STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	157578	A. BUILDING 00 B. WING	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMEDISYS HOME HEALTH	1332 W ARCH HAVEN AVE STE E BLOOMINGTON, IN 47403

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E 0000 Bldg. 00	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 484.102, for a home health agency. Survey Dates: 1-26, 1-27, 1-28, 1-29, 2-1, & 2-2-21 Facility: 004926	E 0000		
E 0024 Bldg. 00	403.748(b)(6), 416.54(b)(5), 418.113(b)(4), 441.184(b)(6), 482.15(b)(6), 483.475(b)(6), 483.73(b)(6), 484.102(b)(5), 485.625(b)(6), 485.68(b)(4), 485.727(b)(4), 485.920(b)(5), 491.12(b)(4), 494.62(b)(5) Policies/Procedures-Volunteers and Staffing [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. Based on record review and interview, the agency failed to ensure it had solicited volunteers for service during a disaster or emergency, to include their roles for integration with health care professionals during the disaster/emergency for 1 of 1 home health agency disaster preparedness plan. Findings included: Review of Agency's Emergency Preparedness plan on 1-29-21, failed to evidence the use of volunteers in their emergency preparedness plan. On 1-29-21 at 2:43 p.m., Clinical Manager, Employee C and non-employee Entity A confirmed the lack of use of volunteers in their Emergency Preparedness program. On 1-29-21 at 2:48 p.m., during daily review of the above findings and when queried for additional information, the Administrator provided nothing further.	E 0024	Policies/Procedures-Volunteers and Staffing CFR(s): 484.102(b)(5) The administrator/Director of Operations will be responsible for correcting this deficiency. All active clinical staff and management staff will receive training on the following policies/procedures and will be documented and evidenced by sign-in sheet. Policy EMP-001 Emergency Management Planning Policy TX-012 Emergency Management Plan Corrective Action: Policy TX-012 Emergency Management Plan was revised on 3/4/2021 to include a statement that the Emergency Preparedness Plan does not include the routine use of volunteers in the home health setting.	03/12/2021
G 0000 Bldg. 00				

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	This visit was for a federal recertification, focused infection control, and state licensure survey. This survey was extended on 1-28-21 at 4:08 p.m. Survey Dates: 1-26, 1-27, 1-28, 1-29, 2-1, & 2-2-21 Facility: 004926 These deficiencies reflect state findings in accordance with 410 IAC 17. Refer to state form for additional findings. Quality Review completed on 2/24/2021 A4	G 0000		
G 0682 Bldg. 00	484.70(a) Infection Prevention 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 and record review, the agency failed to follow standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases in 2 of 5 home visits. (Patient #5, #7) Findings included: 1. Review of agency policy titled "Hand Hygiene", last revised 9/18, stated: ". . . The agency must follow accepted standards of practice, including the use of standard precautions (includes hand hygiene), to prevent the transmission of infections and communicable diseases. . . Perform hand hygiene as follows: a. Before having direct contact with patients. b. Before donning gloves. . . d. After contact with a	G 0682	G 682 Infection Prevention CFR(s): 484.70(a) The administrator/Director of Operations will be responsible for correcting this deficiency. All active clinical staff and management staff will receive training on the following policies/procedures and will be documented as evidenced by sign-in sheet. All active clinical staff will receive annual skills check offs and annual on-site evaluation visits. Policy CR-PCP-001 Hand Hygiene Policy ICS-001 Standard Precautions All active skilled nursing clinical	03/12/2021

