STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15K153	A. BUILDING 00 B. WING	09/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AM - PM HOME HEALTH SERVICES LLC	7920 GEORGETOWN ROAD #600 INDIANAPOLIS, IN 46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
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. Facility #: 014070 Survey dates: 9-22, 9-23, 9-24, and 9-25-2020 Skilled Unduplicated Admissions in prior 12 months: 4 Current Census: Skilled Services: 4 Unskilled: 51 Total: 55	E 0000		
E 0006 Bldg. 00	403.748(a)(1)-(2), 416.54(a)(1)-(2), 418.113(a)(1)-(2), 441.184(a)(1)-(2), 482.15(a)(1)-(2), 483.475(a)(1)-(2), 483.73(a)(1)-(2), 484.102(a)(1)-(2), 485.625(a)(1)-(2), 485.68(a)(1)-(2), 485.727(a)(1)-(2), 485.920(a)(1)-(2), 486.360(a)(1)-(2), 491.12(a)(1)-(2), 494.62(a)(1)-(2) Plan Based on All Hazards Risk Assessment [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:]			

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

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	(1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. *[For LTC facilities at §483.73(a)(1):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a)(1):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness			

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	plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. Based on record review and interview, the agency failed to develop and implement an all hazard approach to their emergency preparedness plan that included emerging infectious disease and strategies for addressing the emergency events identified in their hazard vulnerability analysis for 1 of 1 agency. Findings included: On 9-23-2020 at 12:45 p.m., review of provided agency document titled: "Preparing for an Emergency", failed to evidence the inclusion of emerging infectious disease into their policy/plan On 9-23-2020 at 1:00 p.m., review of provided agency policy titled "Emergency Management Policy" evidenced a 20 item list of technological events and a 14 item list of human events, prioritized for probability, risk and preparedness from the American Society for Healthcare Engineering and addressed by the agency as their hazard vulnerability analysis. This document failed to evidence emerging infectious diseases into the potential event list. A review of the above provided documents failed	E 0006	E0006 AM PM DON and clinical staff have developed and implemented a communication plan to include a Chain of Command Communication Tree which identifies staff members responsible for the notification of clients in the event of an emergency on the local, state, and federal level. This process includes utilization of Policy B-400 "Home Care Emergency Procedures" which classifies each clients level of priority to be completed upon initiation of care. AM PM DON has met with clinical staff on 10/26/20 to update and inform them of their responsibilities identified on the Chain of Command Communication Tree. The Emergency Management Policy will be updated to reflect these changes by 10/26/20. The Communication tree will be	10/26/2020

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	to evidence the agency included emerging infectious diseases as well as strategies for addressing potential emergency events identified by the hazard vulnerability analysis. On 9-25-2020 at 2:30 p.m., the Alternate Administrator and Owner acknowledged the lack of emerging infectious disease in their emergency plan and the lack of a strategies to address the hazard analysis, and when queried, provided nothing further.		reviewed and updated annually to reflect any changes in staff and/or specific staff responsibilities as warranted. The DON and/or designee will be responsible for monitoring these corrective actions annually to ensure that this deficiency is corrected and will not recur.	
E 0021 Bldg. 00	484.102(b)(3) HHA- Procedures for Follow up Staff/Pts. [(b) Policies and procedures. The HHA 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.] At a minimum, the policies and procedures must address the following:] (3) The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact. Based on record review and interview, the agency failed to include policies and procedures to inform state and local officials of any on-duty staff or patients that they were unable to be contacted during or due to an emergency for 1 of 1 agency. Findings Included:	E 0021	E0021 AM PM DON and clinical staff has revised and implemented AM PM Emergency Information folder and "Preparing for an Emergency" document to include a process to inform state and local officials of	12/04/2020

