequirement. All new staff will be oriented of this requirement at the time ofhire.	

	evaluation were conducted while Patient was on services. Patient was discharged from the agency on 5/22/2025 due to hospitalization. 2. Messages sent between home health staff on Secure Messaging App B evidenced the following: a. On 5/09/2025 at 11:44 AM, Intake Manager 7 informed staff to contact Person C, healthcare advocate for Patient, if staff were unable to reach Patient to schedule visits. b. On 5/21/2025 at 8:07 AM, Former Employee D, an OT, informed staff that when speaking with Patient on the phone on 5/20/2025, Patient reported a fall had occurred earlier that day. c. On 5/21/2025 at 3:33 PM 3:38 PM, MSW 1 reported Person C was stressed out as no one is calling [him/her]. MSW 1 reported Person C asked when PT would begin and how Patient s wound care was being performed. d. On 5/21/2025 at 4:24 PM, Scheduler 7 documented Person C called the office upset		The corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that the patient's clinical record contained that the recertificationPOC was established and reviewed by the attending physician/practitioner; allverbal orders were recorded in the POC; services were provided only as orderedby a physician or allowed practitioner; the POC was reviewed with the physicianor attending practitioner no less frequently than once every 60 days; topromptly alert the physician for a change in the patient condition and/or needto alter	

	that nursing has not seen patient since SOC &. e. On 5/22/2025 at 1:38 PM, LPN 1 documented Patient s pain was an 8 out of 10 on a numeric pain scale. The messages failed to evidence nursing and aide staff attempted to contact Person C after being unable to schedule visits with Patient. 3. Clinical records from Entity H, a hospital, evidenced Patient was hospitalized beginning 5/22/2025 due to multiple falls resulting in rib and pubic ramus (one of the bones which makes up the pelvis) fractures. The records indicated Patient had fallen around midnight on 5/22/2025 and remained on the floor until approximately 12:00 PM. 4. During an interview on 6/16/2025 beginning at 8:30 AM, Person C reported they and Patient had no record of calls from agency staff attempting to schedule visits. Person C stated agency staff did not show for visits on multiple occasions. The healthcare advocate reported Patient was unable to perform wound care and did not have daily available caregivers to perform the wound care when SN staff did not come for the		the POC; provide a plan of care to the patient in a timely manner; andprovide the patient and/or caregiver with accurate clinical manager information.The Alternate Director of Clinical Services will utilize a chart audit tool toensure that the patient's clinical record contained that the recertificationPOC was established and reviewed by the attending physician/practitioner; allverbal orders were recorded in the POC; services were provided only as orderedby a physician or allowed practitioner; the POC was reviewed with the physicianor attending practitioner no less frequently than once every 60 days; topromptly alert the physician for a change in the patient condition and/or needto alter the POC; provide a plan of care to the patient in a timely manner; andprovide the patient and/or caregiver with accurate clinical manager information.This process of utilizing active chart audit tool will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement.	

G0572	Plan of care 484.60(a)(1) Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. Based on record review and interview, the agency failed to ensure the recertification POC was established and reviewed by the attending physician/practitioner for 3 of 7 patient records reviewed with a recertification (Patient #2, 4 and 7). Findings include: 1. The undated agency policy Plan of Care-CMS #485 and Physician/ Practitioner Orders each patient must receive the home health services that are written in an individualized plan of care which is established, periodically reviewed (every 60 days or more frequently when indicated by changes in the	G0572	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the recertification POC was established and reviewed by theattending physician/practitioner. 35% review of active charts was completed byweek ending 6/28/25. 30% review of active charts was completed by week ending 7/3/25.Remaining 35% review of charts will be completed by week ending 7/12/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0572, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.10.1, titled "Plan of Care – CMS #485 andPhysician Practitioners Orders and the requirement that the recertification POCmust be established and reviewed by the attending	2025-07-18

	patient s condition) and signed by a physician or authorized practitioner. 2. Patient #2 s clinical record was reviewed on 6/12/25 and evidenced a SOC on 4/03/25 and a current certification period of 6/02/25 to 7/31/25. The record failed to include a recertification POC had been created for the certification period beginning 6/02/25 and failed to include documentation of a verbal or written order for SN services to continue. During an interview on 6/13/25 at 2:45 PM, RN 2 relayed she completed an updated comprehensive assessment on 5/29/25 and she failed to create the recertification POC as she was waiting to hear back from the physician s office. 3. Patient #4 s clinical record was reviewed on 6/12/25 and evidenced a SOC on 3/26/25 and a current certification period of 5/25/25 to 7/23/25. The record evidenced a recertification POC was created on 6/05/25, 13 days after the recertification comprehensive assessment visit and failed to evidence collaboration with the		Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Alternate Administrator, Director of Clinical Services andAlternate Director of Clinical Services have completed re-orientation ofagency's policy pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the agency policy 9.10.1,titled "Plan of Care – CMS #485 and Physician Practitioners Orders and theimportance of the requirement that the recertification POC must be establishedand reviewed by the attending physician/practitioner. Citations listed in theclinical record reviews were addressed. All staff understood and acknowledgedthe agency policies and the importance of the requirement. All new staff willbe oriented of this requirement at the time of hire. The corrective actionswere implemented on 6/23/25 and	

	physician for the recertification POC. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed he thought he collaborated with the physician but was unsure if he documented the collaboration. 4. Patient #7 s clinical record was reviewed on 6/13/25 and evidenced a SOC on 5/19/25 and a ROC on 5/28/25. The record failed to include a ROC POC had been created beginning 5/28/25 and failed to include documentation of a verbal or written order for SN services to continue. During an interview on 6/17/25 at 4:00 PM, RN 2 relayed she thought she spoke with the physician s office for orders but she was unsure. She also confirmed she did not create a ROC POC after the 5/28/25 ROC visit.		will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that the recertification POC is established and reviewed by theattending physician/practitioner. The Alternate Director of Clinical Serviceswill utilize a chart audit tool to ensure that the recertification POC isestablished and reviewed by the attending physician/practitioner and documentedin the clinical record. This process of utilizing active chart audit tool willhelp us identify any discrepancies in the clinical records and re-educate allstaff on the above mentioned requirement.	

			Monitoring: In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure the recertification POC is establishedand reviewed by the attending physician/practitioner and is being documented inthe clinical record. The Director of Clinical Services will monitor and reviewAlternate Director of Clinical Services' audit findings of all new admissionsand active charts. Reports will be generated and results will be compiled toensure processes have improved. If any deficiencies are identified, they willcontinue to be addressed with each personnel as needed. This process willcontinue for each week for the next 30 days until 100% compliance is achieved.After 30 days, this process will continue to be monitored on a quarterly basisand will be included in the quarterly chart audit review. Quarterly auditresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the	

			Quality Committee will continue to audit 20% of clinicalrecords quarterly to ensure compliance is maintained. The Administrator andQAPI Committee will send a written report to the Governing Body quarterly fortheir recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0576	All orders recorded in plan of care 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. Based on record review and interview, the home health agency failed to ensure all verbal orders were recorded in the POC according to agency policy for 5 of 16 records reviewed (Patients #5, 6, 7, 10, 15). 5. Patient #7 s clinical record evidenced a SOC on 5/19/25 and a ROC on 6/03/25. The record included a verbal order	G0576	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that all verbal orders were recorded in the POC. 35% review of activecharts was completed by week ending 6/28/25. 30% review of active charts was completedby week ending 7/3/25. Remaining 35% review of charts will be completed by weekending 7/12/25 to complete 100% audit of all active chart audits.	2025-07-18

	for Patient s ROC, documented on 6/03/25 by RN 2. The order failed to evidence the person who provided the order to RN 2. During an interview on 6/17/25 at 4:00 PM, RN 2 relayed she collaborated with the physician regarding the ROC and documented the order in a communication note on 6/09/25. She confirmed the communication notes are not sent to the physician for signature. During an interview on 6/13/25 at 1:27 PM, the CM relayed all verbal orders should be placed on a physician s order form that is sent to the physician for signature and he verified the communication notes are not sent to the physician. 3. Patient #6 s medical record evidenced documentation of two verbal orders. One dated 05/22/2025 for wound care, documented by RN 2. The other for the resumption of care dated 06/13/2025, documented by RN 2. The orders failed to evidence who gave the verbal orders to RN 2. During an interview on		In orderto correct the above deficiency cited under G0576, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policies titled, 9.10.1, titled "Plan of Care – CMS #485and 11.9.1 Physician Practitioner Orders – Verbal Orders pertaining to therequirement. The clinical records with the deficiencies were identified andreviewed. The Administrator, Alternate Administrator, Director of ClinicalServices and Alternate Director of Clinical Services have completedre-orientation of agency's policies pertaining to the requirement on 7/7/25provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policiestitled, 9.10.1, titled "Plan of Care – CMS #485 and 11.9.1 PhysicianPractitioner Orders –	

	06/19/2025 at 02:20 PM, RN 2 indicated verbal orders required the name of the person giving the verbal order. 6. Patient #12 s clinical record evidenced an Order for Delay in SOC Verbal Order dated 05/19/2025. RN 1 completed the order, which stated, Delay SOC, Unable to reach pt [patient] . During an interview on 06/18/2025 at 12:30 PM, RN 1 indicated the order was not documented as a verbal order as it did not include that the order was read back and verified. During an interview on 6/18/2025 at 1:25 PM, the Administrator explained they did not get an order from the physician to delay the SOC; this was to let the physician know the assessment would not be completed in 48 hours. The Administrator indicated an internal communication process caused the delay. Findings include: 1. The undated agency policy Plan of Care CMS #485 and		Verbal Orders and the importance of the requirement to ensurethat all verbal orders were recorded in the POC. Citations listed in theclinical record reviews were addressed. All staff understood and acknowledgedthe agency policies and the importance of the requirement. All new staff willbe oriented of this requirement at the time of hire. The corrective actionswere implemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that all verbal orders were recorded in the POC. The Alternate Directorof Clinical Services will utilize a chart audit tool to ensure that all verbalorders	

	indicated all patient care orders, including verbal orders, must be recorded in the plan of care. Verbal orders were to be put in writing, signed, timed and dated with the date of receipt by an RN or therapist & It is the RN s or therapist s responsibility to make any necessary revisions to the Plan of Care based on that order(s). 2. The agency policy Physician/Practitioner Orders Verbal Orders, dated 11/22/2023, indicated all verbal orders should be written down, read back to verify order and receive confirmation from individual who gave [the] order. A record of this order is documented on a supplemental order form. All orders include: & Physician/practitioner s name. Date and time the order is taken. The signature of the person taking the order. The specific orders(s) &. 5. Patient #10 s clinical record evidenced a SOC of 4/23/2025. The record included a verbal order for delay in SOC, dated as received on 4/23/2025 and documented on 6/15/2025 by RN 2. The order failed to		were recorded in the POC and documented in the clinical record. Thisprocess of utilizing active chart audit tool will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure that all verbal orders were recordedin the POC and documented in the clinical record. The Director of ClinicalServices will monitor and review Alternate Director of Clinical Services' auditfindings of all new admissions and active charts. Reports will be generated andresults will be compiled to ensure processes have improved. If any deficienciesare identified, they will continue to be addressed with each personnel asneeded. This process will continue for each week for the next 30 days	

	provided the order to RN 2. During an interview on 6/19/2025 beginning at 2:13 PM, RN 2 could not recall who provided the order to begin services for Patient. 7. Patient #15 s clinical record evidenced a SOC of 5/12/2025. The record included a verbal order for delay in SOC documented on 5/13/2025 by RN 4. The order failed to evidence the person who provided the order to RN 4. During an interview on 6/17/2025 beginning at 2:05 PM, RN 4 could not recall who provided the order to delay the SOC for Patient.		until100% compliance is achieved. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audit results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the Quality Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0580	Only as ordered by a physician 484.60(b)(1)	G0580	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure services were provided only as	2025-07-18

	Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. Based on record review and interview, the home health agency failed to ensure services were provided only as ordered by a physician or allowed practitioner for 6 of 7 active patient records reviewed with wounds (Patient #1, 2, 4, 7, 9 and 11) and 1 of 1 patient record reviewed with a home visit observation with a PTA (Patient #10). Findings include: 1. The undated agency policy Plan of Care-CMS #485 and Physician/ Practitioner Orders each patient must receive the home health services that are written in an individualized plan of care which is established, periodically reviewed (every 60 days or more frequently when indicated by changes in the patient s condition) and signed by a physician or authorized practitioner. 2. Patient 1 s clinical record included a POC for certification period 5/13/25 to 7/11/25 with orders for SN visit frequencies of three times a week for five weeks effective 5/13/25; PT visit		ordered by a physician or allowedpractitioner. 35% review of active charts was completed by week ending 6/28/25.30% review of active charts was completed by week ending 7/3/25. Remaining 35%review of charts will be completed by week ending 7/12/25 to complete 100%audit of all active chart audits. In orderto correct the above deficiency cited under G0580, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policies titled, 9.10.1, titled “Plan of Care – CMS #485and 11.9.1 Physician Practitioner Orders – Verbal Orders pertaining to therequirement. The clinical records with the deficiencies were identified andreviewed. The Administrator, Alternate Administrator, Director of ClinicalServices and Alternate Director of Clinical Services have completedre-orientation of agency’s policies pertaining to the requirement on 7/7/25provided by the	

	frequencies of one time a week for one week, two times a week for three weeks and one time a week for one week effective 5/26/25 and OT visit frequencies of one time a week for one week, two times a week for three weeks and one time a week for one week effective 5/15/25 . The record evidenced PT visits were performed on 5/26/25, 6/03/25, 6/05/25, 6/10/25 and 6/12/25 and OT visits were performed on 5/15/25, 5/19/25, 5/22/25, 5/27/25, 5/28/25, 6/02/25, 6/06/25 and 6/09/25. The clinical record for Patient #1 failed to include a verbal or signed written order for PT and OT frequencies was obtained prior to the above visits performed. During an interview on 6/13/25 at 1:45 PM, OT 2 relayed she did not collaborate with the physician after the OT Evaluation, and the office faxed the OT POC to the physician for signature.		Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policiestitled, 9.10.1, titled "Plan of Care – CMS #485 and 11.9.1 PhysicianPractitioner Orders – Verbal Orders and the importance of the requirement toensure services were provided only as ordered by a physician or allowedpractitioner. Citations listed in the clinical record reviews were addressed.All staff understood and acknowledged the agency policies and the importance ofthe requirement. All new staff will be oriented of this requirement at the timeof hire. The corrective actions were implemented on 6/23/25 and will becompleted on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing "Home Health Notify", a HIPAA	

	During an interview on 6/13/25 at 1:54 PM, PT 1 relayed she created the PT POC and it was sent to the physician for signature. 3. Patient 2 s clinical record included a POC for certification period 6/02/25 to 7/31/25 with orders for SN visit frequencies of two times a week for four weeks effective 6/02/25; PT visit frequencies of two times a week for four weeks effective 6/02/25 and OT visit frequencies of two times a week for four weeks effective 5/30/25. The record evidenced SN visits were performed on 6/02/25, 6/05/25, 6/09/25 and 6/12/25; PT visits were performed on 6/02/25, 6/06/25 and 6/09/25 and OT visits were performed on 6/02/25 and 6/06/25. The clinical record for Patient #2 failed to include a verbal or signed written order for SN, PT and OT frequencies was obtained prior to the above visits performed.		application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure services were provided only as ordered by a physician or allowedpractitioner. The Alternate Director of Clinical Services will utilize a chartaudit tool to ensure services were provided only as ordered by a physician orallowed practitioner and documented in the clinical record. This process ofutilizing active chart audit tool will help us identify any discrepancies inthe clinical records and re-educate all staff on the above mentionedrequirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure services were provided only asordered by a physician or allowed practitioner and documented in the	

	During an interview on 6/13/25 at 2:42 PM, OT 3 relayed she writes up the evaluation visit and order for OT services and it is sent to the physician for signature. During an interview on 6/13/25 at 2:30 PM, PT 2 relayed he completed the PT reevaluation on 5/29/25 and thought he called the physician for orders. He also relayed the nurse is responsible for sending it to the physician for orders. During an interview on 6/13/25 at 2:45 PM, RN 2 relayed she didn t have time to complete the recertification comprehensive visit note from 5/29/25 and she was unsure if she received a physician s order for the above SN visit frequencies. 4. Patient 4 s clinical record included a POC for certification period 5/25/25 to 7/23/25 with orders for SN visit frequencies of three times a week for two weeks then two times a week for two weeks effective 5/26/25. The record evidenced SN visits were performed on 5/31/25 and 6/02/25. The clinical record for Patient #4 failed to include a		clinicalrecord. The Director of Clinical Services will monitor and review AlternateDirector of Clinical Services' audit findings of all new admissions and activecharts. Reports will be generated and results will be compiled to ensureprocesses have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue foreach week for the next 30 days until 100% compliance is achieved. After 30days, this process will continue to be monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. TheDirector of Clinical Services	

	verbal or signed written order for SN frequencies was obtained prior to the above visits performed. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed he could not remember if he received a call back from the physician s office with orders for the recertification POC frequencies. 5. Patient 7 s clinical record included a ROC on 6/03/25 with orders for SN visit frequencies of two times a week for one week, three times a week for five weeks and then two times a week for one week effective 6/03/25; a PT evaluation and treat effective 6/10/25 and an OT evaluation and treat effective 6/10/25. The record evidenced SN visits were performed on 6/03/25, 6/06/25, 6/09/25, 6/10/25 and 6/13/25 and PT and OT evaluations were performed on 6/12/25. The clinical record for Patient #7 failed to include a verbal or signed written order for the ROC frequencies was obtained prior to the above visits performed. During an interview on 6/17/25		will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	

	at 4:00 PM, RN 2 relayed she collaborated with the physician regarding the ROC and documented it in a communication note on 6/09/25. She confirmed the communication notes were not sent to the physician for signature. During an interview on 6/13/25 at 1:27 PM, the CM relayed all verbal orders should be placed on a physician s order form that is sent to the physician for signature and he verified the communication notes are not sent to the physician. 6. Patient 9 s clinical record included a POC for certification period 5/06/25 to 7/04/25 with orders for SN visit frequencies of two times a week for one week then three times a week for three weeks; HHA visit frequencies of two times a week for four weeks; PT re-eval and treat; and OT visit frequencies of one time a week for one week, two times a week for three weeks and one time a week for one week. The record evidenced SN visits were performed on 5/07/25, 5/09/25, 5/12/25, 5/14/25, 5/16/25,			

	5/26/25, 5/28/25, 5/30/25, 6/03/25, 6/05/25, 6/07/25, 6/09/25, 6/11/25, 6/13/25 and 6/16/25; HHA visits were performed on 5/09/25, 5/23/25, 5/24/25, 5/30/25, 5/31/25, 6/07/25 and 6/13/25; and OT visits were performed on 5/06/25, 5/08/25, 5/12/25, 5/15/25, 5/19/25, 5/22/25 and 5/26/25 . The clinical record for Patient #9 failed to include a verbal or signed written order for SN frequencies was obtained prior to the above visits performed. During an interview on 6/13/25 at 1:45 PM, OT 2 relayed she created a physician s order after the 5/02/25 OT reevaluation and it was sent to the physician for signature. During an interview on 6/17/25 at 4:25 PM, RN 1 relayed she was unsure if she spoke with the physician for the recertification POC. .Patient #11 s medical record evidenced a physician order dated 05/14/2025 for a SN frequency change. The new SN frequency was one visit for one week (effective 05/14/2025), 2			

visits for one week.

Patient #11 received SN visits on 05/27/2025, 05/29/2025, 06/03/2025, 06/04/2025, 06/09/2025, 06/11/2025, and 06/16/2025.

During an interview on 06/18/2025, RN 1 indicated this was not a verbal order, but an order request which was faxed to the physician. RN 1 indicated the order was not valid without a verbal order or a signed order from the physician. SN services were provided without an order.

6. Patient #10 s clinical record evidenced a SOC of 4/23/2025. Patient was to receive one PT visit for one week then two PT visits for four weeks. On 5/22/2025, PT 2 completed a PT re-evaluation visit and documented a physician order to continue PT services for another four weeks. The record failed to evidence the order was signed by Patient s physician.

A home visit observation was conducted on 6/16/2025 beginning at 1:38 PM with Patient. PTA 5 was observed performing a PTA visit with Patient.

	During an interview on 6/19/2025 beginning at 11:15 AM, PT 2 reported he did not obtain a verbal order to continue Patient s therapy services. PT 2 stated Patient s initial order for PT services covered all subsequent continuation orders, so a verbal order to continue services was not needed.			
G0584	Verbal orders 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. Based on record review and interview, the home health agency failed to ensure all verbal orders were authenticated and signed by the ordering physician or	G0584	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure all verbal orders were authenticated and signed by the orderingphysician or practitioner within 30 days. 35% review of active charts wascompleted by week ending 6/28/25. 30% review of active charts was completed byweek ending 7/3/25. Remaining 35% review of charts will be completed by weekending 7/12/25 to complete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0584, during the managementmeeting on	2025-07-18

	practitioner within 30 days for 2 of 14 complete records reviewed (Patients #10, #15). Findings include: 1. The agency policy Physician/Practitioner Orders Verbal Orders, dated 11/22/2023, indicated after a verbal order was documented, it was to be sent to the physician for signature and authentication. 2. The agency QAPI documentation for 2025 evidenced the agency tracked the number of verbal orders received authenticated and signed from the ordering physician within 30 days. 3. Patient #10 s clinical record evidenced a SOC of 4/23/2025. The record evidenced the following verbal orders were obtained: a. An order to delay SOC, dated 4/23/2025 and signed by RN 2. The order was entered in the EMR by RN 2 on 6/15/2025. b. An order to begin home health services, including a PT and OT evaluation, dated 4/23/2025 and signed by RN 2.		7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 11.9.1 Physician Practitioner Orders – VerbalOrders pertaining to the requirement. The clinical records with thedeficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policy pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy 11.9.1Physician Practitioner Orders – Verbal Orders and the importance of therequirement to ensure all verbal orders were authenticated and signed by theordering physician or practitioner within 30 days. Citations listed in theclinical record reviews were addressed.	

	c. An order to begin PT visits and for the PT portion of the POC, dated 4/24/2025 and signed by PT 2. d. An order to begin OT visits, dated 4/28/2028 and signed by OT 6. The record failed to evidence the ordering physician authenticated and signed the verbal orders within 30 days. During an interview on 6/18/2025 beginning at 1:32 PM, Alternate Administrator reported the agency had no signed verbal orders for Patient. 4. Patient #10 s clinical record evidenced a SOC of 5/12/2025. The record evidenced the following verbal orders were obtained: a. An order to delay SOC, dated 5/13/2025 by RN 4. b. An order to begin home health services, including SN and HHA frequencies and a PT, OT, and MSW evaluation, dated 5/13/2025 by RN 4. The record failed to evidence the ordering physician		All staff understood and acknowledgedthe agency policies and the importance of the requirement. All new staff willbe oriented of this requirement at the time of hire. The corrective actionswere implemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure all verbal orders were authenticated and signed by the orderingphysician or practitioner within 30 days. The Alternate Director of ClinicalServices will utilize a chart audit tool to ensure all verbal orders were authenticatedand signed by the ordering physician or practitioner within 30 days and	

	verbal orders within 30 days. During an interview on 6/18/2025 beginning at 1:32 PM, Alternate Administrator reported the agency had no signed verbal orders for Patient. 5. During an interview on 6/19/2025 beginning at 1:42 PM, Administrator reported verbal orders were to be authenticated and signed by the ordering physician within 30 60 days.		placedin the clinical record. This process of utilizing active chart audit tool willhelp us identify any discrepancies in the clinical records and re-educate allstaff on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure all verbal orders were authenticatedand signed by the ordering physician or practitioner within 30 days and placedin the clinical record. The Director of Clinical Services will monitor andreview Alternate Director of Clinical Services' audit findings of all newadmissions and active charts. Reports will be generated and results will becompiled to ensure processes have improved. If any deficiencies are identified,they will continue to be addressed with each personnel as needed. This processwill continue for	

			each week for the next 30 days until 100% compliance isachieved. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audit results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the Quality Committee will continue to audit 20%of clinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0588	Reviewed, revised by physician every 60 days 484.60(c)(1) The individualized plan of care must be reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the HHA as	G0588	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure the POC was reviewed with the	2025-07-18

	frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. Based on record review and interview, the home health agency failed to ensure the POC was reviewed with the physician or attending practitioner no less frequently than once every 60 days, for 4 of 6 active records reviewed with a recertification (Patient #1, 2, 7 and 9). Findings include: 1. The undated agency policy Plan of Care-CMS #485 and Physician/ Practitioner Orders indicated recertification of the Plan of Care is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and the individualized plan of care must be reviewed and revised by the physician/practitioner who is responsible for the home health plan of care and the agency as frequently as the patient s condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. 2. Patient #2 s clinical record was reviewed on 6/12/25 and evidenced a SOC on 4/03/25		physician or attending practitioner noless frequently than once every 60 days and the 60 Day Summary was sent to theattending physician at least every 60 days. 35% review of active charts wascompleted by week ending 6/28/25. 30% review of active charts was completed byweek ending 7/3/25. Remaining 35% review of charts will be completed by weekending 7/12/25 to complete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0588, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.10.1, titled “Plan of Care – CMS #485 andPhysician Practitioners Orders and the requirement that the POC was reviewedwith the physician or attending practitioner no less frequently than once every60 days. The clinical records with the deficiencies were identified andreviewed. The Administrator, Alternate Administrator,	

	and a current certification period of 6/02/25 to 7/31/25. The record failed to include a recertification POC had been created for the certification period beginning 6/02/25. Additional record review on 6/16/25 evidenced a POC had been created for the certification period 6/02/25 to 7/31/25. The record failed to include collaboration with the physician for the recertification POC and failed to evidence the recertification POC and 60 Day Summary were sent to the attending physician at least every 60 days. During an interview on 6/13/25 at 2:45 PM, RN 2 relayed she completed an updated comprehensive assessment on 5/29/25 and she failed to create the recertification POC as she was waiting to hear back from the physician s office. She relayed that she created the POC on 6/12/25 in the evening and she was unsure if she received orders from the physician. 3. Patient #4 s clinical record evidenced a SOC on 3/26/25 and a POC for the certification		Director of ClinicalServices and Alternate Director of Clinical Services have completed re-orientationof agency's policy pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the agency policy 9.10.1,titled "Plan of Care – CMS #485 and Physician Practitioners Orders and theimportance of the requirement that the POC was reviewed with the physician orattending practitioner no less frequently than once every 60 days. Citationslisted in the clinical record reviews were addressed. All staff understood andacknowledged the agency policies and the importance of the requirement. All newstaff will be oriented of this requirement at the time of hire. The correctiveactions were implemented on 6/23/25 and will be completed on 7/18/25.	

	The record failed to include collaboration with the physician for the recertification POC and failed to evidence the recertification POC and 60 Day Summary were sent to the attending physician at least every 60 days. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed he thought he collaborated with the physician but was unsure if he documented the collaboration. 4. Patient #7 s clinical record evidenced a SOC on 5/19/25 and included a ROC POC effective 6/03/25. The ROC indicated the patient was to receive an OT evaluation and treat visit and a PT evaluation and treat visit. The clinical record evidenced the OT evaluation was completed by OT 3 on 6/12/25 and the PT evaluation was completed by PT 2 on 6/12/25. The record failed to evidence collaboration with the physician after the OT and PT evaluations for the POC. During an interview on 6/13/25 at 2:42 PM, OT 3 confirmed that she did not collaborate with the physician for the ROC POC and		**Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that the POC was reviewed with the physician or attending practitionerno less frequently than once every 60 days. The Alternate Director of ClinicalServices will utilize a chart audit tool to ensure that the POC was reviewedwith the physician or attending practitioner no less frequently than once every60 days and documented in the clinical record. This process of utilizing activechart audit tool will help us identify any discrepancies in the clinicalrecords and re-educate all staff on the above mentioned requirement. **Monitoring:** In orderto ensure	

	relayed she writes up the evaluation and physician orders and it is sent to the physician via the computer. She was unsure if any orders had been received back from the physician's office. During an interview on 6/13/25 at 2:30 PM, PT 2 confirmed he did not collaborate with the physician for the PT POC. He relayed he created the PT POC and it was sent to the physician. 5. Patient #9 s clinical record evidenced a SOC on 11/07/24 and a POC for the certification period of 5/06/25 to 7/04/25. The record failed to include collaboration with the physician for the recertification POC and failed to evidence the recertification POC and 60 Day Summary were sent to the attending physician at least every 60 days. During an interview on 6/17/25 at 4:25 PM, RN 1 relayed she was unsure if she spoke with the physician for the recertification POC.		implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure the POC was reviewed with thephysician or attending practitioner no less frequently than once every 60 daysand is being documented in the clinical record. The Director of ClinicalServices will monitor and review Alternate Director of Clinical Services' auditfindings of all new admissions and active charts. Reports will be generated andresults will be compiled to ensure processes have improved. If any deficienciesare identified, they will continue to be addressed with each personnel asneeded. This process will continue for each week for the next 30 days until100% compliance is achieved. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audit results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the Quality Committee willcontinue to audit 20% of clinical records	

			quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Director of Clinical Services will beresponsible for corrective action of this deficiency, measure to assure norecurrence and monitoring of this deficiency.	
G0590	Promptly alert relevant physician of changes 484.60(c)(1) The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered. Based on record review and interview, the home health agency failed to promptly alert the physician for a change in the patient condition and/or need to alter the POC for 1 of 1 record reviewed which evidenced a patient fall (Patient #15) and 2 of 4 records reviewed which evidenced missed visits (Patient #4, #15). 2. Patient #4 s clinical record evidenced a SOC date of 3/26/25 and included a POC for the certification period 5/25/25	G0590	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure to promptly alert the physician for a change in the patient conditionand/or need to alter the POC. 35% review of active charts was completed by weekending 6/28/25. 30% review of active charts was completed by week ending 7/3/25.Remaining 35% review of charts will be completed by week ending 7/12/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0590, during the managementmeeting on	2025-07-18

	visits three times a week for two weeks and then two times a week for two weeks effective 5/26/25. The record indicated SN missed visits were documented on 5/27/25 and 5/28/25. The record failed to evidence Patient #4 s physician was notified of the missed visits. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed he did collaborate with the physician regarding the missed visits. During an interview on 6/18/25 at 1:37 PM, Patient #4 relayed he was not notified in advance of the missed visits. He was frustrated with the home health agency due to several missed visits and not receiving wound care when needed and he requested to be transferred to another home health agency. Findings include: 1. The agency policy Notification of Physician Regarding Missed Visits, dated 02/2024, indicated a missed visit which could not be rescheduled was to be communicated to the physician. Staff were to document the time faxed, the time and person		7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.38.1, titled “Notification to Physician RegardingMissed Visits” and the requirement to ensure to promptly alert the physicianfor a change in the patient condition and/or need to alter the POC. Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Alternate Administrator, Director of Clinical Services andAlternate Director of Clinical Services have completed re-orientation ofagency’s policy pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the agency policy 9.38.1,titled “Notification to Physician Regarding Missed Visits” and the requirement toensure to promptly alert the physician for a change in the patient	

	notice was mailed. 3. Patient #15 s clinical record evidenced a SOC date of 5/12/2025. Patient s POC included service orders for SN visits three times a week, HHA visits three times a week, and PT, OT, and MSW evaluations. The record indicated a SN missed visit was documented on 5/15/2025, Patient did not receive a SN visit between 5/12/2025 5/22/2025, and a HHA missed visit was documented on 5/19/2025 and 5/21/2025. The record failed to evidence Patient s physician was notified of the missed visits. During an interview on 6/17/2025 beginning at 11:17 AM, LPN 1 reported when she arrived for Patient s SN visit on 5/22/2025, Patient was found on the floor and reported they have fallen. The record indicated on 5/22/2025, LPN 1 documented she was present at Patient s home for a visit. The record failed to evidence the nurse notified Patient s physician of the fall. During an interview on		conditionand/or need to alter the POC. Citations listed in the clinical record reviewswere addressed. All staff understood and acknowledged the agency policies andthe importance of the requirement. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 6/23/25and will be completed on 7/18/25. **Measuresto assure No recurrence:** In order toensure that there is no recurrence of this deficiency, the Agency is utilizing"Home Health Notify", a HIPAA compliant communication application for theAgency, clinicians, inter-disciplinary teams, Patients, Physicians and Externalorganizations to ensure real-time visibility into patient care and to ensure topromptly alert the physician for a change in the patient condition and/or needto alter the POC. The Alternate Director of Clinical Services will utilize achart audit tool to ensure to promptly alert the physician for a change in thepatient condition and/or	

	AM, LPN 1 reported she did not report the missed SN visits to Patient s physician. During an interview on 6/18/2025 beginning at 12:42 PM, HHA 2 stated she reported the missed aide visits to staff at the agency, but could not recall to whom.		need to alter the POC and it is documented in theclinical record. This process of utilizing active chart audit tool will help usidentify any discrepancies in the clinical records and re-educate all staff onthe above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to promptly alert the physician for a change inthe patient condition and/or need to alter the POC and is being documented inthe clinical record. The Director of Clinical Services will monitor and reviewAlternate Director of Clinical Services' audit findings of all new admissionsand active charts. Reports will be generated and results will be compiled toensure processes have improved. If any deficiencies are identified, they willcontinue to be addressed with each personnel as needed.	