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	patient's intact skin. . . f. When moving from a contaminated body site to a clean body site during patient care. g. After contact with inanimate objects (e.g., medical equipment) in the immediate vicinity of the patient. H. After removing gloves. . . Remove gloves after caring for a patient. . . change gloves during patient care if moving from a contaminated body site to a clean body site. . ." 2. During a home visit with Patient #5 on 1/28/21 at 10:00 a.m., agency Physical Therapist, Employee I, was observed sanitizing their hands and donning gloves then performing a physical assessment of Patient #5 which included the performance of vital sign measurement, cleaning of vital sign equipment, documentation of vital signs in patient's folder, placement of gait belt, ambulation of and assist in movement of Patient #5, instruction in patient exercises, cleaning of own fogged face shield with gloved hand, & documentation of home visit, all without changing of gloves and sanitizing hands. Upon completion of care, Employee I, removed the original pair of gloves and sanitized hands. 3. During a home visit with Patient #7 on 1/28/21 at 12:15 p.m., Registered Nurse, Employee D was observed preparing a medication vial for an intramuscular injection by removing vial cap and inserting needle to withdraw medication. This attempt was unsuccessful, and Employee D retrieved a larger gauge needle and accessed the vial without sanitizing vial hub. Further observation evidenced Employee D, with gloved hands, performing medication reconciliation for Patient #7 then contacting Patient #7's pharmacy using Employee D's cell phone then proceeding to fill Patient #7's medication planner. Employee D failed to change her gloves and sanitize her hands		staff will receive training on the following policies/procedures and will be documented as evidenced by sign-in sheet. MA-023 Intramuscular Injections/Z-Track CR-MA-001 Medication Administration Monitoring process: Administrator/Director of Operations, Clinical Manager, or designee of the agency will perform 8 total visits comprised of 4 onsite visits in the home for Parent care center and 4 onsite visits in the home for Branch care center per quarter to assess compliance of infection prevention until 100% compliance has been met x 2 quarters and a record kept of findings. On-site visit with employee I completed by Area Vice President of Clinical on 03/02/2021. On-site visit with employee D completed by Area Vice President of Clinical on 02/10/2021. All education will be completed with active staff by 03/12/2021.	

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	when moving from clean to dirty to clean environment. Employee D was then observed providing a written medication list to Patient #7's spouse then removed her gloves and cleaned her computer tablet without sanitizing her hands. Employee D was not observed performing hand hygiene at the conclusion of the home visit. 4. On 1-29-21 at 2:48 p.m., during daily review of the above findings and when queried for additional information, the Administrator provided nothing further. 17-12-1(m)			
G 0946 Bldg. 00	484.105(b)(1)(i) Administrator appointed by governing body (i) Be appointed by and report to the governing body; Based on record review and interview, the Agency failed to provide evidence of the Administrator reporting to the Governing Body for 1 of 1 agency. Findings included: Review of Agency policy titled "Governing Body", last revised 6/2020, stated: ". . . must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operation plans, and its quality assessment and performance improvement program. . . will develop an organization structure for each Amedisys home health agency: the Administrator/Director of Operations (DOO) (or regional DOO/Acting or Interim DOO, or person with a similar function) of each home health agency will follow a chain of	G 0946	Administrator appointed by governing body CFR(s): 484.105(b)(1)(i) The administrator/Director of Operations of the agency will be responsible for correcting this deficiency. Administrator and Branch Director of Operations will receive training on the following policies/procedures and will be documented and evidenced by sign-in sheet. Education provided on 02/22/2021 by Area Vice President of Operations. Policy CR-HH-LD-001 Governing Body Measures to ensure deficiency does not reoccur: Indiana Administrator of Home Health Agency will attend Indiana	03/12/2021

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	command by reporting to a designated Area Vice President (AVP), who reports to a designated Vice President of Operations who reports to a designated Senior Vice President of Operations in communicating pertinent information to the Governing Body; . . . annually review and adopt policies for the operation and administration . . . ensure that an annual operating budget and capital expenditure plan. . . ensure that there are adequate resources. . . establish, maintain and ensure that an organization-wide performance improvement program for quality improvement and patient safety. . . review and annually approve the quality improvement/infection prevention/safety program. . ." Review of the "2020 Bi-Annual Governing Body Meeting Minutes" provided on 1-27-21 at 10:52 a.m. by the Clinical Manager and dated 10-14-2020 at 1:00 p.m., failed to evidence the attendance of the Agency Administrator and failed to evidence or mention any Agency operational items specific to said Agency such as an operational plan, budget and/or quality assurance/performance improvement activities (QAPI). During an interview with the Alternate Administrator on 1-27-21 at 2:37 p.m., when queried as to involvement with or attendance/reporting to the Governing Board, the Alternate Administrator responded "No, that is more of a corporate thing (responsibility)." During an interview with the Administrator on 1-28-21 at 4:06 p.m., when queried as to involvement with or attendance/reporting to the Governing Board, the Administrator responded "Honestly not much role. Mainly COPs (Conditions of Participation) and accreditation standards." When queried further if the		Governing Body meeting annually. During this meeting the Administrator will report to Governing Board on trends, top occurrences, and QAPI for previous year, and top focus areas for upcoming/current year via teams meeting. A record of the meeting minutes and attendees will be documented.	