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	On 9-23-2020 at 12:45 p.m., review of provided agency document titled: "Preparing for an Emergency", failed to evidence identification of state and/or local emergency officials and a plan or process to inform said officials if they were unable to contact staff and/or patients. On 9-23-2020 at 1:00 p.m., review of provided agency policy titled "Emergency Management Policy", failed to evidence identification of state and/or local emergency officials and a plan or process to inform said officials if they were unable to contact staff and/or patients. On 9-25-2020 at 2:30 p.m., the Alternate Administrator and Owner acknowledged the lack of process that includes the identification/list of local and/or state emergency officials to contact in an emergency, and when queried, provided nothing further.		any on-duty staff or patients in the event that AM PM staff are unable to contact staff or patients during or due to an emergency. AM PM will also revise policy B-400 "Emergency Management Policy" to include a procedure for informing local and state officials for notification of inability to contact staff or clients in the event of an emergency by 12/04/20. AM PM DON and clinical staff will update and utilize Policy B-400 "Home Care Emergency Procedures" (Document for SOC packet) and include level of priority for each client in Plan of care as notification to PCP of AM PM's emergency Plan for the client and will include brief explanation of what that level means for the client in the event of an emergency. Policy B-400 will include community officials and resources such as the local fire department, red cross, IMPD, and local church organizations for assistance when unable to contact staff or clients in the event of an emergency. 10% of charts will be audited quarterly, and the policy will be reviewed and revised as needed annually by the DON and/or designee to ensure compliance with these corrective actions. The DON and/or designee will be responsible for monitoring these	

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			corrective actions annually to ensure that this deficiency is corrected and will not recur.	
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 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			

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	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 the their roles for integration with health care professionals during the disaster/emergency for 1 of 1 home health agency disaster preparedness plan. Findings Included: On 9-23-2020 at 12:45 p.m., review of provided agency document titled: Preparing for an Emergency", failed to evidence the use of volunteers into their policy/plan. On 9-23-2020 at 1:00 p.m., review of provided agency policy titled "Emergency Management Policy", failed to evidence the use of volunteers into their policy/plan. On 9-25-2020 at 2:30 p.m., the Alternate Administrator and Owner acknowledged the lack of volunteers in their emergency plan and when queried, provided nothing further.	E 0024	E0024 AM PM clinical staff will contact local Pike Township Fire Dept., IMPD-West Side District, Red Cross, Mt. Pleasant MBC, a local area hospital, and Coalition Area 5 to solicit volunteers for service during a disaster or emergency, including their roles for integration with agency health care professionals during the disaster/emergency by 10/27/2020. AM PM DON will update the document "Preparing for an Emergency" by 12/04/20 (pending confirmation from all entities to partner) to include these entities and develop and maintain a partnership with agreeing community organizations for assistance in the event of a disaster or emergency. The Emergency Management Policy has been revised to include the process of contacting and maintaining a relationship with those entities, local officials and organizations who agree to be a resource for our agency in the event of a disaster or emergency. HR and or designee will maintain annual contact with the above listed local officials/organizations	12/04/2020

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			to ensure continued availability for assistance in the event of an emergency or disaster. The Emergency Management Policy will be reviewed and revised as needed annually by the DON and/or designee to ensure compliance with these corrective actions. The DON and/or designee will be responsible for monitoring these corrective actions annually to ensure that this deficiency is corrected and will not recur.	
E 0029 Bldg. 00	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC). Based on record review and interview, the agency failed to ensure the development and implementation of an emergency communication plan for 1 of 1 agency. Findings include: On 9-23-2020 at 12:45 p.m., review of provided agency document titled: Preparing for an Emergency", failed to evidence the development and implementation of an agency specific	E 0029	E0029 AM PM DON and clinical staff has updated Policy B-400 Emergency Management policy to include a specific emergency communication plan for AM PM in the event of a disaster or emergency. AM PM DON has held a meeting with all clinical staff on 10/23/20 to review each members role in the	10/23/2020