			This process willcontinue for each week for the next 30 days until 100% compliance is achieved.After 30 days, this process will continue to be monitored on a quarterly basisand will be included in the quarterly chart audit review. Quarterly auditresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the Quality Committee will continue to audit 20% of clinicalrecords quarterly to ensure compliance is maintained. The Administrator andQAPI Committee will send a written report to the Governing Body quarterly fortheir recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0620	Other pertinent instructions 484.60(e)(4) Any other pertinent instruction related to the	G0620	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical	2025-07-18

	patient's care and treatments that the HHA will provide, specific to the patient's care needs. Based on record review and interview, the home health agency failed to provide a plan of care to the patient in a timely manner for 2 of 6 home visit observations (Patients #10, #13). 2. Patient #13 s clinical record evidenced a SOC date of 6/10/25 and included a POC for the certification period 6/10/25 to 8/08/25. The record evidenced Patient #13 received SN and OT visits on 6/13/25. During an interview with Patient #13 on 6/16/25 beginning at 1:45 PM, Patient #13 relayed an unidentified person from the home health agency came in to her home unannounced and dropped off a copy of the POC a few minutes before the home visit was scheduled. She was able to show the POC to Surveyor during the home visit observation and was questioning what the document was. Findings include: 1. Patient #10 s clinical record evidenced a SOC date of 4/23/2025. RN 2 conducted a comprehensive assessment on 4/23/2025. A POC for the initial		records on 6/23/25to ensure that the plan of care is provided to the patient in a timely manner. 35%review of active charts was completed by week ending 6/28/25. 30% review ofactive charts was completed by week ending 7/3/25. Remaining 35% review ofcharts will be completed by week ending 7/12/25 to complete 100% audit of allactive chart audits. In orderto correct the above deficiency cited under G0620, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.13.1 “Coordination of Patient Care” and therequirement to ensure that the plan of care is provided to the patient in atimely manner. The clinical records with the deficiencies were identified andreviewed. The Administrator, Alternate Administrator, Director of ClinicalServices and Alternate Director of Clinical Services have completed re-orientationof agency’s policy	

	certification period of 4/23/2025 6/21/2025 evidenced Patient was to receive PT and OT services. During a home visit observation on 6/16/2025 beginning at 1:38 PM, Patient #10 had a manilla folder laying on their kitchen table, which included a POC for the certification period of 4/23/2025 6/21/2025. During an interview on 6/16/2025 beginning at 2:32 PM, Patient reported approximately half an hour prior to the start of the home visit observation, an unknown female employee of the agency came to Patient s home and gave Patient the file folder with the POC. Patient reported the employee told him/her that the papers within the folder would be needed for the home visit observation. Patient stated the agency had not previously provided a POC. During an interview on 6/19/2025 beginning at 2:27 PM, RN 2 reported it was the office staff s responsibility to provide the POC to Patient.		pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. All active patients will be provided copy of current planof care and acknowledgement document will be placed in patient clinical recordsand all newly admitted patients will be provided with copy of current plan ofcare in a timely manner. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the agency policy 9.13.1 “Coordinationof Patient Care” and the requirement to ensure that the plan of care isprovided to the patient in a timely manner. Citations listed in the clinicalrecord reviews were addressed. All staff understood and acknowledged the agencypolicies and the importance of the requirement. All new staff will be orientedof this requirement at the time of hire. The corrective actions wereimplemented on 6/23/25 and will be completed on 7/18/25.	

			Measuresto assure No recurrence: In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and agencypolicy 9.13.1 “Coordination of Patient Care” and the requirement to ensure thatthe plan of care is provided to the patient in a timely manner. The AlternateDirector of Clinical Services will utilize a chart audit tool agency policy 9.13.1“Coordination of Patient Care” and the requirement to ensure that the plan ofcare is provided to the patient in a timely manner and it is documented in theclinical record. This process of utilizing active chart audit tool will help usidentify any discrepancies in the clinical records and re-educate all staff onthe above mentioned requirement.	

			Monitoring: In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis agency policy 9.13.1 "Coordination of Patient Care"and the requirement to ensure that the plan of care is provided to the patientin a timely manner and is being documented in the clinical record. The Directorof Clinical Services will monitor and review Alternate Director of ClinicalServices' audit findings of all new admissions and active charts. Reports willbe generated and results will be compiled to ensure processes have improved. Ifany deficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for each week for the next 30days until 100% compliance is achieved. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly chart audit review. Quarterly audit results will be compiled and sentto the QAPI Committee for	

			review. Once threshold is met, the Quality Committeewill continue to audit 20% of clinical records quarterly to ensure complianceis maintained. The Administrator and QAPI Committee will send a written reportto the Governing Body quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0622	Name/contact information of clinical manager 484.60(e)(5) Name and contact information of the HHA clinical manager. Based on observation, document review and interview, the home health agency failed to provide the patient and/or caregiver with accurate clinical manager information for 9 of 9 active patients reviewed with SOC in the past 90 days (Patient #1, 2, 3, 4, 5, 7, 10, 12 and 13).	G0622	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the patient and/or caregiver is provided with accurate clinicalmanager contact information. 35% review of active charts was completed by weekending 6/28/25. 30% review of active charts was completed by week ending 7/3/25.Remaining 35% review of charts will be completed by	2025-07-18

	Findings include: 1. During a home visit observation with Patient #1 on 6/13/24 at 9:27 AM, the home health agency s folder was reviewed and included a copy of a document titled Admission Instructions to Patient which was signed by Patient #1 on 5/13/25 during the SOC visit. The document failed to evidence the correct name and contact information of the clinical manager. 2. Patient #2 s clinical record included a document titled Admission Instructions to Patient which was signed by Patient #2 on 4/03/25 during the SOC visit. The document failed to evidence the correct name and contact information of the clinical manager. 3. Patient #3 s clinical record included a document titled Admission Instructions to Patient which was signed by Patient #3 on 5/06/25 during the SOC visit. The document failed to evidence the correct name and contact information of the clinical manager. 4. Patient #4 s clinical record included a document titled		week ending 7/12/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0622, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.13.1 “Coordination of Patient Care” and therequirement to ensure that the patient and/or caregiver is provided withaccurate clinical manager contact information. The clinical records with thedeficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency’s policy pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. The Administratorhas also updated the “Admission Instructions to Patient” document in theAdmission packet to reflect accurate clinical manager contact information. Allactive	

	Admission Instructions to Patient which was signed by Patient #4 on 3/26/25 during the SOC visit. The document failed to evidence the correct name and contact information of the clinical manager. 6. Patient #7 s clinical record included a document titled Admission Instructions to Patient which was signed by Patient #7 on 5/19/25 during the SOC visit. The document failed to evidence the correct name and contact information of the clinical manager. 7. Patient #3 s clinical record included a document titled Admission Instructions to Patient which was signed by Patient #3 on 5/06/25 during the SOC visit. The document failed to evidence the correct name and contact information of the clinical manager. 10. During a home visit observation with Patient #13 on 6/16/24 at 1:45 PM, the home health agency s folder was reviewed and included a copy of a document titled Admission		patients will be provided accurate contact information for clinicalmanager and acknowledgement document will be placed in patient clinical recordsand all newly admitted patients will be provided with updated Admission Packetthat contains accurate contact information for clinical manager. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the agency policy 9.13.1 “Coordinationof Patient Care” and the requirement to ensure that the patient and/orcaregiver is provided with accurate clinical manager contact information. Citationslisted in the clinical record reviews were addressed. All staff understood andacknowledged the agency policies and the importance of the requirement. All newstaff will be oriented of this requirement at the time of hire. The correctiveactions were implemented on 6/23/25 and will be completed on 7/18/25.	

	Instructions to Patient which was signed by Patient #13 on 6/10/25 during the SOC visit. The document failed to evidence the correct name and contact information of the clinical manager. 11. During an interview on 6/12/25 at 11:25 AM, the Alternate Administrator verified the current clinical manager. She also confirmed the patient handbook had incorrect CM information. 12. During an interview on 6/13/25 at 1:27 PM, the CM verified the clinical manager listed in the patient s home binder was inaccurate and indicated the patients should have been given the correct information to include the current clinical manager s name and contact information. 5. Patient #5 s medical record evidenced an undated document titled Admission Instructions to Patient. The document signed by Patient #5 on 03/14/2025 included the contact information for the former Clinical Manager. The current Clinical Manager took the position on 03/10/2025.		**Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing "Home Health Notify", a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and agencypolicy 9.13.1 "Coordination of Patient Care" and the requirement to ensure thatthe patient and/or caregiver is provided with accurate clinical manager contactinformation. The Alternate Director of Clinical Services will utilize a chartaudit tool agency policy 9.13.1 "Coordination of Patient Care" and therequirement to ensure that the patient and/or caregiver is provided withaccurate clinical manager contact information. This process of utilizing activechart audit tool will help us identify any discrepancies in the clinicalrecords and re-educate all staff on the above mentioned requirement.	

	The agency failed to notify patients of the contact information of the current clinical manager. 8. Patient #12 s medical record evidenced an undated document titled Admission Instructions to Patient. The document, signed by Patient #12 on 05/19/2025, included the contact information for the former Clinical Manager. The current Clinical Manager took the position on 03/10/2025. The agency failed to notify patients of the contact information of the current clinical manager. 7. Patient #10 s clinical record included a document titled Admission Instructions to Patient, which was signed by Patient #10 on 4/23/2025 during the SOC visit. The document failed to evidence the correct name and contact information of the clinical manager. During a home visit observation on 6/16/2025 beginning at 1:38 PM, the home health agency s folder was reviewed. The handbook evidenced Former Clinical Manager 3 was listed as		**Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis agency policy 9.13.1 “Coordination of PatientCare” and the requirement to ensure that the patient and/or caregiver isprovided with accurate clinical manager contact information and is beingdocumented in the clinical record. The Director of Clinical Services willmonitor and review Alternate Director of Clinical Services’ audit findings ofall new admissions and active charts. Reports will be generated and resultswill be compiled to ensure processes have improved. If any deficiencies areidentified, they will continue to be addressed with each personnel as needed.This process will continue for each week for the next 30 days until 100%compliance is achieved. After 30 days, this process will continue to be monitoredon a quarterly basis and will be	

	the agency s clinical manager. 10. Patient #15 s clinical record included a document titled Admission Instructions to Patient, which was signed by Patient #10 on 5/12/2025 during the SOC visit. The document failed to evidence the correct name and contact information of the clinical manager.		included in the quarterly chart audit review.Quarterly audit results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the Quality Committee will continue to audit 20%of clinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0642	Program scope 484.65(a)(1),(2) Standard: Program scope. (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care. (2) The HHA must measure, analyze, and track	G0642	**CorrectiveAction:** The Alternate Director of Clinical Services implementedutilization of EMRs tracking and analysis of data regardingpatient use of emergency care services, hospital admissions, and hospitalre-admission on 7/7/25. TheAlternate Director of Clinical Services started internal audit	2025-07-18

	quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations. Based on QAPI documentation review, policy review, and interview, the home health agency failed to measure, analyze, and track patient use of emergent care services, which had the potential to affect all agency patients. Findings include: 1. The undated agency policy Quality Assurance and Performance Improvement (QAPI) Plan and Program) indicated the agency s QAPI program would collect and analyze data on patient use of emergent care services. 2. The agency s QAPI meeting minutes from 2/16/2024 4/25/2025 failed to evidence the agency collected and analyzed data on patient use of emergent care services. 3. During an interview on 6/19/2025 beginning at 1:42 PM, Administrator reported that agency s QAPI committee did not track patient use of emergent care services.		review of allactive clinical records on 7/7/25 to ensure tracking and analysis of data regardingpatient use of emergency care services. 20% review of active charts will becompleted by week ending 7/12/25. 25% review of active charts will be completedby week ending 7/19/25. 30% review of active charts will be completed by weekending 7/26/25. Remaining 25% review of active charts will be completed by 8/2/25to complete 100% audit of all active chart audits. In orderto correct the above deficiency cited, the Administrator and Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 10.1.1 titled, “Quality Assurance and PerformanceImprovement (QAPI) Program”. During this management meeting on 7/7/25,deficiencies cited in QAPI documentation under G-0642 were reviewed, addressedand discussed in detail. The Administrator, Director of Clinical Services andAlternate Director of Clinical	

			re-orientation ofagency's policies pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. An in-service was conducted by the Administrator on 7/9/25 withall staff. During the meeting, the Administrator discussed the agency policy10.1.1 titled, "Quality Assurance and Performance Improvement (QAPI) Program"and the importance of the requirement to measure, track, and analyze allquality indicators according to its Quality Assessment and PerformanceImprovement (QAPI) Program policy. Citations listed in the QAPI documentationwere addressed with all staff. The Administrator re-educated all staff on theimportance of this requirement. All staff understood and acknowledged theagency policy 10.1.1 titled, "Quality Assurance and Performance Improvement(QAPI) Program" and the importance of the requirement to measure, track, andanalyze all quality indicators	

			according to its Quality Assessment andPerformance Improvement (QAPI) Program policy. All new staff will be oriented of this requirement at the time of hire. TheAdministrator concluded that the agency will document the measurement,tracking, and analysis of all quality indicators according to its QualityAssessment and Performance Improvement (QAPI) Program policy after the end ofthis quarter in next quarterly QAPI meeting minutes. The corrective actionswere implemented on 7/7/25 and will be completed on 7/18/25. **Measuresto assure No recurrence** In orderto ensure that there is no recurrence of this deficiency, the Administratorwill utilize an audit tool with the help of the Director of Clinical Servicesto ensure that the organization measure, track, and analyze all qualityindicators according to its Quality Assessment and Performance Improvement(QAPI) Program.	

			This process will help us identify and implement improvementsin maintaining the Quality Assessment and Performance Improvement (QAPI)Program and make corrective adjustments in the future. **Monitoring** In order to ensure implementation andeffectiveness of this corrective action, the Administrator will audit 100% ofQuality Assessment and Performance Improvement (QAPI) Program progress on amonthly basis to ensure that the organization measures, tracks, and analyzesall quality indicators according to its Quality Assessment and PerformanceImprovement (QAPI) Program. Monthly reports will be generated by QAPI Committeeand results will be compiled and sent to the Administrator to ensure thatprocesses have improved. This process will continue every month for the nextthree months until 100% compliance is achieved and to maintain this level ofcompliance, all new staff	

			at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and if any deficiencies are identified within three months, theywill continue to be addressed with staff re-training and re-education inworkshops and in-services and with each individual personnel as needed. Once100% compliance is achieved, the QAPI Committee will continue to audit QAPI Programon a semi-annual basis to ensure compliance is maintained. The Administratorand QAPI Committee will send a written report to the Governing Bodysemi-annually for their recommendations. The Administrator will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0658	Performance improvement projects 484.65(d)(1)(2) Standard: Performance improvement projects.	G0658	**CorrectiveAction:** TheAdministrator concluded that the agency will document the measurable progressachieved on this	2025-07-18

	Beginning July 13, 2018 HHAs must conduct performance improvement projects. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations. (2) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects. Based on QAPI documentation review and interview, the home health agency failed to document the measurable progress achieved on performance improvement projects (PIP), which had the potential to affect all active patients. Findings include: 1. The agency s QAPI documentation indicated a PIP related to fall prevention was enacted for 1/01/2025 12/31/2025. The PIP documentation evidenced a goal to reduce the incident of patient falls by 20% within 12 months and objectives to conduct comprehensive fall risk assessments for 100% of new admissions & educate 100% of staff on fall prevention protocols and safe mobility practices & perform		project every quarter. The measurable progress will be conductedtentatively on 8/1/25 one month post second quarter. The completion date ofperformance improvement project will be 12/31/25. In orderto correct the above deficiency cited, the Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices reviewed and discussed the agency policy 10.6.1 titled, “PerformanceImprovement Projects”. During this management meeting on 7/7/25, deficienciescited in QAPI documentation under G-0658 were reviewed, addressed and discussedin detail. The Administrator, Director of Clinical Services and AlternateDirector of Clinical Services have completed re-orientation of agency’spolicies pertaining to the requirement on 7/7/25 provided by the Governing BodyChair.	

	environmental safety assessments for 90% of high-risk patients to identify hazards and implement modifications .... The committee was to provide quarterly reports to leadership on fall rates, interventions implemented, and outcomes achieved. QAPI meeting minutes for a meeting held 4/25/2025 failed to evidence the committee documented the measurable progress it had achieved towards its PIPs, including interventions implemented, outcomes achieve, and potential need to modify interventions. 2. During an interview on 6/19/2025 beginning at 1:42 PM, Administrator reported during the 4/25/2025 QAPI meeting, the agency discussed the number of patient falls which occurred during the previous quarter, but did not discuss anything further regarding the status of the PIP.		An in-servicewas conducted by the Administrator on 7/9/25 with all staff. During themeeting, the Administrator discussed the agency policy 10.6.1 titled,"Performance Improvement Projects" and the importance of the requirement thatthe organization documents the measurable progress achieved on PI project.Citations listed in the QAPI documentation were addressed with all staff. TheAdministrator re-educated all staff on the importance of this requirement. Allstaff understood and acknowledged the agency policy 10.6.1 titled, "PerformanceImprovement Projects" and the importance of the requirement that theorganization documents the measurable progress achieved on these projects. All new staff will be oriented of this requirementat the time of hire. **Measures toassure No recurrence** In orderto ensure that there is no recurrence of this deficiency, the Administratorwill utilize an	

			Director of Clinical Servicesto ensure that the organization documents the measurable progress achieved onthese projects. This process will help us identify and implement improvementsin maintaining the performance Improvement projects and make correctiveadjustments in the future. **Monitoring:** In order to ensure implementation andeffectiveness of this corrective action, the Administrator will audit 100% ofPerformance Improvement project's progress on a monthly basis to ensure thatthe organization documents the measurable progress achieved on these projectsand that the Performance Improvement Project approval is documented inGoverning Body minutes. Monthly reports will be generated by QAPI Committee andresults will be compiled and sent to the Administrator to ensure that processeshave improved. This process will continue every month for the	

			next three monthsuntil 100% compliance is achieved and to maintain this level of compliance, allnew staff at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and if anydeficiencies are identified within three months, they will continue to beaddressed with staff re-training and re-education in workshops and in-servicesand with each individual personnel as needed. Once 100% compliance is achieved,the QAPI Committee will continue to audit performance improvement projectsundertaken on a semi-annual basis to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody semi-annually for their recommendations. The Administrator will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

G0682	Infection Prevention 484.70(a) Standard: Infection Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Based on observation, record review, and interview, the agency failed to ensure employees followed standards of practice for hand hygiene, bag technique and cleaning of equipment to reduce the spread of infections for 2 of 3 home visit observations with a SN (Patient #1 and 11) and 1 of 1 home visit observation with a PTA (Patient #10). Findings include: 1. The undated agency Hand Hygiene Policy and Compliance Program indicated staff should perform hand hygiene before and after direct patient care, before re-entering the nursing bag or patient s clean supplies 2. During a home visit observation conducted with Patient #1 and the CM on 6/13/25 beginning at 9:27 AM,	G0682	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure staff followed accepted standards of practice and their own policiesto prevent the transmission of infections and communicable diseases. 25% reviewof active charts was completed by week ending 6/28/25. 15% review of activecharts was completed by week ending 7/3/25. 15% review of active charts will becompleted by week ending 7/12/25. 20% review of active charts will be completedby 7/19/25, 15% review of active charts will be completed by 7/26/25. Remaining10% review of charts will be completed by week ending 8/2/25 to complete 100%audit of all active chart audits. In order to correct the abovedeficiency cited under G-0682, in Management meeting on 7/7/25, theAdministrator, Alternate administrator, Director of Clinical Services andAlternate	2025-07-18

	Patient #1 s wound supply box. The CM failed to perform hand hygiene prior to obtaining clean wound supplies. The CM was also observed getting in the nurse bag to gather additional gloves five times throughout the visit. The CM failed to perform hand hygiene after closing the nurse bag. During an interview on 6/13/25 at 1:27 PM, the CM relayed hand hygiene should be performed before the start and at the end of every visit, anytime you are soiled and when accessing the bag, hand hygiene should be performed before getting in the bag. 3. Pt #10-EC 4. Pt #11-SH 4. During a home visit observation conducted with Patient #11 and LPN 2 on 06/16/2025 beginning at 02:30 PM, LPN 2 completed Patient #11 s assessment and donned gloves. LPN 2 failed to use alcohol based hand rub before donning new gloves. LPN 2 removed the wound dressing, cleaned the wound, and applied the clean wound dressing. LPN 2 failed to use alcohol- based		Director of Clinical Services reviewed, discussed the agency policies5.4.1 titled "Exposure Control Plan: OSHA Regulations", 5.7.1 titled"Hand Hygiene Policy and Compliance Program" and 3.1.1 titled“Equipment Maintenance” under Infection Prevention and Control section. Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency’s policies pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. An in-service was conducted byDirector of Clinical Services on 7/9/25 and attended by all staff includingfield staff. During the meeting, the DCS discussed the importance of therequirement that hand hygiene, using correct technique and equipment must becleaned after each use with an agency approved disinfectant after each use bythe employee who has possession of the equipment;	

	hand rub before donning gloves and failed to complete hand hygiene and don new gloves after removing the soiled wound dressing. During an interview immediately after the visit, LPN 2 indicated they thought they used alcohol- based hand rub between glove changes. LPN 2 indicated they were not sure they completed hand hygiene and donned new gloves after removing the soiled bandage. 3. During a home visit observation on 6/16/2025 beginning at 1:38 PM, PTA 5 was observed obtaining Patient #10 s vital signs with a thermometer and oxygen saturation (SpO2) monitor. After cleaning the equipment with a Clorox wipe, PTA 5 laid the equipment down to dry on the same side of a barrier field which had been used to store the dirty equipment (dirty side). During an interview on 6/16/2025 beginning at 2:28 PM, PTA 5 reported her barrier field was divided by a clean side and a dirty side, separated by her supply bag in the middle.		and hands should be washedbefore re-entering the nursing bag. Citations listed in the home visits wereaddressed with the field staff. Based on the deficiency listed, the DCSreiterated agency's policy, "Hand Hygiene Policy and Compliance Program5.7", states that the agency will follow the Centers for Disease Controland Prevention (CDC) guidelines for hand hygiene: Put enough sanitizer on yourhands to cover all surfaces ... Rub your hands together until they feel dry(this should take around 20 seconds) and agency policy “Equipment Maintenance”to ensure that the equipment must be cleaned after each use with an agencyapproved disinfectant after each use by the employee who has possession of theequipment; and hands should be washed before re-entering the nursing bag. Allstaff understood and acknowledged the significance of ensuring that they followproper Hand technique and accepted infection control practices must be followedas per guidelines and all field staff will be able to demonstrate it as well.All new staff will be oriented of this requirement at	

	PTA 5 reported used equipment was not to be moved from one side to the other.		the time of hire. Thecorrective actions were implemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence** In order to ensure that there is norecurrence of this deficiency, the Alt DCS will utilize a supervisory visitaudit tool to ensure that hand hygiene techniques and equipment maintenancepolicy is being followed by all field staff. This process of utilizingsupervisory visit audit tool on all staff will help us identify anydiscrepancies in the supervisory visits pertaining to staff compliance andre-educate all staff including contracted personnel on the above mentionedrequirement. **Monitoring:** In order to ensure implementation andeffectiveness of the corrective action, the following monitoring process willbe put into place. The Alternate DCS will do random supervisory visits on allfield staff every 2 weeks to monitor and ensure that all staff is following	

			thepolicy for hand hygiene techniques and equipment must be cleaned after each usewith an agency approved disinfectant after each use by the employee who has possessionof the equipment; and hands should be washed before re-entering the nursingbag. This process will continue for the next 3-6 months until 100% complianceis achieved and to maintain this level of compliance all new employees at thetime of hire will be oriented with this policy. If compliance is not achievedat the desired target of 100% compliance, the DCS will provide re-education of"Hand hygiene and compliance program" and "Equipment Maintenance" Policy andprocedure in in-service to all field staff and provide individual training toall field staff including therapy staff that are not in compliance. TheInfection Control Committee will analyze and track data from infection controlsurveillance system and trend the field staff that are not compliant with "Handhygiene and compliance program" "Equipment Maintenance" Policy and procedure asmandated. The Administrator	

			will conduct a meeting with the Clinical Managementteam, Infection Control Committee and field staff to discuss the process. Ifnon-compliance continues, the agency will no longer provide patients tonon-compliant field staff until acceptable level of compliance is demonstratedand is achieved by the field staff. Once threshold is met the QAPI Committeewill continue to audit 20% of supervisory visits quarterly to ensure complianceis maintained. The Administrator and QAPI Committee will send a written reportto the Governing Body quarterly for their recommendations. The Director of Clinical Services willbe responsible for corrective action of this deficiency, measure to assure norecurrence and monitoring of this deficiency.	
G0706	Interdisciplinary assessment of the patient 484.75(b)(1) Ongoing interdisciplinary assessment of the patient;	G0706	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the skilled professionals	2025-07-18

	Based on observation, policy review, and interview, the PTA failed to conduct a pain assessment for 1 of 1 home visit observation with a PTA (Patient #10), and the SN failed to measure wounds for 1 of 1 discharged wound patient with RN 1 (Patient #16). Findings include: 1. The undated agency policy Pain Assessment and Reassessment indicated patients receiving therapy services, including physical therapy, would have their pain assessed and reassessed as appropriate and relevant to the care provided by the therapist & Each therapist will use the same established criteria for assessing and reassessing pain &. 2. Patient #10 s clinical record evidenced a POC for the initial certification period of 4/23/2025 6/21/2025. The POC indicated PT interventions included to assess functional status & pain management &. During a home visit observation on 6/16/2025 beginning at 1:38 PM, PTA 5 was observed assisting Patient #10 with physical therapy exercises. During the visit, Patient began		conduct pain and wound assessment. 25%review of active charts was completed by week ending 6/28/25. 15% review ofactive charts was completed by week ending 7/3/25. 15% review of active charts willbe completed by week ending 7/12/25. 20% review of active charts will becompleted by 7/19/25, 15% review of active charts will be completed by 7/26/25.Remaining 10% review of charts will be completed by week ending 8/2/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0706, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During	

	to complain of pain to the lower back and had to pause the therapy exercises. Patient also reported pain to the right knee which began approximately one week prior. PTA 5 failed to assess Patient s pain, including severity, description, interventions which make the pain better or worse, etc. During an interview on 6/16/2025 beginning at 2:28 PM, PTA 5 reported she always asked patients what their pain severity was, however she did not assess this during Patient s visit. 3. Patient #16 s medical record evidenced a POC for certification period 12/14/2025 02/11/2025, completed by RN 1. The POC evidenced diagnoses of stage 2 pressure ulcers (shallow open ulcers due to prolonged pressure) of the right and left buttocks. The POC evidenced wound care orders for SN to perform wound care to sacral area. Cleanse wound with soap and water, apply A & D ointment, cover and secure with Duoderm [a type of wound dressing], using aseptic technique. The POC		the meeting, the DCS discussed the pertaining agency policy andthe importance of the requirement to review that the skilled professionals mustconduct pain and wound assessment. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the agency policyand the requirement. All new staff will be oriented of this requirement at thetime of hire. The corrective actions were implemented on 6/23/25 and will becompleted on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that the skilled professionals conducted a thorough and complete painand wound assessment. The Alternate	

	a & taxing effort to leave home due to pressure ulcer wound. Patient #16 s medical record evidenced SN visits performed by RN 1 on 12/30/2024, 01/01/2025, 01/06/2025, 01/08/2025, and 01/15/2025. All SN visit notes indicated RN 1failed to complete wound measurements. The documented reason there were no wound measurements was No measurement tools. During an interview on 06/18/2025 beginning at 12:30 PM, RN 1 indicated wound measurements were due weekly. RN 1 indicated they did not believe the wounds were pressure ulcers and did not require measurements. RN 1 indicated the visit note template required an answer to the reason no measurements were taken, so they used no measurement tools. RN 1 confirmed they did not measure the wound.		Director of Clinical Services will utilizea chart audit tool to ensure in all active clinical records that the skilledprofessionals conducted a thorough and complete pain and wound assessment. Thisprocess of utilizing active chart audit tool will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all active charts ona weekly basis to ensure that the skilled professionals conducted a thoroughand complete pain and wound assessment. The Director of Clinical Services willmonitor and review Alternate Director of Clinical Services' audit findings ofall active charts. Reports will be generated and results will be compiled toensure processes have improved. If any	

			willcontinue to be addressed with each personnel as needed. This process willcontinue for each week for the next 30 days until 100% compliance is achieved.After 30 days, this process will continue to be monitored on a quarterly basisand will be included in the quarterly chart audit review. Quarterly auditresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the Quality Committee will continue to audit 20% of clinicalrecords quarterly to ensure compliance is maintained. The Administrator andQAPI Committee will send a written report to the Governing Body quarterly fortheir recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0716	Preparing clinical notes	G0716	**CorrectiveAction:**	2025-07-18

	484.75(b)(6) Preparing clinical notes; Based on record review and interview, the home health agency failed to ensure all visit note documentation was completed within 14 days for 3 of 7 active patient records reviewed with wounds (Patient #2, 5 and 7) and 4 of 5 discharged records reviewed (Patient's #3, 4, 14 and 15). Findings include: 1. The agency policy Timely Submission of Patient Documentation , last updated 11/22/23, indicated visit itineraries, with all visit notes, must be submitted within fourteen (14) calendar days and upon discharge from services, the patient discharge summary must be submitted within five (5) business days. 2. Patient #2 s clinical record was reviewed on 6/12/25. The record failed to evidence any SN visits performed after 5/22/25. Additional record review on 6/16/25 evidenced a SN visit was completed on 5/27/25. This visit note was completed 6/14/25, 18 days		The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure all visit note documentation was completed within fourteen (14) calendardays and discharge summaries were submitted with five (5) business days. 25%review of active charts was completed by week ending 6/28/25. 15% review ofactive charts was completed by week ending 7/3/25. 15% review of active charts willbe completed by week ending 7/12/25. 20% review of active charts will becompleted by 7/19/25, 15% review of active charts will be completed by 7/26/25.Remaining 10% review of charts will be completed by week ending 8/2/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0716, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical	

	after the visit. A SN recertification visit was completed on 5/29/25. This visit note was completed on 6/13/25, 15 days after the visit. The RN failed to complete SN visit notes within 14 days of the visit. During an interview on 6/13/25 at 2:45 PM, RN 2 relayed she had seven to fourteen days to complete visit notes in the EMR. 3. Patient #3 s clinical record evidenced a discharge date on 5/21/25 and included a discharge summary that was completed on 6/17/25 by the CM. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge. During an interview on 6/17/25 at 12:35 PM, the CM relayed the discharge summary should be sent to the physician as soon as possible once the discharge has been completed. 4. Patient #4 s clinical record evidenced a discharge date on 6/06/25 and included a discharge summary that was completed on 6/17/25 by RN 3. The clinical record failed to include a discharge summary		recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy andthe importance of the requirement to review that the all visit notedocumentation was completed within fourteen (14) calendar days and dischargesummaries were submitted with five (5) business days. Citations listed in theclinical record reviews were addressed. All staff understood and acknowledged theagency policy and the requirement. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 6/23/25and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication	

	that was faxed to the physician within 5 days of discharge. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed the discharge summary had not been sent to the physician because he had not completed the discharge note yet. 6. Patient #7 s clinical record was reviewed on 6/13/25 and evidenced a SOC on 5/19/25 and a ROC on 5/28/25. The record failed to include a ROC SN visit note had been completed for 5/28/25. During an interview on 6/17/25 at 4:00 PM, RN 2 confirmed she did not create a SN visit note for the 5/28/25 ROC visit. She relayed she created this late. 7. Patient #14 s clinical record evidenced a discharge date on 5/27/25. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge.		application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and allvisit note documentation was completed within fourteen (14) calendar days anddischarge summaries were submitted with five (5) business days. The AlternateDirector of Clinical Services will utilize a chart audit tool to ensure in allactive clinical records that all visit note documentation was completed within fourteen(14) calendar days and discharge summaries were submitted with five (5)business days. This process of utilizing active chart audit tool will help usidentify any discrepancies in the clinical records and re-educate all staff onthe above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100%	

	During an interview on 6/18/25 at 11:35 AM, the Alternate Administrator verified the discharge summary for Patient #14 had not been sent to the physician yet. 5. Patient #5 s medical record evidenced documentation of the Recertification assessment dated 05/09/2025, completed by RN 2. The document activity detail report, which identified when a clinician completed a document, indicated RN 2 completed the document on 05/30/2025. During an interview on 06/12/2025 during the entrance conference, the Alternate Administrator indicated clinicians often completed documentation late. Patient #11 s medical record evidenced documentation of a nursing visit on 06/03/2025 completed by LPN 2. The note indicated Patient #11 had a new wound care order. The documentation in the Wound Care Performed section of the note indicated LPN 2 performed wound care inconsistent with the new wound care order. During an interview on 06/19/2025 at 12:50 PM, LPN 2 indicated they performed the wound care as the new order		basis to ensure that all visit note documentation was completed withinfourteen (14) calendar days and discharge summaries were submitted with five(5) business days. The Director of Clinical Services will monitor and reviewAlternate Director of Clinical Services' audit findings of all active charts.Reports will be generated and results will be compiled to ensure processes haveimproved. If any deficiencies are identified, they will continue to beaddressed with each personnel as needed. This process will continue for eachweek for the next 30 days until 100% compliance is achieved. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audit results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQuality Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations.	