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	attendance or meetings was more of an education/training session instead of the Administrator reporting on agency function and operation, the Administrator stated "Yes". 17-12-1(c)(2)			
G 0954 Bldg. 00	484.105(b)(2) Ensures qualified pre-designated person When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section. Based on record review and interview, the Agency failed to establish and communicate clear, distinct lines of authority in the absence of the Administrator for 1 of 1 agency. Findings include: Review of the Agency's Organizational chart received on 1-27-21 at 9:50 a.m., failed to identify names of individuals for each identified/listed position. Review of the Agency's Organization chart first received on 1-26-21 at 2:55 p.m. from the Area Vice President of Clinical Services failed to identify the position and associated names of any of the positions listed as well as the name and position of the Alternate Administrator. Review of the Agency's Organizational chart received again on 1-27-21 at 1:30 p.m., failed to identify the position and associated name of the Alternate Administrator as well as any positions	G 0954	Ensures qualified pre-designated person CFR(s): 484.105(b)(2) The administrator/Director of Operations will be responsible for correcting this deficiency. All active clinical staff and management staff will receive training on the following policies/procedures and organization chart and will be documented and evidenced by sign-in sheet. CR-HH-LD-006 Administrator/Clinical supervision authorization Individualized organizational chart posted within the agency. This includes names of each person holding the named positions. An appointment of alternate administrator was approved by Governing body in April 2015. An appointment of Administrator	03/31/2021

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	listed for the Agency. Review of the Indiana state form titled "Division of Acute Care, Indiana State Department of Health Home Health Agencies Report" completed and submitted by the Agency on 1-27-21 at 10:14 a.m., listed the Clinical Manager for the parent Agency, Registered Nurse, Employee C as the Agency's Alternate Administrator. At the time of this survey entrance conference and during interview with the announced Clinical Manager for the parent location on 1-26-21 at 12:36 p.m., the Clinical Manager, Employee C, for the parent location reported she was the Alternate Administrator for said Agency. When queried as to access to patient documents for the branch location in Terre Haute, IN, she reported she did not have access to their patients. During an interview with the Area Vice President of Clinical Operations for the Agency's owning company, Non-agency Entity A, on 2-27-21 at 9:56 a.m., Entity A was unable to identify the Alternate Administrator on the organizational chart and stated she believed it was Employee C. During an interview with the branch office location's "Director of Operations" Clinical Manager on 2-27-21 at 2:37 p.m., when queried as to the Alternate Administrator for the Agency, she stated "(I) think (called by name) Employee C would be the Alternate Administrator." When queried as to access to the parent agency office patient's she stated, "I do (have access), at least some of them." During an interview with the Agency's Administrator on 2-28-21 at 1:13 p.m., when queried as to the name of the person to serve as		was approved by the Governing body on 6/27/2020 The Area Vice President of Clinical Practice and Area Vice President of Operations will provide education to the administrator/ alternate administrator on the Indiana Administrative Code 17-12-1(c)(8) as cited in this deficiency and where to find requested items for future survey use and knowledge of regulations to ensure a qualified person is authorized in writing to act in the administrator's absence. This education will be completed no later than 03/31/2021.	