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	communication plan for use in an emergency. On 9-23-2020 at 1:00 p.m., review of provided agency policy titled "Emergency Management Policy", failed to evidence the development and implementation of an agency specific communication plan for use in an emergency. During an interview on 9-22-2020 at 12:30 p.m., the Alternate Administrator and Owner acknowledged the lack of an emergency communication plan. On 9-25-2020 at 2:30 p.m., when queried for additional information regarding a communication plan, the Alternate Administrator and Owner provided nothing further.		Communication Plan. The Emergency Management Policy and Communication Plan will be reviewed and revised as needed annually to reflect any changes in staff and/or roles by the DON and/or designee to ensure compliance with these corrective actions. The DON and/or designee will be responsible for monitoring these corrective actions annually to ensure that this deficiency is corrected and will not recur.	
E 0033 Bldg. 00	403.748(c)(4)-(6), 416.54(c)(4)-(6), 418.113(c)(4)-(6), 441.184(c)(4)-(6), 482.15(c)(4)-(6), 483.475(c)(4)-(6), 483.73(c)(4)-(6), 484.102(c)(4)-(5), 485.625(c)(4)-(6), 485.68(c)(4), 485.727(c)(4), 485.920(c)(4)-(6), 491.12(c)(4), 494.62(c)(4)-(6) Methods for Sharing Information [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to			

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	release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.102(c), CORFs under §485.68(c)] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).			
	Based on record review and interview, the facility failed to develop a method for sharing information and medical documentation for patients under the agency's care during disaster relief purposes for 1 of 1 agency emergency preparedness plan. Findings Included: On 9-23-2020 at 12:45 p.m., review of provided agency document titled: "Preparing for an Emergency", failed to evidence a plan for sharing of information and medical documentation for patients under the agency's care during a disaster/emergency. On 9-23-2020 at 1:00 p.m., review of provided agency policy titled "Emergency Management	E 0033	E0033 AM PM DON has revised the Patient Emergency Plan document and included a patient signature line to implement a plan for sharing of information and medical documentation for patients under the agency's care during a disaster and/or emergency. The "Patient Emergency Plan" document will include local agencies (IMPD, Fire dept, ambulance), PCP, hospital of patient's choice, and an emergency contact person the patient agrees may be contacted and informed of health information	12/04/2020

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	Policy", failed to evidence a plan for sharing of information and medical documentation for patients under the agency's care during a disaster/emergency. During an interview on 9-22-2020 at 12:30 p.m., the Alternate Administrator and Owner acknowledged the lack of policy/plan for the release of protected health information and sharing of patient information during an emergency. On 9-25-2020 at 2:30 p.m., when queried for additional information regarding release of protected health information and/or sharing of patient information, the Alternate Administrator and Owner provided nothing further.		in the event of an emergency. B-400 Emergency Management Policy will be updated to reflect these changes by 10/27/20. The DON and clinical staff will update current client charts with the updated Emergency Plan Document form and obtain signatures from clients by 12/04/2020. The DON and/or designee will audit 10% of charts quarterly to ensure compliance with the updated form and its completion. The Emergency Management Policy will be reviewed and revised if necessary annually by the DON and/or designee to ensure compliance with these corrective actions. The DON and/or designee will be responsible for monitoring these corrective actions annually to ensure that this deficiency is corrected and will not recur.	
G 0000 Bldg. 00	This visit was for a Federal Recertification, a Focused Infection Control, and a State Licensure survey of a home health agency. This survey was announced as partial extended on 9-25-2020, at 2:30 p.m.	G 0000		

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	Facility #: 014070 Survey dates: 9-22, 9-23, 9-24, and 9-25-2020 Skilled Unduplicated Admissions in prior 12 months: 4 Current Census: Skilled Services: 4 Unskilled: 51 Total: 55 Record Review: Record reviews with home visit: 3 Record review only: 4 Active record reviews 5 Discharged record reviews 2 Total clinical records reviewed: 7 These deficiencies reflect State Findings in accordance with 410 IAC 17. Refer to state form for additional state findings. Quality Review completed on 10/5/2020 A4			