G0726	Nursing services supervised by RN 484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k). Based on record review and interview, the home health agency failed to ensure the RN supervised the LPN every 30 days on-site for 1 of 1 active clinical record reviewed of patients receiving skilled wound care services with an LPN (Patient #9). Findings include: 1. The undated agency policy Supervision of Licensed Practical/Licensed Vocational Nurse indicated services furnished by a Licensed Practical/Licensed Vocational Nurse will be furnished under the supervision of a qualified registered nurse and supervisory visits will occur every 30 days. 2. Patient #9 s clinical record included a POC for the certification period 5/06/25 to 7/04/25 and included orders for SN, PT, OT and HHA services.	G0726	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure the RN supervised the LPN every 30 days on-site. 25% review of activecharts was completed by week ending 6/28/25. 15% review of active charts was completedby week ending 7/3/25. 15% review of active charts will be completed by weekending 7/12/25. 20% review of active charts will be completed by 7/19/25, 15% reviewof active charts will be completed by 7/26/25. Remaining 10% review of chartswill be completed by week ending 8/2/25 to complete 100% audit of all activechart audits. In orderto correct the above deficiency cited under G0726, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies	2025-07-18

	performed visits on 5/07/25, 5/09/25, 5/12/25, 5/14/25, 5/16/25, 5/19/25, 5/23/25, 5/24/25, 5/26/25, 5/28/25, 5/30/25, 6/03/25, 6/05/25, 6/07/25, 6/09/25, 6/11/25, 6/13/25 and 6/16/25 and RN 1 documented LPN supervisory visits on 4/04/25, 5/06/25 and 5/30/25. The clinical record failed to evidence RN 1 performed on-site LPN supervisory visits every 30 days with Patient #9. 3. During an interview on 6/17/25 at 2:26 PM, Patient #9 relayed RN 1 visited him every couple of months. 4. During an interview on 6/18/25 at 1:49 PM, RN 1 relayed LPN supervisory visits should be done every month and she relayed she didn t always do the supervisory visits in person, she sometimes called Patient #9 to check-in.		were identified and reviewed. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy andthe importance of the requirement to review that the RN supervised the LPNevery 30 days on-site. Citations listed in the clinical record reviews wereaddressed. All staff understood and acknowledged the agency policy and therequirement. All new staff will be oriented of this requirement at the time ofhire. The corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to	

			ensure real-time visibility into patient care and toensure the RN supervised the LPN every 30 days on-site. The Alternate Directorof Clinical Services will utilize a chart audit tool to ensure in all activeclinical records that the RN supervised the LPN every 30 days on-site. Thisprocess of utilizing active chart audit tool will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all active charts ona weekly basis to ensure that the RN supervised the LPN every 30 days on-site. TheAlternate Director of Clinical Services will conduct random supervisory visitson all LPN staff every 2 weeks to monitor and ensure that all LPNs are performingtasks as per Plan of care. The Director of Clinical	

			Alternate Director of Clinical Services' audit findings of all activecharts. Reports will be generated and results will be compiled to ensureprocesses have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue foreach week for the next 30 days until 100% compliance is achieved. After 30days, this process will continue to be monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency,	

			recurrence and monitoring of this deficiency.	
G0750	Home health aide services 484.80 Condition of participation: Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Based on record review and interview, the home health agency failed to ensure the HHA was qualified to provide home health services (See G754); failed to ensure the HHA obtained the appropriate HHA training (See G760); failed to ensure the HHA performed the required competency skills evaluation tasks with a patient or pseudo patient (See G768); failed to ensure HHA s had the required in-service training hours (See G774); failed to ensure the RN supervised the HHA every 14 days (See G808); and failed to ensure the RN completed an on-site HHA supervisory visit every 14 days (See G810). Findings include: The cumulative effect of these systemic problems had the	G0750	**CorrectiveAction:** In order to correct the above deficiency citedunder G0750, the agency immediately removed the unqualified HHA from providingdirect care services effective 6/20/25. Each affected client was reassigned toa qualified HHA who met all federal and state requirements and clients/familieswere notified of the change in personnel. The Administrator has also acquiredservices of RN from outside the agency to conduct the required competencyskills evaluation tasks with a patient or pseudo patient for HHAs. A comprehensive 100% audit wasconducted and completed on all active HHA personnel files by the AlternateAdministrator on 6/20/25 and patient assignments to identify any additionalHHAs who may not have met qualification, training, or competency evaluationrequirements. No additional instances were identified. However,	2025-07-18

	potential to impact all 61 active patients which resulted in the agency being found out of compliance with the Condition of Participation 42 CFR 484.80 Home health aide services.		fortransparency and prevention, any HHA with incomplete documentation wastemporarily removed from client assignments until all requirements were fullyvalidated and documented. Clients were reassigned to fully compliant HHAs toavoid disruption in care. The Alternate Administrator ensured the HHAs were qualified toprovide home health services; the HHA obtained the appropriate HHA training; theHHA performed the required competency skills evaluation tasks with a patient orpseudo patient and HHA's had the required in-service training hours. TheAlternate Director of Clinical Services started internal audit review of allactive clinical records on 6/23/25 to ensure the RN supervised the HHA every 14days and that the RN completed an on-site HHA supervisory visit every 14 days. 35%review of active charts was completed by week ending 6/28/25. 30% review ofactive charts was completed by week ending 7/3/25. Remaining 35% review ofcharts will be completed by week ending 7/11/25 to complete 100% audit of allactive chart audits.	

G0754	A qualified HH aide successfully completed: 484.80(a)(1)(i-iv) A qualified home health aide is a person who has successfully completed: (i) A training and competency evaluation program as specified in paragraphs (b) and (c) respectively of this section; or (ii) A competency evaluation program that meets the requirements of paragraph (c) of this section; or (iii) A nurse aide training and competency evaluation program approved by the state as meeting the requirements of §483.151 through §483.154 of this chapter, and is currently listed in good standing on the state nurse aide registry; or (iv) The requirements of a state licensure program that meets the provisions of paragraphs (b) and (c) of this section. Based on personnel file review and interview, the home health agency failed to ensure the HHA was qualified to provide home health services for 1 of 2 HHA personnel files reviewed who have been employed more than one year (HHA 2). Findings include: 1. The undated agency policy Home Health Aide Services and Training Program indicated a qualified Home Health Aide is a person who has successfully completed: a nurse aide training and competency evaluation	G0754	**CorrectiveAction:** In order to correct the above deficiency citedunder G0754, the agency immediately removed the unqualified HHA from providingdirect care services effective 6/20/25. Each affected client was reassigned toa qualified HHA who met all federal and state requirements and clients/familieswere notified of the change in personnel. The Administrator has also acquiredservices of RN from outside the agency to conduct the required competencyskills evaluation tasks with a patient or pseudo patient for HHAs. Thecompetency evaluation will be completed on 7/11/25. A comprehensive 100% audit wasconducted and completed on all active HHA personnel files by the AlternateAdministrator on 6/20/25 and patient assignments to identify any additionalHHAs who may not have met qualification, training, or competency evaluationrequirements. No additional instances were identified. However, fortransparency and prevention,	2025-07-18

	program approved by the state as meeting the requirements and is currently listed in good standing on the state nurse aide registry. 2. HHA 2 s personnel file indicated a hire date of 6/20/24. The file included a certificate issued by Entity E on 6/13/24. The file failed to evidence a qualified training and competency evaluation program. 3. Review of the State of Indiana s license and certification verification website, www.mylicense.IN.gov, on 6/19/25 failed to evidence an active HHA license for HHA 2. 4. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator confirmed HHA 2 was not listed on the State of Indiana s license and certification verification website. She also relayed that the Administrator initiated the HHA training from Entity E.		documentation wastemporarily removed from client assignments until all requirements were fullyvalidated and documented. Clients were reassigned to fully compliant HHAs toavoid disruption in care. The Alternate Administrator ensured that the HHAswere qualified to provide home health services. During themanagement meeting on 7/7/25, the Administrator, Alternate Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Administrator and Director of Clinical Serviceson 7/9/25 with all staff. During the meeting, the Administrator and the DCSdiscussed the pertaining agency policy and the importance of the requirement toreview that the HHAs were qualified to provide	

			Citationslisted in the personnel record reviews were addressed. All staff understood andacknowledged the agency policy and the requirement. All new staff will beoriented of this requirement at the time of hire. The corrective actions wereimplemented on 6/20/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the AlternateAdministrator will utilize an HR Audit tool that includes verificationof HHA qualification. A monthly file audit system was established, with the HRcoordinator and Director of Clinical Services jointly responsible forverification of all HHA documentation before client assignment. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective	

			action, the AlternateAdministrator will audit 100% of all HHA personnel files on a weekly basis toensure that the HHAs were qualified to provide home health services. The AlternateDirector of Clinical Services will conduct random supervisory visits on all HomeHealth Aide staff every 2 weeks to monitor and ensure that all HHAs are performingtasks as per Plan of care. The Director of Clinical Services will monitor andreview the Alternate Administrator audit findings of all HHA personnel files.Reports will be generated and results will be compiled to ensure processes haveimproved. If any deficiencies are identified, they will continue to beaddressed with each personnel as needed. This process will continue for eachweek for the next 30 days until 100% compliance is achieved. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly personnel audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the	

			Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0760	Classroom and supervised practical training 484.80(b)(1) Home health aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing services to an individual under the direct supervision of a registered nurse, or a licensed practical nurse who is under the supervision of a registered nurse. Classroom and supervised practical training must total at least 75 hours. Based on personnel file review and interview, the home health agency failed to ensure the HHA obtained the appropriate HHA training for 1 of 1	G0760	**CorrectiveAction:** In order to correct the above deficiency citedunder G0760, the agency immediately removed the unqualified HHA with no appropriateHHA training from providing direct care services effective 6/20/25. Eachaffected client was reassigned to a qualified HHA with appropriate HHA trainingwho met all federal and state requirements and clients/families were notifiedof the change in personnel. The Administrator has also acquired	2025-07-18

	unlicensed HHA who was hired in the past year (HHA 2). Findings include: 1. The undated agency policy Home Health Aide Services and Training Program indicated a qualified Home Health Aide is a person who has successfully completed: a nurse aide training and competency evaluation program approved by the state as meeting the requirements and is currently listed in good standing on the state nurse aide registry and home health aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing services to an individual under the direct supervision of a registered nurse, or licensed practical nurse who is under the direct supervision of a registered nurse. Classroom and supervised practical training must total at least 75 hours. 2. HHA 2 s personnel file indicated a hire date of 6/20/24. The file included a certificate titled National Caregiver Certification as a Home Health		services of RNfrom outside the agency to conduct the required competency skills evaluationtasks with a patient or pseudo patient for HHAs. The competency evaluation willbe completed on 7/11/25. A comprehensive 100% audit wasconducted and completed on all active HHA personnel files by the AlternateAdministrator on 6/20/25 and patient assignments to identify any additionalHHAs who may not have met qualification, training, or competency evaluationrequirements. No additional instances were identified. However, fortransparency and prevention, any HHA with incomplete documentation wastemporarily removed from client assignments until all requirements were fullyvalidated and documented. Clients were reassigned to fully compliant HHAs toavoid disruption in care. The Alternate Administrator ensured the HHAs obtained theappropriate HHA training. During themanagement meeting on 7/7/25, the Administrator, Alternate	

	Aide issued by Entity E on 6/13/24. The file failed to evidence HHA 2 participated in a qualified training and competency evaluation program which included classroom and practical training. 3. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator relayed the only training HHA 2 received was the online certification course through Entity E and she was unsure if Entity E s course was an approved training course.		Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Administrator and Director of Clinical Serviceson 7/9/25 with all staff. During the meeting, the Administrator and the DCSdiscussed the pertaining agency policy and the importance of the requirement toreview that the HHAs obtained the appropriate HHA training. Citations listed inthe clinical record reviews were addressed. All staff understood andacknowledged the agency policy and the requirement. All new staff will beoriented of this requirement at the time of hire. The corrective actions wereimplemented on 6/20/25 and will be completed on 7/18/25.	

			Measuresto assure No recurrence: In orderto ensure that there is no recurrence of this deficiency, the AlternateAdministrator will utilize an HR Audit tool that includes verificationof HHA training completion using a standardized form signed by the RNsupervisor.A monthly file audit system was established, with the HR coordinator andDirector of Clinical Services jointly responsible for verification of all HHAdocumentation before client assignment. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, the AlternateAdministrator will audit 100% of all HHA personnel files on a weekly basis toensure that the HHAs obtained the appropriate HHA training. The AlternateDirector of Clinical Services will conduct random supervisory visits on all HomeHealth Aide staff every 2 weeks to monitor and ensure that all HHAs are	

			performingtasks as per Plan of care. The Director of Clinical Services will monitor andreview the Alternate Administrator audit findings of all HHA personnel files.Reports will be generated and results will be compiled to ensure processes haveimproved. If any deficiencies are identified, they will continue to beaddressed with each personnel as needed. This process will continue for eachweek for the next 30 days until 100% compliance is achieved. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly personnel audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. TheDirector of Clinical Services	

			will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0768	Competency evaluation 484.80(c)(1)(2)(3) Standard: Competency evaluation. An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with a patient or pseudo-patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient, or with a pseudo-patient as part of a simulation. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section.	G0768	**CorrectiveAction:** In order to correct the above deficiency citedunder G0768, the agency immediately removed the unqualified HHA with no competencyskills evaluation tasks with a patient or pseudo patient from providing directcare services effective 6/20/25. Each affected client was reassigned to aqualified HHA with appropriate HHA training who met all federal and staterequirements and clients/families were notified of the change in personnel. TheAdministrator has also acquired services of RN from outside the agency toconduct the required competency skills evaluation tasks with a patient orpseudo patient for HHAs. The competency skills evaluation will be completed on7/11/25. A comprehensive 100% audit	2025-07-18

	(3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. Based on record review and interview, the home health agency failed to ensure the HHA performed the required competency skills evaluation tasks with a patient or pseudo patient (person acting as a patient) for 2 of 2 new hired HHA s in the past year (HHA 2 and HHA 3). Findings include: 1. The undated agency policy Home Health Aide Services and Training Program indicated a home health aide training program must address each of the following subject areas: communication skills; observation of patient status; reading and recording temperature, pulse, and respiration; basic infection prevention and control procedures; basic elements of body functioning and changes in body function; maintenance of a clean, safe, and healthy environment; recognizing emergencies and the knowledge of instituting emergency procedures and their application; the physical,		wasconducted and completed on all active HHA personnel files by the AlternateAdministrator on 6/20/25 and patient assignments to identify any additionalHHAs who may not have met qualification, training, or competency evaluationrequirements. No additional instances were identified. However, fortransparency and prevention, any HHA with incomplete documentation wastemporarily removed from client assignments until all requirements were fullyvalidated and documented. Clients were reassigned to fully compliant HHAs toavoid disruption in care. The Alternate Administrator ensured the HHAs obtained competencyskills evaluation tasks with a patient or pseudo patient prior to providingdirect patient care. During themanagement meeting on 7/7/25, the Administrator, Alternate Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical	

	emotional, and developmental needs of and ways to work with the populations served by the HHA; appropriate and safe techniques in performing personal hygiene and grooming tasks; safe transfer techniques and ambulation; normal range of motion and positioning; adequate nutrition and fluid intake; recognizing and reporting changes in skin condition; and any other task that the HHA may choose to have an aide perform as permitted under state law. 2. HHA 2 s personnel file evidenced a hire date of 6/20/24 and included a document titled Initial Competency Checklist dated 6/14/25, signed by OTA 7. The skills included reading and recording temperature, pulse, blood pressure and respiration; shower bath, sink, tub or bed shampoo, safe transfer techniques, recognition of emergencies and knowledge of emergency procedures were marked as met via observation in the home with a patient. The document failed to evidence all required competencies were completed.		recordswith the deficiencies were identified and reviewed. An in-servicewas conducted by the Administrator and Director of Clinical Services on 7/9/25with all staff. During the meeting, the Administrator and the DCS discussed thepertaining agency policy and the importance of the requirement to review that theHHAs obtained competency skills evaluation tasks with a patient or pseudopatient. Citations listed in the clinical record reviews were addressed. Allstaff understood and acknowledged the agency policy and the requirement. Allnew staff will be oriented of this requirement at the time of hire. Thecorrective actions were implemented on 6/20/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the AlternateAdministrator will utilize an HR Audit tool that includes verificationof theHHAs	

	A telephone call was placed to HHA 2 on 6/19/25 at 1:33 PM with no response. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator relayed HHA 2 trained with OTA 7 one day to do the skills competencies. She also verified that OTA 7 is not an RN. 3. HHA 3 s personnel file evidenced a hire date of 4/16/25 and included a document titled Initial Competency Checklist dated 4/24/25. The skills included reading and recording temperature, pulse, blood pressure and respiration; bed bath; sponge, tub or shower bath; shampoo; sink, tub or bed; oral hygiene; toileting and elimination; normal range of motion; positioning; safe transfer techniques; ambulation; fluid intake; adequate nutrition; communication skills; infection control: standard precautions; observing and reporting patient status and care furnished; documenting patient status and care furnished; maintenance of clean, safe and healthy environment; elements of body function and changes to report		obtaining competency skills evaluation tasks with a patient or pseudopatient using a standardized form signed by the RN supervisor. Amonthly file audit system was established, with the HR coordinator and Directorof Clinical Services jointly responsible for verification of all HHAdocumentation before client assignment. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, the AlternateAdministrator will audit 100% of all HHA personnel files on a weekly basis toensure that the HHAs obtained competency skills evaluation tasks with a patientor pseudo patient. The Alternate Director of Clinical Services will conductrandom supervisory visits on all Home Health Aide staff every 2 weeks tomonitor and ensure that all HHAs are performing tasks as per Plan of care. TheDirector of Clinical Services will monitor and review the AlternateAdministrator	

	to supervisor; recognition of emergencies; knowledge of emergency procedures; physical, emotional and developmental needs and ways to work with patients; respect for patient; respect for patient privacy; and respect for patient property were marked as met via observation. The document failed to evidence if the competencies were performed on a patient or pseudo-patient and failed to include the Observer signature/Title. During an interview on 6/19/25 at 1:11 PM, HHA 3 relayed she shadowed HHA 2 and did not complete any skills check-off competencies with a nurse. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator relayed she thought HHA 3 was checked off by RN 1 and was unsure if the competencies were completed on a patient or pseudo-patient. She also relayed that HHA 3 trained with HHA 2 one time before taking on patients alone.		audit findings of all HHA personnel files. Reports will be generatedand results will be compiled to ensure processes have improved. If anydeficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for each week for the next 30days until 100% compliance is achieved. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly personnel audit review. Quarterly audit results will be compiled andsent to the QAPI Committee for review. Once threshold is met, the QualityCommittee will continue to audit 20% of clinical records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. The Directorof Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of	

			this deficiency.	
G0774	12 hours inservice every 12 months 484.80(d) Standard: In-service training. A home health aide must receive at least l2 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient. Based on personnel file review and interview, the home health agency failed to ensure HHA s had the required in-service training hours for 2 of 2 HHA s who have been employed greater than 12 months (HHA 2 and HHA 3). Findings include: 1. The undated agency policy Home Health Aide Services and Training Program indicated a home health aide must receive at least 12 hours of in-service training during each 12-month period and in-service training may occur while an aide is furnishing care to a patient. 2. HHA 2 s personnel file evidenced a hire date of 6/20/24. The file included certificates of attendance for 6.0	G0774	**CorrectiveAction:** In order to correct the abovedeficiency cited under G0774, A comprehensive 100% audit was conducted andcompleted on all active HHA personnel files by the Alternate Administrator on6/20/25 and patient assignments to identify any additional HHAs who may nothave met qualification, training, or competency evaluation requirements. Noadditional instances were identified. However, for transparency and prevention,any HHA with incomplete documentation was temporarily removed from clientassignments until all requirements were fully validated and documented. Clientswere reassigned to fully compliant HHAs to avoid disruption in care. The AlternateAdministrator ensured the HHA's had the required in-service training hours whohave been employed greater than 12 months. During themanagement meeting on 7/7/25, the	2025-07-18

	failed to evidence at least 12 hours of in-service training had been completed in the past 12 months. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator verified the personnel file for HHA 2 did not include at least 12 hours of required in-service training. 3. HHA 4 s personnel file evidenced a hire date of 1/11/22. The file included certificates of attendance for 10.0 hours of HHA training. The file failed to evidence at least 12 hours of in-service training had been completed in the past 12 months. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator verified the personnel file for HHA 4 did not include at least 12 hours of required in-service training.		Administrator, Alternate Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Administrator and Director of Clinical Serviceson 7/9/25 with all staff. During the meeting, the Administrator and the DCSdiscussed the pertaining agency policy and the importance of the requirement toreview that the HHA's must have the required in-service training hours who havebeen employed greater than 12 months. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the agency policyand the requirement. All new staff will be oriented of this requirement at thetime of hire. The corrective actions were implemented on 6/20/25 and will becompleted on 7/18/25.	

			Measuresto assure No recurrence: In orderto ensure that there is no recurrence of this deficiency, the AlternateAdministrator will utilize an HR Audit tool that includes verificationof theHHA's must have the required in-service training hours who have been employedgreater than 12 months. A monthly file audit system wasestablished, with the HR coordinator and Director of Clinical Services jointlyresponsible for verification of all HHA documentation before client assignment. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, the AlternateAdministrator will audit 100% of all HHA personnel files on a weekly basis toensure that the HHA's must have the required in-service training hours who havebeen employed greater than 12 months. The Alternate Director of ClinicalServices will conduct random supervisory	

			visits on all Home Health Aide staffevery 2 weeks to monitor and ensure that all HHAs are performing tasks as perPlan of care. The Director of Clinical Services will monitor and review theAlternate Administrator audit findings of all HHA personnel files. Reports willbe generated and results will be compiled to ensure processes have improved. Ifany deficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for each week for the next 30days until 100% compliance is achieved. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly personnel audit review. Quarterly audit results will be compiled andsent to the QAPI Committee for review. Once threshold is met, the QualityCommittee will continue to audit 20% of clinical records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations.	

			TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0808	Onsite supervisory visit every 14 days 484.80(h)(1)(i) (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services (A) A registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section. Based on record review and interview, the home health agency failed to ensure the RN supervised the HHA every 14 days for 1 of 1 active clinical record reviewed of patients	G0808	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure the RN supervised the HHA every 14 days on-site. 35% review of activecharts was completed by week ending 6/28/25. 30% review of active charts was completedby week ending 7/3/25. Remaining 35% review of charts will be completed by weekending 7/12/25 to complete 100% audit of all active chart audits. In orderto correct the above deficiency cited under G0808, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed	2025-07-18

	services and HHA services (Patient #9). Findings include: 1. The undated agency policy Home Health Aide Supervision indicated if home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient s plan of care and the written patient care instructions must make an onsite visit to the patient s home no less frequently than every 14 days. 2. Patient #9 s clinical record included a POC for the certification period 5/06/25 to 7/04/25 and included orders for SN, PT, OT and HHA services. The record evidenced the RN performed HHA supervisory visits on 4/30/25, 5/16/25, 5/30/25 and 6/11/25. The clinical record failed to evidence RN 1 performed HHA supervisory visits every 14 days. 3. During an interview on 6/17/25 at 2:26 PM, Patient #9		the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy andthe importance of the requirement to review that to ensure the RN supervisedthe HHA every 14 days on-site. Citations listed in the clinical record reviewswere addressed. All staff understood and acknowledged the agency policy and therequirement. All new staff will be oriented of this requirement at the time ofhire. The corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency,	

	relayed RN 1 visited him every couple of months. 4. During an interview on 6/17/25 at 4:25 PM, RN 1 relayed HHA supervisory visits should be done every 30 days and when queued, she stated she did not perform HHA supervisory visits for Patient #9 every 14 days.		clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure the RN supervised the HHA every 14 days on-site. The Alternate Directorof Clinical Services will utilize a chart audit tool to ensure in all activeclinical records that to ensure the RN supervised the HHA every 14 days on-site.This process of utilizing active chart audit tool will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In order to ensure implementation andeffectiveness of this corrective action, the Alternate Director of ClinicalServices will audit 100% of all active charts on a weekly basis to ensure that toensure the RN supervised the HHA every 14 days on-site. The Alternate Directorof Clinical Services will conduct random supervisory visits on all Home	

			to monitor and ensure that all HHAs are performing tasksas per Plan of care. The Director of Clinical Services will monitor and reviewAlternate Director of Clinical Services' audit findings of all active charts.Reports will be generated and results will be compiled to ensure processes haveimproved. If any deficiencies are identified, they will continue to beaddressed with each personnel as needed. This process will continue for eachweek for the next 30 days until 100% compliance is achieved. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audit results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQuality Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations.	

			TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G0810	If concern identified, direct observation 484.80(h)(1)(ii) The supervisory assessment must be completed onsite (that is, an in person visit), or on the rare occasion by using two-way audio-video telecommunications technology that allows for real-time interaction between the registered nurse (or other appropriate skilled professional) and the patient, not to exceed 1 virtual supervisory assessment per patient in a 60-day episode. Based on record review and interview, the home health agency failed to ensure the RN completed an on-site HHA supervisory visit every 14 days for 2 of 2 active clinical record reviewed of patients receiving HHA services (Patient #9 and 12). Findings include: 1. The undated agency policy Home Health Aide Supervision indicated if home health aide services are provided to a patient who is receiving skilled nursing, physical or	G0810	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure the RN completed an on-site HHA supervisory visit every 14 days. 35%review of active charts was completed by week ending 6/28/25. 30% review ofactive charts was completed by week ending 7/3/25. Remaining 35% review ofcharts will be completed by week ending 7/12/25 to complete 100% audit of allactive chart audits. In orderto correct the above deficiency cited under G0808, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical	2025-07-18

	occupational therapy or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient s plan of care and the written patient care instructions must make an onsite visit to the patient s home no less frequently than every 14 days. 2. Patient #9 s clinical record included a POC for the certification period 5/06/25 to 7/04/25 and included orders for SN, PT, OT and HHA services. The record evidenced the RN performed HHA supervisory visits on 4/30/25, 5/16/25, 5/30/25 and 6/11/25. The clinical record failed to evidence RN 1 performed HHA supervisory visits every on-site14 days. During an interview on 6/17/25 at 2:26 PM, Patient #9 relayed RN 1 visited him every couple of months. During an interview on 6/17/25 at 4:25 PM, RN 1 relayed HHA supervisory visits should be done every 30 days and when queued, she stated she did not perform HHA supervisory visits		recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy andthe importance of the requirement to review that to ensure the RN completed anon-site HHA supervisory visit every 14 days. Citations listed in the clinicalrecord reviews were addressed. All staff understood and acknowledged the agencypolicy and the requirement. All new staff will be oriented of this requirementat the time of hire. The corrective actions were implemented on 6/23/25 andwill be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency,	

	for Patient #9 every 14 days in person. She relayed she sometimes called Patient #9 to check-in. Patient #12 s medical record evidenced documentation of a supervisory visit for HHA 2 dated 05/28/2025. The note failed to evidence RN 1 met with Patient #12 in person to review HHA 2 s performance. During an interview on 06/18/2025 beginning at 12:30 PM, RN 1 indicated they called Patient #12 to review HHA s performance and did not make a visit with Patient #12. During an interview on 06/19/2025 beginning at 04:37 PM, the Administrator indicated RN s need to do supervisory visits in the patients homes.		clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure the RN completed an on-site HHA supervisory visit every 14 days. TheAlternate Director of Clinical Services will utilize a chart audit tool toensure in all active clinical records that to ensure the RN completed anon-site HHA supervisory visit every 14 days. This process of utilizing active chartaudit tool will help us identify any discrepancies in the clinical records andre-educate all staff on the above mentioned requirement. **Monitoring:** In order to ensure implementation andeffectiveness of this corrective action, the Alternate Director of ClinicalServices will audit 100% of all active charts on a weekly basis to ensure that toensure the RN completed an on-site HHA supervisory visit every 14 days. The AlternateDirector of Clinical Services will conduct random	

			HomeHealth Aide staff every 2 weeks to monitor and ensure that all HHAs are performingtasks as per Plan of care. The Director of Clinical Services will monitor andreview Alternate Director of Clinical Services' audit findings of all activecharts. Reports will be generated and results will be compiled to ensureprocesses have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue foreach week for the next 30 days until 100% compliance is achieved. After 30days, this process will continue to be monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for their recommendations.	

			TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G1008	Clinical records 484.110 Condition of participation: Clinical records. The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically. Based on record review and interview, the home health agency failed to ensure the patient address was in accurate the medical record (See G1018); failed to submit the discharge summary to the physician within 5 days of discharge (See G1022); and failed to ensure documentation was complete, accurate, and authenticated (See G1024).	G1008	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active and discharged clinicalrecords on 6/23/25 to ensure that the patients address in medical record wasaccurate; all verbal orders were recorded in the POC; the discharge summary wassubmitted to the physician within 5 days of discharge; and documentation wascomplete, accurate, and authenticated. 35% review of active charts wascompleted by week ending 6/28/25. 30% review of active charts was completed byweek ending 7/3/25. Remaining 35% review of charts will be completed by weekending 7/12/25 to complete 100% audit of all active chart audits. In orderto correct the above	2025-07-18

	Findings include: The cumulative effect of these systemic problems had the potential to impact all 165 active patients which resulted in the agency being found out of compliance with the Condition of Participation 42 CFR 484.110 Clinical records		during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policies pertaining to the requirement. The clinicalrecords with the deficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policiesand the importance of the requirement to review that the patients address inmedical record was accurate; all verbal orders were recorded in the POC; thedischarge summary was submitted to the physician within 5 days of discharge;	

			anddocumentation was complete, accurate, and authenticated. Citations listed inthe clinical record reviews were addressed. All staff understood andacknowledged the agency policies and the importance of the requirement. All newstaff will be oriented of this requirement at the time of hire. The correctiveactions were implemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing "Home Health Notify", a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that the patients address in medical record was accurate; all verbalorders were recorded in the POC; the discharge summary was submitted to thephysician within 5 days of	

			was complete, accurate,and authenticated. The Alternate Director of Clinical Services will utilize achart audit tool to ensure that the patients address in medical record wasaccurate; all verbal orders were recorded in the POC; the discharge summary wassubmitted to the physician within 5 days of discharge; and documentation wascomplete, accurate, and authenticated. This process of utilizing active chartaudit tool will help us identify any discrepancies in the clinical records andre-educate all staff on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions,active and discharged charts on a weekly basis to ensure that the patientsaddress in medical record was accurate; all verbal orders were recorded in thePOC; the discharge summary	

			within 5 days ofdischarge; and documentation was complete, accurate, and authenticated. TheDirector of Clinical Services will monitor and review Alternate Director ofClinical Services' audit findings of all new admissions, active and discharged charts.Reports will be generated and results will be compiled to ensure processes haveimproved. If any deficiencies are identified, they will continue to beaddressed with each personnel as needed. This process will continue for eachweek for the next 30 days until 100% compliance is achieved. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audit results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQuality Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations.	

			TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
G1018	Contact information for the patient 484.110(a)(4) Contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s); Based on record review and interview, the agency failed to ensure the patient address was in the medical record for 1 of 1 home visit observations scheduled on 06/13/2025 with RN 2 (Patient #5). Findings include: On 06/12/2025 at 4:05 PM, the Alternate Administrator provided Patient #5 s POC document, which included the address of Patient, for a home visit scheduled for 06/13/2025 at 10 AM. On 06/13/2025, the surveyor arrived at the address listed on the POC at 09:30 AM. At 10:10	G1018	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the patients address in medical record was accurate. 35% reviewof active charts was completed by week ending 6/28/25. 30% review of activecharts was completed by week ending 7/3/25. Remaining 35% review of charts willbe completed by week ending 7/12/25 to complete 100% audit of all active chartaudits. In orderto correct the above deficiency cited under G1018, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed	2025-07-18

	the identified address. There was no answer. At 10:20 AM the surveyor called RN 2 to enquire about the nurse s estimated time of arrival. When the surveyor gave the address, RN 2 indicated this was the patient s old address.		the agency policies pertaining to the requirement. The clinicalrecords with the deficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policiesand the importance of the requirement to review that the patients address inmedical record was accurate. Citations listed in the clinical record reviewswere addressed. All staff understood and acknowledged the agency policies andthe importance of the requirement. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 6/23/25and will be completed on 7/18/25.	

			Measuresto assure No recurrence: In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that the patients address in medical record was accurate. The AlternateDirector of Clinical Services will utilize a chart audit tool to ensure that thepatients address in medical record was accurate. This process of utilizingactive chart audit tool will help us identify any discrepancies in the clinicalrecords and re-educate all staff on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective	

			Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure that the patients address in medicalrecord was accurate. The Director of Clinical Services will monitor and reviewAlternate Director of Clinical Services' audit findings of all new admissionsand active charts. Reports will be generated and results will be compiled toensure processes have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue foreach week for the next 30 days until 100% compliance is achieved. After 30days, this process will continue to be monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for	

			theirrecommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
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.	G1022	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all discharged clinical records on 7/7/25to ensure that the discharge summary was submitted to the physician within 5days of discharge. 35% review of discharged charts was completed by week ending6/28/25. 30% review of discharged charts was completed by week ending 7/3/25. Remaining35% review of charts will be completed by week ending 7/12/25 to complete 100%audit of all discharged chart audits. In orderto correct the above deficiency cited under G1022, during the managementmeeting on 7/7/25, the Administrator,	2025-07-18

	Based on record review and interview, the home health agency failed to submit the discharge summary to the physician within 5 days of discharge for 5 of 5 discharged records reviewed (Patient #3, 4, 14, 15 and 16). Findings include: 1. The agency policy Discharge Summary , last revised 02/2021 indicated a discharge summary will be sent within 5 business days of patient discharge to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient. 2. The agency policy Timely Submission of Patient Documentation , last updated 11/22/23, indicated visit itineraries, with all visit notes, must be submitted within fourteen (14) calendar days and upon discharge from services, the patient discharge summary must be submitted within five (5) business days. 3. Patient #3 s clinical record evidenced a discharge date on 5/21/25 and included a		Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policies pertaining to the requirement. The clinicalrecords with the deficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policiesand the importance of the requirement to review that the discharge summary wassubmitted to the physician within 5 days of discharge. Citations listed in theclinical record reviews were addressed. All staff understood and acknowledged theagency policies and the importance of the requirement. All new staff	

	completed on 6/17/25 by the CM. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge. During an interview on 6/17/25 at 12:35 PM, the CM relayed the discharge summary should be sent to the physician as soon as possible once the discharge has been completed. 4. Patient #4 s clinical record evidenced a discharge date on 6/06/25 and included a discharge summary that was completed on 6/17/25 by RN 3. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed the discharge summary had not been sent to the physician because he had not completed the discharge note yet. 5. Patient #14 s clinical record evidenced a discharge date on 5/27/25. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge.		will beoriented of this requirement at the time of hire. The corrective actions wereimplemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that the discharge summary was submitted to the physician within 5 daysof discharge. The Alternate Director of Clinical Services will utilize a chartaudit tool to ensure that the discharge summary was submitted to the physicianwithin 5 days of discharge. This process of utilizing active chart audit toolwill help us identify any discrepancies in the clinical records and re-educateall staff	

	During an interview on 6/18/25 at 11:35 AM, the Alternate Administrator verified the discharge summary for Patient #14 had not been sent to the physician yet. 5. Patient #15 s clinical record evidenced a discharge date of 5/22/2025. A discharge summary was completed on 5/22/2025, however the record failed to evidence the discharge summary was sent to Patient s physician within 5 days of discharge. During an interview on 6/19/2025 beginning at 10:50 AM, Alternate Administrator reported the agency had no record of Patient s discharge summary being sent to the physician within 5 days of discharge. 6. Patient #13 s medical record evidenced a SOC of 12/14/2024 and a discharge date of 01/17/2025. The Secure Messaging application B evidenced a note by the Alternate Administrator on 02/25/2025, which indicated Patient #16 was discharged. During an interview on		on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all dischargedcharts on a weekly basis to ensure that the discharge summary was submitted tothe physician within 5 days of discharge. The Director of Clinical Serviceswill monitor and review Alternate Director of Clinical Services' audit findingsof all discharged charts. Reports will be generated and results will becompiled to ensure processes have improved. If any deficiencies are identified,they will continue to be addressed with each personnel as needed. This processwill continue for each week for the next 30 days until 100% compliance isachieved. After 30 days, this process will continue to be monitored on a quarterlybasis and will be included in the quarterly chart audit review. Quarterly auditresults will be	

	the Alternate Administrator indicated there was no record of the discharge summary being sent to Patient #13 s primary care provider.		compiled and sent to the QAPI Committee for review. Oncethreshold is met, the Quality Committee will continue to audit 20% of clinicalrecords quarterly to ensure compliance is maintained. The Administrator andQAPI Committee will send a written report to the Governing Body quarterly fortheir recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
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 documentation was	G1024	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the documentation was complete, accurate, and authenticated. 35%review of active charts was completed by week ending 6/28/25. 30% review ofactive charts was completed by week ending 7/3/25. Remaining 35% review	2025-07-18

	complete, accurate, and authenticated for 5 of 12 active records reviewed (Patients #4, 5, 9, 11, and 12). Findings include: .Patient #4's clinical record included a Re-cert Verbal Oder for Home Care: dated 5/23/25 at 1:44 AM completed by RN 3. The comprehensive assessment visit note failed to evidence the patient signature confirming the visit. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed he thought he collaborated with the physician but was unsure if he documented the collaboration and he confirmed he did not receive any orders at 1:44 AM. .Patient #9 s clinical record included an OASIS Recertification completed by RN 1 dated 5/02/25. The recertification visit note failed to include the patient s signature for the visit. Review of the notes from the Secure Messaging Application B for Patient #9 evidenced an		ofcharts will be completed by week ending 7/12/25 to complete 100% audit of allactive chart audits. In orderto correct the above deficiency cited under G1024, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policies pertaining to the requirement. The clinicalrecords with the deficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policiesand the importance of	

	5:49 PM indicated she would see Patient #9 on 5/06/25 at 12:00 PM. Another entry made by RN 1 on 5/06/25 at 3:02 PM indicated the recertification visit had been completed. The OASIS Recertification visit note failed to evidence the accurate date that the visit occurred on. During an interview on 6/13/25 at 1:27 PM, the CM relayed the recertification comprehensive assessment should be completed within the last five days of the certification period. During an interview on 6/17/25 at 4:25 PM, RN 1 relayed she did not complete the recertification visit on 5/02/25 and she confirmed the visit was completed on 5/06/25. 1.The undated agency policy Timely Submission of Patient Documentation indicated documentation must be completed within 14 calendar days. 3. Patient #5 s medical record evidenced a comprehensive assessment for the SOC dated 03/14/2025, completed by RN		the requirement to review that the documentation wascomplete, accurate, and authenticated. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the agency policiesand the importance of the requirement. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 6/23/25and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that the documentation was complete, accurate, and authenticated. TheAlternate Director of Clinical Services will utilize a chart audit tool toensure that the	

	Consent for Service, Fall Safety Education, and the Emergency plan on 03/14/2025. The agency required these documents to be reviewed and signed at the SOC. The Secure Messaging application B notes included a note by RN 2 that they completed the SOC on 03/14/2025. Patient #5 s POC completed for certification period 05/13/2025 07/11/2025, identified the SOC date 03/13/2025. During an interview on 06/13/2025 at 03:50 PM, Intake Manager 7 indicated they had the SOC as 03/13/2025. The Alternate Administrator confirmed the SOC was 03/14/2025. 5.Patient #11 s medical record evidenced documentation of supervisory visits for LPN 2 dated 05/14/2025 and 06/12/2025, completed by RN 1. There was no global positioning services documentation of RN 1 at Patient #11 s home on 05/14/2025 or 06/12/2025. The record included SN Follow -Up/ Goals Re- Assessment Note completed by RN 1 on		documentation was complete, accurate, and authenticated. Thisprocess of utilizing active chart audit tool will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure that the documentation was complete,accurate, and authenticated. The Director of Clinical Services will monitor andreview Alternate Director of Clinical Services' audit findings of all newadmissions and active charts. Reports will be generated and results will becompiled to ensure processes have improved. If any deficiencies are identified,they will continue to be addressed with each personnel as needed. This processwill continue for each week for the next 30 days until 100% compliance	

	05/22/2025 and 06/16/2025. Global positioning services documentation indicated RN 1 was at Patient #11 s home on those dates. During an interview on 06/18/2025 beginning at 12:30 PM, RN 1 indicated they did supervisory visits on 05/22/2025 and 06/16/2025 but did not put the correct date on the supervisory visit notes. 6.Patient #12 s medical record evidenced documentation of a supervisory visit for LPN 2 dated 06/09/2025, completed by RN 1. The record included a SN Follow -Up/ Goals Re-Assessment Note dated 06/09/2025, completed by RN 1. Global positioning services documentation indicated RN 1 s presence at Patient #12 s home was 06/11/2025 not 06/09/2025. The record failed to evidence global positioning documentation for RN 1 on 06/09/2025. During an interview on 06/18/2025 beginning at 12:30 PM, RN 1 indicated the dates on the supervisory visit note and the SN Follow -Up/ Goals Re-Assessment Note were		isachieved. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audit results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the Quality Committee will continue to audit 20%of clinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the Governing Bodyquarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	

	incorrect. The agency failed to ensure clinicians documentation included the correct date of service.			
N0000	Initial Comments This visit was for a Complaint survey of a Deemed HHA Provider. Survey Dates: June 12, 13, 16, 17, 18 and 19, 2025 Complaint: IN115701 with related deficiencies cited. 12 Month Unduplicated Skilled Admissions: 765	N0000		
N0458	Home health agency administration/management 410 IAC 17-12-1(f) Rule 12 Sec. 1(f) Personnel practices for employees shall be supported by written policies. All employees caring for patients in Indiana shall be subject to Indiana licensure, certification, or registration required to perform the respective service. Personnel records of employees who deliver home health services shall be kept current and shall include documentation of orientation to the job, including the following:	N0458	**Corrective Action:** The Administratorstarted review of all current 45 personnel files on 6/23/25. Review of 75%personnel files was conducted by week ending 6/27/25. Review of 20% personnelfiles was conducted by week ending 7/3/25. Review of remaining 5% personnelfiles was completed on 7/10/25 and it was concluded that all Personnel filesare in compliance and include documented evidence of orientation documentationand a national/expanded criminal history background check for existingpersonnel files. The Administratorhas communicated with our	2025-07-18

	(1) Receipt of job description. (2) Qualifications. (3) A copy of an employee's national/expanded criminal history background check pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on personnel file review and interview, the home health agency failed to ensure personnel files included orientation documentation for 1 of 1 Alternate CM and failed to include a national/expanded criminal history background check for 7 of 7 employee records reviewed with a hire date in the past 18 months (Admin 2, Admin 9, PT1, PT 4, RN 3, HHA 2 and HHA 3). Findings include: 1. The Alternate CM's personnel file indicated a hire date of 10/22/24 and evidenced an appointment as the Alternate		7/7/25 and theyhave stated that their background check includes national/expanded criminalhistory background check. IdentGo will send us a written confirmation and asof 7/11/25, we are still awaiting their response. In order tocorrect the above deficiency cited, in Management meeting on 7/7/25, the Administrator,Alternate Administrator, Director of Clinical Services (DCS) and Alternate Directorof Clinical Services (DCS) reviewed, discussed the agency policy 4.8.1 titled"Personnel Records" under Human Resources Section. During thismeeting, deficiencies cited under N-0458 were reviewed, addressed and discussedin detail. The Administrator has completed re-orientation of agency's policiespertaining to the requirement on 7/7/25 provided by the Governing Body Chair. An in-servicemeeting was conducted by the Administrator and attended by all staff on 7/9/25to discuss agency policy 4.13.1 titled "Personnel Records" underHuman Resources Section. During this meeting, deficiencies cited under N-0458were reviewed, addressed and discussed in detail with all staff. TheAdministrator emphasized on the importance of the requirement that the HomeHealth agency is required to have documented evidence of orientationdocumentation and a national/expanded criminal history background check for allstaff in their personnel records, including the staff that will have directcontact with patients. All staff understood and acknowledged the requirement.All active staff or newly hired staff will provide and the agency will maintaindocumented evidence of orientation documentation and a national/expandedcriminal history background check in their Personnel records. The abovementioned corrective actions were implemented on 6/23/25 and will be completedon 7/18/25 **Measures to assure No recurrence:** In order toensure that there is no recurrence of this deficiency, the HR Manager has madea process update to tracking all License/Personnel Records in EMR as well	

	to evidence a signed job description upon appointment to the Alternate CM position. 2. Admin 2 s personnel file indicated a hire date of 11/06/23 and evidenced an appointment as the Alternate Administrator on 3/01/25. The file failed to evidence a full Expanded criminal history check was performed upon hire. 3. Admin 9 s personnel file indicated a hire date of 3/23/24. The file failed to evidence a full Expanded criminal history check was performed upon hire. 4. PT 1 s personnel file indicated a hire date of 5/22/25. The file failed to evidence a full Expanded criminal history check was performed upon hire. 5. PT 4 s personnel file indicated a hire date of 4/11/25. The file failed to evidence a full Expanded criminal history check was performed upon hire. 6. RN 3 s personnel file indicated a hire date of 12/23/24. The file failed to evidence a full Expanded criminal history check was performed upon hire.		withHire date and expiration date and it will alert the staff and Administrator ofany upcoming expiring documents. The HR Manager will also utilize an HR audittool to ensure that all personnel record contents are current and all personnelfiles contain documented evidence of orientation documentation and anational/expanded criminal history background check. This process of utilizingEMR's License/Personnel records Tracking system and HR audit tool will help usidentify any discrepancies in the personnel files and enforce all staff to havetheir files completed and up to date prior to providing patient care in thehome. **Monitoring:** In order toensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizeEMR's License/Personnel records Tracking system and the HR audit tool and audit100% of all personnel file records on a monthly basis to ensure that all activepersonnel file records show documented evidence of orientation documentationand a national/expanded criminal history background check. The Administratorwill review HR Manager's audit findings of all active personnel file records.Monthly reports will be generated and results will be compiled and sent to theAdministrator to ensure that processes have improved. This process willcontinue for each month for the next 3 months until 100% compliance is achievedand to maintain this level of compliance all new employees at the time of hirewill be oriented with this requirement. If compliance is not achieved at thedesired target of 100% compliance and any deficiencies are identified withinthe next 3 months, they will continue to be addressed with staff re-trainingand re-education in workshops and in-services and with each individualpersonnel as needed. After 3 months, this process will continue to be monitoredon a quarterly basis and will be included in the quarterly HR audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 100%of personnel file records quarterly to	

	7. HHA 2 s personnel file indicated a hire date of 6/20/24. The file failed to evidence a full Expanded criminal history check was performed upon hire. 8. HHA 3 s personnel file indicated a hire date of 4/16/25. The file failed to evidence a full Expanded criminal history check was performed upon hire. 9. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator verified the personnel file for the Alternate CM was missing the signed job description and she verified the home health agency did not have records of the full expanded criminal background checks for Admin 2, Admin 9, PT1, PT 4, RN 3, HHA 2 and HHA 3.		TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. The Administrator will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0460	Home health agency administration/management 410 IAC 17-12-1(g) Rule 12 Sec. 1(g) As follows, personnel records of the supervising nurse, appointed under subsection (d) of this rule, shall: (1) Be kept current. (2) Include a copy of the following: (A) National/ Expanded criminal history	N0460	**Corrective Action:** The Administratorstarted review of all current 45 personnel files on 6/23/25. Review of 75%personnel files was conducted by week ending 6/27/25. Review of 20% personnelfiles was conducted by week ending 7/3/25. Review of remaining 5% personnelfiles was completed on 7/10/25 and it was concluded that all Personnel filesare in compliance and include documented evidence of orientation documentationand a national/expanded criminal history background check for existingpersonnel files. The Administratorhas communicated with our	2025-07-18

	background check pursuant to 16-27-2. (B) Nursing license. (C) Annual performance evaluations. (D) Documentation of orientation to the job. Performance evaluations required by this subsection must be performed every nine (9) to fifteen (15) months of active employment. Based on personnel file review and interview, the home health agency failed to ensure the supervising nurse personnel files included a national/expanded criminal history background check for 2 of 2 supervising nurse personnel files reviewed (Clinical Manager and Alternate Clinical Manager). Findings include: 1. The CM's personnel file indicated a hire date of 3/25/16 and evidenced an appointment as the CM on 3/10/25. The file failed to evidence a full Expanded criminal history check		background check company, IdentGo on 7/7/25 and theyhave stated that their background check includes national/expanded criminalhistory background check. IdentGo will send us a written confirmation and as of7/11/25, we are still awaiting their response. In order tocorrect the above deficiency cited, in Management meeting on 7/7/25, the Administrator,Alternate Administrator, Director of Clinical Services (DCS) and Alternate Directorof Clinical Services (DCS) reviewed, discussed the agency policy 4.8.1 titled"Personnel Records" under Human Resources Section. During thismeeting, deficiencies cited under N-0460 were reviewed, addressed and discussedin detail. The Administrator has completed re-orientation of agency's policiespertaining to the requirement on 7/7/25 provided by the Governing Body Chair. An in-servicemeeting was conducted by the Administrator and attended by all staff on 7/9/25to discuss agency policy 4.13.1 titled "Personnel Records" underHuman Resources Section. During this meeting, deficiencies cited under N-0460were reviewed, addressed and discussed in detail with all staff. TheAdministrator emphasized on the importance of the requirement that the HomeHealth agency is required to have documented evidence of a national/expandedcriminal history background check for all staff in their personnel records,including the staff that will have direct contact with patients. All staffunderstood and acknowledged the requirement. All active staff or newly hiredstaff will provide and the agency will maintain documented evidence of anational/expanded criminal history background check in their Personnel records. The abovementioned corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measures to assure No recurrence:** In order toensure that there is no recurrence of this deficiency, the HR Manager has madea process update to tracking all License/Personnel Records in EMR as well withHire date and expiration date and it will alert the staff and Administrator ofany	

	was performed and failed to include orientation documentation upon appointment to the CM position. 2**.** The Alternate CM's personnel file indicated a hire date of 10/22/24 and evidenced an appointment as the Alternate CM on 3/10/25. The file failed to evidence a full Expanded criminal history check was performed and failed to include orientation documentation upon appointment to the Alternate CM position. 3. During an interview on 6/17/25 at 4:35 PM, the Alternate CM was unsure who the CM was and she referred to the CM as the Alternate CM. 4. During an interview on 6/18/25 at 2:00 PM, the Alternate Administrator verified the personnel files for the CM and Alternate CM did not include full criminal history checks and did not include any orientation to the positions.		upcoming expiring documents. The HR Manager will also utilize an HR audittool to ensure that all personnel record contents are current and all personnelfiles contain documented evidence of a national/expanded criminal historybackground check. This process of utilizing EMR's License/Personnel recordsTracking system and HR audit tool will help us identify any discrepancies inthe personnel files and enforce all staff to have their files completed and upto date prior to providing patient care in the home. **Monitoring:** In order toensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizeEMR's License/Personnel records Tracking system and the HR audit tool and audit100% of all personnel file records on a monthly basis to ensure that all activepersonnel file records show documented evidence of a national/expanded criminalhistory background check. The Administrator will review HR Manager's auditfindings of all active personnel file records. Monthly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each month for thenext 3 months until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within the next 3 months, theywill continue to be addressed with staff re-training and re-education inworkshops and in-services and with each individual personnel as needed. After 3months, this process will continue to be monitored on a quarterly basis andwill be included in the quarterly HR audit review. Quarterly audits resultswill be compiled and sent to the QAPI Committee for review. Once threshold ismet, the QAPI Committee will continue to audit 100% of personnel file recordsquarterly to ensure compliance is maintained. The Administrator and QAPICommittee will send a written report to the Governing Body quarterly for theirrecommendations.	

			The Administrator will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0464	Home health agency administration/management 410 IAC 17-12-1(i) Rule 12 Sec. 1(i) The home health agency shall ensure that all employees, staff members, persons providing care on behalf of the agency, and contractors having direct patient contact are evaluated for tuberculosis and documentation as follows: (1) Any person with a negative history of tuberculosis or a negative test result must have a baseline two-step tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual has documentation that a tuberculin skin test has been applied at any time during the previous twelve (12) months and the result was negative. (2) The second step of a two-step tuberculin skin test using the Mantoux method must be administered one (1) to three (3) weeks after the first tuberculin skin test was administered. (3) Any person with: (A) a documented: (i) history of tuberculosis; (ii) previously positive test result for tuberculosis; or (iii)completion of treatment for tuberculosis; or (B) newly positive results to the tuberculin skin test; must have one (1) chest rediograph to exclude a diagnosis of tuberculosis. (4) After baseline testing, tuberculosis screening must:	N0464	**Corrective Action:** The Administratorstarted review of all current 45 personnel files on 6/23/25. Review of 75%personnel files was conducted by week ending 6/27/25. Review of 20% personnelfiles was conducted by week ending 7/3/25. Review of remaining 5% personnelfiles was completed on 7/10/25 and it was concluded that all Personnel filesare in compliance and include all employees providing care to patients werescreened for tuberculosis (TB, a contagious lung infection) upon hire. In order tocorrect the above deficiency cited, in Management meeting on 7/7/25, the Administrator,Alternate Administrator, Director of Clinical Services (DCS) and Alternate Directorof Clinical Services (DCS) reviewed, discussed the agency policy 4.8.1 titled"Personnel Records" under Human Resources Section. During thismeeting, deficiencies cited under N-0464 were reviewed, addressed and discussedin detail. The Administrator has completed re-orientation of agency's policiespertaining to the requirement on 7/7/25 provided by the Governing Body Chair. An in-servicemeeting was conducted by the Administrator and attended by all staff on 7/9/25to discuss agency policy 4.13.1 titled "Personnel Records" underHuman Resources Section. During this meeting, deficiencies cited under N-0464were reviewed, addressed and discussed in detail with all staff. The Administratoremphasized on the importance of the requirement that all employees providingcare to patients must be screened for tuberculosis (TB, a contagious lunginfection) upon hire and documentation must be present in their personnelrecords. All staff understood and acknowledged the requirement. All activestaff or newly hired staff will provide and the agency will maintain documentedevidence of all employees providing care to patients are screened fortuberculosis (TB, a contagious	2025-07-18

	(A) be completed annually; and (B) include, at a minimum, a tuberculin skin test using the Mantoux method or a quantiferon-TB assay unless the individual was subject to subdivision (3). (5) Any person having a positive finding on a tuberculosis evaluation may not: (A) work in the home health agency; or (B) provide direct patient contact; unless approved by a physician to work. (6) The home health agency must maintain documentation of tuberculosis evaluations showing that any person: (A) working for the home health agency; or (B) having direct patient contact; has had a negative finding on a tuberculosis examination within the previous twelve (12) months. Based on personnel record review and interview, the home health agency failed to ensure all employees providing care to patients were screened for tuberculosis (TB, a contagious lung infection) upon hire for 1 of 2 PT personnel files reviewed with direct patient care (PT 4). Findings include: 1. The agency policy Occupational Exposure to Tuberculosis/ Prevention of Transmission of TB Plan indicated employees who have		lung infection) upon hire must be present intheir Personnel records. The abovementioned corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measures to assure No recurrence:** In order toensure that there is no recurrence of this deficiency, the HR Manager has madea process update to tracking all License/Personnel Records in EMR as well withHire date and expiration date and it will alert the staff and Administrator ofany upcoming expiring documents. The HR Manager will also utilize an HR audit toolto ensure that all personnel record contents are current and all personnelfiles contain documented evidence that all employees providing care to patientswere screened for tuberculosis (TB, a contagious lung infection) upon hire.This process of utilizing EMR's License/Personnel records Tracking system andHR audit tool will help us identify any discrepancies in the personnel filesand enforce all staff to have their files completed and up to date prior toproviding patient care in the home. **Monitoring:** In order toensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizeEMR's License/Personnel records Tracking system and the HR audit tool and audit100% of all personnel file records on a monthly basis to ensure that all activepersonnel file records show documented evidence that all employees providingcare to patients must were screened for tuberculosis (TB, a contagious lunginfection) upon hire. The Administrator will review HR Manager's audit findingsof all active personnel file records. Monthly reports will be generated andresults will be compiled and sent to the Administrator to ensure that processeshave improved. This process will continue for each month for the next 3 monthsuntil 100% compliance is achieved and to maintain this level of compliance allnew employees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100%	

	not had a documented negative PPD test during the preceding 12 months, the baseline PPD testing will include two-step method. 2. The Alternate CM s personnel file evidenced a hire date of 10/22/24. The employee's health file included a tuberculin skin test (TST) dated 10/09/24. The personnel health file for the Alternate CM failed to evidence a two-step TB TST was performed upon hire. 3. PT 4 s personnel file evidenced a hire date of 4/11/25. The employee's health file included a tuberculin skin test (TST) dated 4/07/25 and 5/06/25. The 5/06/25 TB test was not read until 6/08/25. The personnel health file for PT 4 failed to evidence the two-step TB TST was completed within one to three weeks after the first step TB TST. 4. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator verified the health personnel files for the Alternate CM and PT 4 did not include appropriate two-step TB tests.		compliance and any deficienciesare identified within the next 3 months, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 3 months, this process will continueto be monitored on a quarterly basis and will be included in the quarterly HRaudit review. Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will continueto audit 100% of personnel file records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Administrator will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

N0466	Home health agency administration/management 410 IAC 17-12-1(j) Rule 12 Sec. 1(j) The information obtained from the: (1) physical examinations required by subsection (h); and (2) tuberculosis evaluations and clinical follow-ups required by subsection (i) must be maintained in separate medical files and treated as confidential medical records, except as provided in subsection (k). Based on observation, personnel file and medical file review, the home health agency failed to maintain the tuberculosis evaluations in a separate medical file for 10 of 10 personnel files reviewed (CM, Alternate CM, Admin 2, Admin 9, PT1, PT 4, RN 3, HHA 2, HHA 3 and HHA 4). Findings include:	N0466	**Corrective Action:** TheAdministrator started review of all current 45 personnel files on 6/23/25. Reviewof 75% personnel files was conducted by week ending 6/27/25. Review of 20%personnel files was conducted by week ending 7/3/25. Review of remaining 5%personnel files was completed on 7/10/25 and it was concluded that allPersonnel files are in compliance and the tuberculosis evaluations aremaintained in a separate medical file. In orderto correct the above deficiency cited, in Management meeting on 7/7/25, the Administrator,Alternate Administrator, Director of Clinical Services (DCS) and Alternate Directorof Clinical Services (DCS) reviewed, discussed the agency policy 4.8.1 titled"Personnel Records" under Human Resources Section. During thismeeting, deficiencies cited under N-0466 were reviewed, addressed and discussedin detail. The	2025-07-18