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	her alternate in her absence, she stated: "(Called employee name-Employee B)" On 2-2-21 at 3:45 p.m., during review of the above findings and when queried for additional information, the Administrator provided nothing further. 17-12-1(c)(8)			
G 0974 Bldg. 00	484.105(d)(2) Direct support and administrative control The parent HHA provides direct support and administrative control of its branches. Based on record review and interview, the Agency failed to provide administrative control of its branch location for 1 of 1 agency and 1 of 1 branch. Findings included: On 1-26-21 at 12:36, during survey entrance conference, Registered Nurse, Employee C reported agency had a branch office location in Terre Haute, IN, with Registered Nurse, Employee B as their Clinical Manager. On 1-27-21 at 9:50 a.m., the Director of Operations for the branch office location (Clinical Manager) provided an organizational chart which evidenced the branch Director of Operations reported to the Administrator/Director of Operations. This organizational chart failed to evidence names of individuals holding these positions. During interview with the parent office's Clinical Manager and Registered Nurse, Employee C on 1-27-21 at 10:45 a.m., stated: "I don't have anything to do (oversight) with the Terre Haute office (branch). Their EP (emergency	G 0974	Direct support and administrative control CFR(s): 484.105(d)(2) The administrator/Director of Operations, Clinical Manager, or designee of the agency will be responsible for correcting this deficiency. All management staff will receive training on the organization chart and will be documented and evidenced by sign-in sheet. Parent Branch Meeting Agenda/Minutes Revised on 02/22/2019. Parent obtained revised Branch Emergency Preparedness on 03/02/2021. Measures to prevent deficiency from reoccurring: Parent Branch Meetings will be conducted monthly with one meeting per quarter conducted on-site at Branch location to include supervision of QAPI RCAs, employee file review, staffing	03/26/2021

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	preparedness) is separate from Terre Haute (branch office location)." During an interview with non-agency Entity A on 1-27-21 at 2:37 p.m., stated: "Terre Haute (branch office) has their own separate QAPI (Quality Assurance Performance Improvement), it's online." When queried as to who covers for the branch clinical manager in her absence, non-agency Entity A responded: "I don't know. I will have to look who is reported to the state." During an interview with the branch Director of Operations (Clinical Manager) on 1-27-21 at 2:38 p.m., the Director stated: ". . . Think (called by name) Employee C would be the Alternate Administrator. . . My performance evaluation is done by (the) AVP (Area Vice President) of Operations, non-employee entity B . . . We have our own separate EP and turn it into corporate, not Bloomington (parent). . . QAPI is turned into corporate too. . . The Bloomington (parent) office manager has access (branch personnel files), but our (branch) office manager maintains the electronic copies. . . (access to parent office patient records) I do, some of them. All of them." On 2-2-21 at 3:45 p.m., during final review of the above findings and when queried for additional information, the Administrator provided nothing further. 17-12-1(a)(1) 17-12-1(a)(2)		dashboard, clinical chart review. Administrator will be present either in person or via Teams for one patient care conference per quarter for branch location. Administrator will be present for Quality Assurance Performance Improvement meeting either in person or via Teams quarterly. Area Vice President of Operations will monitor quarterly to ensure branch supervision is occurring and being documented.	
G 0988 Bldg. 00	484.105(h) Institutional planning Standard: Institutional planning. The HHA, under the direction of the governing body, prepares an overall plan and a budget that			

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	includes an annual operating budget and capital expenditure plan. (1) Annual operating budget. There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. However, it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense. (2) Capital expenditure plan. (i) There is a capital expenditure plan for at least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than $600,000 for items that would under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time, but are components of an overall plan or patient care objective, are viewed in their entirety without regard to their timing. Other costs			

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	related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds. (ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health Services Block Grant) or title XVIII (Medicare) or title XIX (Medicaid) of the Social Security Act, the plan specifies the following: (A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. (B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations. (C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency. (3) Preparation of plan and budget. The overall plan and budget is prepared under the direction of the governing body of the HHA by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the HHA. (4) Annual review of plan and budget. The overall plan and budget is reviewed and updated at least annually by the committee			

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	157578	A. BUILDING 00 B. WING	02/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AMEDISYS HOME HEALTH	1332 W ARCH HAVEN AVE STE E BLOOMINGTON, IN 47403