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G 0766 Bldg. 00	484.80(b)(4) HHA maintains documentation of training The HHA must maintain documentation that demonstrates that the requirements of this standard have been met. Based on record review and interview, the agency failed to maintain and provide documentation of home health aide competency evaluation and skills check-off for 2 (Employee C & E) of 3 home health aide records reviewed. Findings Included: Review of provided personnel file for home health aide, Employee C, date of hire 10-1-2017 and first patient contact of December 2018, failed to evidence documentation of home health aide competency testing and/or evaluation of skills for a home health aide. Review of provided personnel file for home health aide, Employee E, date of hire 11-20-2017 and a first patient contact of December 2017, failed to evidence documentation of home health aide competency testing and/or evaluation of skills for a home health aide. On 9-25-2020 at 2:30 p.m., the Alternate Administrator and Owner acknowledged the above findings and when queried, provide nothing further. 17-14-1(l)(2)	G 0766	G0766 AM PM DON and clinical staff will update and individualize current HHA Competency Checklist, completed upon hire by 12/04/20. AM PM HR will maintain documentation of home health aide competency evaluation, skills check-off, and HHA competency assessment exam in each employee file upon hire and prior to initial patient contact. HR has audited employee files to ensure completion and inclusion of the Home health aide competency evaluation, skills check off, and HHA competency assessment exam in each employee file. DON and/or designee will ensure maintenance of employee files related to home health aide competency annually. AM PM DON, HR, and/or designee will complete new hire chart audits upon hire of new employees prior to 1st patient contact to ensure completion of employee file. HR will complete quarterly audits of 10% of Personnel files to monitor these corrective actions to ensure this deficiency is corrected and will not recur.	12/04/2020

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	15K153	A. BUILDING 00 B. WING	09/25/2020

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AM - PM HOME HEALTH SERVICES LLC	7920 GEORGETOWN ROAD #600 INDIANAPOLIS, IN 46268

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G 0798 Bldg. 00	484.80(g)(1) Home health aide assignments and duties Standard: Home health aide assignments and duties. Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional, with written patient care instructions for a home health aide prepared by that registered nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist). Based on record review and interview, the agency failed to ensure the Registered Nurse provided current and complete written care instructions for the home health aide in 1 (Patient #5) of 2 aide home visits in a total sample of 7 clinical records. Findings include: Review of Patient #5's clinical record evidenced a start of care of 10-31-19, a certification period of 8-26-2020 to 10-24-2020, and a diagnosis of ESRD (end stage renal disease or kidney failure) and on dialysis with treatments on Monday, Wednesday & Friday and Diabetes (elevated blood sugar), with orders for home health aide services for 12 hours per day, 7 days per week. The Aide plan of care or assignment sheet failed to evidence Patient #5's travel to dialysis, dialysis treatment length, days and times of treatment or any dietary and/or fluid precautions/limitations due to Patient #5's kidney failure. On 9-25-2020 at 2:30 p.m., the Alternate Administrator, Owner and Patient #5's primary	G 0798	G0798 AM PM DON has educated clinical staff/RN to include in each aide plan of care current and complete written care instructions for the home health aide to include but not limited to, patient specific dietary/fluid restrictions and dialysis schedule including travel time. SN/RN will case conference with primary care providers, dialysis centers, patients private transportation and/or waiver services to coordinate care and will document in patient chart under the Case Conference Summary document. Skilled nursing will contact/case conference with current patients' PCP and/or dialysis centers for orders and review and update home health aid care plans to reflect specific dietary restrictions, dialysis schedules, and	12/04/2020

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	Registered Nurse, Employee D acknowledged the above findings and when queried, provided nothing further. 17-14-1(m)		transportation arrangements if applicable. **DON and/or designee will complete quarterly charts audits on 10% of all charts to monitor these corrective actions: dietary/fluid restrictions specific to each client and care coordination with dialysis centers, other agencies involved, and transportation arrangements included in plan of care.** DON and/or designee will be responsible for monitoring these corrective actions annually to ensure that this deficiency is corrected and will not recur.	
N 0000 Bldg. 00	This visit was for a State Licensure survey of a home health agency. Facility #: 014070 Survey dates: 9-22, 9-23, 9-24, and 9-25-2020 Skilled Unduplicated Admissions in prior 12 months: 4 Current Census: Skilled Services: 4	N 0000		

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	Unskilled: 51 Total: 55 Record Review: Record reviews with home visit: 3 Record review only: 4 Active record reviews 5 Discharged record reviews 2 Total clinical records reviewed: 7			
N 0460 Bldg. 00	410 IAC 17-12-1(g) Home health agency administration/management 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) Limited criminal history pursuant to IC 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.			