	1. The CM s personnel file included an envelope stapled to the inside of the personnel file. The envelope contained medical information for the CM. The agency failed to maintain a separate medical file for the CM. 2. The Alternate CM s personnel file included an envelope stapled to the inside of the personnel file. The envelope contained medical information for the Alternate CM. The agency failed to maintain a separate medical file for the Alternate CM. 3. Admin 2 s personnel file included an envelope stapled to the inside of the personnel file. The envelope contained medical information for Admin 2. The agency failed to maintain a separate medical file for Admin 2. 4. Admin 9 s personnel file included an envelope stapled to the inside of the personnel file. The envelope contained medical information for Admin 9. The agency failed to maintain a separate medical file for Admin 9. 5. PT 1 s personnel file included		Administrator has completed re-orientation of agency's policiespertaining to the requirement on 7/7/25 provided by the Governing Body Chair. An in-servicemeeting was conducted by the Administrator and attended by all staff on 7/9/25to discuss agency policy 4.13.1 titled "Personnel Records" underHuman Resources Section. During this meeting, deficiencies cited under N-0466were reviewed, addressed and discussed in detail with all staff. TheAdministrator emphasized on the importance of the requirement that thetuberculosis evaluations are maintained in a separate medical file. All staffunderstood and acknowledged the requirement. All active staff or newly hiredstaff will provide and the agency will maintain the tuberculosis evaluations ina separate medical file. The abovementioned corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measures to assure No recurrence:** In order toensure that there is no recurrence of this deficiency, the HR Manager has madea process update to tracking all License/Personnel Records in EMR as well withHire date and expiration date and it will alert the staff and Administrator ofany upcoming expiring documents. The HR Manager will also utilize an HR audittool to ensure that the tuberculosis evaluations are maintained in a separatemedical file. This process of utilizing EMR's License/Personnel recordsTracking system and HR audit tool will help us identify any discrepancies inthe personnel files and enforce all staff to have their files completed and upto date prior to providing patient care in the home. **Monitoring:** In order toensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place, the HR Manager will utilizeEMR's	

	an envelope stapled to the inside of the personnel file. The envelope contained medical information for PT 1. The agency failed to maintain a separate medical file for PT 1. 6. PT 4 s personnel file included an envelope stapled to the inside of the personnel file. The envelope contained medical information for PT 4. The agency failed to maintain a separate medical file for PT 4. 7. RN 3 s personnel file included an envelope stapled to the inside of the personnel file. The envelope contained medical information for RN 3. The agency failed to maintain a separate medical file for RN 3. 8. HHA 2 s personnel file included an envelope stapled to the inside of the personnel file. The envelope contained medical information for HHA 2. The agency failed to maintain a separate medical file for HHA 2.		License/Personnel records Tracking system and the HR audit tool and audit100% of all personnel file records on a monthly basis to ensure that thetuberculosis evaluations are maintained in a separate medical file. TheAdministrator will review HR Manager's audit findings of all active personnelfile records. Monthly reports will be generated and results will be compiledand sent to the Administrator to ensure that processes have improved. Thisprocess will continue for each month for the next 3 months until 100%compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this requirement. If complianceis not achieved at the desired target of 100% compliance and any deficienciesare identified within the next 3 months, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 3 months, this process will continueto be monitored on a quarterly basis and will be included in the quarterly HRaudit review. Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will continueto audit 100% of personnel file records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. The Administrator will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

	9. HHA 3 s personnel file included an envelope stapled to the inside of the personnel file. The envelope contained medical information for HHA 3. The agency failed to maintain a separate medical file for HHA 3. 10. HHA 4 s personnel file included an envelope stapled to the inside of the personnel file. The envelope contained medical information for HHA 4. The agency failed to maintain a separate medical file for HHA 4. 11. During an interview on 6/19/25 at 1:49 PM, the Administrator relayed the personnel files are kept in a locked cabinet and the medical information should be kept separate.			
N0470	Home health agency administration/management 410 IAC 17-12-1(m) Rule 12 Sec. 1(m) Policies and procedures shall be written and implemented for the control of communicable disease in compliance with applicable federal and state laws. Based on observation, record review, and interview, the	N0470	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure staff followed accepted standards of practice and their own policiesto prevent the transmission of infections and communicable diseases. 25% reviewof active charts was	2025-07-18

	agency failed to ensure employees followed standards of practice for hand hygiene, bag technique and cleaning of equipment to reduce the spread of infections for 2 of 3 home visit observations with a SN (Patient #1 and 11) and 1 of 1 home visit observation with a PTA (Patient #10). Findings include: 1. The undated agency Hand Hygiene Policy and Compliance Program indicated staff should perform hand hygiene before and after direct patient care, before re-entering the nursing bag or patient s clean supplies 2. During a home visit observation conducted with Patient #1 and the CM on 6/13/25 beginning at 9:27 AM, the CM removed supplies from Patient #1 s wound supply box. The CM failed to perform hand hygiene prior to obtaining clean wound supplies. The CM was also observed getting in the nurse bag to gather additional gloves five times throughout the visit. The CM failed to perform hand hygiene after closing the nurse bag. During an interview on 6/13/25		completed by week ending 6/28/25. 15% review of activecharts was completed by week ending 7/3/25. 15% review of active charts will becompleted by week ending 7/12/25. 20% review of active charts will be completedby 7/19/25, 15% review of active charts will be completed by 7/26/25. Remaining10% review of charts will be completed by week ending 8/2/25 to complete 100%audit of all active chart audits. In order to correct the abovedeficiency cited under N0470, in Management meeting on 7/7/25, the Administrator,Alternate administrator, Director of Clinical Services and Alternate Directorof Clinical Services reviewed, discussed the agency policies 5.4.1 titled"Exposure Control Plan: OSHA Regulations", 5.7.1 titled "HandHygiene Policy and Compliance Program" and 3.1.1 titled “EquipmentMaintenance” under Infection Prevention and Control section. The clinicalrecords with the deficiencies were identified and	

	at 1:27 PM, the CM relayed hand hygiene should be performed before the start and at the end of every visit, anytime you are soiled and when accessing the bag, hand hygiene should be performed before getting in the bag. 4. During a home visit observation conducted with Patient #11 and LPN 2 on 06/16/2025 beginning at 02:30 PM, LPN 2 completed Patient #11 s assessment and donned gloves. LPN 2 failed to use alcohol based hand rub before donning new gloves. LPN 2 removed the wound dressing, cleaned the wound, and applied the clean wound dressing. LPN 2 failed to use alcohol- based hand rub before donning gloves and failed to complete hand hygiene and don new gloves after removing the soiled wound dressing. During an interview immediately after the visit, LPN 2 indicated they thought they used alcohol- based hand rub between glove changes. LPN 2 indicated they were not sure they completed hand hygiene		reviewed. The Administrator,Director of Clinical Services and Alternate Director of Clinical Services havecompleted re-orientation of agency's policies pertaining to the requirement on 7/7/25provided by the Governing Body Chair. An in-service was conducted byDirector of Clinical Services on 7/9/25 and attended by all staff includingfield staff. During the meeting, the DCS discussed the importance of therequirement that hand hygiene, using correct technique and equipment must becleaned after each use with an agency approved disinfectant after each use bythe employee who has possession of the equipment; and hands should be washedbefore re-entering the nursing bag. Citations listed in the home visits wereaddressed with the field staff. Based on the deficiency listed, the DCSreiterated agency's policy, "Hand Hygiene Policy and Compliance Program 5.7",states that the agency will follow the Centers for Disease Control	

	and donned new gloves after removing the soiled bandage. 3. During a home visit observation on 6/16/2025 beginning at 1:38 PM, PTA 5 was observed obtaining Patient #10 s vital signs with a thermometer and oxygen saturation (SpO2) monitor. After cleaning the equipment with a Clorox wipe, PTA 5 laid the equipment down to dry on the same side of a barrier field which had been used to store the dirty equipment (dirty side). During an interview on 6/16/2025 beginning at 2:28 PM, PTA 5 reported her barrier field was divided by a clean side and a dirty side, separated by her supply bag in the middle. PTA 5 reported used equipment was not to be moved from one side to the other.		andPrevention (CDC) guidelines for hand hygiene: Put enough sanitizer on yourhands to cover all surfaces ... Rub your hands together until they feel dry(this should take around 20 seconds) and agency policy “Equipment Maintenance”to ensure that the equipment must be cleaned after each use with an agencyapproved disinfectant after each use by the employee who has possession of theequipment; and hands should be washed before re-entering the nursing bag. Allstaff understood and acknowledged the significance of ensuring that they followproper Hand technique and accepted infection control practices must be followedas per guidelines and all field staff will be able to demonstrate it as well.All new staff will be oriented of this requirement at the time of hire. Thecorrective actions were implemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence** In order to ensure that there is	

			the Alt DCS will utilize a supervisory visitaudit tool to ensure that hand hygiene techniques and equipment maintenancepolicy is being followed by all field staff. This process of utilizingsupervisory visit audit tool on all staff will help us identify anydiscrepancies in the supervisory visits pertaining to staff compliance andre-educate all staff including contracted personnel on the above mentionedrequirement. **Monitoring:** In order to ensure implementation andeffectiveness of the corrective action, the following monitoring process willbe put into place. The Alternate DCS will do random supervisory visits on allfield staff every 2 weeks to monitor and ensure that all staff is following thepolicy for hand hygiene techniques and equipment must be cleaned after each usewith an agency approved disinfectant after each use by the employee who haspossession of the equipment; and hands should	

			be washed before re-entering thenursing bag. This process will continue for the next 3-6 months until 100%compliance is achieved and to maintain this level of compliance all newemployees at the time of hire will be oriented with this policy. If complianceis not achieved at the desired target of 100% compliance, the DCS will providere-education of "Hand hygiene and compliance program" and "EquipmentMaintenance" Policy and procedure in in-service to all field staff and provideindividual training to all field staff including therapy staff that are not incompliance. The Infection Control Committee will analyze and track data frominfection control surveillance system and trend the field staff that are notcompliant with "Hand hygiene and compliance program" "Equipment Maintenance"Policy and procedure as mandated. The Administrator will conduct a meeting withthe Clinical Management team, Infection Control Committee and field staff todiscuss the process. If non-compliance continues, the agency will no longerprovide	

			patients to non-compliant field staff until acceptable level ofcompliance is demonstrated and is achieved by the field staff. Once thresholdis met the QAPI Committee will continue to audit 20% of supervisory visitsquarterly to ensure compliance is maintained. The Administrator and QAPICommittee will send a written report to the Governing Body quarterly for theirrecommendations. The Director of Clinical Services willbe responsible for corrective action of this deficiency, measure to assure norecurrence and monitoring of this deficiency.	
N0472	Q A and performance improvement 410 IAC 17-12-2(a)	N0472	**CorrectiveAction:** TheAdministrator concluded that the agency will document the measurable progressachieved on this project every quarter. The measurable progress will beconducted tentatively on 8/1/25 one month post second quarter. The completiondate of performance improvement project will be 12/31/25.	2025-07-18

	Rule 12 Sec. 2(a) The home health agency must develop, implement, maintain, and evaluate a quality assessment and performance improvement program. The program must reflect the complexity of the home health organization and services (including those services provided directly or under arrangement). The home health agency must take actions that result in improvements in the home health agency's performance across the spectrum of care. The home health agency's quality assessment and performance improvement program must use objective measures. Based on QAPI documentation review, policy review, and interview, the home health agency failed to measure, analyze, and track patient use of emergent care services and failed to document the measurable progress achieved on performance improvement projects (PIP), which had the potential to affect all agency patients. Findings include: 1. The undated agency policy Quality Assurance and Performance Improvement (QAPI) Plan and Program) indicated the agency s QAPI program would collect and analyze data on patient use of emergent care services. 2. The agency s QAPI documentation indicated a PIP related to fall prevention was enacted for 1/01/2025 12/31/2025. The PIP		In orderto correct the above deficiency cited, the Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices reviewed and discussed the agency policy 10.6.1 titled, “PerformanceImprovement Projects”. During this management meeting on 7/7/25, deficienciescited in QAPI documentation under N0472 were reviewed, addressed and discussedin detail. The Administrator, Director of Clinical Services and AlternateDirector of Clinical Services have completed re-orientation of agency’spolicies pertaining to the requirement on 7/7/25 provided by the Governing BodyChair. Anin-service was conducted by the Administrator on 7/9/25 with all staff. Duringthe meeting, the Administrator discussed the agency policy 10.6.1 titled,“Performance Improvement Projects” and the	

	documentation evidenced a goal to reduce the incident of patient falls by 20% within 12 months and objectives to conduct comprehensive fall risk assessments for 100% of new admissions & educate 100% of staff on fall prevention protocols and safe mobility practices & perform environmental safety assessments for 90% of high-risk patients to identify hazards and implement modifications .... The committee was to provide quarterly reports to leadership on fall rates, interventions implemented, and outcomes achieved. QAPI meeting minutes from 2/16/2024 4/25/2025 failed to evidence the agency collected and analyzed data on patient use of emergent care services. The meeting minutes for the meeting held 4/25/2025 failed to evidence the committee documented the measurable progress it had achieved towards its PIPs, including interventions implemented, outcomes achieve, and potential need to modify interventions.		importance of the requirement thatthe organization documents the measurable progress achieved on PI project.Citations listed in the QAPI documentation were addressed with all staff. TheAdministrator re-educated all staff on the importance of this requirement. Allstaff understood and acknowledged the agency policy 10.6.1 titled, "PerformanceImprovement Projects" and the importance of the requirement that theorganization documents the measurable progress achieved on these projects. All new staff will be oriented of thisrequirement at the time of hire. **Measuresto assure No recurrence** In orderto ensure that there is no recurrence of this deficiency, the Administratorwill utilize an audit tool with the help of the Director of Clinical Services toensure that the organization documents the measurable progress achieved onthese projects. This process will help us identify and implement	

	3. During an interview on 6/19/2025 beginning at 1:42 PM, Administrator reported that agency s QAPI committee did not track patient use of emergent care services. Administrator stated during the 4/25/2025 QAPI meeting, the agency discussed the number of patient falls which occurred during the previous quarter, but did not discuss anything further regarding the status of the PIP.		improvementsin maintaining the performance Improvement projects and make correctiveadjustments in the future. **Monitoring:** In order to ensure implementation andeffectiveness of this corrective action, the Administrator will audit 100% ofPerformance Improvement project's progress on a monthly basis to ensure thatthe organization documents the measurable progress achieved on these projectsand that the Performance Improvement Project approval is documented inGoverning Body minutes. Monthly reports will be generated by QAPI Committee andresults will be compiled and sent to the Administrator to ensure that processeshave improved. This process will continue every month for the next three monthsuntil 100% compliance is achieved and to maintain this level of compliance, allnew staff at the time of hire will be oriented with this requirement.	

			Ifcompliance is not achieved at the desired target of 100% compliance and if anydeficiencies are identified within three months, they will continue to beaddressed with staff re-training and re-education in workshops and in-servicesand with each individual personnel as needed. Once 100% compliance is achieved,the QAPI Committee will continue to audit performance improvement projectsundertaken on a semi-annual basis to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody semi-annually for their recommendations. The Administrator will be responsiblefor corrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0500	Patient Rights 410 IAC 17-12-3(b)(2)(B) Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the	N0500	**CorrectiveAction:** The Administrator started internal audit review of all complaintlogs on 6/23/25 to ensure the agency documented,	2025-07-18

	home health agency as follows: (2) The patient has the right to the following: (B) Voice grievances regarding treatment or care that is (or fails to be) furnished, or regarding the lack of respect for property by anyone who is furnishing services on behalf of the home health agency and must not be subjected to discrimination or reprisal for doing so. Based on record review, policy review, and interview, the home health agency failed to document and investigate complaints regarding treatment of care which failed to be furnished for 1 of 2 records reviewed which evidenced a report was made to the agency that treatment failed to be furnished by staff (Patient #15). Findings include: 1. The undated agency policy Complaint Resolution, indicated the agency would document the existence, investigate, and document the resolution of a complaint. 2. Patient #15 s clinical record evidenced a SOC of 5/12/2025. The agency noted Patient was discharged from a local hospital on 5/09/2025. Patient was referred for SN, PT, and OT services. A POC for the initial certification period of 5/12/2025 7/10/2025 evidenced Patient was to		investigated, followed up andresolved complaints regarding treatment of care which failed to be furnished. 100% review of complaint logs wascompleted by week ending 6/28/25. 100% review of complaint logs was completedby week ending 7/5/25. 100% review of complaint logs will be completed by weekending 7/12/25. In order to correctthe above deficiency cited under N0500, during the management meeting on7/7/25, the Administrator, Alternate Administrator, Director of ClinicalServices and Alternate Director of Clinical Services reviewed and discussed theorganization's policy under section XII titled “Patient Bill of Rights andResponsibilities 12.1.5" that the patient has the right “to havecomplaints investigated and complaint resolution policy 12.3.1 that the Agencywill investigate complaints made by a patient, the patient’s representative (ifany) and the patient’s caregivers and family”. The clinical records andcomplaint logs with the deficiencies were	

	receive SN visits three times a week, HHA visits three times a week, and a MSW, PT, and OT evaluation. SN interventions were to include wound care to be performed at each visit to wounds on both of Patient s heels. The record evidenced Patient received only one subsequent SN visit, and no HHA, MSW, PT, or OT visits prior to being re-admitted to a hospital on 5/22/2025. Review of messages sent between staff on Secure Messaging Application B evidenced on 5/21/2025, MSW 1 reported she spoke with Person C, healthcare advocate for Patient #15. Person C was reportedly stressed out as no one is calling [him/her], and asking when Patient s wound care and therapy would begin. On 5/21/2025 at 4:24 PM, Scheduler 7 sent a message to staff reporting Person C called the office upset that nursing has not seen Patient since SOC. 3. The agency s log of complaints received 1/01/2025 6/12/2025 failed to evidence a complaint regarding failure to furnish care to Patient #15 was		identified and reviewed. TheAdministrator, Alternate Administrator, Director of Clinical Services andAlternate Director of Clinical Services have completed re-orientation ofagency's policies pertaining to the requirement on 8/23/23 provided by theGoverning Body Chair. The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 7/7/25to ensure that the agencydocumented,investigated, followed up and resolved complaints regarding treatment of carewhich failed to be furnished. 20% review of active charts will be completed byweek ending 7/12/25. 25% review of active charts will be completed by weekending 7/19/25. 30% review of active charts will be completed by week ending 7/26/25.Remaining 25% review of active charts will be completed by 8/2/25 to complete100% audit of all active chart audits.	

	documented, investigated, and resolved. 4. During an interview on 6/16/2025 beginning at 8:30 AM, Person C stated they spoke with Alternate Administrator to report their concerns of visits not being conducted with Patient. Person C reported they were not notified an investigation of the concern would be conducted nor a resolution of the complaint. 5. During an interview on 6/18/2025 beginning at 1:32 PM, Alternate Administrator reported she spoke with Person C, who reported Patient was not getting their nursing visits as ordered and that staff had not contacted Person C to schedule visits. Alternate Administrator reported she did not document or investigate this report as a complaint.		An in-service meeting was conducted by the Administrator andattended by all staff on 7/9/25 to discuss the agency policy under section XIIof the policy titled Patient Bill of Rights and Responsibilities 12.1.4 andcomplaint resolution policy 12.3.1. All staff were informed and re-educated onthe requirement that the patient has the right “to have complaints investigatedand that the Agency will investigate complaints made by a patient, thepatient’s representative (if any) and the patient’s caregivers and family. Citations listed in the clinical recordreviews and complaints logs were addressed. All staff understood andacknowledged the requirement and importance of the need to ensure that thepatient has the right “to have complaints investigated and that the Agency willinvestigate complaints made by a patient, the patient’s representative (if any)and the patient’s caregivers and family. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 7/7/25and completed on 7/18/25.	

			Measuresto assure No recurrence In order to ensure that there is no recurrence of thisdeficiency, Alternate Administrator has made a process update and the Agencywill be utilizing “Home Health Notify”, a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients,Physicians and External organizations to ensure real-time visibility intopatient care and to document, investigate, follow-up and resolve all patientcomplaints. The Alternate Administrator will utilize a complaint log audit tooland audit 100% of all patient complaints on a weekly basis to ensure that allcomplaint logs reflect that patient complaints are fully documented,investigated, followed up and resolved and it must be present in the complaintlogs. This process of utilizing complaint audit tool will help us identify anydiscrepancies in the complaint process and resolution and take	

correctivemeasures accordingly.

Monitoring

In order to ensure implementation and effectiveness of thiscorrective action, the following monitoring process will be put in place; theAdministrator will monitor and review Alternate Director of Clinical Servicesaudit findings of all active patients. Weekly reports will be generated andresults will be compiled and sent to the Administrator to ensure that processeshave improved. This process will continue for each week for the next 30 daysuntil 100% compliance is achieved and to maintain this level of compliance allnew employees at the time of hire will be oriented with this requirement. Ifcompliance is not achieved at the desired target of 100% compliance and anydeficiencies are identified within 30 days, they will continue to be addressedwith staff re-training and re-education in workshops and in-services and witheach individual personnel as needed. After 30 days, this process will

			continueto be monitored on a quarterly basis and will be included in the audit review.Quarterly audits results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the QAPI Committee will continue to audit 25% ofcomplaint logs quarterly to ensure compliance is maintained. The Administratorand QAPI Committee will send a written report to the Governing Body quarterlyfor their recommendations. The Administrator will be responsible for corrective actionof this deficiency, measure to assure no recurrence and monitoring of thisdeficiency.	
N0504	Patient Rights 410 IAC 17-12-3(b)(2)(D)(i) Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows:	N0504	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure the patients were informed about and received the initial therapy orany other discipline assessments, patients were notified of delay in PT or anyother services it was	2025-07-18

	(i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. Based on record review and interview, the home health agency failed to ensure patients were informed about and received the initial therapy assessment for 2 of 4 active records reviewed with a referral for therapy services in the past 40 days (Patient #9 and 12) and 1 of 2 discharge records reviewed with discharge in the past 30 days (Patient #15). Findings include: 1. The undated agency policy Patient Admission Criteria indicated during the initial visit, the admitting professional will verify the information on the referral form. 2. The undated agency policy Patient Bill of Rights and Responsibilities indicated patients have the right to be admitted by the Agency only if it has the resources needed to provide care safely and at the required level of intensity, as determined by a professional		documented, therapy evaluations were completed withinfive days of the comprehensive assessment and Frequencies for all disciplinesordered were followed as per plan of care. 25% review of active charts wascompleted by week ending 6/28/25. 15% review of active charts was completed byweek ending 7/3/25. 15% review of active charts will be completed by weekending 7/12/25. 20% review of active charts will be completed by 7/19/25, 15%review of active charts will be completed by 7/26/25. Remaining 10% review ofcharts will be completed by week ending 8/2/25 to complete 100% audit of allactive chart audits. In orderto correct the above deficiency cited under N0504, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the organization's policy titled “Patient Bill of Rights andResponsibilities 12.1.4" that the clinician is to provide	

	assessment and the patient has the right to receive all services in the plan of care. 3. Patient #9 s clinical record included a recertification POC for the certification period 5/06/25 to 7/04/25. The POC included orders for SN visits two times a week for one week and then three times a week for three weeks; HHA visits two times a week for four weeks; OT visits one time a week for one week, two times a week for three weeks and one time a week for one week; and PT re-eval and treat. The record failed to evidence a PT Evaluation was performed and failed to evidence documentation that the Patient was notified of the delay in PT services. During an interview on 6/13/25 at 1:07 PM, the CM relayed the PT evaluation should be done within five days of the comprehensive assessment. During an interview on 6/17/25 at 2:26 PM, Patient #9 relayed he was told all of the PT s went on vacation at the same time and someone would be calling him to do the PT evaluation		information tothe patient both orally and in writing and that patients have the right toreceive all services in the plan of care and the right to participate in, beinformed about and consent or refuse care in advance of and during treatment.The clinical records with the deficiencies were identified and reviewed. TheAdministrator, Alternate Administrator Director of Clinical Services and theAlternate Director of Clinical Services have completed re-orientation ofagency's policies pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. An in-service meeting was conducted bythe Administrator and attended by all staff on 7/9/25 to discuss the agencypolicy titled, Patient Bill of Rights and Responsibilities 12.1.4". Allstaff were informed and re-educated on the requirement that that the clinicianis to provide information to the patient both orally and in writing:"Patients have the right to receive all	

	when they returned from vacation and he stated he was still waiting on someone to call him for the PT evaluation. 4. Patient #12 s medical record evidenced documentation of a verbal SOC order dated 05/19/2025 and included an order for physical therapy to evaluate and treat. The record failed to evidence a physical therapy evaluation. Documentation failed to evidence the patient was notified there would be no physical therapy assessment. During an interview on 06/17/2025 at 03:50 PM, the Alternate Administrator confirmed Patient #12 did not receive a physical therapy evaluation and was unsure if the MD discontinued the order for the evaluation. 5. Patient #15 s clinical record included a POC for the initial certification period of 5/12/2025 7/10/2025. The POC included orders for SN visits three times a week and HHA visits three times a week. SN interventions included but were not limited to performing wound care to wounds on both		andthe right to participate in, be informed about and consent or refuse care inadvance of and during treatment". Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the requirementand importance of the need to ensure the patients were informed about andreceived the initial therapy or any other discipline assessments, patients werenotified of delay in PT or any other services it was documented, therapyevaluations were completed within five days of the comprehensive assessment andFrequencies for all disciplines ordered were followed as per plan of care. Allnew staff will be oriented of this requirement at the time of hire. Thecorrective actions were implemented on 7/7/25 and will be completed on 7/18/25. **Measuresto assure No recurrence** In orderto ensure that there is no recurrence of this deficiency, the Agency iscurrently utilizing "Home Health Notify", a HIPAA compliant	

	heels. The record evidenced a SOC visit was completed on 5/12/2025. RN 4 noted Patient lived alone with no available caregiver, was legally blind with highly impaired ability to see in adequate light, and required assistance with grooming, dressing, bathing, ambulating, and meal set-up. The record failed to evidence a subsequent SN visit was conducted until 5/22/2025 and failed to evidence a HHA visit was conducted. Patient was admitted to a local hospital on 5/22/2025 and discharged from the agency. A review of messages sent between home health staff on Secure Messaging App B evidenced on 5/09/2025 at 11:44 AM, Intake Manager 7 informed staff to contact Person C, healthcare advocate for Patient, if staff were unable to reach Patient to schedule visits. The record failed to evidence nursing and aide staff attempted to contact Person C after being unable to schedule visits with Patient. During an interview on		communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients,Physicians and External organizations to ensure real-time visibility intopatient care and to ensure that the patients were informed about and receivedthe initial therapy assessment. The Alternate Director of Clinical Serviceswill utilize a chart audit tool and audit 100% of all active patients on aweekly basis to ensure that all clinical records show evidence that thepatients were informed about and received the initial therapy or any otherdiscipline assessments, patients were notified of delay in PT or any other servicesit was documented, therapy evaluations were completed within five days of thecomprehensive assessment and Frequencies for all disciplines ordered werefollowed as per plan of care. The Alternate Director of Clinical Services willfurther ensure that communication with the patient or patient's representativeis present documenting delay in initiating therapy or any other services. Thisprocess of utilizing chart audit tool will help us identify	

	6/16/2025 beginning at 8:30 AM, Person C reported they and Patient had no record of calls from agency staff attempting to schedule visits. Person C stated agency staff did not show for visits on multiple occasions. During an interview on 6/17/2025 beginning at 11:17 AM, LPN 1 reported she had not been told by the agency to contact Person C to arrange for visits until the visit on 5/22/2025. During an interview on 6/18/2025 beginning at 2:04 PM, HHA 2 thought she had attempted to contact Patient and Person C to schedule a HHA visit, but was unsure where these attempts were documented.		any discrepanciesin clinical records and take corrective measures accordingly. **Monitoring** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place; the Alternate Director ofClinical Services will audit 100% of all new admissions on a weekly basis toensure that all clinical records show evidence that the patients were informedabout and received the initial therapy or any other discipline assessments,patients were notified of delay in PT or any other services it was documented, therapyevaluations were completed within five days of the comprehensive assessment andFrequencies for all disciplines ordered were followed as per plan of care andit must be present in home health agency's clinical record. The Director ofClinical Services will monitor and review Alternate Director of ClinicalServices' audit findings	

			of all active patients. Weekly reports will begenerated and results will be compiled and sent to the Administrator to ensurethat processes have improved. This process will continue for each week for thenext 30 days until 100% compliance is achieved and to maintain this level ofcompliance all new employees at the time of hire will be oriented with thisrequirement. If compliance is not achieved at the desired target of 100% complianceand any deficiencies are identified within 30 days, they will continue to beaddressed with staff re-training and re-education in workshops and in-servicesand with each individual personnel as needed. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly chart audit review. Quarterly audits results will be compiled andsent to the QAPI Committee for review. Once threshold is met, the QAPICommittee will continue to audit 20% of clinical records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the	

			Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0505	Patient Rights 410 IAC 17-12-3(b)(2)(D)(ii) Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (ii) The patient has the right to participate in the planning of the care. The home health agency shall advise the patient in advance of the right to participate in planning the following: (AA) The care or treatment. (BB) Changes in the care or treatment. Based on record review and interview, the home health agency failed to ensure the patient received all visits as ordered on the POC for 4 of 5	N0505	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the patients received all services and visits as ordered on thePOC and the patient and physician was notified of the delay in services. 25%review of active charts was completed by week ending 6/28/25. 15% review ofactive charts was completed by week ending 7/3/25. 15% review of active charts willbe completed by week ending 7/12/25. 20% review of active charts will becompleted by 7/19/25, 15% review of active charts will be completed by 7/26/25.Remaining 10% review of charts will be completed by	2025-07-18

	SOC in the past 40 days (Patient #1, 3, 7 and 13) and 2 of 2 discharged records reviewed with discharge in the past 30 days (Patient #14 and 15). Findings include: 1. The undated agency policy Patient Bill of Rights and Responsibilities indicated patients have the right to be admitted by the Agency only if it has the resources needed to provide care safely and at the required level of intensity, as determined by a professional assessment and the patient has the right to receive all services in the plan of care. 2. Patient #1 s clinical record evidenced a SOC on 5/13/25 and included a POC for the certification period 5/13/25 to 7/11/25. The POC indicated the patient was to receive SN visits three times a week for five weeks; OT visits one time a week for one week, two times a week for three weeks, one time a week for one week; and PT evaluation and treat visit effective 5/13/25. The clinical record evidenced the PT evaluation was completed by PT 1 on 5/26/25, 13 days after SOC.		week ending 8/2/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under N0505, during the management meetingon 7/7/25, the Administrator, Alternate Administrator, Director of ClinicalServices and Alternate Director of Clinical Services reviewed and discussed theorganization's policy titled “Patient Bill of Rights and Responsibilities12.1.4" that the that the patient has the right to receive all servicesoutlined in the plan of care”. The clinical records with the deficiencies wereidentified and reviewed. The Administrator, Alternate Administrator Director ofClinical Services and the Alternate Director of Clinical Services havecompleted re-orientation of agency’s policies pertaining to the requirement on 7/7/25provided by the Governing Body Chair. An in-service meeting was conducted bythe Administrator and attended by all staff on	

	The record failed to evidence documentation that Patient #1 and the physician were notified of the delay in the PT Evaluation as ordered on the POC. During an interview on 6/13/25 at 1:07 PM, the CM relayed the PT evaluation should be done within five days of the SOC comprehensive assessment. During an interview on 6/13/25 at 1:54 PM, PT 1 relayed she was hired and completed the PT evaluation on 5/26/25. She was unsure if the patient or physician was notified of the delay of PT services. 3. Patient #3 s clinical record evidenced a SOC on 5/06/25 and included a POC for the certification period 5/06/25 to 7/04/25. The POC indicated the patient was to receive an OT evaluation and treat visit and a PT evaluation and treat visit effective 5/06/25. The clinical record evidenced the OT evaluation was completed by OT 2 on 5/12/25, 6 days after SOC. The clinical record failed to evidence the PT evaluation had been completed and failed to include documentation that Patient #3 and the physician		7/9/25 to discuss the agencypolicy titled, Patient Bill of Rights and Responsibilities 12.1.4". Allstaff were informed and re-educated on the requirement that the patient has the right to receive allservices outlined in the plan of care" and the patient and physician mustbe notified of the delay in services. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the requirementand importance of the need to ensure patients were informed of a delay in startof services. All new staff will be oriented of this requirement at the time ofhire. The corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measuresto assure No recurrence** In orderto ensure that there is no recurrence of this deficiency, the Agency iscurrently utilizing "Home Health Notify", a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams,	

	were notified of the delay in the OT and PT Evaluations as ordered on the POC. During an interview on 6/13/25 at 1:07 PM, the CM relayed the OT and PT evaluations should be done within five days of the SOC comprehensive assessment. During an interview on 6/13/25 at 1:45 PM, OT 1 relayed she thought the initial OT evaluation should be done within 24 hours and she was unsure if the patient or physician was notified of the delay of OT services. During an interview on 6/17/25 at 12:17 PM, PT 4 relayed the PT evaluation should be done within 24 to 48 hours of initial patient encounter and he was not the PT originally assigned to do the evaluation. He also relayed he was unsure if the patient or physician was notified of the delay of PT services. 4. Patient #7 s clinical record evidenced a SOC on 5/19/25 and included a ROC POC		organizations to ensure real-time visibility intopatient care and to ensure that the patients received all services outlined inthe plan of care and the patient and physician was notified of the delay inservices. The Alternate Director of Clinical Services will utilize a chartaudit tool and audit 100% of all active patients on a weekly basis to ensurethat all clinical records show evidence that patients received all servicesoutlined in the plan of care and the patient and physician was notified of thedelay in services. This process of utilizing chart audit tool will help usidentify any discrepancies in clinical records and take corrective measuresaccordingly. **Monitoring** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring process will be put in place; the Alternate Director ofClinical Services will audit 100% of all new admissions on a weekly basis toensure that all clinical	

	indicated the patient was to receive an OT evaluation and treat visit and a PT evaluation and treat visit. The clinical record evidenced the OT evaluation was completed by OT 3 on 6/12/25, 9 days after ROC and the PT evaluation was completed by PT 2 on 6/12/25, 9 days after ROC. The clinical record failed to include documentation that Patient #7 and the physician were notified of the delays in the OT and PT Evaluations as ordered on the ROC. During an interview on 6/13/25 at 2:42 PM, OT 3 relayed she completed the evaluation when she had time and she was unsure if Patient #7 or the physician had been notified of the delay in the OT Evaluation. During an interview on 6/13/25 at 2:30 PM, PT 2 verified the PT evaluation was not completed within five days of ROC and he was unsure if Patient #7 or the physician had been notified of the delay in the PT Evaluation.		records show evidence that the patients received all servicesoutlined in the plan of care and the patient and physician notification of thedelay in services must be present in home health agency's clinical record. The Director of Clinical Services will monitorand review Alternate Director of Clinical Services' audit findings of allactive patients. Weekly reports will be generated and results will be compiledand sent to the Administrator to ensure that processes have improved. Thisprocess will continue for each week for the next 30 days until 100% complianceis achieved and to maintain this level of compliance all new employees at thetime of hire will be oriented with this requirement. If compliance is notachieved at the desired target of 100% compliance and any deficiencies areidentified within 30 days, they will continue to be addressed with staffre-training and re-education in workshops and in-services and with eachindividual personnel as needed. After 30 days, this process will continue to bemonitored on a quarterly	

	5. Patient #13 s clinical record evidenced a SOC on 6/10/25 and included a POC for the certification period 6/10/25 to 8/08/25. The POC indicated the patient was to receive SN visits three times a week for one week, two times a week for two weeks and one time a week for one week; an OT evaluation visit one time a week for one week; and a PT evaluation visit one time a week for one week. The clinical record evidenced the OT evaluation was completed by OT 4 on 6/13/25 and SN visits were completed by the CM on 6/10/25 and 6/13/25. The record failed to evidence Patient #13 received three SN visits as ordered on the POC. The PT evaluation was completed by PT 1 on 6/16/25, 6 days after SOC. The record failed to evidence documentation that Patient #13 and the physician were notified of the delay in the PT Evaluation as ordered on the POC. During an interview on 6/16/25 at 12:35 PM, the CM verified Patient #13 did not receive		basis and will be included in the quarterly chartaudit review. Quarterly audits results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the QAPI Committee will continueto audit 20% of clinical records quarterly to ensure compliance is maintained.The Administrator and QAPI Committee will send a written report to theGoverning Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	

three SN visits as ordered during the week of 6/10/25 and he stated he needed to mark it as a missed visit.