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	referred to in paragraph (i)(3) of this section under the direction of the governing body of the HHA. Based on record review and interview, the agency failed to participate in the preparation of the agency annual plan and the governing board minutes failed to evidence plan & budgetary oversight for said agency for 1 of 1 agency with 1 of 1 branch location. Findings included: Review of Agency policy titled "Governing Body", last revised 6/2020, stated: ". . . must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operation plans, and its quality assessment and performance improvement program. . . will develop an organization structure for each Amedisys home health agency: the Administrator/Director of Operations (DOO) (or regional DOO/Acting or Interim DOO, or person with a similar function) of each home health agency will follow a chain of command by reporting to a designated Area Vice President (AVP), who reports to a designated Vice President of Operations who reports to a designated Senior Vice President of Operations in communicating pertinent information to the Governing Body; . . . annually review and adopt policies for the operation and administration . . . ensure that an annual operating budget and capital expenditure plan. . . ensure that there are adequate resources. . . establish, maintain and ensure that an organization-wide performance improvement program for quality improvement and patient safety. . . review and annually approve the quality improvement/infection prevention/safety program. . ."	G 0988	Institutional planning CFR(s): 484.105(h) The administrator/Director of Operations of the agency will be responsible for correcting this deficiency. Policy CR-HH-LD-001 Governing Body Measures to be taken to ensure the deficiency does not reoccur: The administrator/Director of Operations will make recommendations for the annual operating budget and capital expenditure plan based on agency needs (i.e., additional staff, increased office space, office equipment/furniture, electronic equipment, etc.). These recommendations will be discussed with the AVP and will progress up the chain of command and will ultimately be reviewed and approved by the Governing Body. This will occur annually.	03/12/2021

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	During an interview with the Administrator on 1-28-21 at 1:13 p.m., the Administrator stated: "I (manage) QAPI (quality assurance & performance improvement). All forms are loaded into Sharepoint (company software system). Our AVPC (area vice president of clinical services) and AVPO (area vice president of operations) review it and I update based on their and my review." When queried if input into the agency's budget, the Administrator responded: "No. It comes from Leadership." When queried who Leadership was, the Administrator stated: "The AVP's then to me. (Called AVP by name) Non-entity B, sends to me." When queried if has any specific contact with the Governing Board, the Administrator responded: "Not since I have taken this role (Administrator). We have team meetings with the VP (vice presidents) of home care." When queried as to content of the discussion, agency specific needs or corporate business, the Administrator stated: "Overall company business." The Administrator further stated: "I was right, the governing board develops the budget with input from the area vice presidents and then they reach out to us as a group (corporation's agency administrators)." On 1-29-21 at 2:48 p.m., during daily review of the above findings and when queried for additional information, the Administrator provided nothing further. 17-12-1(b)(3)			
N 0000 Bldg. 00	This visit was for a state re-licensure survey.	N 0000		

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	Survey Dates: 1-26, 1-27, 1-28, 1-29, 2-1, & 2-2-21 Facility: 004926			
N 0458 Bldg. 00	410 IAC 17-12-1(f) Home health agency administration/management 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: (1) Receipt of job description. (2) Qualifications. (3) A copy of limited criminal history pursuant to IC 16-27-2. (4) A copy of current license, certification, or registration. (5) Annual performance evaluations. Based on record review and interview, the agency failed to ensure personnel files were current and complete in relation to having documentation that an employee signed a job description for 4 (Employee A, B, E, & I) of 14 employee records reviewed; failed to ensure documentation of orientation to their position in their employee record for 7 (Employee B, E, G, I, L, M, & N) of 14 employee records reviewed; failed to evidence a performance evaluation for the most recent annual appraisal period for 9 (Employee A, B, D, E, G, I, L, M, & N) of 14 employee records reviewed; failed to ensure license and/or certifications were verified for 3 (Employees B, I & M) of 14 employee records reviewed; failed to evidence an expanded or national criminal background checks within 3	N 0458	The Administrator/Director of Operations, or Office Manager of the agency will be responsible for the correcting of this deficiency. All active clinical staff and management staff will receive training on the following policies/procedures and will be documented and evidenced on sign-in sheet. Policy HR-001(a). Personnel File Requirements for Agency Staff Policy HR-007. Background checks Employee personnel records	03/31/2021