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	Based on record review and interview, the agency failed to ensure provide personnel files were current and complete in relation to having documentation that an employee signed a job description for 3 (Employee C, D, & E) of 6 personnel files reviewed; failed to ensure documentation of orientation to their position in their personnel file for 3 (Employee C, D, & E) of 6 personnel files reviewed; failed to evidence a performance evaluation for the most recent annual appraisal period for 3 (Employee C, D, & E) of 6 employees. Findings included: Review of Home Health Aide, Employee C's personnel record, date of hire 10-1-2017, failed to evidence the presence of a signed Home Health Aide job description, orientation to the home health aide position, and a performance evaluation for the most recent annual appraisal period. Review of Registered Nurse, Employee D's personnel record, date of hire 3-15-2019, failed to evidence the presence of a signed Registered Nurse job description, orientation to the registered nurse position, and a performance evaluation for the most recent annual appraisal period. Review of Home Health Aide, Employee E's personnel record, date of hire 11-20-17, failed to evidence the presence of a signed Home Health Aide job description, orientation to the Home Health Aide position, and a performance evaluation for the most recent annual appraisal period. On 9-25-2020 at 2:30 p.m., the Alternate Administrator and Owner acknowledged the	N 0460	N0460 AM-PM Home Health Services Human Resource has reviewed employee personnel files and ensured that all employee files contain the appropriate job descriptions signed by the employee. AM PM HR and DON has reviewed job descriptions with staff to ensure they understand their job description prior to signing the form. AM-PM Home Health Services Human Resources has implemented 180 day performance evaluations for all employees that have been employed for 180 days and has revised AM PM policies D-260 to reflect this requirement. AM PM HR and DON will ensure each employee has completed the orientation checklist and include in their employee files. AM PM DON will implement and create separate orientation checklists specific to nursing and HHA by 11/07/2020. HR will do new hire chart audits upon hire of new employees prior to 1st patient contact to ensure completion of employee file. HR will also perform 10% of personnel file audits monthly. AM PM DON and HR will coordinate together and take responsibility to monitor these	11/07/2020

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	above findings and when queried, provided nothing further.		corrective actions annually to ensure that this deficiency is corrected and will not recur.	
N 0488 Bldg. 00	410 IAC 17-12-2(i) and (j) Q A and performance improvement Rule 12 Sec. 2(i) A home health agency must develop and implement a policy requiring a notice of discharge of service to the patient, the patient's legal representative, or other individual responsible for the patient's care at least fifteen (15) calendar days before the services are stopped. (j) The fifteen (15) day period described in subsection (i) of this rule does not apply in the following circumstances: (1) The health, safety, and/or welfare of the home health agency's employees would be at immediate and significant risk if the home health agency continued to provide services to the patient. (2) The patient refuses the home health agency's services. (3) The patient's services are no longer reimbursable based on applicable reimbursement requirements and the home health agency informs the patient of community resources to assist the patient following discharge; or (4) The patient no longer meets applicable regulatory criteria, such as lack of physician's order, and the home health agency informs the patient of community resources to assist the patient following discharge. Based on record review and interview, the agency failed to develop and implement a policy for a 15 day notice of impending patient discharge for 1 of 1 agency with the potential to impact all 55 agency	N 0488	N-0488 Director of Nursing (DON) has updated Policy C-500 "Client Discharge Process" to reflect the	10/23/2020

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	patients. Findings included: Review of an undated agency policy titled "Client Discharge Process" stated ". . . clients are told in a timely manner of the need to plan for discharge, but at least five (5) calendar days before services are stopped . . ." On 9-25-2020 at 2:30 p.m., the Alternate Administrator and Owner acknowledged the agency's policy of 5 day notice of discharge and when queried regarding the requirement of a 15 day notice of discharge, provided nothing further.		15 day notification of impending patient discharge (10/23/20). Nurses will discontinue the five (5) day notification of impending discharge immediately and begin using the updated policy attached (10/23/20). DON held in-service with RN case managers to educate on policy change and requirements (10/23/20). Going forward, 100% of all discharged clients charts will be audited by DON or designee for one quarter for evidence that a 15 day notice of impending patient discharge is given as applicable. Going forward, 10% of all discharged clients charts will be audited quarterly for compliance with this corrective action. AM PM DON or designee will be responsible for monitoring these corrective actions quarterly to ensure that this deficiency is corrected and will not recur.	