During an interview on 6/18/25 at 10:29 AM, PT 1 relayed she discussed the delay in PT evaluation on Sunday 6/15/25 and she left a message with the physician on 6/16/25 after the PT evaluation visit. She also verified she had not completed any documentation of the discussion of the delay with the patient and had not documented the PT evaluation visit yet.

6. Patient #14 s clinical record evidenced a SOC on 4/11/25 and included a POC for the certification period 4/11/25 to 6/09/25. The POC indicated the patient was to receive a PT evaluation and treat visit and OT visits one time a week for one week, two times a week for three weeks and then one time a week for one week.

Review of the agency complaint

	log evidenced Patient #14 filed a complaint on 5/01/25 due to not receiving the PT evaluation. The clinical record evidenced the PT evaluation was completed on 5/02/25, 21 days after SOC. The record failed to evidence documentation that Patient #14 and the physician were notified of the delay in the PT Evaluation as ordered on the POC. During an interview on 6/18/25 at 10:59 AM, PT 2 relayed he was not sure why the PT evaluation was delayed and he was unsure if the patient or physician had been notified of the delay in PT services. 6. Patient #15 s clinical record evidenced Patient was discharged from a local hospital on 5/09/2025 and SOC date was 5/12/2025. Patient was referred for SN, PT, and OT services. A POC for the initial certification period of 5/12/2025 7/10/2025 included orders for SN visits three times a week, HHA visits			

	three times a week, and an OT evaluation. SN interventions included but were not limited to performing wound care to wounds on both heels. The record evidenced a SOC visit was completed on 5/12/2025. RN 4 noted Patient lived alone with no available caregiver, was legally blind with highly impaired ability to see in adequate light, and required assistance with grooming, dressing, bathing, ambulating, and meal set-up. The record failed to evidence a subsequent SN visit was conducted until 5/22/2025. Patient was admitted to a local hospital for multiple falls on 5/22/2025 and discharged from the agency. The record failed to evidence a HHA visit was conducted while Patient was on services, and failed to evidence an OT evaluation was conducted while Patient was on services. A review of messages sent between home health staff on Secure Messaging App B evidenced on 5/09/2025 at 11:44 AM, Intake Manager 7 informed staff to contact Person C, healthcare advocate for			

	reach Patient to schedule visits. The record failed to evidence nursing and aide staff attempted to contact Person C after being unable to schedule visits with Patient. The messages also failed to evidenced Former Employee D, an OT, attempted to contact Patient or Person C to schedule the OT evaluation until 5/19/2025, which was seven days after the SOC. During an interview on 6/16/2025 beginning at 8:30 AM, Person C reported they and Patient had no record of calls from agency staff attempting to schedule visits. Person C stated agency staff did not show for visits on multiple occasions. The healthcare advocate reported Patient was unable to perform wound care and did not have any available caregivers to perform the wound care when SN staff did not come for the visits.			

	During an interview on 6/17/2025 beginning at 11:17 AM, LPN 1 reported she had not been told by the agency to contact Person C to arrange for visits until the visit on 5/22/2025. During an interview on 6/18/2025 beginning at 2:04 PM, HHA 2 thought she had attempted to contact Patient and Person C to schedule a HHA visit, but was unsure where these attempts were documented. During an interview on 6/19/2025 beginning at 10:57 AM, Alternate Administrator reported the agency had delays in conducting the PT and/or OT evaluation visits due to requiring an order from the physician prior to the evaluation.			
N0520	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Patients shall be accepted for care on the basis of a reasonable expectation that the patient's health needs can be adequately met by the home health agency in the patient's place of residence.	N0520	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the agency meets the patient’s medical, nursing, andrehabilitative needs. 25%	2025-07-18

	Based on record review and interview, the home health agency failed to meet the patient s medical, nursing, and rehabilitative needs for 1 of 1 record reviewed which evidenced the patient was re-admitted to the hospital within two weeks of hospital discharge (Patient #15). Findings include: 1. Patient #15 s clinical record evidenced Patient was discharged from a local hospital on 5/09/2025 and SOC date was 5/12/2025. Patient was referred for SN, PT, and OT services. A POC for the initial certification period of 5/12/2025 7/10/2025 included orders for SN visits three times a week, HHA visits three times a week, a MSW, PT, and OT evaluation. SN interventions included but were not limited to performing wound care to wounds on both heels. The record evidenced a SOC visit was completed on 5/12/2025. RN 4 noted Patient lived alone with no available caregiver, was legally blind with highly impaired ability to see in adequate light, and required		review of active charts was completed by week ending 6/28/25.15% review of active charts was completed by week ending 7/3/25. 15% review ofactive charts will be completed by week ending 7/12/25. 20% review of activecharts will be completed by 7/19/25, 15% review of active charts will be completedby 7/26/25. Remaining 10% review of charts will be completed by week ending8/2/25 to complete 100% audit of all active chart audits. In orderto correct the above deficiency cited under N0520, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the organization's policy 9.3.1 titled “Patient Admission Criteria”.The clinical records with the deficiencies were identified and reviewed. TheAdministrator, Alternate Administrator Director of Clinical Services and theAlternate Director of Clinical	

	assistance with grooming, dressing, bathing, ambulating, and meal set-up. The record failed to evidence a subsequent SN visit was conducted until 5/22/2025, which was 10 days between visits, and failed to evidence a HHA visit nor OT evaluation were conducted while Patient was on services. Patient was discharged from the agency on 5/22/2025 due to hospitalization. 2. Messages sent between home health staff on Secure Messaging App B evidenced the following: a. On 5/09/2025 at 11:44 AM, Intake Manager 7 informed staff to contact Person C, healthcare advocate for Patient, if staff were unable to reach Patient to schedule visits. b. On 5/21/2025 at 8:07 AM, Former Employee D, an OT, informed staff that when speaking with Patient on the phone on 5/20/2025, Patient reported a fall had occurred earlier that day. c. On 5/21/2025 at 3:33 PM 3:38 PM, MSW 1 reported Person C was stressed out as		re-orientation ofagency's policies pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. An in-service meeting was conducted bythe Administrator and attended by all staff on 7/9/25 to discuss the agencypolicy 9.3.1 titled "Patient Admission Criteria". All staff were informed andre-educated on the requirement that the agency must meet the patient's medical,nursing, and rehabilitative needs. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the requirementand importance of the need to ensure patients were informed of a delay in startof services. All new staff will be oriented of this requirement at the time ofhire. The corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measuresto assure No recurrence** In orderto ensure that there is	

	MSW 1 reported Person C asked when PT would begin and how Patient s wound care was being performed. d. On 5/21/2025 at 4:24 PM, Scheduler 7 documented Person C called the office upset that nursing has not seen patient since SOC &. e. On 5/22/2025 at 1:38 PM, LPN 1 documented Patient s pain was an 8 out of 10 on a numeric pain scale. The messages failed to evidence nursing and aide staff attempted to contact Person C after being unable to schedule visits with Patient. 3. Clinical records from Entity H, a hospital, evidenced Patient was hospitalized beginning 5/22/2025 due to multiple falls resulting in rib and pubic ramus (one of the bones which makes up the pelvis) fractures. The records indicated Patient had fallen around midnight on 5/22/2025 and remained on the floor until approximately 12:00 PM. 4. During an interview on 6/16/2025 beginning at 8:30 AM, Person C reported they and		no recurrence of this deficiency, the Agency iscurrently utilizing “Home Health Notify”, a HIPAA compliant communicationapplication for the Agency, clinicians, inter-disciplinary teams, Patients,Physicians and External organizations to ensure real-time visibility intopatient care and to ensure that the agency meets the patient’s medical, nursing,and rehabilitative needs. The Alternate Director of Clinical Services willutilize a chart audit tool and audit 100% of all active patients on a weeklybasis to ensure that all clinical records show evidence that agency meets thepatient’s medical, nursing, and rehabilitative needs. This process of utilizingchart audit tool will help us identify any discrepancies in clinical recordsand take corrective measures accordingly. **Monitoring** In orderto ensure implementation and effectiveness of this corrective action, thefollowing monitoring	

	Patient had no record of calls from agency staff attempting to schedule visits. Person C stated agency staff did not show for visits on multiple occasions. The healthcare advocate reported Patient was unable to perform wound care and did not have any available caregivers to perform the wound care when SN staff did not come for the visits. 5. During an interview on 6/17/2025 beginning at 11:17 AM, LPN 1 reported she had not been told by the agency to contact Person C to arrange for visits until the visit on 5/22/2025. The nurse was unsure who was performing wound care when nursing was unable to conduct visits. LPN 1 stated when she arrived for the SN visit on 5/22/2025, Patient was found on the floor and he/she reported a fall. The nurse stated patient had no broken bones but reported pain to the hip. Patient reportedly declined to have EMS called and she advised Patient to take a dose of his/her pain medication. The record failed to evidence documentation of the nurse s assessment nor Patient		process will be put in place; the Alternate Director ofClinical Services will audit 100% of all new admissions on a weekly basis toensure that all clinical records show evidence that the agency meets thepatient's medical, nursing, and rehabilitative needs and it must be present inhome health agency's clinical record. TheDirector of Clinical Services will monitor and review Alternate Director ofClinical Services' audit findings of all active patients. Weekly reports willbe generated and results will be compiled and sent to the Administrator toensure that processes have improved. This process will continue for each weekfor the next 30 days until 100% compliance is achieved and to maintain thislevel of compliance all new employees at the time of hire will be oriented withthis requirement. If compliance is not achieved at the desired target of 100%compliance and any deficiencies are identified within 30 days, they willcontinue to be addressed with staff re-training and re-education in workshopsand in-services and with each individual personnel as needed. After 30 days,this	

	declination of EMS. 6. During an interview on 6/18/2025 beginning at 2:04 PM, HHA 2 thought she had attempted to contact Patient and Person C to schedule a HHA visit but was unsure where these attempts were documented. 7. During an interview on 6/19/2025 beginning at 10:57 AM, Alternate Administrator reported the agency had delays in conducting the PT and/or OT evaluation visits due to requiring an order from the physician prior to the evaluation.		process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audits results will be compiledand sent to the QAPI Committee for review. Once threshold is met, the QAPICommittee will continue to audit 20% of clinical records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. The Director of Clinical Services will be responsible forcorrective action of this deficiency, measure to assure no recurrence andmonitoring of this deficiency.	
N0522	Patient Care 410 IAC 17-13-1(a) Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, licensed advanced practice registered nurse, licensed physician assistant, dentist, chiropractor, podiatrist, or an optometrist.	N0522	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure services were provided only as ordered by a physician or allowedpractitioner. 35% review	2025-07-18

	Based on record review and interview, the home health agency failed to ensure services were provided only as ordered by a physician or allowed practitioner for 6 of 7 active patient records reviewed with wounds (Patient #1, 2, 4, 7, 9 and 11) and 1 of 1 patient record reviewed with a home visit observation with a PTA (Patient #10). Findings include: 1. The undated agency policy Plan of Care-CMS #485 and Physician/ Practitioner Orders indicated recertification of the Plan of Care is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and the		of active charts was completed by week ending 6/28/25.30% review of active charts was completed by week ending 7/3/25. Remaining 35%review of charts will be completed by week ending 7/12/25 to complete 100%audit of all active chart audits. In orderto correct the above deficiency cited under N0522, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policies titled, 9.10.1, titled “Plan of Care – CMS #485and 11.9.1 Physician Practitioner Orders – Verbal Orders pertaining to therequirement. The clinical records with the deficiencies were identified andreviewed. The Administrator, Alternate Administrator, Director of ClinicalServices and Alternate Director of Clinical Services have completedre-orientation of agency’s policies pertaining to the requirement on 7/7/25provided by the Governing Body Chair.	

	individualized plan of care must be reviewed and revised by the physician/practitioner who is responsible for the home health plan of care and the agency as frequently as the patient s condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. 2. Patient #2 s clinical record was reviewed on 6/12/25 and evidenced a SOC on 4/03/25 and a current certification period of 6/02/25 to 7/31/25. The record failed to include a recertification POC had been created for the certification period beginning 6/02/25 and failed to include documentation of a verbal or written order for SN services to continue. During an interview on 6/13/25 at 2:45 PM, RN 2 relayed she completed an updated comprehensive assessment on 5/29/25 and she failed to create the recertification POC as she was waiting to hear back from the physician s office. 3. Patient #4 s clinical record was reviewed on 6/12/25 and evidenced a SOC on 3/26/25 and a current certification		Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policiestitled, 9.10.1, titled “Plan of Care – CMS #485 and 11.9.1 PhysicianPractitioner Orders – Verbal Orders and the importance of the requirement toensure services were provided only as ordered by a physician or allowedpractitioner. Citations listed in the clinical record reviews were addressed.All staff understood and acknowledged the agency policies and the importance ofthe requirement. All new staff will be oriented of this requirement at the timeof hire. The corrective actions were implemented on 6/23/25 and will becompleted on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary	

	period of 5/25/25 to 7/23/25. The record evidenced a recertification POC was created on 6/05/25, 13 days after the recertification comprehensive assessment visit and failed to evidence collaboration with the physician for the recertification POC. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed he thought he collaborated with the physician but was unsure if he documented the collaboration. 4. Patient #7 s clinical record was reviewed on 6/13/25 and evidenced a SOC on 5/19/25 and a ROC on 5/28/25. The record failed to include a ROC POC had been created beginning 5/28/25 and failed to include documentation of a verbal or written order for SN services to continue. During an interview on 6/17/25 at 4:00 PM, RN 2 relayed she thought she spoke with the physician s office for orders but she was unsure. She also confirmed she did not create a ROC POC after the 5/28/25 ROC visit. .Patient #11 s medical record		teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure services were provided only as ordered by a physician or allowedpractitioner. The Alternate Director of Clinical Services will utilize a chartaudit tool to ensure services were provided only as ordered by a physician orallowed practitioner and documented in the clinical record. This process ofutilizing active chart audit tool will help us identify any discrepancies in theclinical records and re-educate all staff on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure services were provided only asordered by a physician or allowed practitioner and documented in the clinicalrecord. The Director of Clinical Services will monitor	

	evidenced a physician order dated 05/14/2025 for a SN frequency change. The new SN frequency was one visit for one week (effective 05/14/2025), 2 visits for three weeks, and three visits for one week. Patient #11 received SN visits on 05/27/2025 and 05/29/2025 (week one), 06/03/2025, 06/04/2025, 06/09/2025, 06/11/2025, and 06/16/2025. During an interview on 06/18/2025, RN 1 indicated this was not a verbal order, but an order request which was faxed to the physician. RN 1 indicated the order was not valid without a verbal order or a signed order from the physician. SN services were provided without an order. 6. Patient #10 s clinical record evidenced a SOC of 4/23/2025. Patient was to receive one PT visit for one week then two PT visits for four weeks. On 5/22/2025, PT 2 completed a PT re-evaluation visit and documented a physician order to continue PT services for another four weeks. The record failed to evidence the order was signed by Patient s physician. A home visit observation was		and review AlternateDirector of Clinical Services' audit findings of all new admissions and activecharts. Reports will be generated and results will be compiled to ensureprocesses have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue foreach week for the next 30 days until 100% compliance is achieved. After 30days, this process will continue to be monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency,	

	conducted on 6/16/2025 beginning at 1:38 PM with Patient. PTA 5 was observed performing a PTA visit with Patient. During an interview on 6/19/2025 beginning at 11:15 AM, PT 2 reported he did not obtain a verbal order to continue Patient s therapy services. PT 2 stated Patient s initial order for PT services covered all subsequent continuation orders, so a verbal order to continue services was not needed.		measure to assure no recurrence and monitoring of this deficiency.	
N0526	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1(a)(2) The total medical plan of care shall be reviewed by the attending physician, licensed advanced practice registered nurse, licensed physician assistant, dentist, chiropractor, podiatrist, an optometrist, and home health agency personnel as often as the severity of the patient's condition requires, but at least once every two (2) months.	N0526	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure the POC was reviewed with the physician or attending practitioner noless frequently than once every 60 days and the 60 Day Summary was sent to theattending physician at least every 60 days. 35% review of active charts wascompleted by week ending 6/28/25. 30% review of active charts was completed byweek ending 7/3/25. Remaining 35% review	2025-07-18

	Based on record review and interview, the home health agency failed to ensure the POC was reviewed with the physician or attending practitioner no less frequently than once every 60 days, for 4 of 6 active records reviewed with a recertification (Patient #1, 2, 7 and 9). Findings include: 1. The undated agency policy Plan of Care-CMS #485 and Physician/ Practitioner Orders indicated recertification of the Plan of Care is required at least every 60 days when there is a need for continuous home health care after an initial 60-day episode and the individualized plan of care must be reviewed and revised by the physician/practitioner who is responsible for the home health plan of care and the agency as frequently as the patient s condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. 2. Patient #2 s clinical record was reviewed on 6/12/25 and evidenced a SOC on 4/03/25		of charts will be completed by weekending 7/12/25 to complete 100% audit of all active chart audits. In orderto correct the above deficiency cited under N0526, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.10.1, titled "Plan of Care – CMS #485 andPhysician Practitioners Orders and the requirement that the POC was reviewedwith the physician or attending practitioner no less frequently than once every60 days. The clinical records with the deficiencies were identified andreviewed. The Administrator, Alternate Administrator, Director of ClinicalServices and Alternate Director of Clinical Services have completed re-orientationof agency's policy pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. Anin-service was conducted by	

	and a current certification period of 6/02/25 to 7/31/25. The record failed to include a recertification POC had been created for the certification period beginning 6/02/25. Additional record review on 6/16/25 evidenced a POC had been created for the certification period 6/02/25 to 7/31/25. The record failed to include collaboration with the physician for the recertification POC and failed to evidence the recertification POC and 60 Day Summary were sent to the attending physician at least every 60 days. During an interview on 6/13/25 at 2:45 PM, RN 2 relayed she completed an updated comprehensive assessment on 5/29/25 and she failed to create the recertification POC as she was waiting to hear back from the physician s office. She relayed that she created the POC on 6/12/25 in the evening and she was unsure if she received orders from the physician. 3. Patient #4 s clinical record evidenced a SOC on 3/26/25 and a POC for the certification		the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the agency policy 9.10.1, titled"Plan of Care – CMS #485 and Physician Practitioners Orders and the importanceof the requirement that the POC was reviewed with the physician or attendingpractitioner no less frequently than once every 60 days. Citations listed inthe clinical record reviews were addressed. All staff understood andacknowledged the agency policies and the importance of the requirement. All newstaff will be oriented of this requirement at the time of hire. The correctiveactions were implemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing "Home Health Notify", a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to	

	The record failed to include collaboration with the physician for the recertification POC and failed to evidence the recertification POC and 60 Day Summary were sent to the attending physician at least every 60 days. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed he thought he collaborated with the physician but was unsure if he documented the collaboration. 4. Patient #7 s clinical record evidenced a SOC on 5/19/25 and included a ROC POC effective 6/03/25. The ROC indicated the patient was to receive an OT evaluation and treat visit and a PT evaluation and treat visit. The clinical record evidenced the OT evaluation was completed by OT 3 on 6/12/25 and the PT evaluation was completed by PT 2 on 6/12/25. The record failed to evidence collaboration with the physician after the OT and PT evaluations for the POC. During an interview on 6/13/25 at 2:42 PM, OT 3 confirmed that she did not collaborate with the		ensure real-time visibility into patient care and toensure that the POC was reviewed with the physician or attending practitionerno less frequently than once every 60 days. The Alternate Director of ClinicalServices will utilize a chart audit tool to ensure that the POC was reviewedwith the physician or attending practitioner no less frequently than once every60 days and documented in the clinical record. This process of utilizing activechart audit tool will help us identify any discrepancies in the clinicalrecords and re-educate all staff on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure the POC was reviewed with thephysician or attending practitioner no less frequently than once every 60 daysand is	

	relayed she writes up the evaluation and physician orders and it is sent to the physician via the computer. She was unsure if any orders had been received back from the physician's office. During an interview on 6/13/25 at 2:30 PM, PT 2 confirmed he did not collaborate with the physician for the PT POC. He relayed he created the PT POC and it was sent to the physician. 5. Patient #9 s clinical record evidenced a SOC on 11/07/24 and a POC for the certification period of 5/06/25 to 7/04/25. The record failed to include collaboration with the physician for the recertification POC and failed to evidence the recertification POC and 60 Day Summary were sent to the attending physician at least every 60 days. During an interview on 6/17/25 at 4:25 PM, RN 1 relayed she was unsure if she spoke with the physician for the recertification POC.		clinical record. The Director of ClinicalServices will monitor and review Alternate Director of Clinical Services' auditfindings of all new admissions and active charts. Reports will be generated andresults will be compiled to ensure processes have improved. If any deficienciesare identified, they will continue to be addressed with each personnel asneeded. This process will continue for each week for the next 30 days until100% compliance is achieved. After 30 days, this process will continue to bemonitored on a quarterly basis and will be included in the quarterly chartaudit review. Quarterly audit results will be compiled and sent to the QAPICommittee for review. Once threshold is met, the Quality Committee willcontinue to audit 20% of clinical records quarterly to ensure compliance ismaintained. The Administrator and QAPI Committee will send a written report tothe Governing Body quarterly for their recommendations. TheDirector of Clinical Services	

			action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N0527	Patient Care 410 IAC 17-13-1(a)(2) Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. Based on record review and interview, the home health agency failed to promptly alert the physician for a change in the patient condition and/or need to alter the POC for 1 of 1 records reviewed which evidenced a patient fall (Patient #15) and 2 of 4 records reviewed which evidenced missed visits (Patient #4, #15). 3. Patient #4 s clinical record evidenced a SOC date of 3/26/25 and included a POC for the certification period 5/25/25 to 7/23/25 with orders for SN visits three times a week for two	N0527	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure to promptly alert the physician for a change in the patient conditionand/or need to alter the POC. 35% review of active charts was completed by weekending 6/28/25. 30% review of active charts was completed by week ending 7/3/25.Remaining 35% review of charts will be completed by week ending 7/12/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under N0527, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.38.1, titled “Notification to Physician	2025-07-18

	week for two weeks effective 5/26/25. The record indicated SN missed visits were documented on 5/27/25 and 5/28/25. The record failed to evidence Patient #4 s physician was notified of the missed visits. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed he did collaborate with the physician regarding the missed visits. During an interview on 6/18/25 at 1:37 PM, Patient #4 relayed he was not notified in advance of the missed visits. He was frustrated with the home health agency due to several missed visits and not receiving wound care when needed and he requested to be transferred to another home health agency. Findings include: 1. The agency policy Notification of Physician Regarding Missed Visits, dated 02/2024, indicated a missed visit which could not be rescheduled was to be communicated to the physician. Staff were to document the time faxed, the time and person communicated with, or the date notice was mailed.		RegardingMissed Visits" and the requirement to ensure to promptly alert the physicianfor a change in the patient condition and/or need to alter the POC. Theclinical records with the deficiencies were identified and reviewed. TheAdministrator, Alternate Administrator, Director of Clinical Services andAlternate Director of Clinical Services have completed re-orientation ofagency's policy pertaining to the requirement on 7/7/25 provided by theGoverning Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the agency policy 9.38.1,titled "Notification to Physician Regarding Missed Visits" and the requirement toensure to promptly alert the physician for a change in the patient conditionand/or need to alter the POC. Citations listed in the clinical record reviewswere addressed. All staff understood and acknowledged the agency policies andthe importance of the requirement. All new staff	

	2. Patient #15 s clinical record evidenced a SOC date of 5/12/2025. Patient s POC included service orders for SN visits three times a week, HHA visits three times a week, and PT, OT, and MSW evaluations. The record indicated a SN missed visit was documented on 5/15/2025, Patient did not receive a SN visit between 5/12/2025 5/22/2025, and a HHA missed visit was documented on 5/19/2025 and 5/21/2025. The record failed to evidence Patient s physician was notified of the missed visits. During an interview on 6/17/2025 beginning at 11:17 AM, LPN 1 reported when she arrived for Patient s SN visit on 5/22/2025, Patient was found on the floor and reported they have fallen. The record indicated on 5/22/2025, LPN 1 documented she was present at Patient s home for a visit. The record failed to evidence the nurse notified Patient s physician of the fall. During an interview on 6/19/2025 beginning at 10:02 AM, LPN 1 reported she did not		will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 6/23/25and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure to promptly alert the physician for a change in the patient conditionand/or need to alter the POC. The Alternate Director of Clinical Services willutilize a chart audit tool to ensure to promptly alert the physician for achange in the patient condition and/or need to alter the POC and it isdocumented in the clinical record. This process of utilizing active chart audittool will help us identify any discrepancies in the clinical records andre-educate all staff	

	report the missed SN visits to Patient s physician. During an interview on 6/18/2025 beginning at 12:42 PM, HHA 2 stated she reported the missed aide visits to staff at the agency, but could not recall to whom.		on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to promptly alert the physician for a change inthe patient condition and/or need to alter the POC and is being documented inthe clinical record. The Director of Clinical Services will monitor and reviewAlternate Director of Clinical Services' audit findings of all new admissionsand active charts. Reports will be generated and results will be compiled toensure processes have improved. If any deficiencies are identified, they willcontinue to be addressed with each personnel as needed. This process willcontinue for each week for the next 30 days until 100% compliance is achieved.After 30 days, this process will continue to be monitored on a quarterly	

			basisand will be included in the quarterly chart audit review. Quarterly auditresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the Quality Committee will continue to audit 20% of clinicalrecords quarterly to ensure compliance is maintained. The Administrator andQAPI Committee will send a written report to the Governing Body quarterly fortheir recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N0540	Scope of Services 410 IAC 17-14-1(a)(1)(A) Rule 14 Sec. 1(a) (1)(A) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (A) Make the initial evaluation visit.	N0540	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that an initial assessment to determine the patient's immediate needswas performed within 48 hours of referral, or within 48 hours of the	2025-07-18

	Based on record review and interview, the home health agency failed to conduct an initial assessment to determine the patient's immediate care and support needs within 48 hours of referral for 4 of 5 active records reviewed with SOC in the past 40 days (Patient #1, 3, 12 and 13) and 1 of 1 discharged record reviewed with SN services in the past 30 days (Patient #15). Findings include: 1. The undated agency policy Initial Assessments/ Comprehensive Assessments indicated a RN, PT or SLP must conduct the initial assessment visit within 48 hours of referral, within 48 hours of the patient s return home or on the physician/practitioner-ordered start of care date. 2. Patient #1 s clinical record evidenced a referral was received on 5/06/25 and an initial assessment/SOC visit was conducted on 5/13/25. The record failed to evidence documentation of the reason		patient'sreturn home, or on the physician or allowed practitioner -ordered start of caredate or reason for delay in conducting an initial assessment is documented. 25%review of active charts was completed by week ending 6/28/25. 15% review ofactive charts was completed by week ending 7/3/25. 15% review of active charts willbe completed by week ending 7/12/25. 20% review of active charts will becompleted by 7/19/25, 15% review of active charts will be completed by 7/26/25.Remaining 10% review of charts will be completed by week ending 8/2/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under N0540, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 9.6.1 titled, “Initial	

	for delay in conducting an initial assessment. During an interview on 6/13/25 at 1:27 PM, the CM verified the initial assessment was not completed within 48 hours for Patient #1 and relayed it should have been documented in the communication notes or the Secure Messaging Application B that is used internally. Review of the Secure Messaging Application B notes for Patient #1 failed to evidence any documentation of the delay in the initial assessment. 3. Patient #3 s clinical record evidenced a referral was received on 4/29/25 with a planned discharge from the skilled nursing facility on 5/02/25. The initial assessment/SOC visit was conducted on 5/06/25. The record failed to evidence documentation of the reason for delay in conducting an initial assessment. During an interview on 6/13/25 at 1:27 PM, the CM verified the initial assessment was not completed within 48 hours for Patient #3 and relayed it should have been documented in the		sessments". The clinical records with the deficiencies were identified andreviewed. The Administrator, Alternate Administrator, Director of ClinicalServices and Alternate Director of Clinical Services have completedre-orientation of agency's policies pertaining to the requirement on 7/7/25provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed agency policy 9.6.1 titled, "InitialAssessments/Comprehen sive Assessments" and the importance of the requirement thatan initial assessment visit must be held either within 48 hours of referral, orwithin 48 hours of the patient's return home, or on the physician or allowedpractitioner -ordered start of care date" or reason for delay in conducting aninitial assessment is documented. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the agency policy9.6.1 titled, "Initial	