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	days of hire pursuant to IC: 16-27-2 for 2 (Employees B & I) of 14 employee records reviewed . Findings Include: 1. Review of agency policy titled "Background Checks" with last revision date of 12/20/19, stated: ". . . A home health agency or personal services agency may not employ a person to provide services in a patient's or client's temporary or permanent residence for more than three (3) business days without applying for a national criminal history background check or an expanded criminal history check. . ." Review of agency policy titled "Home Health Aide Monthly In-service Training", last revised 1/2018, stated: ". . . Documentation of orientation and continuing education must include the dates(s) and hour(s), content, and name and title of the person providing the orientation/education. It is the responsibility of the home health agency to ensure that employees/contractors are proficient to carry out the care assigned in a safe, effective and efficient manner. All newly hired employees and contractors must pass a competency evaluation test prior to providing care to patients and annually thereafter. . ." 2. Review of the Administrator's (Employee A) record, failed to evidence the presence of a signed and dated Administrator job description. Review of the Alternate Administrator's (Employee B) record failed to evidence the presence of a signed and dated Alternate Administrator job description. Review of Registered Nurse's (Employee E) record		either paper-based or electronic will include: · Receipt of job description § Each active and new hire employee will be given a job description to review and sign. This will be filed in the employee's personnel file. · Qualifications/Credentials · Pursuant to IC 16-27-2, a national criminal history or expanded criminal history check § Each employee personnel file will contain national criminal history or expanded criminal history. · A copy of current license, certification, or registration. § Each active and new hire employee personnel file will have copy of current licensure, certification, or registration required to perform their respective service. · Annual performance evaluation § Each employee will receive an annual performance evaluation based on the standards of the job description. § The performance evaluation will be signed by the supervisor and the employee § The evaluation will be placed in the employee personnel file and copy of the evaluation provided to the employee. · Annual skills competency § Qualified personnel will observe and evaluate each direct	

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	failed to evidence the presence of a signed and dated registered nurse job description. Review of Physical Therapist's (Employee I) record failed to evidence the presence of a signed and dated physical therapist job description. 3. Review of the Alternate Administrator's (Employee B) record failed to evidence orientation to her Alternate Administrator's position. Review of Registered Nurse's (Employee E) record failed to evidence orientation to her registered nurse position. Review of Licensed Practical Nurse's (Employee G) record failed to evidence orientation to her licensed practical nurse position. Review of Physical Therapist's (Employee I) record failed to evidence orientation to her physical therapist position. Review of Medical Social Work's (Employee L) record failed to evidence orientation to her medical social work position. Review of Home Health Aide's (Employee M) record failed to evidence orientation to her home health aide position. Review of Home Health Aide's (Employee N) record failed to evidence orientation to her home health aide position. 4. Review of the following employee records failed to evidence the most current period performance evaluations signed, dated & timed by both the author and the following employees: Alternate Administrator (Employee A) with date of hire of 8-8-16; Alternate Administrator (Employee B) with date of hire 5-4-12; Registered Nurse (Employee		service/care staff performing their job duties no less than annually to ensure all patient care is provided in compliance with professional and industry standards and principles. § Annual skills competency checklist will be placed in each active clinical staff employee personnel file · On-Hire skills competency § Each employee will be oriented to their position and the company as evidenced by completion of the Orientation Checklist during the 90-day orientation period. § The Orientation Checklist will be placed in the employee personnel file. · Pursuant to Ind Code IC 16-27-2.5-2 § Applicable employees will receive a drug screen upon hire, prior to having contact with any patient. Drug screen results will be placed in employee file. § Home Health Aides will receive annual drug screens with a copy of results placed in employee personnel file. Monitoring process: · Administrator/Director of Operations/Office Manager or designee will audit the personnel file of each active employee by 3/31/2021. · Administrator/Director of Operations/Office Manager or designee will review any employee	

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	D) with date of hire of 2-16-15; Registered Nurse (Employee E) with date of hire of 9-17-18; Licensed Practical Nurse (Employee G) with date of hire 4-29-19; Physical Therapist (Employee I) with date of hire of 7-13-15; Medical Social Worker (Employee L) with date of hire of 6-29-15; Home Health Aide (Employee M) with date of hire 9-10-18; & Home Health Aide (Employee N) with date of hire of 10-15-18. 5. Review of employee record for the Alternate Administrator & Registered Nurse, (Employee B) failed to evidence the presence of a current and active registered nurse license. Review of the employee record for Physical Therapist (Employee I) failed to evidence the presence of a current and active physical therapy license. Review of the employee record for Home Health Aide (Employee M) failed to evidence the presence of a current and active home health aide license or registry listing. 6. Review of Alternate Administrator & Registered Nurse (Employee B) record with date of hire of 5-4-12, failed to evidence the completion of a criminal history check. Review of Physical Therapist's (Employee I) record with date of hire of 7-13-15, failed to evidence the completion of a criminal history check. Employee M's personnel file further failed to evidence verification of Employee M's home health aide license, an annual employee performance evaluation, orientation to her position of home health aide and competency		file for those hired within the previous calendar month the by the last business day of the current calendar month to ensure completeness of employee personnel files according to agency policy. · Administrator will audit no less than 1 personnel files combined between parent and branch agency, at least monthly for 6 months or until 100% compliance is achieved with personnel file policies and regulations. · Branch Director of Operations will audit no less than 1 employee personnel file monthly for no less than 6 months or until 100% compliance is achieved with personnel file policies and regulations. Office Manager or designee will immediately notify Administrator/Director of Operations of any missing components of employee files prompting an immediate resolution. · Administrator/Director of Operations/Office Manager in collaboration with Human Resources will ensure personnel files are accurate, complete, and current for each employee yearly and within 2 weeks of new hire date.	