	Secure Messaging Application B. Review of the Secure Messaging Application B notes for Patient #3 failed to evidence any documentation of the delay in the initial assessment. 4. 5. Patient #13 s clinical record evidenced a referral was received on 6/04/25 with a planned discharge from the skilled nursing facility on 6/06/25. The initial assessment/SOC visit was conducted on 6/10/25. The record failed to evidence documentation of the reason for delay in conducting an initial assessment. During an interview on 6/17/25 at 12:35 PM, the CM verified the initial assessment was not completed within 48 hours for Patient #13. Review of the Secure Messaging Application B notes for Patient #13 failed to evidence any documentation of the delay in the initial assessment. 6. Patient #5 s medical record evidenced documentation of the Recertification assessment		Assessments/Comprehensive Assessments" and therequirement that "an initial assessment visit must be held either within 48hours of referral, or within 48 hours of the patient's return home, or on thephysician or allowed practitioner -ordered start of care date" or reason for delayin conducting an initial assessment must be documented. All new staff will beoriented of this requirement at the time of hire. The corrective actions wereimplemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing "Home Health Notify", a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that "an initial assessment to determine the patient's	

	dated 05/09/2025, completed by RN 2. The document activity detail report, which identified when a clinician completed a document, indicated RN 2 completed the document on 05/30/2025. During an interview on 06/12/2025 during the entrance conference, the Alternate Administrator indicated clinicians often completed documentation late. 6. Patient #15 s clinical record evidenced Patient was referred to the agency on 5/06/2025 and was discharged from a local hospital on 5/09/2025. On 5/09/2025 at 10:43 AM, Scheduler 7 messaged RN 4 thru the EMR, informing her that Patient needed to be seen for a SOC visit on 5/10/2025. The record failed to evidence an initial assessment was conducted until 5/12/2025, which was three days after Patient s hospital discharge. The record failed to evidence the reason for this delay. The review of messages sent between staff on Secure Messaging Application B failed		immediate needs isperformed within 48 hours of referral, or within 48 hours of the patient'sreturn home, or on the physician or allowed practitioner -ordered start of caredate" or reason for delay in conducting an initial assessment must bedocumented. The Alternate Director of Clinical Services will utilize a chartaudit tool to ensure that an initial assessment to determine the patient'simmediate needs is performed within 48 hours of referral, or within 48 hours ofthe patient's return home, or on the physician or allowed practitioner -orderedstart of care date or reason for delay in conducting an initial assessment mustbe documented. This process of utilizing active chart audit tool will help usidentify any discrepancies in the clinical records and re-educate all staff onthe above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of	

	to evidence RN 4 attempted to contact Patient and Person C, healthcare advocate for Patient, to schedule an initial assessment until 5/12/2025. During an interview on 6/16/2025 beginning at 8:30 AM, Person C reported they spoke with Scheduler 7 prior to Patient s discharge from the hospital to ensure agency staff would be able to conduct a visit on 5/10/2025, as Patient lived alone, did not have a caregiver available, and was legally blind. Person C stated Scheduler 7 reported a nurse would conduct an initial assessment on 5/10/2025, however no staff conducted the visit or called to report a delay until 5/12/2025. Person C reported they were later told by RN 4 the delay was due to staff availability. During an interview on 6/17/2025 beginning at 2:05 PM, RN 4 reported she would conduct an initial assessment within three to five days of the agency receiving the referral, depending on if the referral was received prior to the weekend. The nurse did not recall if Patient s initial assessment was delayed for any reason. The		Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure that an initial assessment to determine the patient's immediate needs wasperformed within 48 hours of referral, or within 48 hours of the patient'sreturn home, or on the physician or allowed practitioner -ordered start of caredate or reason for delay in conducting an initial assessment is being clearlydocumented in the clinical record. The Director of Clinical Services willmonitor and review Alternate Director of Clinical Services' audit findings ofall new admissions and active charts. Reports will be generated and resultswill be compiled to ensure processes have improved. If any deficiencies areidentified, they will continue to be addressed with each personnel as needed.This process will continue for each week for the next 30 days until 100% complianceis achieved. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audit results will be compiled and sent to the QAPI Committee forreview.	

	nurse stated she did attempt to contact Patient multiple times to schedule the visit, but could not recall the date she began attempting to schedule the visit. During an interview on 6/18/2025 beginning at 1:30 PM, Scheduler 7 reported she had informed Person C that an initial assessment was to be conducted on 5/10/2025.		Once threshold is met, the Quality Committee will continue to audit 20%of clinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. The Directorof Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N0541	Scope of Services 410 IAC 17-14-1(a)(1)(B) Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. Based on observation, record review, and interview, the home health agency failed to ensure the comprehensive assessment included an accurate review of all medications the patient was currently taking for 2 of 6 home	N0541	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the Comprehensive Assessment included an accurate review of allmedications the patient was currently taking and patient's integumentary status.25% review of active charts was completed by week ending 6/28/25. 15% review ofactive charts was completed by week ending 7/3/25. 15% review of	2025-07-18

	visit observations conducted (Patients #1, #10) and failed to ensure the RN performed a wound assessment during the recertification comprehensive assessment for 1 of 1 active clinical record reviewed with wounds and HHA services (Patient #9). The undated agency policy Initial Assessments/Comprehensive Assessments indicated the comprehensive assessment must include integumentary status. 2. Patient #1 s clinical record evidenced a SOC on 5/13/25 and included a comprehensive assessment completed by the CM on 5/13/25 and a POC for the certification period 5/13/25 to 7/11/25. SN visits completed on 5/15/25, 5/16/25, 5/19/25, 5/23/25, 5/26/25, 5/28/25, 6/02/25 and 6/09/25 which evidenced drug regimen review was completed. During a home visit observation conducted with Patient #1 and the CM on 6/13/25 at 9:27 AM, Surveyor comparison of the home health agency s POC medication list against the		active charts willbe completed by week ending 7/12/25. 20% review of active charts will becompleted by 7/19/25, 15% review of active charts will be completed by 7/26/25.Remaining 10% review of charts will be completed by week ending 8/2/25 tocomplete 100% audit of all active chart audits.	

	medications in the home evidenced the following discrepancy: a) Levofloxacin (an antibiotic used to treat a bacterial infection) 750 milligrams (mg), 1 tablet by mouth at bedtime for 14 days. Per Patient #1, they finished this medication a couple of weeks ago. During the entrance conference on 6/12/25 at 9:27 AM, the Alternate Administrator relayed medications should be reconciled on a regular basis. During an interview on 6/17/25 at 12:35 PM, the CM relayed mediations should be reconciled in the home every visit, at least once a week. 3. Patient #9 s clinical record included a comprehensive assessment completed by RN 1 on 5/6/25. The comprehensive assessment evidenced Patient #9 had a pressure ulcer and wound care was performed earlier that day. Patient #9 showed RN 1 a picture of the wound. RN 1 failed to assess Patient #9 s wound during the comprehensive assessment. During an interview on 6/18/25		In orderto correct the above deficiency cited under N0541, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policies pertaining to the requirement. The clinicalrecords with the deficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed agency policies and theimportance of the requirement. Citations listed in the clinical record reviewswere addressed. All staff understood and acknowledged the agency policies andthe importance of	

	at 1:49 PM, RN 1 confirmed she did not perform a skin assessment on Patient #9 during the comprehensive assessment. She stated he is comfortable with the LPN and they have a routine. When asked when she had performed a skin assessment on Patient #9, she relayed it was done on SOC on 11/07/24, six months prior. During an interview on 6/19/25 at 4:34 PM, the Administrator relayed the nurse who is taking care of the patient is responsible for wound assessment and the RN should assess the wound upon every supervisory visit. Findings include: 1. The undated agency policy Medication Reconciliation indicated during the admission comprehensive assessment, the admitting clinician should create and document a complete list of medications that [the] patient is taking at home, including dose, strength, route, and frequency. 3. Patient #10 s clinical record evidenced RN 2 conducted an initial comprehensive		the requirement. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 6/23/25and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that the RN performs a Comprehensive Assessment included an accuratereview of all medications the patient was currently taking skin and woundassessment in the integumentary status during the and it must be documented.The Alternate Director of Clinical Services will utilize a chart audit tool toensure that the RN performs a Comprehensive Assessment included an accuratereview of all	

	documented Patient s Hydrocodone-acetaminophen order was 5-325 mg, one tablet every four hours PRN. During a home visit observation on 6/16/2025 beginning at 1:38 PM, Patient #10 s medication bottles were reviewed. The bottles evidenced Patient s prescription for Hydrocodone-acetaminophen (a combination of an opioid and Tylenol used to treat pain) was 10-325 milligrams (mg), one tablet five times a day as needed (PRN). During an interview on 6/16/2025 beginning at 2:45 PM, Patient reported they had been on the Hydrocodone-acetaminophen dose of 10-325 mg, one tablet five times a day PRN, prior to admission to the home health agency. During an interview on 6/19/2025 beginning at 2:13 PM, RN 2 reported on admission, she would review all medication bottles in the home and compare to the ordering physician s medication list.		medications the patient was currently taking skin and woundassessment in the integumentary status during the and it must be documented.This process of utilizing active chart audit tool will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure that the RN performs a ComprehensiveAssessment included an accurate review of all medications the patient wascurrently taking skin and wound assessment in the integumentary status duringthe and is being clearly documented in the clinical record. The Director ofClinical Services will monitor and review Alternate Director of ClinicalServices' audit findings of all new admissions and active	

			charts. Reports willbe generated and results will be compiled to ensure processes have improved. Ifany deficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for each week for the next 30days until 100% compliance is achieved. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly chart audit review. Quarterly audit results will be compiled and sentto the QAPI Committee for review. Once threshold is met, the Quality Committeewill continue to audit 20% of clinical records quarterly to ensure compliance is maintained. The Administrator and QAPI Committee will send a written reportto the Governing Body quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	

N0544	Scope of Services 410 IAC 17-14-1(a)(1)(E) Rule 14 Sec. 1(a) (1)(E) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (E) Prepare clinical notes. Based on record review and interview, the home health agency failed to ensure all visit note documentation was completed within 14 days for 3 of 7 active patient records reviewed with wounds (Patient #2, 5 and 7) and 2 of 5 discharged records reviewed (Patient's #3 and 4). Findings include: 1. The agency policy Timely Submission of Patient Documentation , last updated 11/22/23, indicated visit itineraries, with all visit notes, must be submitted within fourteen (14) calendar days and upon discharge from services, the patient discharge summary must be submitted within five (5) business days. 2. Patient #2 s clinical record was reviewed on 6/12/25. The	N0544	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure all visit note documentation was completed within fourteen (14) calendardays and discharge summaries were submitted with five (5) business days. 25%review of active charts was completed by week ending 6/28/25. 15% review ofactive charts was completed by week ending 7/3/25. 15% review of active charts willbe completed by week ending 7/12/25. 20% review of active charts will becompleted by 7/19/25, 15% review of active charts will be completed by 7/26/25.Remaining 10% review of charts will be completed by week ending 8/2/25 tocomplete 100% audit of all active chart audits. In orderto correct the above deficiency cited under N0544, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and	2025-07-18

	record failed to evidence any SN visits performed after 5/22/25. Additional record review on 6/16/25 evidenced a SN visit was completed on 5/27/25. This visit note was completed 6/14/25, 18 days after the visit. A SN recertification visit was completed on 5/29/25. This visit note was completed on 6/13/25, 15 days after the visit. The RN failed to complete SN visit notes within 14 days of the visit. During an interview on 6/13/25 at 2:45 PM, RN 2 relayed she had seven to fourteen days to complete visit notes in the EMR. 3. Patient #3 s clinical record evidenced a discharge date on 5/21/25 and included a discharge summary that was completed on 6/17/25 by the CM. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge. During an interview on 6/17/25 at 12:35 PM, the CM relayed the discharge summary should be sent to the physician as soon as possible once the discharge has been completed.		Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy andthe importance of the requirement to review that the all visit notedocumentation was completed within fourteen (14) calendar days and dischargesummaries were submitted with five (5) business days. Citations listed in theclinical record reviews were addressed. All staff understood and acknowledgedthe agency policy and the requirement. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 6/23/25and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency,	

	4. Patient #4 s clinical record evidenced a discharge date on 6/06/25 and included a discharge summary that was completed on 6/17/25 by RN 3. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed the discharge summary had not been sent to the physician because he had not completed the discharge note yet. 6. Patient #7 s clinical record was reviewed on 6/13/25 and evidenced a SOC on 5/19/25 and a ROC on 5/28/25. The record failed to include a ROC SN visit note had been completed for 5/28/25. During an interview on 6/17/25 at 4:00 PM, RN 2 confirmed she did not create a SN visit note for the 5/28/25 ROC visit. She relayed she created this late. . Patient #5 s medical record evidenced documentation of the Recertification assessment dated 05/09/2025, completed		the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and allvisit note documentation was completed within fourteen (14) calendar days anddischarge summaries were submitted with five (5) business days. The AlternateDirector of Clinical Services will utilize a chart audit tool to ensure in allactive clinical records that all visit note documentation was completed within fourteen(14) calendar days and discharge summaries were submitted with five (5)business days. This process of utilizing active chart audit tool will help usidentify any discrepancies in the clinical records and re-educate all staff onthe above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective	

	detail report, which identified when a clinician completed a document, indicated RN 2 completed the document on 05/30/2025. During an interview on 06/12/2025 during the entrance conference, the Alternate Administrator indicated clinicians often completed documentation late.		action, theAlternate Director of Clinical Services will audit 100% of all active charts ona weekly basis to ensure that all visit note documentation was completed withinfourteen (14) calendar days and discharge summaries were submitted with five(5) business days. The Director of Clinical Services will monitor and reviewAlternate Director of Clinical Services' audit findings of all active charts.Reports will be generated and results will be compiled to ensure processes haveimproved. If any deficiencies are identified, they will continue to beaddressed with each personnel as needed. This process will continue for eachweek for the next 30 days until 100% compliance is achieved. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audit results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQuality Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written	

			report to the Governing Body quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N0547	Scope of Services 410 IAC 17-14-1(a)(1)(H) Rule 14 Sec. 1(a) (1)(H) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (H) Accept and carry out physician, licensed advanced practice registered nurse, licensed physician assistant, dentist, chiropractor, podiatrist, or optometrist orders (oral and written). Based on record review and	N0547	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure all verbal orders were authenticated and signed by the orderingphysician or practitioner within 30 days. 35% review of active charts wascompleted by week ending 6/28/25. 30% review of active charts was completed byweek ending 7/3/25. Remaining 35% review of charts will be completed by weekending 7/12/25 to complete 100% audit of all active chart audits. In orderto correct the above deficiency cited under N0547, during the managementmeeting on	2025-07-18

	agency failed to ensure all verbal orders were authenticated and signed by the ordering physician or practitioner within 30 days for 2 of 14 complete records reviewed (Patients #10, #15). Findings include: 1. The agency policy Physician/Practitioner Orders Verbal Orders, dated 11/22/2023, indicated after a verbal order was documented, it was to be sent to the physician for signature and authentication. 2. The agency QAPI documentation for 2025 evidenced the agency tracked the number of verbal orders received authenticated and signed from the ordering physician within 30 days. 3. Patient #10 s clinical record evidenced a SOC of 4/23/2025. The record evidenced the following verbal orders were obtained: a. An order to delay SOC, dated 4/23/2025 and signed by RN 2.		7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy 11.9.1 Physician Practitioner Orders – VerbalOrders pertaining to the requirement. The clinical records with thedeficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policy pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy 11.9.1Physician Practitioner Orders – Verbal Orders and the importance of therequirement to ensure all verbal orders were authenticated and signed by theordering physician or practitioner within 30 days. Citations listed in theclinical record reviews were addressed.	

	EMR by RN 2 on 6/15/2025. b. An order to begin home health services, including a PT and OT evaluation, dated 4/23/2025 and signed by RN 2. c. An order to begin PT visits and for the PT portion of the POC, dated 4/24/2025 and signed by PT 2. d. An order to begin OT visits, dated 4/28/2028 and signed by OT 6. The record failed to evidence the ordering physician authenticated and signed the verbal orders within 30 days. During an interview on 6/18/2025 beginning at 1:32 PM, Alternate Administrator reported the agency had no signed verbal orders for Patient. 4. Patient #10 s clinical record evidenced a SOC of 5/12/2025. The record evidenced the following verbal orders were obtained: a. An order to delay SOC, dated 5/13/2025 by RN 4. b. An order to begin home health services, including SN		All staff understood and acknowledgedthe agency policies and the importance of the requirement. All new staff willbe oriented of this requirement at the time of hire. The corrective actionswere implemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure all verbal orders were authenticated and signed by the orderingphysician or practitioner within 30 days. The Alternate Director of ClinicalServices will utilize a chart audit tool to ensure all verbal orders were authenticatedand signed by the ordering physician or practitioner within 30 days and	

	OT, and MSW evaluation, dated 5/13/2025 by RN 4. The record failed to evidence the ordering physician authenticated and signed the verbal orders within 30 days. During an interview on 6/18/2025 beginning at 1:32 PM, Alternate Administrator reported the agency had no signed verbal orders for Patient. 5. During an interview on 6/19/2025 beginning at 1:42 PM, Administrator reported verbal orders were to be authenticated and signed by the ordering physician within 30 60 days.		placedin the clinical record. This process of utilizing active chart audit tool willhelp us identify any discrepancies in the clinical records and re-educate allstaff on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure all verbal orders were authenticatedand signed by the ordering physician or practitioner within 30 days and placedin the clinical record. The Director of Clinical Services will monitor andreview Alternate Director of Clinical Services' audit findings of all newadmissions and active charts. Reports will be generated and results will becompiled to ensure processes have improved. If any deficiencies are identified,they will continue to be addressed with each personnel as needed. This processwill continue for	

			each week for the next 30 days until 100% compliance isachieved. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audit results will be compiled and sent to the QAPI Committee forreview. Once threshold is met, the Quality Committee will continue to audit 20%of clinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N0549	Scope of Services 410 IAC 17-14-1(a)(1)(J) Rule 14 Sec. 1(a) (1)(J) Except where services	N0549	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical	2025-07-18

	are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (J) Direct the activities of the licensed practical nurse. Based on record review and interview, the home health agency failed to ensure the RN supervised the LPN every 30 days on-site for 1 of 1 active clinical record reviewed of patients receiving skilled wound care services with an LPN (Patient #9). Findings include: 1. The undated agency policy Supervision of Licensed Practical/Licensed Vocational Nurse indicated services furnished by a Licensed Practical/Licensed Vocational Nurse will be furnished under the supervision of a qualified registered nurse and supervisory visits will occur every 30 days. 2. Patient #9 s clinical record included a POC for the certification period 5/06/25 to 7/04/25 and included orders for SN, PT, OT and HHA services. The record evidenced the LPN performed visits on 5/07/25,		the RN supervised the LPN every 30 days on-site. 25% review of activecharts was completed by week ending 6/28/25. 15% review of active charts was completedby week ending 7/3/25. 15% review of active charts will be completed by weekending 7/12/25. 20% review of active charts will be completed by 7/19/25, 15% reviewof active charts will be completed by 7/26/25. Remaining 10% review of chartswill be completed by week ending 8/2/25 to complete 100% audit of all activechart audits. In orderto correct the above deficiency cited under N0549, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Director of Clinical Services	

	5/16/25, 5/19/25, 5/23/25, 5/24/25, 5/26/25, 5/28/25, 5/30/25, 6/03/25, 6/05/25, 6/07/25, 6/09/25, 6/11/25, 6/13/25 and 6/16/25 and RN 1 documented LPN supervisory visits on 4/04/25, 5/06/25 and 5/30/25. The clinical record failed to evidence RN 1 performed on-site LPN supervisory visits every 30 days with Patient #9. 3. During an interview on 6/17/25 at 2:26 PM, Patient #9 relayed RN 1 visited him every couple of months. 4. During an interview on 6/18/25 at 1:49 PM, RN 1 relayed LPN supervisory visits should be done every month and she relayed she didn t always do the supervisory visits in person, she sometimes called Patient #9 to check-in.		on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy andthe importance of the requirement to review that the RN supervised the LPNevery 30 days on-site. Citations listed in the clinical record reviews wereaddressed. All staff understood and acknowledged the agency policy and therequirement. All new staff will be oriented of this requirement at the time ofhire. The corrective actions were implemented on 6/23/25 and will be completedon 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure the RN supervised the LPN every 30 days on-site. The Alternate	

			utilize a chart audit tool to ensure in all activeclinical records that the RN supervised the LPN every 30 days on-site. Thisprocess of utilizing active chart audit tool will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all active charts ona weekly basis to ensure that the RN supervised the LPN every 30 days on-site. TheAlternate Director of Clinical Services will conduct random supervisory visitson all LPN staff every 2 weeks to monitor and ensure that all LPNs are performingtasks as per Plan of care. The Director of Clinical Services will monitor andreview Alternate Director of Clinical Services' audit findings of all activecharts. Reports will be generated and results will be compiled to ensureprocesses	

			have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue foreach week for the next 30 days until 100% compliance is achieved. After 30days, this process will continue to be monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	

N0554	Scope of Services 410 IAC 17-14-1(a)(2)(B) Rule 14 Sec. 1(a) (2) (B) For purposes of practice in the home health setting, the licensed practical nurse shall do the following: (B) Prepare clinical notes. Based on record review and interview, the LPN failed to document SN visit notes for 1 of 4 record reviewed of LPNs providing care (Patient #15). Findings include: 1. Patient #15 s clinical record included a POC for the initial certification period of 5/12/2025 7/10/2025. Patient was ordered to receive skilled nurse visits three times a week, with interventions to include SN to perform complete physical assessment each visit & notify physician immediately of any potential problems &. The SN was also to perform wound care to wounds on both heels. On 5/22/2025, LPN 1 documented a communication note stating she was at Patient s home for assessment visit. The record failed to evidence any further documentation	N0554	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the LPN documented SN visit notes to include the SN assessment,wound care performed, and physician notification of Patient's fall forapplicable patient records. 25% review of active charts was completed by weekending 6/28/25. 15% review of active charts was completed by week ending 7/3/25.15% review of active charts will be completed by week ending 7/12/25. 20%review of active charts will be completed by 7/19/25, 15% review of activecharts will be completed by 7/26/25. Remaining 10% review of charts will be completedby week ending 8/2/25 to complete 100% audit of all active chart audits. In orderto correct the above deficiency cited under N0554, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator,	2025-07-18

	regarding the visit, including the SN assessment, wound care performed, and physician notification of Patient s fall. During an interview on 6/17/2025 beginning at 11:17 AM, LPN 1 reported she conducted one visit with Patient but could not recall the date of the visit. The nurse stated she found Patient lying on the floor and Patient reported they had fallen. LPN 1 stated she conducted an assessment, including vital signs and stuff, but was unsure if she had documented this assessment. LPN 1 reported she notified Patient s physician of the fall, however there was no documentation of this report.		Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy andthe importance of the requirement to review that the LPN documented SN visitnotes to include the SN assessment, wound care performed, and physiciannotification of Patient's fall for applicable patient records. Citations listedin the clinical record reviews were addressed. All staff understood andacknowledged the agency policy and the requirement. All new staff will beoriented of this requirement at the time of hire. The corrective actions wereimplemented on 6/23/25 and will be completed on 7/18/25.	

			Measuresto assure No recurrence: In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and allSN visit note documentation was completed and included the SN assessment, woundcare performed, and physician notification of Patient’s fall for applicablepatient records. The Alternate Director of Clinical Services will utilize achart audit tool to ensure in all active clinical records that all SN visitnote documentation was completed and included the SN assessment, wound careperformed, and physician notification of Patient’s fall for applicable patientrecords. This process of utilizing active chart audit tool will help usidentify any discrepancies in the clinical records and re-educate all staff onthe above mentioned requirement.	

			Monitoring: In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all active charts ona weekly basis to ensure that all SN visit note documentation was completed andincluded the SN assessment, wound care performed, and physician notification ofPatient's fall for applicable patient records. The Director of ClinicalServices will monitor and review Alternate Director of Clinical Services' auditfindings of all active charts. Reports will be generated and results will becompiled to ensure processes have improved. If any deficiencies are identified,they will continue to be addressed with each personnel as needed. This processwill continue for each week for the next 30 days until 100% compliance isachieved. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audit results will be compiled and	

			sent to the QAPI Committee forreview. Once threshold is met, the Quality Committee will continue to audit 20%of clinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N0566	Scope of Services 410 IAC 17-14-1(c)(5) Rule 14 Sec. 1(c) The appropriate therapist listed in subsection (b) of this rule shall: (5) prepare clinical notes;	N0566	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure all visit note documentation was completed within fourteen (14) calendardays and discharge summaries were submitted with five (5) business days. 25%review of active charts was completed by week ending 6/28/25. 15% review of activecharts was completed by	2025-07-18

	Based on record review and interview, the home health agency failed to ensure all visit note documentation was completed within 14 days for 1 of 1 PT discharged record reviewed (Patient #14). Findings include: 1. The agency policy Timely Submission of Patient Documentation , last updated 11/22/23, indicated visit itineraries, with all visit notes, must be submitted within fourteen (14) calendar days and upon discharge from services, the patient discharge summary must be submitted within five (5) business days. 2. Patient #14 s clinical record evidenced a discharge date on 5/27/25. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge. During an interview on 6/18/25 at 11:35 AM, the Alternate Administrator verified the discharge summary for Patient #14 had not been completed by PT 2 and had not been sent to the physician.		week ending 7/3/25. 15% review of active charts will becompleted by week ending 7/12/25. 20% review of active charts will be completedby 7/19/25, 15% review of active charts will be completed by 7/26/25. Remaining10% review of charts will be completed by week ending 8/2/25 to complete 100%audit of all active chart audits. In orderto correct the above deficiency cited under N0566, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy andthe importance of the requirement to review that the all visit notedocumentation was	

			completed within fourteen (14) calendar days and dischargesummaries were submitted with five (5) business days. Citations listed in theclinical record reviews were addressed. All staff understood and acknowledgedthe agency policy and the requirement. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 6/23/25and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing "Home Health Notify", a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and allvisit note documentation was completed within fourteen (14) calendar days anddischarge summaries were submitted with five (5) business days. The	

			Services will utilize a chart audit tool to ensure in allactive clinical records that all visit note documentation was completed within fourteen(14) calendar days and discharge summaries were submitted with five (5)business days. This process of utilizing active chart audit tool will help usidentify any discrepancies in the clinical records and re-educate all staff onthe above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all active charts ona weekly basis to ensure that all visit note documentation was completed withinfourteen (14) calendar days and discharge summaries were submitted with five(5) business days. The Director of Clinical Services will monitor and reviewAlternate Director of Clinical Services' audit findings of all active charts.Reports will be generated and results will be	

			haveimproved. If any deficiencies are identified, they will continue to beaddressed with each personnel as needed. This process will continue for eachweek for the next 30 days until 100% compliance is achieved. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly chart audit review. Quarterly audit results will becompiled and sent to the QAPI Committee for review. Once threshold is met, theQuality Committee will continue to audit 20% of clinical records quarterly toensure compliance is maintained. The Administrator and QAPI Committee will senda written report to the Governing Body quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	

N0586	Scope of Services 410 IAC 17-14-1(h) Rule 14 Sec. 1(h) Home health aides must receive continuing education. Such continuing education shall total at least twelve (12) hours from January 1 through December 31, inclusive, with a minimum of eight (8) hours in any eight (8) of the following subject areas: (1) Communications skills, including the ability to read, write, and make brief and accurate oral presentations to patients, caregivers, and other home health agency staff. (2) Observing, reporting, and documenting patient status and the care or service furnished. (3) Reading and recording temperature, pulse, and respiration. (4) Basic infection control procedures and universal precautions. (5) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. (6) Maintaining a clean, safe, and healthy environment. (7) Recognizing emergencies and knowledge of emergency procedures. (8) The physical, emotional, and developmental needs of and ways to work with the populations served by the home health agency, including the need for respect for the patient, the patient's privacy, and the patient's property. (9) Appropriate and safe techniques in personal hygiene and grooming that include the following: (A) Bed bath. (B) Bath; sponge, tub or shower.	N0586	**CorrectiveAction:** In order to correct the above deficiencycited under N0586, A comprehensive 100% audit was conducted and completed onall active HHA personnel files by the Alternate Administrator on 6/20/25 andpatient assignments to identify any additional HHAs who may not have metqualification, training, or competency evaluation requirements. No additionalinstances were identified. However, for transparency and prevention, any HHAwith incomplete documentation was temporarily removed from client assignmentsuntil all requirements were fully validated and documented. Clients werereassigned to fully compliant HHAs to avoid disruption in care. The AlternateAdministrator ensured the HHA’s had the required in-service training hours whohave been employed greater than 12 months. During themanagement meeting on 7/7/25, the Administrator, Alternate	2025-07-18

	(C) Shampoo, sink, tub, or bed. (D) Nail and skin care. (E) Oral hygiene. (F) Toileting and elimination. (10) Safe transfer techniques and ambulation. (11) Normal range of motion and positioning. (12) Adequate nutrition and fluid intake. (13) Medication assistance. (14) Any other task that the home health agency may choose to have the home health aide perform. Based on personnel file review and interview, the home health agency failed to ensure HHA s had the required in-service training hours for 2 of 2 HHA s who have been employed greater than 12 months (HHA 2 and HHA 3). Findings include: 1. The undated agency policy Home Health Aide Services and Training Program indicated a home health aide must receive at least 12 hours of in-service training during each 12-month period and in-service training may occur while an aide is furnishing care to a patient. 2. HHA 2 s personnel file		Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Administrator and Director of Clinical Serviceson 7/9/25 with all staff. During the meeting, the Administrator and the DCSdiscussed the pertaining agency policy and the importance of the requirement toreview that the HHA's must have the required in-service training hours who havebeen employed greater than 12 months. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the agency policyand the requirement. All new staff will be oriented of this requirement at thetime of hire. The corrective actions were implemented on 6/20/25 and will becompleted on 7/18/25.	

	evidenced a hire date of 6/20/24. The file included certificates of attendance for 6.0 hours of HHA training. The file failed to evidence at least 12 hours of in-service training had been completed in the past 12 months. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator verified the personnel file for HHA 2 did not include at least 12 hours of required in-service training. 3. HHA 4 s personnel file evidenced a hire date of 1/11/22. The file included certificates of attendance for 10.0 hours of HHA training. The file failed to evidence at least 12 hours of in-service training had been completed in the past 12 months. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator verified the personnel file for HHA 4 did not include at least 12 hours of required in-service training.		**Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the AlternateAdministrator will utilize an HR Audit tool that includes verificationof theHHA's must have the required in-service training hours who have been employedgreater than 12 months. A monthly file audit system wasestablished, with the HR coordinator and Director of Clinical Services jointlyresponsible for verification of all HHA documentation before client assignment. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, the AlternateAdministrator will audit 100% of all HHA personnel files on a weekly basis toensure that the HHA's must have the required in-service training hours who havebeen employed greater than 12 months. The Alternate Director of ClinicalServices will conduct random supervisory	

			visits on all Home Health Aide staffevery 2 weeks to monitor and ensure that all HHAs are performing tasks as perPlan of care. The Director of Clinical Services will monitor and review theAlternate Administrator audit findings of all HHA personnel files. Reports willbe generated and results will be compiled to ensure processes have improved. Ifany deficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for each week for the next 30days until 100% compliance is achieved. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly personnel audit review. Quarterly audit results will be compiled andsent to the QAPI Committee for review. Once threshold is met, the QualityCommittee will continue to audit 20% of clinical records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations.	

			TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N0596	Scope of Services 410 IAC 17-14-1(l)(A) Rule 14 Sec. 1(l) The home health agency shall be responsible for ensuring that, prior to patient contact, the individuals who furnish home health aide services on its behalf meet the requirements of this section as follows: (1) The home health aide shall: (A) have successfully completed a competency evaluation program that addresses each of the subjects listed in subsection (h) of this rule; and Based on personnel file review and interview, the home health agency failed to ensure the HHA was qualified to provide home health services for 1 of 2 HHA personnel files reviewed who have been employed more	N0596	**CorrectiveAction:** In order to correct the above deficiency citedunder N0596, the agency immediately removed the unqualified HHA from providingdirect care services effective 6/20/25. Each affected client was reassigned toa qualified HHA who met all federal and state requirements and clients/familieswere notified of the change in personnel. The Administrator has also acquiredservices of RN from outside the agency to conduct the required competencyskills evaluation tasks with a patient or pseudo patient for HHAs. Thecompetency evaluation will be completed on 7/11/25. A comprehensive 100% audit wasconducted and completed on all active HHA personnel files	2025-07-18

	than one year (HHA 2). Findings include: 1. The undated agency policy Home Health Aide Services and Training Program indicated a qualified Home Health Aide is a person who has successfully completed: a nurse aide training and competency evaluation program approved by the state as meeting the requirements and is currently listed in good standing on the state nurse aide registry. 2. HHA 2 s personnel file indicated a hire date of 6/20/24. The file included a certificate issued by Entity E on 6/13/24. The file failed to evidence a qualified training and competency evaluation program. 3. Review of the State of Indiana s license and certification verification website, www.mylicense.IN.gov, on 6/19/25 failed to evidence an active HHA license for HHA 2. 4. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator confirmed HHA 2 was not listed on the State of Indiana s license		by the AlternateAdministrator on 6/20/25 and patient assignments to identify any additionalHHAs who may not have met qualification, training, or competency evaluationrequirements. No additional instances were identified. However, fortransparency and prevention, any HHA with incomplete documentation wastemporarily removed from client assignments until all requirements were fullyvalidated and documented. Clients were reassigned to fully compliant HHAs toavoid disruption in care. The Alternate Administrator ensured that the HHAs were qualifiedto provide home health services. During themanagement meeting on 7/7/25, the Administrator, Alternate Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed.	

	and certification verification website. She also relayed that the Administrator initiated the HHA training from Entity E.		Anin-service was conducted by the Administrator and Director of Clinical Serviceson 7/9/25 with all staff. During the meeting, the Administrator and the DCSdiscussed the pertaining agency policy and the importance of the requirement toreview that the HHAs were qualified to provide home health services. Citationslisted in the personnel record reviews were addressed. All staff understood andacknowledged the agency policy and the requirement. All new staff will beoriented of this requirement at the time of hire. The corrective actions wereimplemented on 6/20/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the AlternateAdministrator will utilize an HR Audit tool that includes verificationof HHA qualification. A monthly file audit system was established, with the HRcoordinator and	

			jointly responsible forverification of all HHA documentation before client assignment. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, the AlternateAdministrator will audit 100% of all HHA personnel files on a weekly basis toensure that the HHAs were qualified to provide home health services. The AlternateDirector of Clinical Services will conduct random supervisory visits on all HomeHealth Aide staff every 2 weeks to monitor and ensure that all HHAs are performingtasks as per Plan of care. The Director of Clinical Services will monitor andreview the Alternate Administrator audit findings of all HHA personnel files.Reports will be generated and results will be compiled to ensure processes haveimproved. If any deficiencies are identified, they will continue to beaddressed with each personnel as needed.	

			This process will continue for eachweek for the next 30 days until 100% compliance is achieved. After 30 days,this process will continue to be monitored on a quarterly basis and will beincluded in the quarterly personnel audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N0597	Scope of Services 410 IAC 17-14-1(l)(1)(B) Rule 14 Sec. (1)(l)(1) The home health aide	N0597	**CorrectiveAction:** In order to correct the above deficiency citedunder N0597, the agency immediately	2025-07-18

	shall: (B) be entered on and be in good standing on the state aide registry. Based on personnel file review and interview, the home health agency failed to ensure the HHA was listed on and in good standing on the state aide registry for 1 of 2 HHA personnel files reviewed who have been employed greater than one year (HHA 2). Findings include: 1. The undated agency policy Home Health Aide Services and Training Program indicated a qualified Home Health Aide is a person who has successfully completed: a nurse aide training and competency evaluation program approved by the state as meeting the requirements and is currently listed in good standing on the state nurse aide registry.		removed the unqualified HHA that was listedin not good standing on the state nurse aide registry upon hire effective6/20/25. Each affected client was reassigned to a qualified HHA with appropriateHHA training who met all federal and state requirements and clients/familieswere notified of the change in personnel. The Administrator has also acquiredservices of RN from outside the agency to conduct the required competencyskills evaluation tasks with a patient or pseudo patient for HHAs. A comprehensive 100% audit wasconducted and completed on all active HHA personnel files by the AlternateAdministrator on 6/20/25 and patient assignments to identify any additionalHHAs who may not have met qualification, training, or competency evaluation or goodstanding on the state nurse aide registry requirements. No additional instanceswere identified. However, for transparency and prevention, any HHA withincomplete documentation was temporarily removed from	

	2. HHA 2 s personnel file indicated a hire date of 6/20/24. The file failed to evidence the agency verified the HHA was listed in good standing on the state nurse aide registry upon hire. 3. Review of the State of Indiana s license and certification verification website, www.mylicense.IN.gov, on 6/19/25 failed to evidence an active HHA license for HHA 2. 4. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator confirmed HHA 2 was not listed on the State of Indiana s license and certification verification website.		requirements were fully validated and documented. Clients were reassignedto fully compliant HHAs to avoid disruption in care. The Alternate Administrator ensuredthe HHAs were listed in good standing on the state nurse aide registryupon hireprior to providing direct patient care. During themanagement meeting on 7/7/25, the Administrator, Alternate Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Administrator and Director of Clinical Serviceson 7/9/25 with all staff. During the meeting, the Administrator and the DCSdiscussed the pertaining agency policy and the importance of the requirement toreview that the HHAs must be listed in good standing on the state nurseaide registry upon hire prior to	

			providing direct patient care. Citations listed in theclinical record reviews were addressed. All staff understood and acknowledgedthe agency policy and the requirement. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 6/20/25and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the AlternateAdministrator will utilize an HR Audit tool that includes verificationthat theHHAs must be listed in good standing on the state nurse aide registryupon hireprior to providing direct patient care. A monthly file audit systemwas established, with the HR coordinator and Director of Clinical Servicesjointly responsible for verification of all HHA documentation before clientassignment. **Monitoring:**	

			In orderto ensure implementation and effectiveness of this corrective action, the AlternateAdministrator will audit 100% of all HHA personnel files on a weekly basis toensure that the HHAs must be listed in good standing on the state nurseaide registry upon hire prior to providing direct patient care. The Alternate Director ofClinical Services will conduct random supervisory visits on all Home HealthAide staff every 2 weeks to monitor and ensure that all HHAs are performing tasksas per Plan of care. The Director of Clinical Services will monitor and review theAlternate Administrator audit findings of all HHA personnel files. Reports willbe generated and results will be compiled to ensure processes have improved. Ifany deficiencies are identified, they will continue to be addressed with eachpersonnel as needed. This process will continue for each week for the next 30days until 100% compliance is achieved. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly personnel audit	

			review. Quarterly audit results will be compiled andsent to the QAPI Committee for review. Once threshold is met, the QualityCommittee will continue to audit 20% of clinical records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N0606	Scope of Services 410 IAC 17-14-1(n) Rule 14 Sec. 1(n) Notwithstanding any other law or administrative rule, a home health agency may satisfy the requirements of supervising home health aide services by complying with 42 CFR 484.80(H) et seq. If a patient is receiving SN, PT, OT, or SLP, a visit must be completed no less than every 14 days. If a patient is only receiving non-skilled services, then a visit must be conducted every 60 days and twice a year. The RN must conduct the supervisory visit observing the home health aide providing care pursuant to	N0606	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure the RN completed an on-site HHA supervisory visit every 14 days. 5%review of active charts was completed by week ending 6/28/25. 30% review ofactive charts was completed by week ending 7/3/25. Remaining 35%	2025-07-18

	IC 16-27-1-20. Based on record review and interview, the home health agency failed to ensure the RN completed an on-site HHA supervisory visit every 14 days for 2 of 2 active records reviewed of patients receiving HHA services (Patient #9 and 12). Findings include: 1. The undated agency policy Home Health Aide Supervision indicated if home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient s plan of care and the written patient care instructions must make an onsite visit to the patient s home no less frequently than every 14 days. 2. Patient #9 s clinical record		review ofcharts will be completed by week ending 7/12/25 to complete 100% audit of allactive chart audits. In orderto correct the above deficiency cited under N0606, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policy pertaining to the requirement. The clinical recordswith the deficiencies were identified and reviewed. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policy andthe importance of the requirement to review that to ensure the RN completed anon-site HHA supervisory visit every 14 days. Citations listed in the clinicalrecord reviews were addressed. All staff understood and acknowledged the agencypolicy and the requirement. All new staff will be oriented of this	

	included a POC for the certification period 5/06/25 to 7/04/25 and included orders for SN, PT, OT and HHA services. The record evidenced the RN performed HHA supervisory visits on 4/30/25, 5/16/25, 5/30/25 and 6/11/25. The clinical record failed to evidence RN 1 performed HHA supervisory visits every on-site14 days. During an interview on 6/17/25 at 2:26 PM, Patient #9 relayed RN 1 visited him every couple of months. During an interview on 6/17/25 at 4:25 PM, RN 1 relayed HHA supervisory visits should be done every 30 days and when queued, she stated she did not perform HHA supervisory visits for Patient #9 every 14 days in person. She relayed she sometimes called Patient #9 to check-in. Patient #12 s medical record evidenced documentation of a supervisory visit for HHA 2 dated 05/28/2025. The note failed to evidence RN 1 met with Patient #12 in person to review HHA 2 s performance. During an interview on		requirementat the time of hire. The corrective actions were implemented on 6/23/25 andwill be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure the RN completed an on-site HHA supervisory visit every 14 days. TheAlternate Director of Clinical Services will utilize a chart audit tool toensure in all active clinical records that to ensure the RN completed anon-site HHA supervisory visit every 14 days. This process of utilizing activechart audit tool will help us identify any discrepancies in the clinicalrecords and re-educate all staff on the above mentioned requirement.	

	06/18/2025 beginning at 12:30 PM, RN 1 indicated they called Patient #12 to review HHA s performance and did not make a visit with Patient #12. During an interview on 06/19/2025 beginning at 04:37 PM, the Administrator indicated RN s need to do supervisory visits in the patients homes.		**Monitoring:** In order to ensure implementation andeffectiveness of this corrective action, the Alternate Director of ClinicalServices will audit 100% of all active charts on a weekly basis to ensure that toensure the RN completed an on-site HHA supervisory visit every 14 days. The AlternateDirector of Clinical Services will conduct random supervisory visits on all HomeHealth Aide staff every 2 weeks to monitor and ensure that all HHAs are performingtasks as per Plan of care. The Director of Clinical Services will monitor andreview Alternate Director of Clinical Services' audit findings of all activecharts. Reports will be generated and results will be compiled to ensureprocesses have improved. If any deficiencies are identified, they will continueto be addressed with each personnel as needed. This process will continue foreach week for the next 30 days until 100% compliance is achieved. After 30days, this process will continue to be	

			monitored on a quarterly basis and willbe included in the quarterly chart audit review. Quarterly audit results willbe compiled and sent to the QAPI Committee for review. Once threshold is met,the Quality Committee will continue to audit 20% of clinical records quarterlyto ensure compliance is maintained. The Administrator and QAPI Committee willsend a written report to the Governing Body quarterly for theirrecommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N0608	Clinical Records 410 IAC 17-15-1(a)(1-6) Rule 15 Sec. 1(a) Clinical records containing pertinent past and current findings in accordance with accepted professional standards shall be maintained for every patient as follows: (1) The medical plan of care and appropriate identifying information.	N0608	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all discharged clinical records on 6/23/25to ensure that the discharge summary was submitted to the physician within 5days of discharge. 35% review of	2025-07-18

	(2) Name of the physician, dentist, chiropractor, podiatrist, or optometrist. (3) Drug, dietary, treatment, and activity orders. (4) Signed and dated clinical notes contributed to by all assigned personnel. Clinical notes shall be written the day service is rendered and incorporated within fourteen (14) days. (5) Copies of summary reports sent to the person responsible for the medical component of the patient's care. (6) A discharge summary. Based on record review and interview, the home health agency failed to submit the discharge summary to the physician within 5 days of discharge for 5 of 5 discharged records reviewed (Patient #3, 4, 14, 15 and 16). Findings include: 1. The agency policy Discharge Summary , last revised 02/2021 indicated a discharge summary will be sent within 5 business days of patient discharge to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient. 2. The agency policy Timely		discharged charts was completed by week ending6/28/25. 30% review of discharged charts was completed by week ending 7/3/25. Remaining35% review of charts will be completed by week ending 7/12/25 to complete 100%audit of all discharged chart audits. In orderto correct the above deficiency cited under N0608, during the managementmeeting on 7/7/25, the Administrator, Alternate Administrator, Director ofClinical Services and Alternate Director of Clinical Services reviewed anddiscussed the agency policies pertaining to the requirement. The clinicalrecords with the deficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 7/7/25 provided by the Governing Body Chair.	

	Documentation , last updated 11/22/23, indicated visit itineraries, with all visit notes, must be submitted within fourteen (14) calendar days and upon discharge from services, the patient discharge summary must be submitted within five (5) business days. 3. Patient #3 s clinical record evidenced a discharge date on 5/21/25 and included a discharge summary that was completed on 6/17/25 by the CM. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge. During an interview on 6/17/25 at 12:35 PM, the CM relayed the discharge summary should be sent to the physician as soon as possible once the discharge has been completed. 4. Patient #4 s clinical record evidenced a discharge date on 6/06/25 and included a discharge summary that was completed on 6/17/25 by RN 3. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge. During an interview on 6/16/25		Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policiesand the importance of the requirement to review that the discharge summary wassubmitted to the physician within 5 days of discharge. Citations listed in theclinical record reviews were addressed. All staff understood and acknowledgedthe agency policies and the importance of the requirement. All new staff willbe oriented of this requirement at the time of hire. The corrective actionswere implemented on 6/23/25 and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing “Home Health Notify”, a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into	

	at 4:53 PM, RN 3 relayed the discharge summary had not been sent to the physician because he had not completed the discharge note yet. 5. Patient #14 s clinical record evidenced a discharge date on 5/27/25. The clinical record failed to include a discharge summary that was faxed to the physician within 5 days of discharge. During an interview on 6/18/25 at 11:35 AM, the Alternate Administrator verified the discharge summary for Patient #14 had not been sent to the physician yet. . Patient #13 s medical record evidenced a SOC of 12/14/2024 and a discharge date of 01/17/2025. The Secure Messaging application B evidenced a note by the Alternate Administrator on 02/25/2025, which indicated Patient #16 was discharged.		patient care and toensure that the discharge summary was submitted to the physician within 5 daysof discharge. The Alternate Director of Clinical Services will utilize a chartaudit tool to ensure that the discharge summary was submitted to the physicianwithin 5 days of discharge. This process of utilizing active chart audit toolwill help us identify any discrepancies in the clinical records and re-educateall staff on the above mentioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all dischargedcharts on a weekly basis to ensure that the discharge summary was submitted tothe physician within 5 days of discharge. The Director of Clinical Serviceswill monitor and review Alternate Director of Clinical Services' audit findingsof all discharged	

	During an interview on 06/17/2025 beginning at 4 PM, the Alternate Administrator indicated there was no record of the discharge summary being sent to Patient #13 s primary care provider. 5. Patient #15 s clinical record evidenced a discharge date of 5/22/2025. A discharge summary was completed on 5/22/2025, however the record failed to evidence the discharge summary was sent to Patient s physician within 5 days of discharge. During an interview on 6/19/2025 beginning at 10:50 AM, Alternate Administrator reported the agency had no record of Patient s discharge summary being sent to the physician within 5 days of discharge.		generated and results will becompiled to ensure processes have improved. If any deficiencies are identified,they will continue to be addressed with each personnel as needed. This processwill continue for each week for the next 30 days until 100% compliance isachieved. After 30 days, this process will continue to be monitored on a quarterlybasis and will be included in the quarterly chart audit review. Quarterly auditresults will be compiled and sent to the QAPI Committee for review. Oncethreshold is met, the Quality Committee will continue to audit 20% of clinicalrecords quarterly to ensure compliance is maintained. The Administrator andQAPI Committee will send a written report to the Governing Body quarterly fortheir recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	

N0610	Clinical Records 410 IAC 17-15-1(a)(7) Rule 15 Sec. 1. (a)(7) All entries must be legible, clear, complete, and appropriately authenticated and dated. Authentication must include signatures or a secured computer entry. Based on record review and interview, the agency failed to ensure documentation was complete, accurate, and authenticated for 5 of 12 active records reviewed (Patients #4, 5, 9, 11, and 12). Findings include: .Patient #4's clinical record included a Re-cert Verbal Oder for Home Care: dated 5/23/25 at 1:44 AM completed by RN 3. The comprehensive assessment visit note failed to evidence the patient signature confirming the visit. During an interview on 6/16/25 at 4:53 PM, RN 3 relayed he thought he collaborated with the physician but was unsure if he documented the collaboration and he confirmed he did not receive any orders at	N0610	**CorrectiveAction:** The Alternate Director of ClinicalServices started internal audit review of all active clinical records on 6/23/25to ensure that the documentation was complete, accurate, and authenticated. 35%review of active charts was completed by week ending 6/28/25. 30% review ofactive charts was completed by week ending 7/3/25. Remaining 35% review ofcharts will be completed by week ending 7/12/25 to complete 100% audit of allactive chart audits. In orderto correct the above deficiency cited under N0610, during the management meetingon 7/7/25, the Administrator, Alternate Administrator, Director of ClinicalServices and Alternate Director of Clinical Services reviewed and discussed theagency policies pertaining to the requirement. The clinical records with thedeficiencies were identified and reviewed. The Administrator, AlternateAdministrator, Director of Clinical Services and Alternate Director of	2025-07-18

	1:44 AM. .Patient #9 s clinical record included an OASIS Recertification completed by RN 1 dated 5/02/25. The recertification visit note failed to include the patient s signature for the visit. Review of the notes from the Secure Messaging Application B for Patient #9 evidenced an entry by RN 1 on 5/04/25 at 5:49 PM indicated she would see Patient #9 on 5/06/25 at 12:00 PM. Another entry made by RN 1 on 5/06/25 at 3:02 PM indicated the recertification visit had been completed. The OASIS Recertification visit note failed to evidence the accurate date that the visit occurred on. During an interview on 6/13/25 at 1:27 PM, the CM relayed the recertification comprehensive assessment should be completed within the last five days of the certification period. During an interview on 6/17/25 at 4:25 PM, RN 1 relayed she did not complete the		ClinicalServices have completed re-orientation of agency's policies pertaining to therequirement on 7/7/25 provided by the Governing Body Chair. Anin-service was conducted by the Director of Clinical Services on 7/9/25 withall staff. During the meeting, the DCS discussed the pertaining agency policiesand the importance of the requirement to review that the documentation wascomplete, accurate, and authenticated. Citations listed in the clinical recordreviews were addressed. All staff understood and acknowledged the agency policiesand the importance of the requirement. All new staff will be oriented of thisrequirement at the time of hire. The corrective actions were implemented on 6/23/25and will be completed on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Agency isutilizing "Home	

	recertification visit on 5/02/25 and she confirmed the visit was completed on 5/06/25. .The undated agency policy Timely Submission of Patient Documentation indicated documentation must be completed within 14 calendar days. . Patient #5 s medical record evidenced a comprehensive assessment for the SOC dated 03/14/2025, completed by RN 2. Patient #5 signed the Consent for Service, Fall Safety Education, and the Emergency plan on 03/14/2025. The agency required these documents to be reviewed and signed at the SOC. The Secure Messaging application B notes included a note by RN 2 that they completed the SOC on 03/14/2025. Patient #5 s POC completed for certification period 05/13/2025 07/11/2025, identified the SOC date 03/13/2025. During an interview on 06/13/2025 at 03:50 PM, Intake Manager 7 indicated they had the SOC as 03/13/2025. The Alternate Administrator confirmed the SOC was		Health Notify", a HIPAA compliant communication application forthe Agency, clinicians, inter-disciplinary teams, Patients, Physicians andExternal organizations to ensure real-time visibility into patient care and toensure that the documentation was complete, accurate, and authenticated. TheAlternate Director of Clinical Services will utilize a chart audit tool toensure that the documentation was complete, accurate, and authenticated. Thisprocess of utilizing active chart audit tool will help us identify anydiscrepancies in the clinical records and re-educate all staff on the abovementioned requirement. **Monitoring:** In orderto ensure implementation and effectiveness of this corrective action, theAlternate Director of Clinical Services will audit 100% of all new admissions andactive charts on a weekly basis to ensure that the documentation was complete,accurate, and authenticated. The Director of	

	03/14/2025. .Patient #11 s medical record evidenced documentation of supervisory visits for LPN 2 dated 05/14/2025 and 06/12/2025, completed by RN 1. There was no global positioning services documentation of RN 1 at Patient #11 s home on 05/14/2025 or 06/12/2025. The record included SN Follow -Up/ Goals Re- Assessment Note completed by RN 1 on 05/22/2025 and 06/16/2025. Global positioning services documentation indicated RN 1 was at Patient #11 s home on those dates. During an interview on 06/18/2025 beginning at 12:30 PM, RN 1 indicated they did supervisory visits on 05/22/2025 and 06/16/2025 but did not put the correct date on the supervisory visit notes. .Patient #12 s medical record evidenced documentation of a supervisory visit for LPN 2 dated 06/09/2025, completed by RN 1. The record included a SN Follow -Up/ Goals Re-Assessment Note dated		Clinical Services will monitor andreview Alternate Director of Clinical Services' audit findings of all newadmissions and active charts. Reports will be generated and results will becompiled to ensure processes have improved. If any deficiencies are identified,they will continue to be addressed with each personnel as needed. This processwill continue for each week for the next 30 days until 100% compliance isachieved. After 30 days, this process will continue to be monitored on aquarterly basis and will be included in the quarterly chart audit review.Quarterly audit results will be compiled and sent to the QAPI Committee for review.Once threshold is met, the Quality Committee will continue to audit 20% ofclinical records quarterly to ensure compliance is maintained. TheAdministrator and QAPI Committee will send a written report to the GoverningBody quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective	

	1. Global positioning services documentation indicated RN 1 s presence at Patient #12 s home was 06/11/2025 not 06/09/2025. The record failed to evidence global positioning documentation for RN 1 on 06/09/2025. During an interview on 06/18/2025 beginning at 12:30 PM, RN 1 indicated the dates on the supervisory visit note and the SN Follow -Up/ Goals Re-Assessment Note were incorrect. The agency failed to ensure clinicians documentation included the correct date of service.		action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	
N9999	Final Observations Authority IC 16-27-1.5-5 "Approved dementia training for home health aides" Sec. 5 (a) This section applies to a registered home health aide who: (1) is employed as a home health aide; and (2) provides care to an individual who has been diagnosed with or experiences symptoms of Alzheimer's disease, dementia, or a related cognitive disorder. (b) As used in this section, "approved dementia training" refers to a dementia training program: (1) for use in training home health aides in the care of individuals described in subsection (a)(2); and (2) that has been approved by the state	N9999	**CorrectiveAction:** Inorder to correct the above deficiency cited under N9999, A comprehensive 100%audit was conducted and completed on all active HHA personnel files by theAlternate Administrator on 6/20/25 to identify the HHAs that have not completed therequired 6 hours of initial dementia training and 3 hours of annual dementia trainingprior to providing care to a patient diagnosed with dementia and	2025-07-18

department under subsection (f).

(c) Not later than sixty (60) days after the date on which a home health aide is initially hired to care for an individual with Alzheimer's disease, dementia, or a related cognitive disorder, the home health aide shall complete at least six (6) hours of approved dementia training.

(d) Before December 31 of each year, a home health aide who has been employed as a home health aide for at least one (1) year shall complete at least three (3) hours of approved dementia training.

(e) A home health aide who:

(1) has received the training required by subsections (c) and (d);

(2) has been employed as a home health aide for at least twenty-four (24) consecutive months; and

(3) is hired by a home health agency; is not required to repeat the training required by this section.

(f) The state department shall do the following:

(1) Identify and approve each dementia training program that meets the following requirements:

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

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

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

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

(iv) Procedures for providing patient centered quality care.

(v) The daily activities of individuals with dementia.

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

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

annuallythereafter. The Administrator has tentatively scheduled Approveddementia training for home health aides that will be completed by 8/2/2025.

During themanagement meeting on 7/7/25, the Administrator, Alternate Administrator, Directorof Clinical Services and Alternate Director of Clinical Services reviewed anddiscussed the requirement. The clinical records with the deficiencies wereidentified and reviewed.

Anin-service was conducted by the Administrator and Director of Clinical Serviceson 7/9/25 with all staff. During the meeting, the Administrator and the DCSdiscussed the importance of the requirement to review that the HHAs that mustcomplete the required 6 hours of initial dementia training and 3 hours ofannual dementia training prior to providing care to a patient diagnosed withdementia and annually thereafter. Citations listed in the personnel

	(B) The dementia training program: (i) must be culturally competent; and (ii) may be provided online. (2) Establish and implement a process for state department approval of a dementia training program. (g) To the extent allowed by 42 CFR 484.80, the hours of approved dementia training completed under this section satisfies an equivalent number of hours of the home health aide training required by 42 CFR 484.80. (h) An entity that provides approved dementia training shall provide to each home health aide who successfully completes the training a certificate of completion. (i) A home health aide: (1) is responsible for maintaining the home health aide's certificate of completion; and (2) may use the certificate of completion as proof of compliance with this section. As added by P.L.44-2022, SEC.1. Authority IC 16-27-1.5-6 "Conditions required to administer gastrointestinal and jejunostomy tube feedings; training" Sec. 6 (a) A registered home health aide may administer gastrointestinal and jejunostomy tube feedings to a specific patient only if the following conditions are met: (1) The registered home health aide has completed the training curriculum described in subsection (b). (2) A registered nurse, providing registered nursing under IC 25-23-1-1.1(b)(6), either: (A) supervises the registered home health aide in administering the gastrointestinal and jejunostomy tube feedings; or (B) delegates responsibility for administering the gastrointestinal and jejunostomy tube		recordreviews were addressed. All staff understood and acknowledged the agency policyand the requirement. All new staff will be oriented of this requirement at thetime of hire. The corrective actions were implemented on 6/20/25 and will becompleted on 7/18/25. **Measuresto assure No recurrence:** In orderto ensure that there is no recurrence of this deficiency, the Alternate Administratorwill utilize an HR Audit tool that includes verification of the HHAsthat must complete the required 6 hours of initial dementia training and 3hours of annual dementia training prior to providing care to a patientdiagnosed with dementia and annually thereafter. A monthly file audit systemwas established, with the HR coordinator and Director of Clinical Servicesjointly responsible for verification of all HHA documentation before clientassignment.	

based on the registered nurse's assessment of the registered home health aide's competency to administer gastrointestinal and jejunostomy tube feedings.

(3) The home health agency that the registered home health aide is employed with:

(A) allows the registered home health aide to administer gastrointestinal and jejunostomy tube feedings;

(B) establishes a procedure for:

(i) the delegation of the administration of gastrointestinal and jejunostomy tube feedings from a registered nurse to a registered home health aide that includes patient specific clinical parameters based on the registered nurse's assessment of the patient and the registered home health aide's competency to administer the gastrointestinal and jejunostomy tube feedings; and

(ii) the assessment by the registered nurse of the patient specific clinical parameters;

(C) retains documentation that the registered home health aide has completed the training curriculum described in subsection (b); and

(D) notifies each patient requiring gastrointestinal and jejunostomy tube feedings upon admission that the home health aide agency may allow registered home health aides to administer gastrointestinal and jejunostomy tube feedings.

(b) Training curriculum for home health aides to administer gastrointestinal and jejunostomy tube feedings must:

(1) be approved by the state department; and

(2) include the following concerning the administration of gastrointestinal and jejunostomy tube feedings:

(A) At least four (4) hours and not more than eight (8) hours of classroom training.

(B) At least two (2) hours and not more than four (4) hours of practical training.

(C) A written and practical examination administered by the trainer.

(c) A registered home health aide may not

Monitoring:

In orderto ensure implementation and effectiveness of this corrective action, the AlternateAdministrator will audit 100% of all HHA personnel files on a weekly basis toensure that the HHAs that must complete the required 6 hours of initialdementia training and 3 hours of annual dementia training prior to providingcare to a patient diagnosed with dementia and annually thereafter. The AlternateDirector of Clinical Services will conduct random supervisory visits on all HomeHealth Aide staff providing care to a patients diagnosed with dementia every 2weeks to monitor and ensure that all HHAs are performing tasks as per Plan ofcare. The Director of Clinical Services will monitor and review the AlternateAdministrator audit findings of all HHA personnel files. Reports will begenerated and results will be compiled to ensure processes have improved. Ifany deficiencies are identified, they will continue to be addressed with

	administer gastrointestinal and jejunostomy tube feedings until the home health aide has successfully: (1) completed the curriculum described in subsection (b); and (2) passed the examinations described in subsection (b)(2)(C). (d) The state department may require a registered home health aide who administers gastrointestinal and jejunostomy tube feedings under this section to annually complete not more than one (1) hour of in service training specific to the administration of gastrointestinal and jejunostomy tube feedings. (e) Before January 1, 2024, the state department must approve at least one (1) training curriculum described in subsection (b). As added by P.L.117-2023, SEC.6. Based on personnel file review, clinical record review, and interview, the home health agency failed to ensure the HHA completed the required dementia training prior to providing care to a patient diagnosed with dementia and annually thereafter for 3 of 3 HHA personnel files reviewed (HHA 2, HHA 3 and HHA 4),		eachpersonnel as needed. This process will continue for each week for the next 30days until 100% compliance is achieved. After 30 days, this process willcontinue to be monitored on a quarterly basis and will be included in thequarterly personnel audit review. Quarterly audit results will be compiled andsent to the QAPI Committee for review. Once threshold is met, the QualityCommittee will continue to audit 20% of clinical records quarterly to ensurecompliance is maintained. The Administrator and QAPI Committee will send awritten report to the Governing Body quarterly for their recommendations. TheDirector of Clinical Services will be responsible for corrective action of thisdeficiency, measure to assure no recurrence and monitoring of this deficiency.	

which had the potential to affect 3 of 3 active patients who received HHA services and had a diagnosis of dementia (Patients #17, 18 and 19).

Findings include:

1. A list of current agency employees evidenced three HHA s employed by the home health agency.

2. HHA 2 s personnel file indicated a hire date of 6/20/24. The file failed to evidence the HHA had received the required 6 hours of initial dementia training.

3. HHA 3 s personnel file indicated a hire date of 4/16/25. The file failed to evidence the HHA had received the required 6 hours of initial dementia training.

During an interview on 6/19/25 at 1:11 PM, HHA 3 relayed had not completed any dementia training.

4. HHA 4 s personnel file indicated a hire date of 1/11/22. The file failed to evidence the HHA had received the required 6 hours of initial dementia training and failed to evidence

	the 3 hours of annual dementia training. 5. During an interview on 6/19/25 at 2:00 PM, the Alternate Administrator verified the personnel files for HHA 2, HHA 3 and HHA 4 did not include any dementia training. 6. During the exit conference on 6/19/25 at 4:37 PM, the Alternate Administrator presented an annual training binder for review. The binder failed to include any dementia training for HHA 2, HHA 3 or HHA 4.			

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
Waqas Rashid	Administrator	7/23/2025 4:48:24 PM