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	testing of skills via test and/or observation of skills. 7. On 2/2/21 at 3:45 p.m., when queried for additional information regarding the above, the Administrator was without comment & provided nothing further.			
N 9999 Bldg. 00	410 IAC 16-27-2.5 Sec. 1. (a) After giving a job applicant written notice of the home health agency's drug testing policy, a home health agency shall require a job applicant who is seeking employment with the home health agency for a position that will have direct contact with a patient to be tested for the illegal use of a controlled substance...(c) If a job applicant is hired by the home health agency before the job applicant's results of the drug test are received, the hired individual may not have any contact with patients until the home health agency obtains results of the drug test that indicate that the individual tested negative on the drug test.... Based on personnel file review and interview, the administrator failed to ensure the personnel files of 2 home health aides contained evidence of completion of a negative urine drug screen, as required by Indiana Code 16-27-2.5, upon hire and prior to first patient contact for 2 (Employees M and N) of 2 home health aides employed after 7-1-2017, of a total sample of 2 personnel records of home health aides. Findings included:	N 9999	The Administrator/Director of Operations, or Office Manager of the agency will be responsible for the correcting of this deficiency. All active clinical staff and management staff will receive training on the following policies/procedures and will be documented and evidenced on sign-in sheet. Policy HR-001(a). Personnel File Requirements for Agency Staff · Pursuant to Ind Code IC 16-27-2.5-2 § Applicable employees will receive a drug screen upon hire, prior to having contact with any patient. Drug screen results will be placed in employee file. § Home Health Aides will receive annual drug screens with a copy of results placed in employee personnel file. Monitoring process: · Administrator/Director of Operations/Office Manager or designee will audit the personnel file of each active employee by	03/31/2021

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	Review of agency policy titled "Background Checks" with last revision date of 12/20/19, stated: ". . . Affected employees: The statutory requirement for mandatory drug testing is applicable to any applicant or employee that will or does have direct contact with patients AND is not licensed under Ind Code § 25. [Ind. Code 16-27-2.5-05; Ind. Code § 16-27-2.5-2(b)(1)(A) & (B)] . . . Frequency of testing: All affected employees must submit to, and successfully pass a drug test at the time of hire. . ." Review of Home Health Aide, Employee M's personnel file, date of hire 9/10/18, failed to evidence the performance of a urine drug test at the time of hire and prior to first patient contact of 9/17/18. Review of Home Health Aide, Employee N's personnel file, date of hire 10/15/18, failed to evidence the performance of a urine drug test at the time of hire and prior to first patient contact of 11/6/18. On 2/2/21 at 3:45 p.m., when queried for additional information regarding the above, the Administrator provided nothing further.		3/31/2021. · Administrator/Director of Operations/Office Manager or designee will review any employee file for those hired within the previous calendar month the by the last business day of the current calendar month to ensure completeness of employee personnel files according to agency policy. · Administrator will audit no less than 1 personnel files combined between parent and branch agency, at least monthly for 6 months or until 100% compliance is achieved with personnel file policies and regulations. · Branch Director of Operations will audit no less than 1 employee personnel file monthly for no less than 6 months or until 100% compliance is achieved with personnel file policies and regulations. Office Manager or designee will immediately notify Administrator/Director of Operations of any missing components of employee files prompting an immediate resolution. · Administrator/Director of Operations/Office Manager in collaboration with Human Resources will ensure personnel files are accurate, complete, and current for each employee yearly and within 2 weeks of new hire date.	

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